Gwinnett Neurology & Sleep Disorders Clinic

2331 Henry Clower Blvd. Ste A, Snellville, GA 30
Phone (770)972-3002 / Fax (770)985-6392

Thank you for selecting our clinic to serve you! In order for us to properly bill your insurance, we request you to fill out the following information. This information will be used for billing/appointment purposes **only** and is otherwise kept confidential.

PATIENT INFORMATION:

Full Name: _____

Date of Birth: _____ Social Sec #: _____Gender (at birth):_____

Email address: _____

Cell Phone: _____ Home/Work Phone: _____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Phone: _____

Email: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

EMPLOYER INFORMATION:

Company Name: _____

Address: _____

Position: _____ Work Phone #: _____

Status: Full Time: _____ Part Time: _____ Unemployed: _____

Q: Is today's visit related to a **work injury**? **Y/N** **Date of Injury** _____

Q: Is today's visit related to an **auto injury (MVA)**? **Y/N** **Date of Injury** _____

INSURANCE INFORMATION:

Insurance Company: _____

Phone #_____ Policy Holder: _____ DOB: _____

SS#_____ Member ID#:_____

Secondary Ins Company: _____ Phone#_____

Policy Holder: _____ DOB:_____ SS#_____

Member ID#:_____

MEDICAL INFORMATION:

Primary Care Physician Name: _____

Phone: _____ Fax #_____

Referring Physician Name: _____

Phone: _____ Fax #_____

Please read and Sign:

I hereby authorize treatment of the above named patient by Dr. Badar Syed. I authorize the release of information to my insurance companies (or the above named patient's companies) regarding the treatment and care from Dr. Syed. I authorize the direct payment of insurance benefits for services rendered. I understand that I am responsible for payment of co-payments, deductibles, coinsurance and non-covered items. I also understand that it is my responsibility to make sure that my referral is accurate, and denial of payment because of my not obtaining this will result in my being personally responsible for the charges incurred. I promise to pay for all charges on my account including professional services, office visits of any nature, broken appointments, and late cancel charges. There is a fee for all checks returned for any reason, legal or collection fees.

_____
(Initial)

_____ _____

Signature of Patient/Guardian Date **L1**

Gwinnett Neurology & Sleep Disorders Clinic

Patient's Name:_____ DOB:_____

As part of becoming a Piedmont Hospital Provider, we are required to screen patients for certain measures yearly, we will provide you with the educational material if you give your consent.

1. **If you are 12 years or older, we are required to ask if you want to be screened for depression today.**
It is a 10 question screening. If you would like to go ahead with screening, then please answer the questions in the box. If you do not wish to answer, please circle **Patient Declined**.

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
TOTAL				
10. If you checked off any problems, how difficult? Have these problems made it for you to do your work, take care of things at home, or get along with other people? Not difficult at all				
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	

Active Diagnosis **G9717** Positive Screening **G8431** Negative Screening **G8510** **Patient Declined G84**

PLEASE COMPLETE QUESTIONS 2 AND 3 EVEN IF YOU DECLINE THE DEPRESSION SCREENING

2. Do you **currently** smoke cigarettes ***or*** use other tobacco products?
   a. Yes **(G9902)** b. No **(G9903)**

If **yes**, would you be interested in receiving tobacco counseling and/or pharmacotherapy materials?
   a. Yes **(G9902 and G9906)** b. No **(G9902 and G9907)**

3. Are you 65 **or** older? a) YES b) NO

If **yes**, would you like to receive Advance Care planning? We can provide you with Georgia Advance Directives, and you can fill it out at your convenience.

   a. Yes **(1124F)** b. NO **(1124F)**

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Patient Name: _____ Date:_____

REASON FOR TODAY'S VISIT (must answer):

_____

_____

_____

_____

CURRENT MEDICATIONS, including all Vitamins:

Medication / Vitamin Name	Dosage/Time

DRUG AND FOOD ALLERGIES:

Name	Type of Reaction

SURGICAL HISTORY: (List operation(s) **or** write none)

Operations/Diseases Treating Facility	DATE(s) **or** Year

➢ **Pregnancies/Miscarriages/Abortions:** _____

❖ Have your recently been admitted to the HOSPITAL or seen in the EMERGENCY ROOM FOR THIS NEUROLOGICAL PROBLEM: **YES / NO**

If **yes**, which facility and date:

_____

DIAGNOSTIC STUDIES: (MRI's, CT's, SLEEP STUDIES, EEG's, EMG/NCS, etc. regarding your neurological problem)

Procedure	Facility	Date

FAMILY HISTORY: LIST DISEASES IN YOUR **IMMEDIATE FAMILY**: (PARENTS-SIBLINGS-CHILDREN)

DISEASE	AGE	RELATIONSHIP	DECEASED
Early Heart Attack	____	_____	YES/NO
Stroke	____	_____	YES/NO
Diabetes Mellitus	____	_____	YES/NO
Multiple Sclerosis	____	_____	YES/NO
Neuropathy	____	_____	YES/NO
Alzheimer/Dementia	____	_____	YES/NO
Any Other Neurologic Disease	____	_____	YES/NO

SOCIAL HISTORY:

Currently Smoking/Vaping: YES/NO If yes, packs per day _____ **Prior** Smoking?: _____
Currently Drink Alcohol: YES/NO If yes, drinks per week _____ **Prior** Drinking?: _____
Recreational Drugs: YES/NO _____ **Caffeine**(coffee/hot tea/iced tea/soda/energy drinks): _____
Years of Education: _____ **Degree(s):** _____
Marital Status: _____ **Children:** _____
Pregnant: YES/NO (if yes, Due Date) _____
Employed: YES/NO _____

REVIEW OF SYSTEMS: (HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? If so, please CIRCLE the appropriate condition(s) and explain if possible)

NEUROLOGICAL: None/ Seizures/ Fainting/ Blackouts/ Memory Loss/ Numbness/ Tingling in the extremities/ Weakness in the Extremities/ Unstable Balance/ Slurred Speech
CONSTITUTIONAL: None/ Weight loss **or** gain/ Fever/ Extreme Fatigue
SKIN: None/ Rash / Itchiness/ Skin Cancer/ Birthmarks
EYES: None/ Blurred Vision/ Double Vision/ Eye Pain
ENT: None/ Dizziness or Vertigo/ Ringing in the ears/ Hearing Impairment/ Difficulty Swallowing/ Grind Teeth
CARDIOVASCULAR: None/ Chest Pain/ Palpitations/ Irregular Heartbeat/ Murmur
RESPIRATORY: None/ Shortness of Breath/ Snoring/ Choking/ Sleep Apnea
GASTROINTESTINAL: None/ Nausea/ Vomiting/ Diarrhea/ Constipation/ Abdomen
UROGENITAL: None/ Incontinence/ Urgency/ Impotence
HEMATOLOGIC: None/ Bleeding Tendency/ Anemia/ Easy Bruising
GYN: None/ Libido/ Menstrual Problems
PSYCHIATRIC: None/ Depression/ Anxiety/ Panic Attacks
MUSCULOSKELETAL: None/ Joint Pain/ Neck Pain/ Back Pain
SLEEP: None/ Excessive Tiredness During The Day/ Sleep Attacks/ Night Terrors

HEADACHE(S):

Location of Headache: _____

Quality (throbbing/pulsating/sharp/dull/pounding)**:** _____

Frequency (per week **or** month)**:** _____ **Relieving Remedies:** _____
Duration: _____ **Triggers:** _____

Associated symptoms (nausea/vomiting/ blurred vision/ light/ sound/ smell sensitivity/ numbness/tingling)**:**
_____

Severity (1 - 10, "10" being the worst)**:** _____

Medications tried: _____

Worsening of headaches around menses (menstrual cycle)**?** _____

COVID-19 QUESTIONNAIRE

1. Do you have:

O A fever of 100.4 degrees Fahrenheit or higher
O A cough
O Shortness of breath or difficulty breathing
O None

2. Have you traveled in the past 14 days to regions affected by COVID-19?

O Yes
O No

3. Have have you been in close contact with anyone who a has a confirmed COVID-19 diagnosis?

O Yes
O No

☆ 4. Do you have heart disease, lung disease, kidney disease or **diabetes**?

O Yes
O No

5. Are you age 60 or older?

O Yes
O No

Gwinnett Neurology & Sleep Disorders Clinic

Patient Record of Disclosure

Patient Name: _____ Date: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (**INITIAL** all that apply):

Home/Cell Phone:
_____ OK to leave message with detailed information

Work Telephone:
_____ OK to leave message with details
_____ Leave message with call back number only
_____ NO WORK TELEPHONE COMMUNICATION

Written Communication:
_____ OK to mail to my home address
_____ OK to mail to my work/office address

I give permission, per HIPAA to the staff at Gwinnett Neurology & Sleep Disorders Clinic and Dr. Badar Syed, to discuss issues regarding my visits, medications, any labs *or* test results, my appointment(s), *or* insurance with the following people:

(IF LEFT BLANK *WE WILL NOT* DISCUSS WITH ANYONE)

LIST NAME, RELATION, & Contact #: ***Please DO NOT include providers.**

_____

_____

_____
I understand this will remain in effect **until** I notify the office in writing of any changes.

_____
Print Name **Date of Birth**

_____
** **Patient or (Guardian)Signature** ** **Date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosing made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.
NOTE: Uses and disclosures for treatment, payment & healthcare operations may be permitted without prior consent in an emergency. For non-emergency requests, written permission will be obtained from the patient .

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Gwinnett Neurology & Sleep Disorders Clinic

Badar H. Syed, M.D., P.C.
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Board of Sleep Medicine

AUTHORIZED REPRESENTATIVE FORM

This form is used in case Gwinnett Neurology & Sleep Disorders Clinic has to pursue a Prior Authorization for you for a procedure or a prescription. Your insurance company wants to make sure that you allow the office to pursue the appeal on your behalf.

I _____, member ID number _____
Date of Birth _____ want Gwinnett Neurology & Sleep Disorders Clinic to pursue a Prior Authorization or an Appeal for me. I understand that personal medical information related to my Prior Authorization or Appeal may be disclosed to the insurance agent.

Name of Representative: Badar H. Syed, M.D, P.C.
Address of Representative: 2331 Henry Clower Blvd Ste A, Snellville, GA 30078
Phone Number: 770-972-3002 / Fax: 770-985-6392.

This PA request/Appeal is being pursued for:

_____

_____

_____

_____
Member OR Guardian's Signature

_____
Staff at Gwinnett Neurology

Gwinnett Neurology & Sleep Disorders Clinic

Dr. Badar H. Syed, M.D., P.C.
2331 Henry Clower Blvd. Ste A
Snellville, GA 30078
Phone: 770-972-3002 / Fax: 770-985-6392

AUTHORIZATION TO RELEASE MEDICAL RECORDS

By signing this form, I authorize you/this office to release confidential health information pertaining to me. Please release a copy of my medical records, a summary **or** narrative of my protected health information to Dr. Badar H. Syed of Gwinnett Neurology and Sleep Disorders Clinic.

Please Fax my records to 770-985-6392.

Patient's name: _____ Date of birth: _____

The disclosure should include:

- ✔ Office notes; inpatient, outpatient and emergency room treatments; clinical charts; reports; treatment plans; hospital admission records; discharge summaries and test results.
- ✔ Laboratory records and specimens; radiology records and films.
- ✔ Prescription records and drug information related to such records.

Doctor/Facility releasing records: _____

Phone: _____

Fax: _____

_____ _____

Patient/Legal Guardian Signature **Date**

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Gwinnett Neurology & Sleep Disorders Clinic

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- ✔ Prescription records and drug information related to such records.

Doctor/Facility releasing records: _____

Phone: _____

Fax: _____

_____ _____

Patient/Legal Guardian Signature **Date**

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Gwinnett Neurology & Sleep Disorders Clinic

OFFICE USE ONLY

PATIENT NAME: _____ **DATE:** _____

VITAL SIGNS: _____ **PULSE:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **RESP:** _____

OFFICE USE ONLY

Patient Name: _____ DATE: _____

HPI: (FOR PHYSICIAN TO FILL OUT)

ASSESSMENT AND PLAN: (FOR PHYSICIAN TO FILL OUT)