

## Welcome to The Sandra and Malcolm Berman Brain & Spine Institute

You have an appointment with Dr. \_\_\_\_\_  
on \_\_\_\_\_, \_\_\_\_\_, 20\_\_\_\_ at \_\_\_\_\_  am  
*day of the week month and day*  pm

You are expected to arrive at your registration time \_\_\_\_\_  am  
 pm

**The clinic is on the 2<sup>nd</sup> floor of 5051 Greenspring Avenue.**

- ☞ You will receive an automated reminder call 48 hours prior to your appointment.
- ☞ Someone from our office will call you the day before your appointment to remind you.

### Things You Must Know or Do

1. Read the pages of this packet for **important instructions**.
2. Complete and sign the forms on pages 5–13 of 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. 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).\*
6. To print out more copies of this packet, go to [www.lifebridgehealth.org/NeurologyAppointments](http://www.lifebridgehealth.org/NeurologyAppointments).

### 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—pages 5–13.
6. A list of current medications (page 13 of this packet) or bring your medication bottles.

If you have any questions, please contact us at

☞ **410-601-9515 or [bsiphysicians@lifebridgehealth.org](mailto:bsiphysicians@lifebridgehealth.org)**

We look forward to caring for you.

## Directions to the Michel Mirowski Medical Office Building

5051 Greenspring Avenue • Baltimore, MD 21209 • 410-601-4417

The clinic in the Mirowski Building is on the 2<sup>nd</sup> floor.

**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 10B, 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 10B, Northern Parkway. **Look below for directions from Northern Parkway.**

**From the West** — From Howard County and points west, head east on I-70 or on 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 10B, Northern Parkway. **Look below for directions from Northern Parkway.**

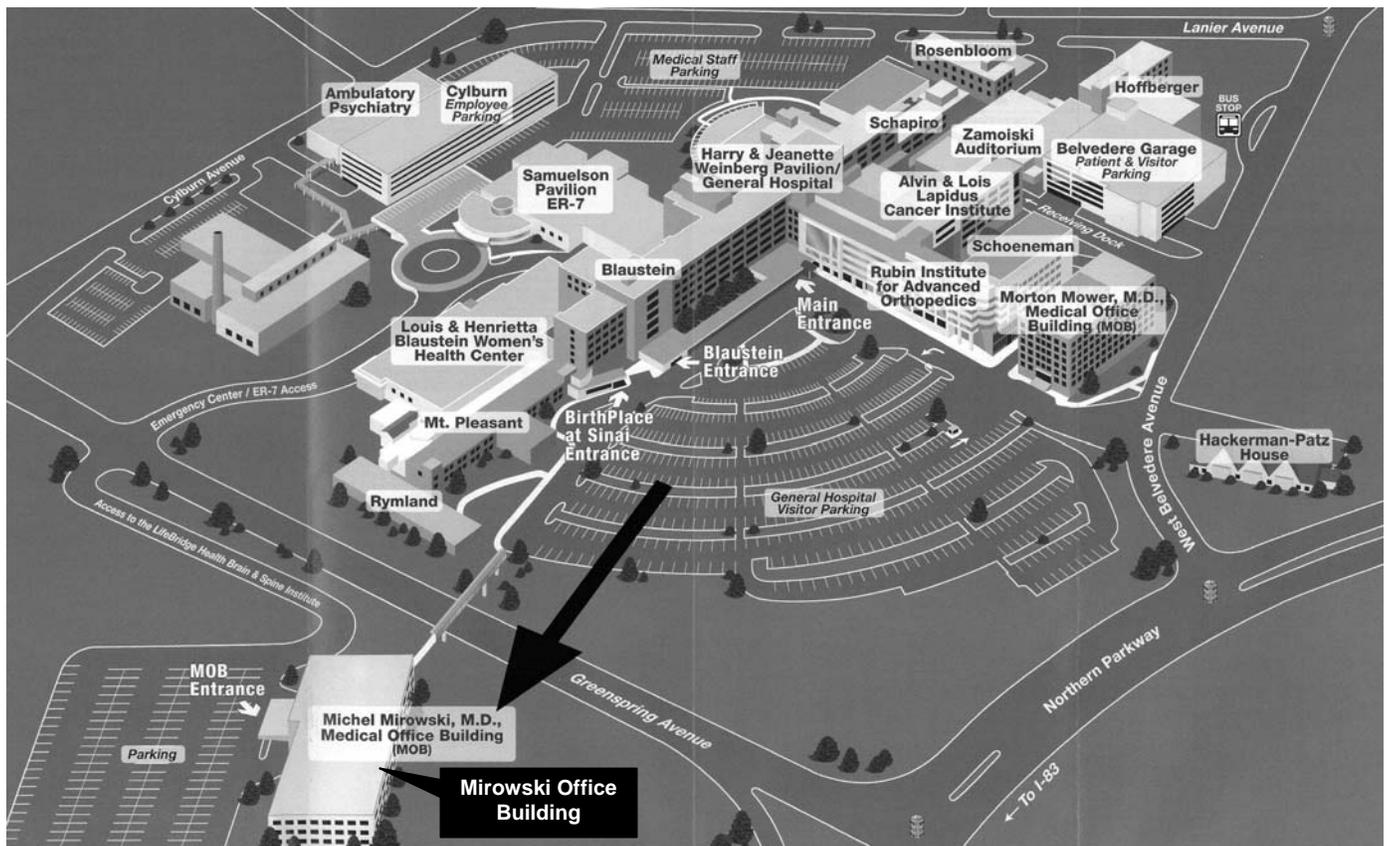
**From the East and Northeast** — From Towson, Harford County, and points farther north, take I-95 South to Exit 64, I-695 West (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. Head west on Northern Parkway. **Look below for directions from Northern Parkway.**

**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-83N/Jones Falls Expressway. Take I-83 North approximately 6 miles to Exit 10B, Northern Parkway West. **Follow directions from Northern Pkwy.**

**DIRECTIONS FROM THE HOFFBERGER BUILDING TO THE MIROWSKI BUILDING** — From the Belvedere Garage turn right onto West Belvedere Avenue, turn right onto Northern Parkway. Turn right onto Greenspring Avenue. **Follow directions below after turn onto Greenspring Avenue.**

### DIRECTIONS FROM NORTHERN PARKWAY TO MIROWSKI BUILDING —

Proceed 0.6 miles up Northern Parkway and turn left at the stoplight onto Greenspring Avenue. Shortly after you pass under a footbridge across Greenspring Avenue, make the very first left into the driveway that leads up the hill to the parking lot. The driveway entrance is directly across from the Emergency Room (ER7) entrance and is marked by a blue sign pointing to the Mirowski Office Building and the Brain & Spine Institute.



## Important Information

**You will be seen in the Michel Mirowski Medical Office Building.  
The clinic is on the 2<sup>nd</sup> floor of 5051 Greenspring Avenue.  
Patient parking is located in front of the main entrance.\***

*Please help us to be respectful to all of our patients and to our physicians.  
On the first page of this packet, you were given an appointment time  
and a registration time. For example,*

if your appointment is scheduled for 8 am, we expect you to arrive  
**15 minutes prior to your appointment time.**

if your appointment is scheduled for any other time, we expect you to arrive  
**30 minutes prior to your appointment time.**

If you do not arrive at these intervals 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 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 scheduled visit, we may need to reschedule your appointment. Please inform us before your appointment of any changes in your insurance coverage.

### **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).

### **SCHEDULING, CANCELLATIONS, and NO-SHOWS**

After your initial visit, we will give you a follow-up appointment card. If you need to reschedule that appointment, please book your follow-up appointments as soon as possible because 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 (on page 9 of this packet) the best way to reach you (home, work, cell, and pager).

If for any reason you cannot make your appointment,  
**please 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.**

### **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 14 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. If you are comfortable with e-mail, we would be happy to communicate with you by email. You can write to our physicians at [bsipphysicians@lifebridgehealth.org](mailto:bsipphysicians@lifebridgehealth.org).

### **PRESCRIPTION REFILLS**

For 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, press #3, and 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, press #3, and leave a complete message. **DO NOT call this phone line for automatic refill requests.**

**NOTE: If you have not been seen by one of our healthcare providers within the last year, we will not write a prescription for you until you have been seen in our clinic.**

### **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.



The Sandra and Malcolm Berman  
Brain & Spine Institute

## Neurology New Patient Registration Sheet

**Please complete these documents and bring them with you 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.

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

PATIENT NAME \_\_\_\_\_

**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.**



The Sandra and Malcolm Berman  
Brain & Spine Institute

## Authorization and Assignment of Insurance Benefits

Patient name \_\_\_\_\_

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. If I have received neurodiagnostic testing, 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*



The Sandra and Malcolm Berman  
Brain & Spine Institute

## 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.

\_\_\_\_\_ *patient signature*

\_\_\_\_\_ *date*



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

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Birthdate \_\_\_\_\_  
mm/dd/year

**Reason for Visit**

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**Medical Problems**

	Yes	No		Yes	No
1. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	6. Head trauma/injury	<input type="checkbox"/>	<input type="checkbox"/>
2. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart disease/attack	<input type="checkbox"/>	<input type="checkbox"/>	8. Surgical Issues/Operations: _____		
4. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____		
5. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____		
			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  Postgraduate  Other

**Occupation:** Past: \_\_\_\_\_ Present: \_\_\_\_\_

**Exercise:**  No  Yes How much? \_\_\_\_\_

**Hobbies:** \_\_\_\_\_

~ continued on other side ~

PATIENT NAME \_\_\_\_\_

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

	<u>Date</u>		<u>Results</u>
1. Brain MRI/MRA	_____	<input type="checkbox"/> Normal	_____
2. Spine MRI	_____	<input type="checkbox"/> Normal	_____
3. Head CT	_____	<input type="checkbox"/> Normal	_____
4. EEG	_____	<input type="checkbox"/> Normal	_____
5. EMG/NCS	_____	<input type="checkbox"/> Normal	_____
6. Carotid ultrasound	_____	<input type="checkbox"/> Normal	_____
7. Other _____			

Please add any additional information you think might be pertinent.

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**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

~ continued ~

PATIENT NAME \_\_\_\_\_

**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

<b>WOMEN ONLY</b>		
# pregnancies _____	# miscarriages _____	
Last menstrual period _____		
Birth control pills	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hormone replacement therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Menopause	<input type="checkbox"/> Yes	<input type="checkbox"/> No

\_\_\_\_\_  
*patient's signature*

\_\_\_\_\_  
*physician's signature*

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

~ continued on other side ~

PATIENT NAME \_\_\_\_\_

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

	<u>Dosage</u>	<u>Times per day</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
8. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____
11. _____	_____	_____
12. _____	_____	_____
13. _____	_____	_____
14. _____	_____	_____

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

<u>Name of Medication</u>	<u>Dosage</u>	<u>Name of Medication</u>	<u>Dosage</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____

**Medication Allergies** *(Please list allergies to medications.)*

\_\_\_\_\_  
\_\_\_\_\_

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