LIFEBRIDGE HEALTH

The Sandra and Malcolm Berman Brain & Spine Institute

SINAI NEUROLOGY FACULTY PRACTICE
Northwest Hospital
5401 Old Court Road, 1st Floor
Randallstown MD 21133
Phone: 410-601-7055
Fax: 410-701-4421

Gurdeep S. Ahluwalia, MD
Neurology

Welcome to The Sandra and Malcolm Berman Brain & Spine Institute

You have an appointment with **Dr. Gurdeep S. Ahluwalia**

on _____, _____, 20_____
Day of the week *Month and Day*

at _____ am/pm.

You will receive an automated reminder call 48 hours prior to your appointment.

Please arrive 30 minutes early to allow a timely registration.

To facilitate your visit, please bring the following enclosed forms:

- Completed Registration Sheet (2-sided yellow)
- Completed New Patient Information Form (3-page green)
- Signed forms (4-page pink)

To print out electronic forms from our web site, please go to:
http://www.lifebridgehealth.org/body.cfm?id=5139

In addition, you must bring:

- Insurance Card
- Photo ID
- Referral if necessary
- A list of your current medications—or bring your medication bottles
- Co-pay if necessary

If you have any questions, please call us at 410-601-7055.

We look forward to caring for you.

LIFEBRIDGE
HEALTH.

The Sandra and Malcolm Berman
Brain & Spine Institute

Gurdeep Singh Ahluwalia, MD, received his medical degree from the Howard University College of Medicine. His postgraduate work includes a one-year internal medicine internship, followed by a four-year neurology residency at the Howard University Hospital.

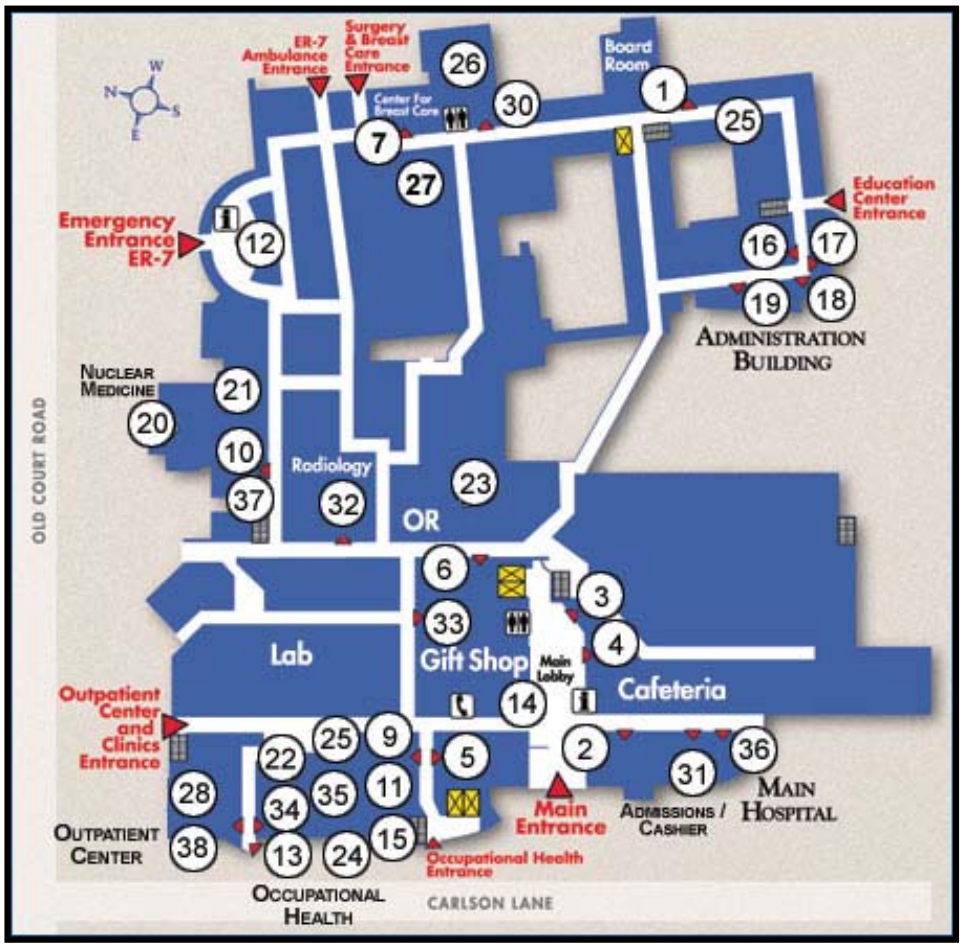
Dr. Ahluwalia received additional fellowship training in clinical neurophysiology at Hahnemann University Hospital (Drexel University). He also holds a master of science degree in genetics and human genetics from Howard University. Dr. Ahluwalia is a frequent lecturer and instructor on stroke, seizures, and other neurologic disorders. His special interests include the use of electromyography and electroencephalography techniques to treat neurophysiologic, neuromuscular, and sleep disorders. As a faculty member of The Sandra and Malcolm Berman Brain & Spine Institute, Dr. Ahluwalia provides services in clinical neurophysiology and consults for general neurology at Northwest Hospital.

Directions to
Northwest Hospital
5401 Old Court Road
Randallstown, MD 21133
410-521-2200

From I-695: Take Beltway Exit 18B (Randallstown) to Liberty Road and proceed two miles to Old Court Road. Turn left onto Old Court Road and go one block to Carlson Lane. The hospital is located on the left.

From I-795: Follow signs to Baltimore. Take Exit 1B to I-695 West (Glen Burnie). Take Exit 18B (Randallstown) to Liberty Road and proceed two miles to Old Court Road. Turn left onto Old Court and go one block to Carlson Lane. The hospital is located on the left.

From Southern Carroll County:
Take Liberty Road (Route 26) toward Baltimore.
Turn right onto Old Court Road and go one block to Carlson Lane. The hospital is located on the left.



LIFEBRIDGE HEALTH®

The Sandra and Malcolm Berman Brain & Spine Institute

Important Information

You will be seen at

Northwest Hospital
5401 Old Court Road, 1st Floor
Randallstown, Maryland

Visitor parking is located on Carlson Lane across the street from the main entrance of the hospital. Enter through the hospital main entrance, make a left at the Gift Shop and continue down the hallway. The Neurology Office is located on the right just past the Outpatient Pharmacy. If you have any questions, please call 410-601-7055

Please help us to be respectful to all of our patients and to our physicians by arriving **15 minutes prior to your appointment time**.

If you do not arrive 15 minutes before the scheduled 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 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, you may need to reschedule, 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 appointments are scheduled through the Neurology Department by calling **410-601-9515**. Please book your follow-up appointments as soon as possible, as we are often full 6–12 weeks in advance. We will call you 2–3 days prior to your appointment to remind you. 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, please call **410-601-7055** 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 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 (MRIs EEG, bloodwork, consultations/reports from other providers), please ensure that you bring those reports and/or films 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. We may be seeing patients all day, and your call may be returned the next day in some instances. Sometimes, your call will be returned by another physician or by our physician assistant, Ms. Kathleen Birnbaum. If you are comfortable with e-mail, we would be happy to communicate with you by email. You can write to our physicians at **bsiphysicians@lifebridgehealth.org**.

PRESCRIPTION REFILLS

For prescriptions refills, your pharmacy must fax a refill authorization request to us at **410-701-4421**. 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 410-601-7055. 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 410-601-7055 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 will receive two bills, one for the doctor's services and one for the hospital's services. For billing questions about your doctor’s bills, please call 410-517-8006. For hospital billing questions relating to any neurodiagnostic tests (EEG, EMG/NCS, or ENG), please call 410-521-5959 or, if you are outside the Baltimore metropolitan area, call toll free at 877-617-1803.

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.

LIFEBRIDGE HEALTH
The Sandra and Malcolm Berman Brain & Spine Institute

Neurology New Patient Registration Sheet

Please bring these documents on the day of your appointment.

NAME:_____ DATE: _____

SOCIAL SECURITY #: _____ DOB: _____ SEX: _____

ADDRESS: _____

CITY, STATE, ZIP _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

CELL PHONE: _____ 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 THOSE DECISIONS FOR YOURSELF? ❒ YES ❒ NO

IF SO, WHO IS THAT PERSON? _____

INSURANCE HOLDER INFORMATION and/or EMPLOYMENT INFORMATION:

NAME OF INSURED IF OTHER THAN PATIENT: _____

SSN: _____

RELATIONSHIP: _____ DOB: _____

EMPLOYER: _____OCCUPATION: _____

ADDRESS: _____ PHONE: _____

CITY, STATE, ZIP: _____

NAME OF INSURANCE: _____

EFFECTIVE DATE: _____ RETIREMENT DATE: _____

INSURANCE ID NUMBER: _____

PLEASE COMPLETE OTHER SIDE

The information furnished above will be used ONLY for billing and accounting purposes.

Neurology New Patient Registration Sheet–page 2

Please bring these documents on the day of your appointment.

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: _____

The information furnished above will be used ONLY for billing and accounting purposes.

LIFEBRIDGE HEALTH

The Sandra and Malcolm Berman Brain & Spine Institute

Neurology New Patient Information Sheet

Please bring these documents on the day of your appointment.

Name: _____ Age: _____

Birthdate _____
mm/dd/year

Reason for Visit

_____

_____

_____

Medical Problems

		Yes	No			Yes	No
1.	Diabetes	☐	☐	6.	Head trauma/injury	☐	☐
2.	Hypertension	☐	☐	7.	Headaches	☐	☐
3.	Heart disease/attack	☐	☐	8.	Surgical Issues/Operations: _____		
4.	Stroke	☐	☐		_____		
5.	Arthritis	☐	☐		_____		
				9.	Other: _____		
					_____		

Family History

Father: age _____ ☐ Deceased Health problems: _____

Mother: age _____ ☐ Deceased Health problems: _____

Brother(s): age _____ ☐ Deceased Health problems: _____

Sister(s): age _____ ☐ Deceased Health problems: _____

Social History

Tobacco ☐ No ☐ Yes (amount)_____ How many years? _____

Alcohol ☐ No (only social) ☐ Yes _____ How many years? _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other # of children _____

Education: ☐ High School ☐ College ☐ Post-graduate ☐ Other

Occupation: Past: _____ Present: _____

Exercise: ☐ No ☐ Yes How much? _____

Hobbies: _____

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

		Dosage	Times per day
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Medications–Previous: (*Medications used in the **past** for **your current problem.***)

	Name of Medication	Dosage		Name of Medication	Dosage
1.	_____	_____	4.	_____	_____
2.	_____	_____	5.	_____	_____
3.	_____	_____	6.	_____	_____

Medication Allergies: _____

Tests (*Please bring copies of results and **ORIGINAL FILMS***).

		Date		*Results*
1.	Brain MRI/MRA	_____	☐ Normal	_____
2.	Spine MRI	_____	☐ Normal	_____
3.	Head CT	_____	☐ Normal	_____
4.	EEG	_____	☐ Normal	_____
5.	EMG/NCS	_____	☐ Normal	_____
6.	Carotid Ultrasound	_____	☐ Normal	_____
7.	Other _____			

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 ☐ Learning problems ☐ Difficulty with concentration
☐ Mood swings ☐ Suicidal thoughts ☐ History of drug abuse ☐ History of alcohol abuse

Cardiovascular

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

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

_____
Patient's Signature

_____
Physician's Signature

LIFEBRIDGE HEALTH

The Sandra and Malcolm Berman Brain & Spine Institute

Patient Authorization

Sinai Hospital of Baltimore Faculty Practice Providers 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 Sinai Neurology Associates 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. 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 email address

5. Make and/or receive calls from pharmacies on my behalf, including prescriptions by FAX.
6. Update my personal demographic information either on the phone or in the office at the time of my appointment.
7. At my request, 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.

_____ _____

Patient Name (print) *Date*

_____

Signature of Patient

LIFEBRIDGE HEALTH

The Sandra and Malcolm Berman Brain & Spine Institute

Authorization and Assignment of Insurance Benefits

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 Sinai 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. 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*

MR7350-501-L

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:

Northwest Hospital, Department of Neurology — Name of Person or Agency

410-601-7055 — Phone Number

5401 Old Court Road, 1st Floor, Randallstown MD 21133 — Address, City, State, Zip Code

410-701-4421 — 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** _____ **Relationship to Patient** _____

Witness _____ **Date** _____

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 _____