



2PSMHX

Welcome to the Neurosciences Department at Inova. We are committed to making your experience with us as pleasant and stress-free as possible. To enhance our service to you, please fill out this information sheet prior to arriving for your appointment. Let us know if there is anything we can do to improve your visit with us. We would like you to have an excellent experience with us and our team.

Date of Appointment: _____

Age: _____ Sex: Male Female Dexterity: Right Handed Left Handed

Patient Address: _____

Primary Care Physician: _____

Who referred you to our office? _____

Preferred Pharmacy: _____ (phone): _____

(address): _____

History of Present Illness

Chief Complaint – What is the problem for which you are here today? _____

When and how did this problem begin? _____

What are your symptoms? _____

How long have you had these symptoms? _____

What makes your symptoms better? _____

What make your symptoms worse? _____

Was the problem the result of an accident? Yes No

If yes: Date of Accident: ____ / ____ / ____ Briefly describe the nature of the accident: _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

Gender: Male Female

**Inova Physician Enterprise
Medical Condition and History –
Neurosurgery Brain**





Attempted Treatments

Treatments	Not Applicable	Medications (check all that apply)		
Anticonvulsants	<input type="checkbox"/>	<input type="checkbox"/> Lyrica/Pregabalin <input type="checkbox"/> Keppra/Levetiracetam	<input type="checkbox"/> Neurotin/Gabapentin <input type="checkbox"/> Other:	<input type="checkbox"/> Topomax/Topiramate
Antidepressants or anxiolytics	<input type="checkbox"/>	<input type="checkbox"/> Ativan/Lorazepam <input type="checkbox"/> Xanax/Alprazolam	<input type="checkbox"/> Elavil/Amitriptyline <input type="checkbox"/> Other:	<input type="checkbox"/> Klonopin/Clonazepam
Anti-inflammatory medications	<input type="checkbox"/>	<input type="checkbox"/> Advil/Ibuprofen <input type="checkbox"/> Mobic/Meloxicam <input type="checkbox"/> Voltran/Diclofenac Sodium	<input type="checkbox"/> Aleve/Naproxen <input type="checkbox"/> Naprosyn/Naproxen <input type="checkbox"/> Other:	<input type="checkbox"/> Celebrex/Celecoxib
Oral steroids	<input type="checkbox"/>	<input type="checkbox"/> Cortisone <input type="checkbox"/> Other:	<input type="checkbox"/> Medrol Dose Pack/MethylPrednisolone	
Muscle relaxants	<input type="checkbox"/>	<input type="checkbox"/> Flexeril/Cyclobenaprine <input type="checkbox"/> Valium/Diazepam	<input type="checkbox"/> Skelaxin/Metaxalone <input type="checkbox"/> Other:	<input type="checkbox"/> Soma/Carisoprodol
Narcotic medications	<input type="checkbox"/>	<input type="checkbox"/> Oxycontin/Oxycodone <input type="checkbox"/> Tylenol #3/Tylenol-Codeine <input type="checkbox"/> Other:	<input type="checkbox"/> Percocet/OxycodoneHydrochloride <input type="checkbox"/> Vicodin/Hydrocodene/Acetaminophen	
Non-narcotic medications	<input type="checkbox"/>	<input type="checkbox"/> Tylenol/Acetaminophen <input type="checkbox"/> Ultram/Tramadol	<input type="checkbox"/> Ultracet/Acetaminophen Tramadol <input type="checkbox"/> Other:	
Other:				

Interventions (check better, worse, or same for each intervention)

Intervention	Indicate effect on your condition			
	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> Same	<input type="checkbox"/> Not Applicable
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bedrest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace or corset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous Brain Surgeries

Not Applicable

Date	Location	Surgeon

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**Inova Physician Enterprise
Medical Condition and History -
Neurosurgery Brain**





Review of Systems

System	Do you currently have, or have you had (check all that apply):
Constitutional	<input type="checkbox"/> Activity change <input type="checkbox"/> Chills <input type="checkbox"/> Face swelling <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sweating
Ear/Nose	<input type="checkbox"/> Ear ringing <input type="checkbox"/> Hearing loss <input type="checkbox"/> Nasal discharge <input type="checkbox"/> Nose bleed <input type="checkbox"/> Postnasal drip
Eyes	<input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye pain <input type="checkbox"/> Light sensitivity
Gastrointestinal	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloody stool <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting
General	<input type="checkbox"/> Appetite change <input type="checkbox"/> Headaches <input type="checkbox"/> Recent weight gain <input type="checkbox"/> Recent weight loss
Genitourinary	<input type="checkbox"/> Discharge <input type="checkbox"/> Frequent urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Urgency <input type="checkbox"/> Urinary retention
Heart	<input type="checkbox"/> Chest pain or tightness <input type="checkbox"/> Fainting <input type="checkbox"/> Palpitations <input type="checkbox"/> Other heart trouble
Hematologic	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen nodes
Lungs	<input type="checkbox"/> Chronic cough <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Wheezing
Musculoskeletal	<input type="checkbox"/> Fractures <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Leg swelling <input type="checkbox"/> Muscle pain
Neurologic	<input type="checkbox"/> Dizziness <input type="checkbox"/> Memory loss <input type="checkbox"/> Seizures <input type="checkbox"/> Speech difficulty <input type="checkbox"/> Tremors
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Excessive stress <input type="checkbox"/> Hallucinations <input type="checkbox"/> Suicidal thoughts
Skin	<input type="checkbox"/> Color change <input type="checkbox"/> Enlarged glands <input type="checkbox"/> Infection <input type="checkbox"/> Moles or skin lesions <input type="checkbox"/> Rash
Throat	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore throat <input type="checkbox"/> Swallowing difficulty <input type="checkbox"/> Voice change
Additional Comments:	

Allergies (check "No Known Allergies" or indicate allergies below): No Known Allergies

Medical History (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nerve disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Muscle disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | | |

Surgical History (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Brain surgery | <input type="checkbox"/> Colon surgery | <input type="checkbox"/> Small intestine surgery |
| <input type="checkbox"/> Breast surgery | <input type="checkbox"/> Cosmetic surgery | <input type="checkbox"/> Spine surgery |
| <input type="checkbox"/> Coronary Artery Bypass Graft (CABG)/Heart bypass surgery | <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Tonsilectomy |
| <input type="checkbox"/> Carotid endarterectomy | <input type="checkbox"/> Fracture repair surgery | <input type="checkbox"/> Tubal ligation |
| <input type="checkbox"/> Cesarean section | <input type="checkbox"/> Hernia repair surgery | <input type="checkbox"/> Valve replacement |
| | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vasectomy |
| | <input type="checkbox"/> Joint replacement surgery | <input type="checkbox"/> Other: _____ |

PATIENT IDENTIFICATION

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Gender: Male Female





Medication

Medication	Dose	Frequency

Family Medical History

Do you have a history of any of the following in your family? (check all that apply)

- Anemia Cancer Heart disease Stroke
 Aneurysm Diabetes Hypertension

Other family medical concerns: _____

Social History

Marital Status: Single Married Domestic partner Divorced Widowed Other: _____

Occupation: _____

Number of Children: _____ Children live with: _____

Do you drink alcoholic beverages? Yes No Never have

If yes, what kind(s): Wine Beer Liquor

How many per week? _____

Do you smoke cigarettes or used tobacco products? Yes No Never have

If yes, how many packs per day? _____ How many years? _____

Do you vape? Yes No Never have How many years? _____

If you have quit smoking or using tobacco products, when did you quit? _____

Do you use recreational drugs? Yes No Never have

If yes, what kind(s): Cocaine Crack cocaine Heroin LSD

Marijuana Methamphetamine Prescription drugs

Other: _____

Do you use caffeine products? Yes No

If yes, what kinds(s): _____

How many much per week: _____

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Gender: Male Female

**Inova Physician Enterprise
Medical Condition and History -
Neurosurgery Brain**





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My signature verifies that the information provided is correct to the best of my knowledge.

Patient or Designated Decision Maker (signature)

Date

Time

If Designated Decision Maker (print name)

Relationship

Reviewed by Physician (signature): _____

Date: _____

Time: _____

Physician (print name): _____

Interpreter Information (To be completed by Inova staff, if applicable):

In person Telephonic Video Interpreter name/ID number (if applicable) _____

Patient/Designated Decision Maker was offered and refused interpreter Waiver signed

PATIENT IDENTIFICATION

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Gender: Male Female

**Inova Physician Enterprise
Medical Condition and History -
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1PMTREV

Patient Name: _____ Medical Record #: _____

Date of Service: _____ Location: _____ Account #: _____

Authorization for Claims Payment and Reviews - Ambulatory

1. For Medicare Recipients:

I certify that the information provided to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf to Inova (or its affiliates) for any services furnished to me during the applicable periods of medical care.

2. Assignment and Coordination of Insurance Benefits:

I agree to provide information regarding all health insurance benefits to which I/the patient may be entitled. I hereby assign payment(s), if any, from insurance carrier(s) health benefit plan to Inova (or its affiliates) for services rendered to the patient. I hereby authorize payments directly to Inova, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to the Inova (or its affiliates) for services rendered to me during the applicable periods of medical care.

3. Unauthorized, Non-covered, or Out of Plan Services:

I understand that if my insurance carrier or administrator of benefits does not consider any service rendered a covered service or has not authorized these services, they will not pay and I agree to pay for these services. I also understand and acknowledge that in the case of out of plan/network, there may be reduced benefits and I may be required to pay a higher co-pay, deductible or co-insurance amount.

4. Responsibility for Payment:

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health benefit deductibles, copayments, co-insurance and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorneys' fees and other collection costs.

5. Automobile Accident Patients - Notice regarding the assignment of medical expense benefits will be provided to you in a separate document.

By signing below, I certify I have read and understand the foregoing; have had the opportunity to ask questions and have them answered and accept the above conditions and terms; **have read the notice regarding assignment of medical expense benefits for automobile accident patients, if applicable;** and I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered. I also agree in the event my account must be placed with an attorney or collection agency to obtain payment, I will pay the reasonable attorneys' fees and other collection costs incurred by Inova. I understand and agree this document will remain in effect for my present visit and any future outpatient or physician office visits to Inova, unless specifically rescinded in writing by me.

PATIENT (GUARDIAN, ETC.)

DATE / TIME

RELATIONSHIP TO PATIENT (IF NOT SIGNED BY PATIENT)

WITNESS

DATE / TIME

Notice: patients are not required to execute this assignment of benefits form. If you do not execute this form, all charges will be billed to you directly instead of to your Insurance Plan.

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: Male Female

**INOVA HEALTH SYSTEM
AUTHORIZATION FOR CLAIMS,
PAYMENT, AND REVIEWS - AMBULATORY**



I certify that I have received Inova's **Notice of Privacy Practices** and that I have a right to receive an additional copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Inova's health care operations. The Notice also describes my rights and Inova's duties with respect to my protected health information. I understand that copies of the **Notice of Privacy Practices** are available in the registration areas of each facility and on Inova's web site at www.inova.org. I may request that a copy be mailed to me by calling **703-204-3342**.

Inova reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**. I may obtain a revised **Notice of Privacy Practices** by calling the above number and requesting a revised copy be mailed to me, by asking for one at the time of my next appointment, or by accessing Inova's web site listed above to view the most current version.

 Patient or Personal Representative (signature)

 Date

 Time

 Patient or Personal Representative (print name)

 Description of Personal Representative's Authority

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: Male Female

**Inova
 ACKNOWLEDGEMENT OF RECEIPT OF
 NOTICE OF PRIVACY PRACTICES**

CAT #84498 / R052516
 PKGS OF 100



1ROI

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule gives you the right to request how and where your healthcare provider communicates with you. We invite you to share your preferred place and manner of communication. You may change, update or revoke this information at any time, though it must be done in person. The information on this form will remain in effect for one year. You may revoke it at any time.

Print Name: _____ Date of Birth: _____

I prefer to be contacted in the following manner (check all that apply):

Patient Portal: MyChart

Phone Contact: Use the following numbers to contact me:

Home Phone: _____

Leave message with detailed information

Leave message with a call back number only

Cell Phone: _____

Leave message with detailed information

Leave message with a call back number only

Work Phone: _____

Leave message with detailed information

Leave message with a call back number only

Written Communication: Mail to my home address Other: _____

Other: _____

Preferred Contacts:

We respect your right to indicate who you prefer to involve in your treatment decisions and/or with whom your information is shared. Please note, however, that we may share your information regarding services we have provided with other persons (such as insurance plan) as needed for your care or treatment, and as set forth in our Notice of Privacy Practices.

Please indicate the person (s) you prefer we share your information with below:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Patient (signature): _____ Date: _____ Time: _____

Patient (print name): _____

Parent or Guardian (if patient is a minor or otherwise not competent):

(signature): _____ Date: _____ Time: _____

(print name): _____ Relation to Patient: _____

Interpreter Information (To be completed by Inova staff, if applicable):

In person Telephonic Video Interpreter name/ID number (if applicable) _____

Patient/Designated Decision Maker was offered and refused interpreter Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: Male Female

**Inova Medical Group
Patient Record of Disclosure-
Preferred Contacts**

Specialty (location): _____
 Primary (location): _____

CAT # 20749DT/R082619 • PKGS OF 50





Inova Staff:

1. If accommodations are requested, page interpreter services at 98824 within 15 minutes of completing this form.
2. A new form should be used at every visit and any time a change in accommodations is requested.

Name of Person Requesting/Declining Accommodations: _____

Relationship to Patient: Self Parent Family Member Friend Other _____

Do you and/or your companions have any special needs that require accommodations? YES (complete boxes A and B)
 NO (complete box B)

A. If you require special accommodations, please check as appropriate:

Deaf and Hard of Hearing: Sign language interpreter Notepad and pen Speak loudly
 Sound amplifier (ex. PockeTalker® or disposable Posey®)
 Uses hearing aid(s): Left Right Bilateral
 Amplified phone with flasher (if admitted)
 Video Remote Interpreter (VRI) (where available)
 Other: _____

Vision: Magnifying sheet Request an escort
 Braille phone Documents read out loud
 Other: _____

Mobility: Uses service animal Walking escort
 Wheelchair escort Extra-wide wheelchair escort
 Accessible exam table Accessible weight scale
 Other: _____

Speech: Point-to-Speak cards Point-to-Speak alphabet Notepad and pen
 Other: _____

Other or Special Instructions: _____

B. All Patients, Representatives and Companions, please read and sign:

By my signature below I hereby certify that: (1) I have been given an opportunity to communicate whether I and/or my companions have any special needs; (2) I have had the opportunity to select appropriate accommodations; (3) I have reviewed the above selections; (4) those selections are true, accurate and complete; (5) those selections reflect my and/or my companions' choices; and (6) I have received or can request a copy of the process for filing a complaint if I am unsatisfied with my own and/or my companions' accommodations. I understand that if my and/or my companions' needs change during my visit, I can request service changes from my caregiver free of charge.

Patient's medical condition does not allow completion at this time.

Patient/Representative/Companion (signature) **Patient/Representative/Companion (print name)** Date Time

Relationship to Patient: Self Parent Family Member Friend Other: _____

Staff Witness (signature) **Staff Witness (print name)** Date Time Contact # Department

Interpreter Information (To be completed by Inova staff, if applicable):

In person Telephonic Video Interpreter name/ID# (if applicable) _____

Patient/Designated Decision Maker was offered and refused interpreter Waiver Signed

PATIENT IDENTIFICATION

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Gender: Male Female

**Inova
Americans with Disabilities Act (ADA)
Special Needs Assessment**

- IAH IFH IFOH ILH IMVH
 IMG: _____ Other: _____



As a patient, you are responsible for: (continued)

- Following the care, service or treatment plan developed for you.
- Understanding that patients may not photograph, videotape, record or film any person or practice on Inova property without prior permission from Inova. This applies to your visitors as well.
- Recognizing that all medications you will take while in the facility will be prescribed by your doctor, dispensed by the facility Pharmacy and administered by a nurse or therapist.
 - Patients may not take their own medications, unless allowed by facility protocol.
 - Patients may not keep medications at their bedside.
- Telling your doctor if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan.
- Providing the facility with accurate contact and billing information.
- Having detailed knowledge of your health insurance coverage including deductibles co-pays and network coverage.
- Being respectful to staff. This applies to your visitors as well.
- Being respectful of other patients and facility property and following facility rules and regulations.
 - This applies to your visitors as well.
- Recognizing that the facility cannot accept responsibility for any personal property.

Notice of Deemed Consent for Infectious Disease Testing:

Virginia Code Section 32.1-45.1 provides that when either a person providing health care or a patient is directly exposed to the bodily fluids of the other in a way that may transmit human immunodeficiency virus (HIV) or Hepatitis B or C virus, such other person is deemed to have consented to testing for those viruses and to release of the test results to the person so exposed, and actual consent is not required.

Consent for Treatment:

- I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care of the care of my minor child or the patient named below.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety. Laboratory tests may include testing for HIV and I understand that I have the right to decline testing for HIV.
- I understand that Inova utilizes an electronic medical record system.
- I authorize the release of my prescription history to my Inova physician from any pharmacy or drug monitoring agency.
- By signing below, I acknowledge and accept the patient rights and responsibilities outlined above and consent to treatment.

 Patient/Guardian/etc. (signature) Patient/Guardian/etc. (print name) Date Time

 Relationship to Patient (if not signed by patient)

 Witness (signature) Witness (print name) Date Time

Interpreter Information (To be completed by inova staff, if applicable): No Interpreter Required

In person Telephonic Video Interpreter name/ID number (if applicable) _____

Patient/Designated Decision Maker was offered and refused interpreter Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

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Date of Birth: _____ Medical Record # _____

Gender: Male Female

**Inova
 Patient Rights and Responsibilities**

