



NORTH TEXAS INSTITUTE OF NEUROLOGY AND HEADACHE

5425 W. Spring Creek Pkwy Ste. 275 Plano, TX 75024
5150 Warren Pkwy Frisco TX, 75034
Office (972) 403-8184 Fax (972) 403-0685

Brian D. Sorin, MD
Karen Bontia, MD
Elaine C. Timm, MD
George R. Nissan, DO
Kathleen Scott, DO
Sara Freeman, PA-C
Viktoria Sattar, NP-C

PATIENT INFORMATION:

Name: _____ Sex: M F Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Drivers License #: _____ Social Security #: _____ Marital Status: S M D W
Home Phone: _____ Work Phone: _____ Cell Phone: _____
E-Mail: _____ Employer : _____ Phone #: _____
Employer's Address: _____
Referring Physician: _____ Family Physician: _____
Referring Doctor's Address: _____ Phone #: _____

SPOUSE/DOMESTIC PARTNER/RESPONSIBLE PARTY IF MINOR (PT UNDER 18):

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Sex: M F Date of Birth _____ Social Security #: _____ Employer: _____

INSURANCE INFORMATION:

Name of Primary Insurance Co: _____ Co-Pay Amount \$ _____ Effective Date _____
Insured's Name: _____ DOB: _____ SS# _____
ID# _____ Group #: _____ Employer _____
Claims Address: _____ City _____ State _____ Zip _____
Name of Secondary Insurance Co: _____ Co-Pay Amount \$ _____ Effective Date _____
Insured's Name: _____ DOB: _____ SS# _____
ID# _____ Group #: _____ Employer _____
Claims Address: _____ City _____ State _____ Zip _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____
Address: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

CONSENT:

I hereby authorize direct payment of my insurance benefits to NTINH for services rendered to myself or my dependents. I understand it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand I am responsible for any co-pay or balance due that is determined by my insurance carrier for any reason. I authorize release of any information that may be necessary for medical evaluation, treatment, consultation, or processing of insurance benefits. I hereby consent to evaluation, testing and treatment as directed by NTINH, including downloaded medication history.

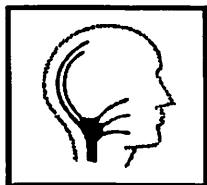
Patient Signature: _____

Date: _____

Neurology
Sleep
Neur-Allergy
NeuroDiagnostics
Massage

Evaluate, Integrate, Recuperate
Setting The Standard In Headache Medicine

Headache
Acute Headache
Concussion / Sports
Imaging
Acupuncture



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OFFICE POLICIES

Office Hours:

Monday – Friday: 8:00 AM - 4:00 PM Lunch- 12:00 PM – 1:30 PM

Saturday: 9:00 AM-1:00 PM Sunday: Closed

Insurance Payment Policy

Please present your insurance card and driver's license at the time of check in. We do not verify benefits for most follow up appointments. Please be aware that it is ultimately your responsibility to know your healthcare benefit coverage. If you do not know your benefits we strongly recommend that you contact your insurance carrier with any questions you may have regarding your coverage prior to your services rendered. On each date of service, you will be expected to pay the co pay/coinsurance/deductible amount that is listed on your insurance card. Please note this is only an estimated amount. After your insurance company has paid their portion, it is probable that you will receive a bill from North Texas Institute of Neurology and Headache for any amount that has been applied to your deductible or coinsurance.

Self-Pay Patients

Our office does not see self-pay patients.

Forms of Payment

We do not accept checks on the initial appointment. Payment is accepted in the forms of cash, checks, or debit cards (Visa, MasterCard, American Express, or Discover).

Medical Records

Medical record requests are now handled by a third party, HealthMark Group. To request your records, submit a request by creating an account at <https://medrelease.healthmark-group.com/360>. You may also request your records through our office. If you choose to submit a request through our office, a records release form will need to be completed in our office or sent to the office via fax. Should any fees be required, HealthMark Group will send out an invoice. Records will be available within 24-48 hours, unless pending payment. If you have not received any response regarding your request, please call our office.

Medication Refills

Please allow our office 72 hours for medication refills. Medication refills will only be filled during our normal business hours listed above. The on-call physician will not fill standard, non-urgent refills after hours.

Outside Venues

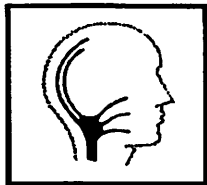
Our office may have contractual financial interests in venues such as Sleep Studies, EEGs, UAs, MRIs and Compound Pharmacies.

These interests do not in any way impact medical decisions, treatment options or financial obligations for our patients.

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Courtesy Policy

Due to the sensitive nature of the conditions that we treat, we ask that all patients refrain from cell phone use, the use of heavy perfumes, lotions and tobacco products. We thank you in advance for your cooperation in this matter.

I have read the above standard policies for North Texas Institute of Neurology and Headache, and I agree to abide by these policies.

Patient Name (please print)

Patient/Guarantor Signature

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CANCELLATION/NO SHOWS

Cancellations

We do our best to confirm appointments with our patients 72 hours in advance, however it is ultimately the responsibility of the patient to confirm or cancel your appointment within 24 hours. Appointments that have not been confirmed by 3:00 PM the day prior to your appointment will be canceled and considered a no show, so that we are able to accommodate patients who are on the waiting list. Patients that no show their appointment or cancel it on the same day of service will be charged with the fee listed below.

- Follow up appointments: \$50.00
- Procedures (including EMG/NCV, injections, Biopsy or Botox/Dysport/Xeomin): \$100.00
- Consult with different Provider in office: \$75.00
- Acupuncture Consult: \$150.00; Follow up: \$100.00
- Counseling Consult and Follow Up: \$150.00
- Radiology: \$150.00
- Massage: \$25.00

Late Policy

If you are more than 15 minutes late, please call our office so we can reschedule your appointment. Please be aware, this will be considered a No Show and a fee will be assessed. Please respect this policy as it ensures that physicians and patients stay on time.

Patient Name (Please Print)

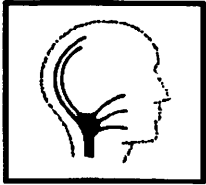
Patient/Guarantor Signature

Date

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, North Texas Institute of Neurology and Headache creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient Name (Please print)

Date

Patient/Guarantor Signature

Last four of SSN#

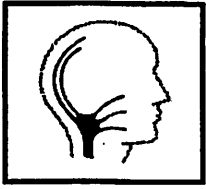
Witness (Optional)

Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: _____

Social Security Number: _____ DOB: _____

I, the above mentioned person, release that the following medical information be sent from North Texas Institute of Neurology and Headache.

_____ All Medical Records _____ All Billing Records

I, the above mentioned person, release North Texas Institute of Neurology and Headache, and their staff from any liability concerning the above mentioned records. Information can be released and sent to:

Who is authorized to receive information:

Name: _____

Name: _____

Name: _____

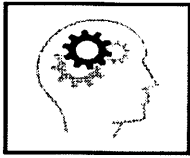
By signing this form, I the above named person release the physician and his staff from any liability concerning my medical records.

Printed Name Signature Date

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NAME: _____ DATE OF BIRTH: ____/____/____ AGE: _____

SO THE PROVIDER MAY UNDERSTAND YOUR HISTORY, PLEASE TAKE THE TIME TO ANSWER THESE QUESTIONS AS CLEAR AND ACCURATE AS POSSIBLE

PHYSICIAN INFORMATION:

WHO REFERRED YOU TO OUR OFFICE? _____ PHONE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ PHONE: _____

WHAT IS THE NAME OF YOUR PHARMACY? _____ PHONE: _____

PLEASE LIST ALL OTHER PROVIDERS INVOLVED IN YOUR CARE; WHO YOU WOULD LIKE A COPY OF YOUR REPORTS SENT TO.

1. _____

2. _____

WHAT IS THE **SPECIFIC REASON** FOR TODAY'S VISIT? HOW LONG HAVE YOU HAD THIS PROBLEM?

IN THE LAST 3 YEARS HAVE YOU HAD ANY OF THE FOLLOWING:

- AMBULATORY EEG
- CT HEAD
- CT NECK
- CT SINUSES
- ECHOCARDIOGRAM

- EEG
- MR ANGIOGRAM HEAD/NECK
- MRI BRACHIAL PLEXUS
- MRI BRAIN
- MRI CERVICAL SPINE

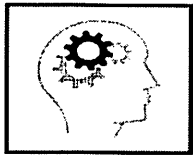
- MRI LUMBAR SPINE
- MRI THORACIC SPINE
- MR VENOGRAM HEAD/NECK
- ULTRASOUND
- X-RAY CHEST/NECK

IF YES BRING FILMS AND REPORT IF AVAILBLE; IF OVER 3 YEARS TESTING WILL BE REPEATED.

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I. CONCUSSION HISTORY:

- 1) In your life, how many concussions have you experienced and when? _____
- 2) Have you ever lost consciousness with a concussion? _____
- 3) Have you experienced a change in personality/mood? _____
- 4) Do you become agitated easily? _____
- 5) Do you have difficulty with your memory? _____
- 6) Do you have difficulty concentrating on a computer screen or TV? _____
- 7) Do you experience dizziness or vertigo? _____
- 8) Do you experience daytime fatigue? _____
- 9) Do you have difficulty initiating or maintaining sleep? _____

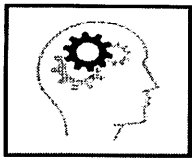
HEADACHE HISTORY:

- 1) Do you experience chronic neck / jaw restriction / pain? _____
- 2) How many headache **free** days do you have per month? _____
- 3) In your life have you ever experienced a head or neck injury? _____
- 4) Are your symptoms: Front / Left / Right / Back of the head / Whole head (**Circle all that apply**)
- 5) Is the pain: sharp / stabbing / dull / achy / throbbing / vise-like (**Circle all that apply**)
- 6) Do you typically experience: Nausea / Vomiting / Light Sensitivity / Noise Sensitivity / Smell Sensitivity (**Circle all that apply**)
- 7) Do you awaken from your sleep with a headache? _____
- 8) If you awaken with a headache does it get better as the day goes on? _____
- 9) Does your headache feel worse after: standing / bending / sitting up / lying down / straining (**Circle all that apply**)
- 10) Do you ever feel your vision is affected by the headache? _____
 - A) Do you get blurriness of visual disturbances upon awakening? _____
 - B) Does this improve as the day goes on? _____
 - C) When was your last vision exam? _____
- 11) Do you experience strange smells, sounds or visual disturbances? If so, what? _____

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12) During a headache, does your nose run from one nostril (right / left)? Does one eye water

(right / left)? _____

A) Does your eye turn red (right/ left)? Does your face droop (right / left)? _____

13) Known triggers? _____

14) What makes your headache feel Better? _____ Worse? _____

15) During a migraine, do you experience numbness and tingling; where? _____

16) Do you experience temperature changes in your hands? _____

17) Do your fingers turn white or blue, hurt or turn red when exposed to cold? YES/NO

18) Do you lose sensation or develop pain when you lift your arms above your head or in a certain direction? YES/NO

II. PRIOR MEDICAL HISTORY:

DO YOU CURRENTLY SUFFER FROM OR PREVIOUSLY SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> DEPRESSION/ANXIETY | <input type="checkbox"/> HYPERTHYROID | <input type="checkbox"/> OBSTRUCTIVE SLEEP APNEA |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HYPOTHYROID | <input type="checkbox"/> TENSION HEADACHE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DRUG ADDICTION | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> SCHIZOPHRENIA |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> FIBROMYALGIA | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> SEASONAL ALLERGIES |
| <input type="checkbox"/> BIPOLAR | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> LUPUS | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> CELIAC DISEASE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> LYME DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CLUSTER HEADACHE | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> MIGRAINE | |
| <input type="checkbox"/> OTHER PSYCHIATRIC CONDITION | | <input type="checkbox"/> CANCER: (TYPE) _____ | |
| <input type="checkbox"/> OTHER: _____ | | | |

HAVE YOU HAD ANY **MAJOR SURGERY**? IF YES, APPROXIMATE YEAR AND NUMBER OF TIMES.

- | | | |
|---|--|--|
| <input type="checkbox"/> BYPASS: _____ | <input type="checkbox"/> GALLBLADDER: _____ | <input type="checkbox"/> SHOULDER: _____ |
| <input type="checkbox"/> BRAIN: _____ | <input type="checkbox"/> HEART VALVE: _____ | <input type="checkbox"/> SPINAL: _____ |
| <input type="checkbox"/> C-SECTION: _____ | <input type="checkbox"/> HYSTERECTOMY: _____ | <input type="checkbox"/> THORACIC OUTLET SYNDROME: _____ |
| <input type="checkbox"/> COSMETIC: _____ | <input type="checkbox"/> HEART VALVE: _____ | <input type="checkbox"/> VASCULAR: _____ |
| <input type="checkbox"/> FACIAL: _____ | <input type="checkbox"/> KNEE: _____ | |
| <input type="checkbox"/> OTHER: _____ | | |

FEMALES ONLY

Last Menstrual Period (If applicable): _____

Are you currently breast feeding? Yes / No

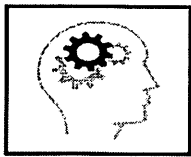
Are you pregnant? Yes / No

Are you planning on conceiving? Yes / No

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III. MEDICATION HISTORY:

DO YOU SUFFER FROM MEDICATION ALLERGIES (YES / NO)

- | | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |

DO YOU SUFFER FROM ANY KNOWN FOOD ALLERGIES? (YES / NO)

If yes, please list foods: _____

WHAT MEDICATIONS DO YOU CURRENTLY TAKE? PLEASE INCLUDE ALL OVER THE COUNTER MEDICATIONS
(NAME/STRENGTH/AMOUNT PER DAY) (DO NOT LIST SEE ATTACHED)

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |
| 10. _____ | 11. _____ | 12. _____ |
| 13. _____ | 14. _____ | 15. _____ |

TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU BEEN ON ANY PREVENTATIVE MEDICATIONS FOR YOUR
CONDITION? (WHAT REACTION, IF ANY, DID YOU HAVE TO FAILED MEDICATION?) PLEASE CIRCLE

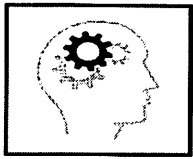
AMERGE/ AXERT / BELBUCA / BUTRANS / CAFERGOT / CAMBIA / COENZYME Q10 / DHE / DOLGIC
 EXCEDRIN / FIORICET / FIORINAL (BUTALBITAL) / FROVA / HYDROCODONE (VICODIN) / HYSINGLA
 IBUPROFEN / IMITREX / MAGNESIUM / MAXALT / MIDRIN / MIGRANAL / MORPHINE / NARATRIPTAN
 NORCO / NUCYNТА / OXYCONTIN / OXYCODONE / PERCOCET / PRODRIN / RELPAX / STADOL / SUMATRIPTAN
 SUMAVEL / TREXIMET / TREZIX / TYLENOL / ZECUITY / ZOMIG

OTHER HEADACHE ABORTIVE MEDICATIONS / SUPPLEMENTS WHICH HAVE FAILED: _____
PREVENTATIVE MEDICATIONS CONTINUED:

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AMLODIPINE / BYSTOLIC / CANDESARTAN / COZAAR (VALSARTAN) / HYZAAR (LOSARTAN)

HYDROCHLORATHIAZIDE (HCTZ) / LASIX / LISINAPRIL / METOPROLOL / NADOLOL

PROPRANOLOL (INDERAL)

ANY OTHER BLOOD PRESSURE MEDICATIONS NOT LISTED: _____

APTIOM / CARBAMAZEPINE / DEPAKOTE (VALPROIC ACID) / DILANTIN (PHENYTOIN)

KEPPRA (LEVETIRACETAM) / LAMICTAL (LAMOTRIGINE) / LYRICA (PREGABALIN)

NEURONTIN (GABAPENTIN) / OXTELLAR / QUDEXY / SAVELLA (FETZIMA) / TOPAMAX (TOPIRAMATE)

TROKENDI / VIMPAT / ZONISAMIDE

ANY OTHER SEIZURE MEDICATIONS NOT LISTED: _____

ABILIFY / AMITRIPTYLINE / BRINTELLIX / CELEXA (CITALOPRAM) / CYMBALTA (DULOXETINE)

GEODON / LATUDA / LEXAPRO / LITHIUM / NAMENDA / NORTRIPTYLINE / PROTRIPTYLINE

PAXIL / PROZAC / SEROQUEL / ZOLOFT (SERTRALINE) / ZYPREXA

ANY OTHER ANTI-DEPRESSANT MEDICATION NOT LISTED: _____

TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU ATTEMPTED ANY OF THESE PROCEDURES FOR MANAGEMENT OF YOUR HEADACHES? IF YES, WHAT PROCEDURES AND WHEN? **PLEASE CIRCLE ALL THAT APPLY.**

BOTOX / DYSPORT / MYOBLOC / XEOMIN

ACUPUNCTURE / CRYOTHERAPY / EPIDURAL STEROID INJECTIONS / FACET INJECTIONS / MASSAGE

NERVE BLOCK / PHYSICAL THERAPY / RHIZOTOMY / TRIGGER POINT INJECTIONS

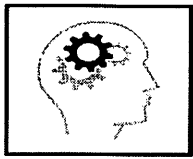
SPINAL CORD STIMULATOR

OTHER: _____

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Neurocognitive / Sports Neurology@
NORTH TEXAS INSTITUTE OF NEUROLOGY AND HEADACHE

5425 W. Spring Creek Pkwy Ste. 275 Plano, TX 75024
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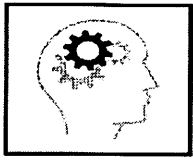
IV. SLEEP

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

- 0= No chance of dozing
- 1= Slight chance of dozing
- 2=Moderate chance of dozing
- 3=High chance of dozing

Situation	Chance of Dozing
Sitting and Reading	_____
Watching T.V.	_____
Sitting inactive in a public place (i.e. theater or meeting)	_____
Passenger in car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
	Total Score _____

Do you awaken frequently to urinate?	Yes / No
Are you clenching/grinding your teeth at night?	Yes / No
Do you snore?	Yes / No
Are you tired all the time?	Yes / No
Do you wake with a headache?	Yes / No
Are you aware that you twitch a lot when sleeping?	Yes / No
Is the person that sleeps with you aware that you twitch when sleeping?	Yes / No
Even if you feel you sleep through the night; do you feel groggy?	Yes / No
Have you gained weight?	Yes / No
Is it difficult for you to button your top button on your shirt?	Yes / No
If you wear a necklace, does it fit tighter?	Yes / No



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V. FAMILY HISTORY:

ARE YOU ADOPTED? (YES / NO)

FATHER: AGE ___ ALIVE DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH _____

MOTHER: AGE ___ ALIVE DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH _____

SIBLINGS: AGE ___ ALIVE DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH _____

SIBLINGS: AGE ___ ALIVE DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH _____

SIBLINGS: AGE ___ ALIVE DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH _____

VI. SOCIAL HISTORY:

OCCUPATION: _____ ARE YOU DISABLED? YES / NO

MARRIED SINGLE SEPARATED DIVORCED WIDOWED

DO YOU CURRENTLY SMOKE? (YES / NO) IF YES, HOW MUCH? _____ (PER DAY, WEEK)
IF YOU QUIT, WHEN? _____

DO YOU CONSUME CAFFEINE (YES / NO) IF YES, HOW MUCH? _____ (PER DAY, WEEK)
(Including: coffee, tea, energy drinks, soda, Excedrin, etc.)

IF YOU DO NOT HAVE CAFFIENE, DO YOU EXPERIENCE HEADACHES? (YES / NO)

DO YOU EXPERIENCE A HEADACHE WHEN YOU ARE NOT CONSISTENT WITH CAFFEINE? YES / NO

DO YOU USE ARTIFICIAL SWEETENERS? SWEET'N LOW SPLENDA NUTRASWEET STEVIA

OTHER: _____

DO YOU CURRENTLY CONSUME ALCOHOL? (YES / NO) IF YES, HOW MUCH? _____ (PER DAY, WEEK)
IF QUIT, WHEN? _____

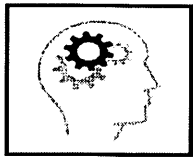
ARE YOU CURRENTLY USING / TAKING: MARIJUANA COCAINE HEROIN METHAMPHETAMINES (ADDERAL /
VYVANSE / RITALIN / AMPHETAMINE NARCOTICS (NORCO / HYDROCODONE / PERCOCET / OXYCODONE / OXYCONTIN
BUTRANS / FENTANYL)

IF YES, HOW FREQUENT: _____

Neurology
Sleep
Neur-Allergy
NeuroDiagnostics
Massage

Evaluate, Integrate, Recuperate
Setting The Standard In Headache Medicine

Headache
Acute Headache
Concussion / Sports
Imaging
Acupuncture



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BRING ALL PERTINENT RADIOLOGY AND LABWORK TO APPOINTMENT, AS THIS WILL ASSIST WITH TREATMENT. IF YOU SHOW UP TO THE APPOINTMENT WITHOUT RADIOLOGY AND LABWORK YOU MAY BE ASKED TO RESCHEDULE.

This office does not participate in **NO FAULT (AUTOMOBILE ACCIDENT CASES), PERSONAL INJURY or WORKMAN'S COMPENSATION** cases.

Is this visit related to: Motor vehicle accident: Yes No Workman's Compensation: Yes No Personal Injury: Yes No

I HAVE NOT AND CURRENTLY DO NOT TAKE ANOTHER PERSON'S MEDICATION. _____
(PATIENT INITIAL'S)

IF YES WHAT? _____

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

Note to the patient:

I understand the providers and staff are here to help my condition. The testing and recommendations are for my benefit. I understand non-compliance can result in a significant impact in my future care which may include dismissal.

(PATIENT INTIALS)

I am interested in memory baseline testing. _____
Initial

I trust my provider more than Google. _____
Initial

Neurology
Sleep
Neur-Allergy
NeuroDiagnostics
Massage

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