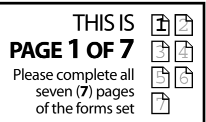
Hartford Headache Center, LLC - **NO SHOW POLICY**

TANYA R. BILCHIK, M.D. DENISE McGRATH, APRN
144 Main Street, Suite D, East Hartford, CT 06118 TEL: 860-895-3133 FAX: 860-895-3131



To Our Valued Patients:

The Hartford Headache Center has instituted a "**NO SHOW**" policy.

Giving our undivided attention to each and every patient is important to us, as we're sure it is to you. We block out the time for your visit accordingly. In fairness to all patients and as a courtesy to our staff, please call our office at your earliest convenience upon becoming aware of potential conflicts with your scheduled appointment time.

PLEASE PROVIDE AT LEAST 24 HR. NOTICE OF ANY CANCELLATION OR RESCHEDULE. The Hartford Headache Center reserves the right to charge you a **$200** administrative fee for any non-emergency cancellation of an initial visit, or $40 for a follow-up visit.

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*I have read the above policy and understand that I will pay Hartford Headache Center, LLC the sum of **$200** in the event that I fail to show up for an initial (first visit) appointment, or **$40** for a follow-up visit, if I fail to provide at least 24 hours notice of cancellation.*

Signature: ______________________________

Patient Name: ______________________________

Date: ______________________________

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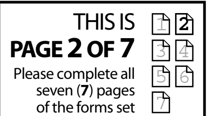

HIPAA/PRIVACY NOTICE

As a patient of Hartford Headache Center, we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Hartford Headache Center is providing you, the patient or the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

Our policy is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients,

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Hartford Headache Center in connection with providing health care treatment, obtaining payment and related health care operations. This relates to past, present or future information that Hartford Headache Center receives from you as our patient.

We will use this information to provide caring and quality medical care to you. Examples of PHI include diagnosis, treatment, and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most efficient manner. For insurance carriers, your information will be used for claims submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and precertification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. Hartford Headache Center limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amount of information provided to that which is "minimally necessary" in order to carry out their work. We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. Hartford Headache Center will provide you with an Authorization Form that will need to be signed by you, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian, at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers' Compensation purposes.

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any requests for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Hartford Headache Center, will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges. If you have any questions, comments or complaints regarding the management of your PHI, please contact the office at 860-895-3133 and ask for the practice manager.

*I acknowledge that I have received the above **Hartford Headache Center Privacy Notice**.*

Patient Name: ____

Date: ____________________

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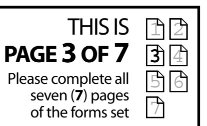

CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I AUTHORIZE to Hartford Headache Center use & disclosure of all individual identifiable personal, health, financial, & demographic information (known as Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment & reimbursement
- Obtaining authorizations from my insurance for test (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purpose & all other uses are known collectively as Treatment, Payment, & Other healthcare options or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to Hartford Headache Center, when needed for the purpose of TPO.

I CONSENT to **Hartford Headache Center** discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).

1. ______________________ Relationship: ______________________
2. ______________________ Relationship: ______________________
3. ______________________ Relationship: ______________________
4. ______________________ Relationship: ______________________
5. ______________________ Relationship: ______________________

I CONSENT to Hartford Headache Center leaving messages on my answering machine, voice mail or cell phone.

I have been given the opportunity to review Hartford Headache Center, Privacy Notice.

I understand my rights to restrict the use & discloser of PHI & to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms & conditions of Hartford Headache Center Privacy Notice, the practice has the right to & will withhold treatment except where required by law.

PATIENT NAME: ____

PATIENT'S SIGNATURE: ______________________________ DATE: ____________

(If indicated) INSURED OR GUARDIAN'S SIGNATURE: ______________________ DATE: ____________

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and discloser of protective health information for treatments, payments, & other healthcare operations without a signed consent & prohibits the use and discloser of protective health information for non healthcare related activities without specific & explicit authorization.

Hartford Headache Center - **Initial Consultation Questionnaire**

TANYA R. BILCHIK, M.D. DENISE McGRATH, APRN
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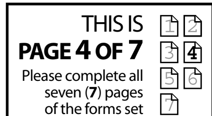

Patient Name: ______________________________ Date: ______________

What are your expections for this visit?: ______________________________

____

MEDICAL HISTORY Answer each by checking *Y*es or *N*o

- Y N Bleeding/clotting disorder
- Y N Diabetes
- Y N Hypertension
- Y N Cancer (if yes, type) ______________
- Y N Stroke
- Y N Heart disease
- Y N Arthritis
- Y N Convulsions/seizure
- Y N Asthma/lung problems
- Y N Depression/anxiety
- Y N Back pain
- Y N Fibromyalgia
- Y N Thyroid disease

(WOMEN) Last period: ______________

❑ Regular ❑ Irregular

Past surgery or hospitalization: *explain, include dates* ______________

____

____

____

____

Medications: list meds taken on *regular basis*, and *as-needed* ______________

______________ How much and how often? ______________

______________ How much and how often? ______________

______________ How much and how often? ______________

______________ How much and how often? ______________

______________ How much and how often? ______________

Other medical conditions: ______________________________

Check medications previously tried for headache:

❑ Amitriphyline/Nortriphyline
❑ Inderal/Propanolol
❑ Verapamil
❑ Prozac ❑ Zoloft ❑ Paxil ❑ Wellbutrin ❑ Effexor ❑ Cymbalta
❑ Depakote ❑ Topamax ❑ Neurontin ❑ Lyrica
❑ DHE 45 ❑ Cafergot ❑ Periactin
❑ Fioricet/Fiorinol
❑ Midrin
❑ Imitrex ❑ Maxalt ❑ Zomig ❑ Axert ❑ Amerge ❑ Frova ❑ Relpax
❑ Percocet ❑ Vicodin ❑ Codiene ❑ Tylenol & Codiene ❑ Oxycodone ❑ Ultram
❑ Promethazine/Compazine ❑ Metoclooprimide/Reglan ❑ Plochlorperazine/Phenergan

FAMILY HISTORY	AGE	ANY DISEASES?	IF DECEASED, CAUSE OF DEATH
Mother:			
Father:			
Siblings:			
Spouse:			
Children:			

Have you seen a neurologist before? Y N If YES, when/where? ______________

Have you had a: ❑ **CAT SCAN** ❑ **MRI** detail: when/where/why? ______________

____

❑ **Spinal Tap** when/where? ______________

❑ **ER visit for migraine?** when/what did you receive? ______________

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Patient Name: ______________________ **Date:** __________

REVIEW OF SYSTEMS
MARK EACH BOX YES OR NO

CONSTITUTIONAL SYMPTOMS - General
- Y N Fever
- Y N Fatigue
- Y N Headaches
- Y N Family history of headaches

EYES
- Y N Eye disease or injury
- Y N Wear glasses/contact lens
- Y N Blurred or double vision
- Y N Glaucoma
- Y N Family history of eye disease

EARS/NOSE/MOUTH/THROAT
- Y N Hearing loss or ringing in the ear
- Y N Earaches or drainage
- Y N Chronic sinus problem or rhinitis
- Y N Nose bleeds
- Y N Mouth sores
- Y N Sinus surgery
- Y N Sore throat or voice change
- Y N Swollen glands in neck
- Y N Family history of hearing loss

CARDIOVASCULAR
- Y N Heart trouble
- Y N Chest pain or angina
- Y N Palpitations
- Y N Shortness of breath when walking
- Y N Swelling in the feet or ankles
- Y N Family history of heart disease

RESPIRATORY
- Y N Chronic or frequent coughs
- Y N Spitting up food
- Y N Shortness of breath
- Y N Asthma or wheezing
- Y N Family history of lung problems

GASTROINTESTINAL
- Y N Loss of appetite
- Y N Irritable bowel syndrome
- Y N Nausea or vomiting
- Y N Frequent diarrhea
- Y N Constipation
- Y N Rectal bleeding
- Y N Abdominal pain or heartburn
- Y N Peptic ulcer
- Y N Family history of gastro intestinal problems

GENTOURINARY
- Y N Frequent urination
- Y N Incontinence or dribbling
- Y N Change in force of stream when urinating
- Y N Kidney stones
- Y N Sexual difficulty
- Y N Female: number of pregnancies __________
- Y N Female: irregular menstruation
- Y N Female: pain with menstruation
- Y N Family history of urinary problems

L R Are you **LEFT** or **RIGHT** handed?

MUSCULOSKELETAL
- Y N Joint pain
- Y N Joint stiffness or swelling
- Y N Weakness of muscles or joints
- Y N Muscle pain or cramps
- Y N Back pain
- Y N Cold extremities
- Y N Difficulty walking
- Y N Neck pain

INTEGUMENTARY/SKIN and BREAST
- Y N Rash or itching
- Y N Change in nails and hair
- Y N Varicose veins
- Y N Raynaud's syndrome
- Y N Breast lump

NEUROLOGICAL
- Y N Stroke
- Y N Frequent or recurring headaches
- Y N Lightheaded or dizziness
- Y N Convulsions or seizures
- Y N Numbness or tingling sensation
- Y N Tremors
- Y N Paralysis
- Y N Head injury
- Y N Family history of stroke
- Y N Family history of dementia

PSYCHIATRIC
- Y N Depression
- Y N Memory loss or confusion
- Y N Family history of depression
- Y N Insomnia
- Y N Anxiety

ENDOCRINE
- Y N Glandular or hormone problems
- Y N Thyroid disease
- Y N Diabetes
- Y N Excessive thirst or urination
- Y N Heat or cold intolerance
- Y N Family history of thyroid disease
- Y N Family history of diabetes

HEMATOLOGICAL/LYMPHATIC
- Y N Enlarged glands
- Y N Slow to heal after cuts
- Y N Bleeding or bruising tendency
- Y N Anemia
- Y N Phlebitis
- Y N Past blood transfusion
- Y N Family history of bleeding disorders

ALLERGIC/IMMUNOLOGIC
History of rash or an adverse reaction to:
- Y N Penicillin or other antibiotics
- Y N Morphine, demoral, narcotics
- Y N Novocaine, anesthetics
- Y N Headache meds/side effects _______________
- Y N Aspirin, pain remedies
- Y N Tetanus or other vaccines
- Y N Iodine or other antiseptics
- Y N Family history of allergies

Physician's Signature: ______________ Date: ______________

Hartford Headache Center, LLC - **GENERAL INFORMATION & BILLING**

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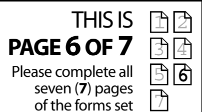

Patient Name ______________________________ Primary Phone ____________

E-mail ______________________________ Other Phone ____________
(optional; for office/patient communication only)

Home address ______________________________ Apt. # ____________

City ______________________________ State ________ Zip Code ____________

Date of Birth ______________ Age ________ **Social Security Number** (for office use only) ______________

Employer ______________________________ Occupation ______________________________

Employer's Address ______________________________ Phone ______________ Ext. ________

Spouse/Guardian/Other ______________________________ Occupation ______________________________

Employer's Address ______________________________ Phone ______________ Ext. ________

MEDICAL INFORMATION

Referring Physician ______________________________ Phone ____________

Referring Physician's Address ______________________________

Primary Care Physician ______________________________ Phone ____________

PC Physician's Address ______________________________

Any known allergies to medication? ______________________________

Pharmacy ______________________________ Phone ____________

Have you seen another neurologist in the past? Yes ___ No ____ If YES, who/where? ______________________________

INSURANCE AND BILLING INFORMATION

This information is for office use and billing purposes only, and will be kept strictly confidential.

Primary Insurance Company ______________________________

Address ______________________________

Name of Insured ______________________________ D.O.B. ____________ Soc.Sec. # of Insured ______________

ID# ______________________________ Group # ______________________________ Co-Pay ____________

Secondary Insurance Company ______________________________

Address ______________________________

Name of Insured ______________________________ D.O.B. ____________ Relationship to patient ______________

ID# ______________________________ Group # ______________________________ Co-Pay ____________

I authorize the release of my medical information and/or payment directly to Hartford Headache Center, LLC.

Signature ______________________________ Today's Date ____________

MIDAS QUESTIONNAIRE

MIGRAINE DISABILITY ASSESSMENT

(Please fill out and give to your doctor.)

MIDAS
Migraine Disability Assessment Programme

▲ PATIENT NAME — MONTH/DAY/YEAR

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about all your headaches over the last **3 months**. Write your answer in the box next to each question. Write zero if you did not do the activity in the last **3 months**.

1. On how many days in the last 3 months did you miss work or school because of your headaches? *(If you do not attend work or school enter zero in the box.)* ______ DAYS

2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school. If you do not attend school or work enter zero in the box.)* ______ DAYS

3. On how many days in the last 3 months did you not do household work because of your headaches? ______ DAYS

4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days counted in question 3, where you did not do household work.)* ______ DAYS

5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches? ______ DAYS

***(Questions 1-5)* TOTAL** ______

A. On how many days in the last 3 months did you have a headache? *(If headache lasted more than 1 day, count each day.)* ______ DAYS

B. On a scale of 0-10, on average, how painful were these headaches? *(Where 0=no pain at all, and 10=pain which is as bad as it can be.)* ______ 0-10

After you have filled out this questionnaire, add the total number of days from questions 1 to 5 (ignore A and B).

MIDAS GRADE	DEFINITION	MIDAS SCORE
I	Little or no disability	0-5
II	Mild disability	6-10
III	Moderate disability	11-20
IV	Severe disability	21+

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The MIDAS program is an educational service provided by AstraZeneca .

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