This welcome packet is for _______________________________________

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

You are scheduled for a transcranial Doppler (TCD) study.

on ____________, ____________, 20____ at _______  am

You are expected to arrive at your registration time _________ am

atorial reminder call 48 hours prior to your appointment.

Your are expected to arrive at the registration time above.

Things You Must Know or Do

1. Read the pages of this packet:
   a. Directions and map
   b. Important instructions
      c. The forms in this packet must be completed and signed before your visit and brought with you when you come (do not mail them).

2. To print more copies of this packet, go to www.lifebridgehealth.org/NeurologyAppointments.

3. Minors must be accompanied by an authorized adult

4. Complete and sign the forms in this packet before your visit and bring them with you when you come (do not mail them).

5. If your insurance company requires you to obtain a referral, it is your responsibility to do so.

6. 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.

7. Please bring cash or credit card for parking.

Things You Must Bring

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

If you have any questions please call us at 410-601-9755.

We look forward to caring for you.
Directions to the Neurodiagnostic Suite • Sinai Hospital of Baltimore
2401 West Belvedere Avenue • Baltimore MD 21215

From the Northwest — From Carroll County, Owings Mills, or Reisterstown, take I-795 to I-695 East (Baltimore Beltway, Towson direction). Take exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10, Northern Parkway. Look below for directions from Northern Pkwy.

From the North — From Pennsylvania and northern Baltimore suburbs, take I-83 South. At junction with I-695 (Baltimore Beltway), enter I-695 heading West (Pikesville direction). Re-enter I-83 South at Exit 23. Proceed for approximately 3 miles and take Exit 10, Northern Parkway. Look below for directions from Northern Pkwy.

From the West — From Howard County and points west, head east on I-70 or I-40 to I-695 East (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10, Northern Parkway. Look below for directions from Northern Pkwy.

From the East and Northeast — From Towson, Harford County, and points further north, take I-95 South to Exit 64, I-695 West (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10, Northern Parkway.

Directions from Northern Parkway to Sinai Hospital — Head west on Northern Parkway. At the second traffic signal, turn left onto West Belvedere Avenue. Sinai Hospital will be on your left. Park in the parking lot and enter through the entrance to the Main Hospital. See "Upon Entering the Hospital" at bottom of this page.

From the South — From the DC, MD, VA area, take I-95 North into downtown Baltimore via the I-395 Exit. Turn RIGHT at W. Pratt Street. Turn LEFT at S. President Street, which becomes I-83 North (Jones Falls Expressway). Take I-83 North to Exit 10B, Northern Parkway West. At the third traffic signal, turn left onto West Belvedere Avenue. Sinai Hospital will be on your left. Park in the parking lot and enter through the entrance to the Main Hospital. See "Upon Entering the Hospital" at bottom of this page.

Parking — At the time of the printing of this packet, parking charges at Sinai are as follows:

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<th>Duration</th>
<th>Charge</th>
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<tr>
<td>0–1/2 hr</td>
<td>$0.00</td>
</tr>
<tr>
<td>1/2–2 hrs</td>
<td>$4.00</td>
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<td>2–3 hrs</td>
<td>$5.00</td>
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<tr>
<td>3–7 hrs</td>
<td>$6.00</td>
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<tr>
<td>Over 7 hrs</td>
<td>$10.00</td>
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Entering the Hospital

1. Enter the hospital through the main entrance and proceed through Covid screening.
2. Look ahead & to the right for a glass-enclosed office and for the sign that says “Patient Registration.”
3. After registering, you will be instructed to have a seat in the main lobby to await a neurodiagnostic technician, who will come to escort you to the 5th floor Neurodiagnostic Suite.
Important Information

Your testing will be performed at

The Neurodiagnostic Suite, Sinai Hospital of Baltimore
2401 W. Belvedere Avenue, Baltimore MD 21215

Please see detailed directions on first page of this packet.

Please help us to be respectful to all of our patients and to our physicians and arrive for your appointment at the time written on the front page of this packet. If you do not arrive on time, we may reschedule your appointment.

✦ Please bring your insurance card and photo ID with you to every visit.

✦ If your insurance requires a referral, please ensure that the referral 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 visit, we may reschedule your test, or you will be responsible for your bill. Please inform us before your appointment of any changes in your insurance coverage.

PAYMENTS FOR CO-PAY AND PARKING
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 let us know 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 patients miss a third appointment without letting us know, we write to advise 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 new providers.

If for any reason you cannot make your appointment, please call 410-601-9755 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.
NECESSARY MEDICAL INFORMATION FOR YOUR VISIT
Please have available for your appointment the name, office address, and phone number of your referring physician and/or primary care provider so that we can communicate with him or her. Please bring a written list (on page 10 of this packet) 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 (MRIs EEG, bloodwork, consultations/reports from other providers), please ensure that you bring the reports, actual images (either on film or CD), or both with you.

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 a physician assistant.

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.
Authorization and Assignment
of Insurance Benefits

Patient name ________________________________ DOB __________

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:

__________________________________________________________________________ __________

insurance company claim number adjuster's phone number

☐ 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:

__________________________________________________________________________ __________

Workers Compensation carrier claim number adjuster's phone number

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

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:

__________________________________________  ____________ relationship

__________________________________________  ____________ relationship

I have read and agree to the above policies.

__________________________________________  ____________ signature of patient  ____________ date (mm/dd/yyyy)
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

Name of Person or Agency 410-601-9515

5051 Greenspring Avenue, Baltimore MD 21209 410-601-8905

Address City, State, Zip Code Phone Number 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.
Patient name ____________________________________________________________

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

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<th>Dosage</th>
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**Medications—Previous** *(Medications used in the past for your current problem.)*

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**Medication Allergies**  
__________________________________________________________________________

*Please complete these documents and bring them with you on the day of your appointment.*