New Orleans Headache & Neurology Clinic, A.P.M.C.

Dhanpat C. Mohnot, M.D., F.A.A.N., F.A.H.S.

Medical Director, Board Certified Neurologist

Cornel T. Rogers, M.D.

Neurologist

Phone (504) 391-7547 ♦ Fax (504) 391-7549

Welcome to our Practice

Dear Patient:

We would like to extend our sincere appreciation for selecting ***New Orleans Headache & Neurology Clinic, A.P.M.C.*** to take care of your neurological problems. We will make all of the attempts to provide you with the best possible high quality neurological care we can deliver and to earn the confidence you have placed in us.

Our survey has indicated that most of you are very much satisfied with our services, **except you would like to reduce your waiting time.** We value your time and we would, as much as you, like to see you as close to your scheduled appointment as possible, **except in emergencies or circumstances beyond our control.**

To accomplish this goal, we would like you to **come prepared with the following information:**

- ✓ **An updated list of all prescription, non-prescription, herbal medications, or any other drugs currently taking.**
- ✓ **List of all medications that need refills.**
- ✓ **Complete headache or seizure diary as directed.**
- ✓ **Date and location of any test taken since your last appointment**
- ✓ **Write down any brief questions or concerns you would like to be addressed. (If questions require longer than anticipated time then we may request you to schedule another appointment)**
- ✓ **Bring the name and phone # of your primary treating physician or their business card.**
- ✓ **Current Insurance Card, and personal information if changed from last appointment.**
- ✓ **Direct any non-medical or administrative questions to our office staff and they will be glad to assist you.**

These simple steps may help us to provide you with our services within reasonable time. Your cooperation is greatly appreciated.

Sincerely,
Doctors and Staff

New Orleans Headache & Neurology Clinic, A.P.M.C.
120 Meadowcrest Street Suite 420
Gretna, Louisiana 70056
Telephone (504) 391-7547 Fax (504) 391-7549

D. C. Mohnot, M.D., F.A.A.N., F.A.H.S.
Medical Director
Board Certified Neurologist
Board Certified Headache Specialist
Headache Management
Neurology, EEG, EMG, NCV, BOTOX

Cornel T. Rogers, M.D.
Neurologist
Neuromuscular Disorders
EMG, NCV

PATIENT REGISTRATION DATE: _____

REFERRED BY: Dr. _____/FRIEND/PHONEBOOK/ATTORNEY/OTHER_____

NAME: _____JR / SR / II /III MARITAL STATUS: S / M / W / D / SEP

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

STREET ADDRESS: _____APT._____ PHONE: ( ) _____

CITY, STATE, ZIP: _____ PAGER/CELL#: ( ) _____

SPOUSE'S NAME: _____DOB:_____ PARENT/GUARDIAN **(IF UNDER 18)**: _____

EMERGENCY CONTACT # (OTHER THAN SPOUSE): ( ) _____RELATIONSHIP: _____

PATIENT'S OCCUPATION: _____ EMAIL ADDRESS: _____@_____

EMPLOYER: _____SPOUSE'S EMPLOYER: _____

WORK NUMBER: ( ) _____EXT. _____ WORK NUMBER: ( ) _____EXT. _____

INSURANCE: _____ **IS YOUR ILLNESS RELATED TO ANY INJURY?**

WORK/CAR ACCIDENT/OTHER: _____

Thank you for choosing **New Orleans Headache & Neurology Clinic, A.P.M.C.** to meet your healthcare needs. Your registration is to provide vital information to assure that your medical record is accurate and so that a medical claim form can be submitted on your behalf. Please review the items listed below to be sure that you clearly understand them. We will be happy to answer any questions concerning our services at **N.O.H.N.C.** including the billing process and your insurance coverage based on the information provided to us by your insurance carrier. I have provided and reviewed the above personal information and it is true and correct. I, the undersigned, hereby consent to such examination and procedures as, in the judgment of my physician, may be considered necessary or advisable while I remain as a patient at **New Orleans Headache & Neurology Clinic, A.P.M.C.** I understand that my insurance will be billed for my convenience as a **courtesy**. **I understand that I am responsible for any non-covered services, deductibles, and co-payments.**

I understand that as a participant of a managed care group my medical care may need a referral from my primary care physician or may require prior authorization from my insurance carrier. **N.O.H.N.C. participates with over 100 insurance companies and makes every effort to obtain authorization, however you are responsible for meeting the demands of your insurance carrier. To avoid any misunderstandings, we advise that you review and know your insurance policy and benefits.**

If you fail to comply with your insurance carrier's requirements it may result in denial of payment at which time you will be responsible for the total charges of our service(s).

NEW ORLEANS HEADACHE & NEUROLOGY CLINIC, A.P.M.C.

Patient Registration Form Cont…

I, the undersigned, hereby authorize N.O.H.N.C. to release all or any part of my medical information necessary to process any claim. I authorize to release any medical information to such insurance company (s), health care plan administrator, workman's compensation carrier, welfare agencies, their respective medical auditors' agents, or to the Social Security Administration or its intermediaries, carriers, to any other person or corporation which is or may be liable under contract or assignment to the clinic for all or any part of the charge(s) rendered. I further authorize the release of medical information to my referring physician, hospital, or Attorney.

I, the undersigned, hereby authorize payment of my medical services directly to **New Orleans Headache & Neurology Clinic, A.P.M.C.** I understand that I am financially responsible for the charges not covered or allowed by my insurance company. Should the account become delinquent and be referred to a collection agency or an attorney, I shall pay any fees and collection expenses. All delinquent accounts could bear an interest rate of 18% per annum.

I, the undersigned, understand that I may be charged $50.00 per appointment that is missed or canceled without giving the office a 24 hour notice. If I continuously fail to keep my appointments the clinic may not continue to provide medical treatment and may terminate medical service(s) to me. **New Orleans Headache & Neurology Clinic, A.P.M.C. reserves the right to charge for broken appointments without 24 hrs advance notice.**

I, the undersigned, understand that it is my responsibility to inform the clinic if I have CHANGED MY HEALTH INSURANCE CARRIER. I also understand that failure to provide this information would leave me responsible for all incurred charges during the course of my treatment at N.O.H.N.C.

For Medicare Patient's Only:
I, the undersigned, hereby certify that the information given by me in applying for payment on my behalf for the services of **N.O.H.N.C.** under Title XVII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payments of authorized benefits and services be made on my behalf to **N.O.H.N.C. or my treating physician.** I understand that I am responsible for any remaining balance not covered by my carrier. I also understand that I have a $226.00 calendar year deductible that must be paid prior to Medicare paying its allowable benefits. **I understand that it is my responsibility to notify N.O.H.N.C. if I have joined a MEDICARE HMO and I also understand that failure to provide this information would leave me responsible for all incurred charges during the course of my treatment at N.O.H.N.C.**

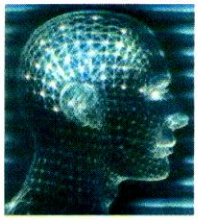
A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL

I, THE UNDERSIGNED, HEREBY CERTIFY THAT I HAVE READ THE FOREGOING, RECEIVED A COPY AND AM THE PATIENT, THE PATIENT'S LEGAL REPRESENTATIVE, OR AM DULY AUTHORIZED BY THE PATIENT, AS THE GENERAL AGENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

_____ _____
Patient's signature **Date**

_____ _____
Signature of Holder-Assignor-Parent-Guardian **Date**

_____
If other than Patient, indicate Relationship



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E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

e-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

• ***Formulary and benefit transactions*** *— Gives the prescriber information about which drugs are covered by the drug benefit plan.*

• ***Medication history transactions*** *- Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.*

• ***Fill status notification*** *- Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.*

By signing this consent form, you are agreeing that New Orleans Headache & Neurology Clinic, A.P.M.C., Dr. D.C. Mohnot, Dr. Cornel T. Rogers, can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to New Orleans Headache & Neurology Clinic, A.P.M.C., Dr. D.C. Mohnot, Dr. Cornel T. Rogers, to enroll me in the e-Prescribe Program.

I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____
Print Patient's Name Patient D.O.B.

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

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NEUROLOGY – HISTORY & PHYSICAL

DATE: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ M / F

REFERRED BY: Dr. _____ Friend/Phonebook/Atty/Other: _____

LIST ANY DRUG ALLERGIES: _____

DESCRIBE DETAILS OF YOUR SYMPTOMS AND DURATION THAT BRINGS YOU TO OUR CLINIC:

_____

_____

IS YOUR ILLNESS RELATED TO ANY TRAUMA OR INJURY? **YES / NO**
IF YES, WHERE DID THE INJURY OCCUR? WORK / CAR ACCIDENT / OTHER: _____

LIST ANY PAST OPERATIONS: Hyst / Gallbladder / Appendix / Neck / Back / Knees / Heart / Bypass / Pacemaker / Carotids / Cataract / Breast / Other: _____

FEMALES ONLY 1ST DAY OF LAST MENSTRUAL CYCLE: _____ **ARE YOU PREGNANT? YES / NO**

DO YOU HAVE OR HAD ANY OF THE FOLLOWING SYMPTOMS:

□ Headache/Migraine	□ Murmur-Heart	□ Cancer	□Menstrual dysfunction
□ Speech Difficulty	□ High Blood Pressure	□ Kidney disease	□ Sexual dysfunction
□ Epilepsy/Seizures	□ Head injury	□ Fatigue	□Gynecological disease
□ Stroke	□ Neck / Back pain	□ Memory	□ Venereal disease
□ Dizziness	□ Spinal Cord Injury	□ Eyes / Vision	□ HIV
□ Poor balance / coordination	□ Tingling / Numbness	□ Ear/Nose/Throat	□ Alcohol abuse
□ Pass-out/ Faint	□ Arthritis neck/back/knee	□ Asthma	□ Smoking
□ Weakness Arms / Legs	□ Bleeding disorder	□ Allergy/hay fever	□ Drug Use
□ Depression/Anxiety	□ Anemia	□ Liver disease/hepatitis	□ _____
□ Heart attack	□ Diabetes	□ Stomach ulcer / Reflux	□ _____
□ Irregular heart beat	□ Poor Circulation	□ Tuberculosis	□ _____
□ Congestive heart failure	□ Thyroid disease	□ Colon Polyp	□ _____
□ Coronary artery disease	□ Wt. loss / gain	□ Emphysema	□ _____

FAMILY HISTORY: □ Heart Disease □ High blood pressure □ Diabetes □ Cancer □ Arthritis □ Headache □ Epilepsy □ Stroke □ Kidney □ Thyroid □ Depression □ Asthma □ Emphysema □ Alzheimer □ Parkinsonism

PERSONAL HISTORY: **Martial Status: Married / Divorced / Single / Widow**
If married how long? _____mths / years **How is your marriage?** _____
Any Children list each age under their gender? Male _____Female_____
Age of your parents (if deceased age when expired)? **Mom _____ yrs Dad _____ yrs**
Any Siblings list each age under their gender: Brothers_____Sisters_____
Any stress: □ Work □ Personal □ Family □ _____

SYMPTOMS LIST: Check off any of these symptoms which have been most bothersome or have occurred frequently during the last 4 weeks.

GENERAL SYMPTOMS

- ☐ Fever
- ☐ Repetitive, senseless thoughts
- ☐ Repetitive, senseless behaviors
- ☐ Fainting or feeling faint
- ☐ Tremors, trembling or shakiness
- ☐ Seizures
- ☐ Easy bruising
- ☐ Skin rash
- ☐ Violent behavior
- ☐ Constant worry
- ☐ Irritability
- ☐ Tension
- ☐ Nervousness
- ☐ Feeling in a dreamlike state
- ☐ Fearful feelings
- ☐ Fear of losing control
- ☐ Jumpiness
- ☐ Keyed up/on edge
- ☐ Restlessness
- ☐ Sweating
- ☐ Dizziness/lightheadedness
- ☐ Weakness
- ☐ Headache
- ☐ Insomnia/trouble sleeping
- ☐ Agitation
- ☐ Fatigue–lack of energy
- ☐ Trouble concentrating
- ☐ Helpless feelings
- ☐ Increase or decrease in appetite
- ☐ Increase or decrease in weight
- ☐ Sad/depressed/down in the dumps
- ☐ Frequent crying or weeping
- ☐ Frequent thoughts of death or suicide
- ☐ Worthless feelings
- ☐ Excessive feelings of guilt
- ☐ Hopeless feelings
- ☐ Lack of/loss of interest in things
- ☐ Feeling life is not worth living
- ☐ Decrease in sex drive
- ☐ Sleeping too much
- ☐ Frequent negative thinking
- ☐ Trouble making decisions
- ☐ Memory problems
- ☐ Fear of doing something uncontrollable
- ☐ Fear of dying
- ☐ Chills
- ☐ Seeing or hearing things that are not real
- ☐ Fear of going crazy

FOCUS

Well-Being Chart

Name _____

☐ Male ☐ Female Age _____ Today's Date _____

Instructions: *This Well-Being Chart is a confidential document between you and your doctor. It is intended to help you and your doctor discuss your well-being openly and candidly. Your doctor may ask you more questions about some of these items to pinpoint problems you may have. Please answer each question in the space provided.*

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Medical Director, Board Certified Neurologist

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Neurologist

Phone (504) 391-7547 ◆ Fax (504) 391-7549

Office comments:

_____

_____

_____

_____

THIS AREA FOR OFFICE USE ONLY

NEW ORLEANS HEADACHE & NEUROLOGY CLINIC'S
STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed
The information covered by this authorization includes:

My Protected Health Information, physician instructions, messages, Communication(s) by telephone and/or personal fax, etc.

Persons Authorized to Use or Disclose information
Information listed above will be used or disclosed by:

NEW ORLEANS HEADACHE & NEUROLOGY CLINIC, A.P.M.C.
D.C. MOHNOT, M.D., F.A.A.N., F.A.H.S.
CORNEL T. ROGERS, M.D.
120 Meadowcrest Street, Ste. 420, Gretna, LA 70056
Telephone (504) 391-7547 ♦ Fax (504) 391-7549

Expiration Date of Authorization
This authorization is effective as dated below unless revoked or terminated by the patient or the patient's Holder-Assignor-Parent-Guardian.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to New Orleans Headache & Neurology Clinic, A.P.M.C.
You should contact our Privacy/Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. **The privacy of this information may not be protected under the federal privacy regulations.**

****In the event of an emergency or otherwise, who would you authorize us to share your information:** Information described above may be disclosed to:

****Spouse / Father / Mother / Other:**

****Name of Person / Employer / Organization:**

Name of patient (Print)

Signature of Patient Date

Signature of Patient's Holder-Assignor-Parent-Guardian.

If other than Patient, indicate Relationship

Acknowledgement of receipt of New Orleans Headache & Neurology Clinic's, Dhanpat C. Mohnot, M.D., F.A.A.N., F.A.H.S., Cornel T. Rogers, M.D. HIPAA Notice of Privacy Practices

I, _____, acknowledge that I have received New Orleans
Print Patient's Name
Headache & Neurology Clinic's Notice of Privacy Practices. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or the request additional confidential treatment of communications between New Orleans Headache & Neurology Clinic, A.P.M.C., Dhanpat C. Mohnot, M.D., Cornel T. Rogers, M.D., and myself or others.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____
Patient's Signature **Date**

_____
Signature of Holder-Assignor-Parent-Guardian

_____
If other than Patient, indicate Relationship

HIPAA Notice of Privacy Practices

NEW ORLEANS HEADACHE & NEUROLOGY CLINIC, A.P.M.C.
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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.