NJ Neurology, Inc.

400 Center Street - Garwood, NJ 07027
908-232-0200 (phone) 908-232-0211 (fax)

Today's Date: _____

Patient's Name: _____ **DOB:** _____ F ___ M ___

S.S. #: _____ Marital Status: _____ Race: _____

Address: _____ **City:** _____ **State/Zip Code:** _____

Home #: _____ Cell #: _____ **Allergies:** _____

Email: _____ Pharmacy / tel: _____

Pediatrician/PCP Name/Phone #: _____

Referring M.D. Name;Phone # (If Different): _____

Parents/Guarantor (Please Circle One) PLEASE INCLUDE DOB OF THE PRIMARY INSURANCE HOLDER

Mother's Name: _____ **DOB:** _____ S.S. #: _____

Address: _____ Home #: _____ Cell #: _____
If different from patient

Employer: _____ Work Phone: _____

Employer Address: _____

Father's Name: _____ **DOB:** _____ S.S. #: _____

Address: _____ Home #: _____ Cell #: _____
(If different from patient)

Employer: _____

Employer Address: _____ Work Phone: _____

Insurance Information:

Primary Insurance: _____ Policy # _____

Name of Policy Holder: _____ Group # _____

Secondary Insurance: _____ Policy # _____

Name of Policy Holder: _____ Group # _____

I understand that I am financiallyl responsible for all charges whether or not covered by said insurance.
I hereby authorized said assignee to release any information necessary to secure payment on my behalf.
I authorize release of (my)/(child's) medical records

Signature: _____ **Date:** _____

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Romana Kulikova, MD **Pediatric Neurology**

CONSENT FOR TREATMENT

Patient Name: _____

1. **CONSENT TO CARE**: I wish to be treated by NJ Neurology, Inc. While I am a patient, I give permission to my doctor to provide care in ways they judge are beneficial to me. I understand that this care may include tests examinations and medical treatments.
2. **RELEASE OF INFORMATION:** NJ Neurology, Inc. may see, release to and/or confirm all or part of any financial and medical information, including information regarding psychological, psychiatric, HIV and related diagnosis, drug and/or alcohol related illness, with any person, corporation or government agency that is or may be responsible to the doctor, the patient, and family member or employer for all or part of the physicians charges or verification of same. I acknowledge that NJ Neurology, Inc. may verify my address through a database search of the Federal Credit Reporting System. I acknowledge that NJ Neurology, Inc. may be required to release patient information to federal and state agencies that monitor healthcare facilities, as well as any industries that produce and/or manufacture medical products.
3. **PRE-CERTIFICATION REQUIREMENTS:** I understand that if I do not comply with my insurance policy pre-certification requirements, such as a referral for office visit or other services requiring authorization, that I may be responsible for any and all physician charges.
4. **ASSIGNMENT OF BENEFITS:** I authorize my health insurance benefits to be paid directly to NJ Neurology, Inc. Under the terms of my policy this payment may not exceed the balance due for services performed during this period of treatment. I further authorize NJ Neurology, Inc. to appeal on behalf of any denial of claims by my insurance carrier.
5. **PAYMENT REQUEST:** I understand that if a payment is requested of me it is because I am responsible to pay for all or part of the physician bill rendered under NJ Neurology, Inc.
6. **FINANCIAL AGREEMENT:** If billed, I agree to make prompt payment to NJ Neurology, Inc. The payment for services rendered is the responsibility of each patient or their guardian, and payment is due within 30 days of the date on the bill you will receive. Payments beyond 30 days will be assessed a $10.00 penalty fee. Payments beyond 60 days will be assessed a $20.00 penalty. Payments beyond 90 days will be assessed a $30.00 penalty. Failure to make payment beyond 120 days will result in referral for collections. All checks returned for insufficient funds will be assessed a $25.00 fee.

I have read the information contained above and I understand its contents. I attest that my personal information provided to NJ Neurology, Inc. is accurate. I understand that providing incorrect information for the purpose of avoiding payment or for any other reason may be considered a violation of state and/or federal law.

Patients objecting to any statement in the Consent Form may put a line through that statement and initial it. This action indicates that the patient is deleting this statement and that their signature does not indicate consent or acknowledge of that item. However, patients cannot delete their consent for treatment or items relating to their financial responsibility.

I understand that this form will be valid for all services rendered by NJ Neurology, Inc. I also understand that I have the right to ask questions at any time regarding my treatment, care or any terms contained in this consent. If I wish to revise my consent, I may do so by completing a new form or if I wish to withdraw my consent I must do so in writing.

_____	_____	_____	_____
Patient/Parent	Date	Guarantor (if other than Parent)	Date
_____	_____	_____	
Witness	Date	Relationship of Guarantor to Patient, if applicable	

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

Patient Name	**DOB**	**Social Security Number**
Address (Street, City, State, Zip Code)		**Telephone Number**

The following individual or organization is authorized to make disclosure to Dr. Kulikova / NJ Neurology Inc:

- ☐ Pediatrician/
- ☐ _____
- ☐ _____

Dr. Kulikova / NJ Neurology Inc. may disclose information to the following individual or organization:

- ☐ _____
- ☐ _____
- ☐

Treatment dates:	**Purpose of Request:**

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event or condition:

_____

If I do not specify an expiration date, event or condition, this authorization will be in effect until revoked.

Re-disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, I may be denied enrollment in the research study.

I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Signature of Patient or Legal Representative	**Date:**

If Signed by Legal Representative, Relationship to Patient

Romana Kulikova, MD / NJ Neurology, Inc.
400 Center Street, Garwood, NJ 07027, tel: 908-232-0200 / fax: 908-232-0211

INITIAL VISIT Date: _____

Name: _____ **DOB:** _____ **Age:**_____

Reason for Evaluation: _____

Referred by: _____ **Informant(s):** ☐mother. ☐father ☐other

Pediatrician/ last physical: _____ **Barriers to care:** ☐language ☐culture ☐religious ☐other

_____

Family History:
Father: age _____ education_____medical problems_____
Mother: age _____ education_____medical problems_____
Siblings (age/sex/medical problems):_____
_____
_____

Please circle neurological conditions in other family members: Headaches, Stroke, Muscle problems, ADHD, Learning problems, Seizures, Psychiatric: If yes please explain:_____
_____

Birth History: ☐full term ☐premature: weeks of gestation_____ at delivery
☐spontaneous vaginal; ☐induced vaginal – reason:_____
☐forceps-assisted vaginal; ☐vacuum-assisted vaginal; ☐ cesarean section - reason: __
_____
Birth Weight: _____
Complications: ☐none
☐during pregnancy: problems _____
☐during delivery: _____
☐problems with the baby: _____
_____

Past Medical History: ☐no medical problems
☐hospitalizations:_____
☐chronic conditions:_____
☐head trauma:_____

Past Surgical History: ☐negative
☐surgeries: _____
_____

Vaccinations: ☐up to date ☐not given – reason:_____

Name/Visit Date: _____

Medications: ☐none
☐medication name: dose: taken since:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

other medications tried: ☐no
☐yes: name - _____
_____

Allergies: ☐none
☐to drugs:_____
☐to seasonal/environmental_____
☐to food:_____

Developmental History: ☐normal ☐concerns
Gross motor: sat at_____ walked at _____concerns:_____
Fine motor: concerns – ☐ no ☐ yes:_____
Speech: first words at_____sentences at_____seems to understand_____
Concerns: ☐ no ☐ yes: _____
Socialization: ☐normal ☐concerns:_____
Early Intervention ☐ no ☐yes:_____
Toilet-trained at:_____ Feeding problems:_____
Handedness (circle)**:** Right-handed Left-Handed Not determined Other_____

Social History: lives with_____
Stressors:_____
School: _____**Grade**:_____
PT_____ OT_____ Speech Tx_____
Other services:_____
Use of tobacco/alcohol/drugs: ☐N/A ☐no ☐yes _____
Lead level checked**:** ☐no ☐yes ☐ N/A

Review of Systems: problems ☐no ☐yes: **(CIRCLE OR WRITE BELOW)**
Constitutional (fever, weight loss/gain, fatigue, recurrent infections, unusual odor) _____
Eyes (double vision/lazy eye, loss of vision, blurring, cataracts, need for glasses)_____
Ear,nose/throat (hearing loss, ringing in ears, dizziness, congestion, hoarseness, difficulty swallowing, dental problems) _____
Respiratory (shortness of breath, wheezing/asthma, cough, coughing blood)_____
Cardiovascular (chest pain, palpitations, blood pressure problems,fainting)_____
GI (nausea, vomiting, constipation, diarrhea, abdominal pain)_____
GU (incontinence, painful urination, blood in urine, kidney stones)_____
Skin (birth marks –dark/light, rashes, patches of hair, hair or nail changes)_____
Musculoskeletal (joint pain/swelling, scoliosis, skeletal deformities, limited motion in joints)
_____
Psychiatric (mood swings/depression/anxiety, obsessive-compulsive behavior, panic attacks)___
Endocrine (thyroid problems, diabetes, growth deficiency)_____
Hematological (paleness, enlarged lymph nodes, abnormal bleeding or clotting)
Allergy (seasonal, food, drug allergies, eczema, hives)_____
Neurological (developmental delays, motor problems, seizures headaches)_____
Other: _____