Welcome! This packet is for ________________________________

Thank you for choosing the Berman Brain & Spine Institute and LifeBridge Health for your healthcare!

✦ You have an appointment with ________________________________
✦ on ________________, ________________, 20 ______
   day of the week  month and day
✦ You are expected to arrive at ________________  ☐ am  ☐ pm
✦ You are expected to arrive at the location checked above (see enclosed directions).
✦ You will receive an automated reminder call 72 hrs prior to your appointment.

Things You Must Know or Do

1. Read the pages of this packet for important instructions.
2. Complete and sign the forms in this packet before your visit and bring them with you when you come (do not mail them).
3. If your insurance company requires you to obtain a referral, it is your responsibility to do so.
4. If you do not arrive in sufficient time to allow for registration or if you do not bring a required referral, your appointment may be rescheduled.
5. Parking is free at most of the locations listed above. With our discounted coupon (given at the visit), parking at Sinai Hospital and the Mirowski Medical Office Building costs $3.
   PLEASE NOTE: The Mirowski Building does NOT have an ATM machine. Please bring cash, check, or credit card (Visa, Master Card, or Discover—NOT American Express) for your co-pay* and cash or credit card for parking.
6. To print out more copies of this packet, go to www.lifebridgehealth.org/bsipaperwork.

Things You Must Bring

1. Insurance card  2. Co-pay, if necessary*  3. Photo ID
4. Referral, if necessary, and/or authorization from requesting physician.
5. Completed and signed pages of this packet.
6. A list of current medications (last page of this packet) or bring your medication bottles.

If you have any questions, please contact us at ☜ 410-601-9515

We look forward to caring for you.
Important Information

Please help us to be respectful to all of our patients and to our physicians and arrive at the registration time that appears on the front page of this packet. If you do not arrive on time, we may reschedule your appointment. If you have any questions, please call 410-601-9515.

- Please bring your insurance card and photo ID with you to every visit.
- If your insurance requires a referral, please ensure that it is valid and that we have a copy of it prior to your visit. It is your responsibility to obtain the referral and to follow through to ensure that we have it. If you do not have your referral at the time of your scheduled visit, we may reschedule your appointment, or you will be responsible for your bill. Please inform us before your appointment of any changes in your insurance coverage.

SCHEDULING, CANCELLATIONS, and NO-SHOWS
All follow-up appointments should be scheduled by calling 410-601-9515. Please book your follow-up appointments as soon as possible. We will call you the day before to remind you. On page 9 of this packet, please let us know the best way to reach you (home, work, cell, and pager) for confirmation.

- If for any reason you cannot make your appointment, call 410-601-9515 to cancel at least 72 hours prior to your appointment.
- If you do not arrive for your scheduled appointment and you have not canceled at least 24 hours in advance, you will be charged a $25 no-show fee.

PAYMENTS FOR CO-PAY AND PARKING
Our building does NOT have an ATM machine. Please bring cash, check, or credit card (Visa, Master Card, or Discover—NOT American Express) for your co-pay and cash or credit card for parking (with our validation, the parking fee is only $3).

NO-SHOW POLICY
After patients miss their first and second appointments without letting us know, we write to remind them that our policy is that they must tell us at least 24 hours in advance if they are going to miss their appointments and that if they do not call at least 24 hours in advance, they will be charged a $25 no-show fee.

If they miss a third appointment without letting us know, we write to advise them that we will no longer provide for their care, that we will be dismissing them from our practice, and that we will renew a needed prescription for only a 30-day supply, so that they have time to find a new provider.
NECESSARY MEDICAL INFORMATION FOR YOUR VISIT
Please have available for the physician the name, office address, and phone number of your referring physician and/or primary care provider so that we can communicate with him/her. Please bring a written list of all medications that you currently take, including dose and frequency, or bring the medication bottles—this is important for new and follow-up patients.

If you have had any relevant testing (MRI, EEG, bloodwork, consultations/reports from other providers), please ensure that you bring those reports and/or films with you. NOTE: We are not able to copy reports that you bring with you. Please come prepared with copies that you will leave with us.

Do not assume that your primary care physician will send this information.

MESSAGES/PHONE CALLS
We attempt to return all phone calls within 24 hours. Sometimes, your call will be returned by another physician or by our physician assistant. If you are comfortable with e-mail, we would be happy to communicate with you by email. See the Patient Authorization form in this packet, where you can provide us with all of your preferred contact information.

PRESCRIPTION REFILLS
For prescription refills, your pharmacy must fax a refill authorization request to us at 410-601-8905. If we have no questions, we will refill your prescription. All refill requests will be completed within 2 business days of receipt, and you should follow-up with your pharmacy to check on the refill.

Please do not wait until the last minute to contact your pharmacy to request a refill.

If your pharmacy advises you of problems with the refill, call 410-601-9515. If your call is answered by the messaging system, please leave a complete message. We will resolve any issues within 2 business days.

IF YOU EXPERIENCE PROBLEMS WITH YOUR MEDICATION AND NEED EMERGENCY CARE, CALL 911.

If you experience problems with your medication but do not need emergency care, call 410-601-9515 and leave a complete message.

DO NOT call this phone line for automatic refill requests.

BILLING QUESTIONS
Before your visit, we check to determine if your insurance is active and to obtain any authorizations that are required. However, it is your responsibility to obtain any referral that may be required by your insurance company and to determine your financial responsibility for your visit, including any amounts that will be charged against your deductible or co-insurance. If you require billing codes to determine your out-of-pocket expenses, we will be happy to provide them. We must receive the request for this information a minimum of 5 business days prior to your appointment.

Following your visit, you may receive two bills, one for physician services and one for hospital services.

For billing questions about your doctor’s bills, please call 410-469-4369.
For questions about bills from Sinai Hospital, call 410-601-1094 (800-788-6995 out of Baltimore area).
For questions about bills from Northwest Hospital, call 410-521-5959 (877-617-1803 out of Baltimore area).

We know that the payment and the insurance process related to your visit may seem confusing. Please do not hesitate to ask any staff member for clarification. We are here to ensure that your visit is productive, positive, and comforting.

Our staff is committed to providing quality care and customer service to all of our patients. Your safety and privacy are important to us, and we will do our utmost to safeguard them. If during your visit you have any questions or concerns, please do not hesitate to let us know. If at any time you are not satisfied with the handling or resolution of your concern, you may contact Guest Relations at 410-601-8778.

Thank you for your attention to our policies. We look forward to seeing you and will do our best to provide you with excellent care.
Please complete these documents and bring them with you on the day of your appointment.

Patient name: _______________________________ Date: ________________

Social security #: ___________________________ DOB: ________________ Sex: ____________________

Address: __________________________________________________________________________

City, state, zip _______________________________________________________________________

Home phone: ______________________________ Work phone: _____________________________

Cellphone: _______________________________ email address: ____________________________

Marital status: _______________ Languages: _______________________________ Religion: __________

ADVANCE DIRECTIVES ~ Do you have a living will or advance directive? ☐ Yes ☐ No

Have you named a person to make medical decisions for you if you are unable to make them for yourself?

☐ Yes ☐ No  If so, who is that person? ____________________________________________________________

INSURANCE HOLDER EMPLOYMENT INFORMATION

Name of insured if other than patient: ______________________________________________________

SSN: _______________________________ DOB ________________ Relationship: ______________________

Employer: __________________________________________________________________________

Occupation: __________________________________________________________________________

Address: ___________________________________________________________________________

City, state, zip: _______________________________________________________________________

Phone: _______________________________________________________________________________

Primary (main) insurance company: _______________________________________________________

Effective date: ________________ Retirement date: ________________

Insurance ID number: _________________________________________________________________

Secondary (supplemental) insurance company: _____________________________________________

Effective date: ________________ Retirement date: ________________

Insurance ID number: _________________________________________________________________

~ continued ~
Patient name ___________________________ DOB ___________________

EMERGENCY CONTACT
Name: ___________________________ Relationship: ___________________________
Work number: ___________________________ Home number: ___________________________

REFERRING PHYSICIAN
Name: ___________________________ Phone: ___________________________
FAX: ___________________________
Address: ___________________________
City, state, zip: ___________________________

PRIMARY CARE PHYSICIAN
Name: ___________________________ Phone: ___________________________
FAX: ___________________________
Address: ___________________________
City, state, zip: ___________________________

PHARMACY
Name: ___________________________
Phone: ___________________________ FAX: ___________________________
Authorization and Assignment of Insurance Benefits

Patient name ___________________________ DOB mm/dd/yyyy

The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees to the following:

1. I authorize payment of medical benefits to the physician(s) rendering service(s).

2. I agree and acknowledge that my signature on this document authorizes my physician(s) to submit claims for benefits, services rendered, or services to be rendered without obtaining my signature on every claim submitted for me and/or my dependent(s). I will be bound by this signature as though the undersigned had personally signed the particular claim.

3. I will pay to the physician(s) any balance due for services rendered. I understand that if payment is not made on my behalf (by my insurer, legal representative, or workers compensation insurance), I will be responsible for any outstanding balance.

4. I understand that the Department of Neurology checked with my insurance company prior to this visit to determine whether my insurance is active and to obtain any required authorizations.

5. If I have received neurodiagnostic testing or services from the Division of Adult & Pediatric Medical Psychology, I understand that following my visit, I will receive two bills—one for the doctor's services and one for the hospital's services.

6. I understand that it is my responsibility to obtain any referrals required by my insurance company and to determine my financial responsibility for all charges for this visit, including those from the doctor and from the hospital and any amounts that will be charged against my deductible or co-insurance.

☐ The reason for this visit is not the result of a motor vehicle accident and is not covered by my automobile insurance.

☐ The reason for this visit is the result of a motor vehicle accident, and the claim for services provided should be submitted to my insurance carrier:


☐ The reason for this visit is not the result of a Workers Compensation claim and, therefore, payment for this visit is not eligible for payment by Workers Compensation insurance.

☐ The reason for this visit is the result of a Workers Compensation claim, and the claim for services provided should be submitted to my Workers Compensation carrier:


I UNDERSTAND THAT IF I HAVE NOT PROVIDED CORRECT AND TRUTHFUL INFORMATION REGARDING THE REASON FOR THIS VISIT AND INSURANCE COVERAGE, I WILL BE RESPONSIBLE FOR ANY UNPAID CLAIMS.


signature of patient, parent/guardian, guarantor ___________________________ date (mm/dd/yyyy)
Patient Authorization

Patient name _______________________________ DOB __________________

The providers in the Department of Neurology are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize the Department of Neurology to:

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.
2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.
3. Send me notices, clinical notes, and lab results via: ☐ text message ☐ email
4. I would like to receive an email invitation that provides instructions on how to register for the Sinai Hospital Patient Portal. ☐ yes ☐ no

______________________________ please print email address ______________________________

5. Call my home or work and leave a message to contact the office.
My preferred method of contact for appointment reminders is
☐ home phone ☐ cell phone ☐ text message on cell phone ☐ email

______________________________ home phone number ______________________________
______________________________ cell phone number ______________________________

6. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.
7. Update my personal demographic information either on the phone or in the office at the time of my appointment.
8. I give permission to discuss my personal health with the designated person(s) below:

______________________________ name ______________________________ relationship
______________________________ name ______________________________ relationship

I have read and agree to the above policies.

______________________________ signature of patient ______________________________
______________________________ date (mm/dd/yyyy) ______________________________

Patient Authorization (06/08/21)
# Authorization for Release of Medical Information

**Patient's Name**

**Patient's Date of Birth**

**Patient's Street Address**

**Social Security Number**

**City, State, Zip Code**

**Phone Number**

I, the undersigned, hereby authorize

- [ ] to release copies of medical records to:
- [ ] to obtain copies of medical records from:
- [ ] Verbal release only of medical information to:

**Sinai Neurology**

410-601-9515

**Name of Person or Agency**

410-601-8905

**Address**

5051 Greenspring Avenue, Baltimore MD 21209

**City, State, Zip Code**

**Fax Number**

The purpose or need for such disclosure is

**Dates of Service:**

is authorized to release the following: (Please check information to be released.) The medical records to be released may contain medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV/AIDS testing, HIV/AIDS results or HIV/AIDS information.

- [ ] Abstract (Summary, Op Report, Paths, Consults, H&P, lab work)
- [ ] Emergency Room Record
- [ ] Outpatient Surgery
- [ ] Discharge Summary
- [ ] Admission History and Physical Consultation Report
- [ ] HIV/AIDS Report
- [ ] Doctor's Office Notes
- [ ] Operative Report / Pathology Report
- [ ] Alcohol / Detox / Drug Abuse
- [ ] X-ray, EKG, EEG, Labs, Cardiopulmonary
- [ ] Physical Therapy / OT / Speech
- [ ] Nuclear Medicine
- [ ] Clinic
- [ ] Mental Health / Psychiatry
- [ ] Other

**Signature**

**Date**

**Time**

**Relationship to Patient**

**Witness**

**Date**

**Time**

**Clock #**

This authorization will expire within 1 year unless otherwise indicated. The consent to disclose information may be revoked by me at any time in writing except to the extent that action has been taken in reliance thereon, as set forth in the LifeBridge Health Notice of Privacy Practices. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. Subsequent re-disclosure or recopying of this information is not authorized without specific consent of the patient or authorized representative as provided in the Annotated Code of the State of Maryland, Article 4-302 (d) *Photo Id may be requested at the time of release.*

**MR#**

**Date Completed**

**Completed By**

**# pages**
Complete these documents at home and bring them with you on the day of your appointment.

Patient name: ____________________________________________  Age: _____

Birthdate ____________________________

**Reason for Visit**

__________________________________________________________

<table>
<thead>
<tr>
<th>Medical Problems</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Diabetes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Hypertension</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>3. Heart disease/attack</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>4. Stroke</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>5. Arthritis</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>6. Head trauma/injury</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>7. Headaches</td>
<td>☐</td>
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<tr>
<td>8. Hyperlipidemia/high cholesterol</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>9. Sleep apnea</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>10. Atrial fibrillation/irregular heartbeat</td>
<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>

8. Surgical issues/operations: ________________________________

9. Other: ________________________________

<table>
<thead>
<tr>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father: age ______ ☐ Deceased  Health problems: ____________________________</td>
</tr>
<tr>
<td>Mother: age ______ ☐ Deceased  Health problems: ____________________________</td>
</tr>
<tr>
<td>Brother(s): age ______ ☐ Deceased  Health problems: ____________________________</td>
</tr>
<tr>
<td>Sister(s): age ______ ☐ Deceased  Health problems: ____________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current smoker ☐ No ☐ Yes (amount)______________ How many years? ________</td>
</tr>
<tr>
<td>Past history of tobacco use ☐ No ☐ Yes (amount)______________ How many years? ________</td>
</tr>
<tr>
<td>Alcohol ☐ No (only social) ☐ Yes (amount)______________ How many years? ________</td>
</tr>
<tr>
<td>Illicit drug use ☐ No ☐ Yes  Type__________________________ How many years? ________</td>
</tr>
<tr>
<td>Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other  # of children ________</td>
</tr>
<tr>
<td>Education: ☐ High School ☐ College ☐ Post-graduate ☐ Other ____________________________</td>
</tr>
<tr>
<td>Occupation: Past: ____________________________ Present: ____________________________</td>
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<tr>
<td>Exercise: ☐ No ☐ Yes  How much? ____________________________</td>
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<tr>
<td>Hobbies: ____________________________</td>
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</tbody>
</table>
### Tests (Please bring copies of results and ORIGINAL FILMS).

<table>
<thead>
<tr>
<th>Test</th>
<th>Date</th>
<th>Results</th>
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<tbody>
<tr>
<td>Brain MRI/MRA</td>
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<tr>
<td>Spine MRI</td>
<td></td>
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<tr>
<td>Head CT</td>
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<td>Head CTA</td>
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<tr>
<td>EEG</td>
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<tr>
<td>EMG/NCS</td>
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<tr>
<td>Carotid ultrasound</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Please add any additional information you think might be pertinent.

Symptoms you have experienced in the past few months.

**General**
- [ ] Weight loss
- [ ] Weight gain
- [ ] Fatigue
- [ ] Fever/chills
- [ ] Nausea
- [ ] Vomiting
- [ ] Sleep problems

**Neurologic**
- [ ] Headaches
- [ ] Memory loss
- [ ] Dizziness
- [ ] Vertigo (sensation of room spinning)
- [ ] Difficulty walking
- [ ] Falls
- [ ] Muscle pain
- [ ] Weakness all over
- [ ] Tremor
- [ ] Muscle spasms
- [ ] Sensitivity to noise
- [ ] Difficulty with coordination
- [ ] Head injury
- [ ] Flashing lights
- [ ] Sensitivity to light
- [ ] Pain radiating into arms or legs
- [ ] Back pain
- [ ] Neck pain
- [ ] Seizures
- [ ] Numbness/tingling in

**Ears/Nose/Mouth/Throat**
- [ ] Hearing loss
- [ ] Ear pain
- [ ] Ringing in ears
- [ ] Vertigo (sensation of room spinning)
- [ ] Swallowing difficulty
- [ ] Poor vision
- [ ] Hoarseness or change in voice

**Psychiatric**
- [ ] Nervousness
- [ ] Anxiety
- [ ] Panic attacks
- [ ] Hallucinations
- [ ] Depression
- [ ] Mood swings
- [ ] Learning problems
- [ ] Difficulty with concentration
- [ ] Suicidal thoughts

~ continued ~
Patient name ___________________________       DOB ___________________________ mm/dd/yyyy

**Cardiovascular**

- High blood pressure
- Heart murmur
- Heart failure
- Shortness of breath
- Irregular heartbeat
- Syncope
- Angina/chest pressure
- Cough
- Faintness/lightheadedness
- Palpitations

**Other**

- Ulcer disease
- Abdominal pain
- Reflux disorder
- Sexual dysfunction
- Skin problems
- Excessive or decreased sweating
- Bleeding problems
- Kidney problems
- Bladder problems

**WOMEN ONLY**

# pregnancies _______  # miscarriages ____

Last menstrual period _______________________

Birth control pills       Yes       No

Hormone replacement therapy       Yes       No

Menopause       Yes       No

_________________________       _______________________

signature of patient       date

_________________________       _______________________

signature of physician       date
### Medications—Current
*(Please include over-the-counter medications, e.g., aspirin, Aleve, Advil, herbs, and vitamins.)*

<table>
<thead>
<tr>
<th></th>
<th>Dosage</th>
<th>Times per day</th>
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<tbody>
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<td>14.</td>
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</table>

### Medications—Previous *(Medications used in the past for your current problem.)*

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Name of Medication</th>
<th>Dosage</th>
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<tbody>
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### Medication Allergies

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Neurology New Patient Information (06/08/21)