



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](http://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
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Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
------	--------------	-------

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

**Home Phone** \_\_\_\_\_

**Cell Phone** \_\_\_\_\_

\_\_\_\_\_ Okay to leave message with details

\_\_\_\_\_ Okay to leave message with details

\_\_\_\_\_ Leave a call back number only

\_\_\_\_\_ Leave a call back number only

**Work Telephone** \_\_\_\_\_

**Written Communication**

\_\_\_\_\_ Okay to leave message with details

\_\_\_\_\_ Okay to mail to home address

\_\_\_\_\_ Leave a call back number only

**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) \_\_\_\_\_

\_\_\_\_\_  
**MIND Employee Signature** Date: \_\_\_\_\_



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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



**MEDICAL INFORMATION SHEET**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ DOB: \_\_\_\_\_

▪ Do you have MS:  Yes  No  Don't Know

▪ Year of Onset of 1<sup>st</sup> Symptoms: \_\_\_\_\_ ▪ Year of Diagnosis: \_\_\_\_\_

**TYPE OF MS:**

- Don't Know
- Secondary Progressive
- CIS (Clinically Isolated Syndrome)
- NMO
- Relapsing Remitting
- Primary Progressive
- Progressive Relapsing
- N/A

**ALLERGIES / MEDICATION ALLERGIES (please list all allergies)** \_\_\_\_\_

**PREVIOUS MS THERAPIES (if applicable)**

MS Therapy	Year Started	Year Stopped	MS Therapy	Year Started	Year Stopped
<input type="checkbox"/> Betaseron®			<input type="checkbox"/> Cytoxan®		
<input type="checkbox"/> Avonex®			<input type="checkbox"/> Novantrone®		
<input type="checkbox"/> Copaxone®			<input type="checkbox"/> Gilenya®		
<input type="checkbox"/> Rebif®			<input type="checkbox"/> Aubagio®		
<input type="checkbox"/> Tysabri®			<input type="checkbox"/> Tecfidera®		
<input type="checkbox"/> Extavia®			<input type="checkbox"/> Other _____		

Other: \_\_\_\_\_

**PAST SURGICAL HISTORY (check all that apply to you and INCLUDE YEAR surgery was done):**

**Cardiac**

- Angioplasty
- Stent
- Bypass

**Bariatric**

- Gastric Bypass
- Lap Band
- Gastric Sleeve

**Skin**

- Biopsy
- Excision (Removal of Lesion)

**Cancer Surgery**

Type \_\_\_\_\_

**Plastic Surgery**

Type \_\_\_\_\_

**Ocular**

- Cataract
- Lasik

**General**

- Gall Bladder
- Hernia Repair
- Appendectomy
- Tonsillectomy/Adenoidectomy

**OB/GYN**

- C-Section
- Hysterectomy
- Tubal Ligation

**Other:**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



**MEDICAL INFORMATION SHEET CONT.**

**PAST MEDICAL HISTORY (check all that apply to you):**

**Respiratory**

- Asthma
- COPD
- Emphysema
- Pneumonia
- PE/DVT
- Other: \_\_\_\_\_

**Cardiovascular**

- Heart Arrhythmia
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Peripheral Vascular Disease
- Other: \_\_\_\_\_

**Psychiatric**

- Depression
- Anxiety
- Psychiatric  
(Bipolar, OCD, Schizophrenic)

**Cancer**

- Type:**  
\_\_\_\_\_

**Genitourinary**

- Frequency
- Urgency
- Retention
- Incontinence
- Self-Catheterizes
- Frequent UTI's
- Other: \_\_\_\_\_

**Gastro-Intestinal**

- Gall Stones
- Diarrhea
- Constipation
- Nausea
- Hepatitis
- Other: \_\_\_\_\_

**Neurological**

- ADD/ADHD
- Aneurysm
- Headaches
- Migraines
- Restless Leg Syndrome
- Seizures/Epilepsy
- TIA / Stroke
- Other: \_\_\_\_\_

**Endocrine**

- Diabetes (Type I or Type III)
- Kidney Stones
- Kidney Disease
- Thyroid Disease
- Other: \_\_\_\_\_

**Skin**

- Eczema
- Psoriasis
- Skin Cancer
  - o Type: \_\_\_\_\_
- Other: \_\_\_\_\_

**Infections**

- HIV / AIDS
- Mononucleosis
- Shingles
- Other: \_\_\_\_\_

**Musculoskeletal**

- Back Pain
- Joint Pain
- Other: \_\_\_\_\_

**Other:**

- \_\_\_\_\_
- \_\_\_\_\_

**SOCIAL HISTORY:**

- Do you Smoke Tobacco (*cigarettes, cigars, pipe etc.*):  Never  Yes  Quit
  - o How many packs/day: \_\_\_\_\_ # of Years Smoked: \_\_\_\_\_ When did you Quit: \_\_\_\_\_
- Do you Drink alcohol:  No  Never  Yes - How many ounces: \_\_\_\_\_ per  Day  Week  Month
- Recreational Drugs:  No  Never  Yes – Please List: \_\_\_\_\_

