M · I · N · D
MICHIGAN INSTITUTE for NEUROLOGICAL DISORDERS
TEL 248 553-0010 FAX 248 553-5957 28595 Orchard Lake Rd · Ste 200 Farmington Hills, MI 48334 MindOnline.com

PATIENT / VISIT INFORMATION

PATIENT INFORMATION

Name of Patient: _____

Date of Birth: _____

Date of Visit: _____

VISIT INFORMATION

Please complete this form in its entirety, and present it to the registration desk when your name is called along with your picture ID and insurance cards.

Is this visit using your health insurance: ☐ Yes ☐ No

Is this visit related to an auto accident: ☐ Yes ☐ No

Is this visit related to a worker's comp claim: ☐ Yes ☐ No

Financially Responsible Party: ☐ Self ☐ Parent/Guardian ☐ Power of Attorney

Name of Responsible Party (if not self): _____

Source of payment today for copays, deductibles or any outstanding balance:

☐ Cash ☐ Check ☐ Visa ☐ Mastercard

I authorize my insurance company to pay all the insurance benefits rendered.
I authorize the release of all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I acknowledge that the above information is correct, and I understand it is my responsibility to inform the office of any changes as soon as possible.

Patient or Representative's Signature: _____

Date: _____

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PATIENT HIPAA COMMUNICATION FORM

Disclosure to Self and to Others

Patient Name: _____ Patient ID: _____

A. **FAMILY AND FRIENDS**: It is the office policy of **MIND** not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment),(iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caregivers/babysitters, please indicate that below, so that we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

Name	Relationship	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. **ALTERNATIVE COMMUNICATION**: I wish to be contacted in the following manner. (check all that apply)

Home Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Cell Phone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Work Telephone _____

_____ Okay to leave message with details

_____ Leave a call back number only

Written Communication

_____ Okay to mail to home address

Patient Portal Yes or No

X_____ _____ _____

Patient or Representative Signature **Relationship to Patient** **Date**

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NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

- **I am a patient of Michigan Institute for Neurological Disorders (MIND) I hereby acknowledge receipt of the MIND Notice of Privacy Practices Summary. Complete privacy practice policies will be provided upon my request.**

  Name: _____

  Signature: _____

  Date: _____

OR

If Unable to Complete and Sign Form

- I am a parent or legal guardian for a patient of Michigan Institute for Neurological Disorders (MIND). I hereby acknowledge receipt of MIND's Notice of Privacy Practices with respect to the above noted patient.

  Name: _____

  Signature: _____

  Relationship to Patient: _____

  Date: _____

- **If the Patient Refuses to Sign - an Employee of MIND Will Note and Sign Below.**

  ☐ Patient Refused – *(Reason – if given)*_____

_____ Date: _____
MIND Employee Signature

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FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drug programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

By signing below I give permission for **MIND** to access my pharmacy benefits data electronically.

This consent will enable **MIND:**

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.

_____ _____
Patient Name (PRINTED) Date of Birth

_____ _____
Patient/Guardian Signature Date

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Name: _____ **Date:** _____

Referring Physician _____ **Primary Care Physician** _____

Reason for Appointment- Please list current symptoms that led to referral and date of onset:

_____

_____

_____

Past Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding disorder
- ☐ Cataracts/Blindness
- ☐ Concussion
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ History of cancer _____
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Peripheral vascular disease
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke or TIA
- ☐ Thyroid disease
- ☐ Ulcers/Reflux

Others: _____

Symptoms:

- ☐ Abdominal pain
- ☐ Abnormal bleeding
- ☐ Anxiety
- ☐ Back pain
- ☐ Blackouts
- ☐ Bladder dysfunction
- ☐ Change in personality
- ☐ Chest pain
- ☐ Cough
- ☐ Depression
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Dizziness/Vertigo
- ☐ Double vision
- ☐ Dry eyes
- ☐ Dry mouth
- ☐ Fatigue
- ☐ Headaches
- ☐ Hearing loss
- ☐ Heat/Cold intolerance
- ☐ Involuntary movements
- ☐ Loss of vision
- ☐ Loss/Decreased balance
- ☐ Memory problems
- ☐ Mood swings
- ☐ Muscle cramps
- ☐ Muscle spasms
- ☐ Nasal congestion
- ☐ Nausea/Vomiting
- ☐ Neck pain
- ☐ Numbness, where ___
- ☐ Palpitations
- ☐ Poor coordination
- ☐ Rash
- ☐ Ringing in ears
- ☐ Shortness of breath
- ☐ Slurred speech
- ☐ Stiffness
- ☐ Swollen glands
- ☐ Swollen joints
- ☐ Tingling/Burning sensation
- ☐ Tremor
- ☐ Weakness, where ___
- ☐ Weight loss
- ☐ Other_____

Have you had an MRI or CT in the last 5 years?_____

If yes, where? _____

(Please turn page over)

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Past Surgical History:

- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bowel resection
- ☐ Breast surgery
- ☐ Caesarean delivery
- ☐ Cancer removal
- ☐ Cardiac pacemaker
- ☐ Carpal tunnel repair
- ☐ Colonoscopy
- ☐ D & C
- ☐ Dialysis
- ☐ Eye surgery
- ☐ Gall bladder removal
- ☐ Heart surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Kidney surgery
- ☐ Knee surgery
- ☐ Laparoscopy
- ☐ Lumbar spine surgery
- ☐ Neck surgery
- ☐ Prostate
- ☐ Shoulder surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Vasectomy

Additional Surgeries: _____

Family History: (Please indicate which family member next to the disorder)

ALS _____
Alzheimer's disease _____
Brain aneurysm _____
Cancer, Type _____
Depression or other mental illness _____
Heart disease _____
High blood pressure _____
Migraines _____
Motor neuron disease _____
Multiple Sclerosis _____
Myelopathy _____
Neuropathy _____
Parkinson's disease _____
Seizures _____
Stroke _____
Tics _____
Tourette's syndrome _____
Tremors _____

List any others _____

Social History:

Do you smoke? ____No ____ Yes _____Former
If yes, how much? _____
Do you consume alcohol?____No ____Yes
If yes, how much? _____

Are you married? _____ # of children? _____

Occupation? _____

Medication Allergies: _____

Medications	Dose	Frequency