NORTHEAST REGIONAL EPILEPSY GROUP

PATIENT

Last Name			
First Name		Middle Initial	
Street Address			
City			
State		Zip Code	
Home Phone		Work Phone	
Cell Phone		Date of Birth	
SS #		Sex	☐ M ☐ F
Marital Status		Email address	

Are you a student? ☐ No ☐ Yes, Full Time or Part time

EMERGENCY CONTACT:_____

How did you hear about us? ☐ MD Ref ☐ Self Ref ☐ Yellow Pages ☐ Support Group ☐ Insurance Carrier ☐ Internet ☐ Other _____

PLEASE SPECIFY COMPLAINT:_____

REFERRING PHYSICIAN

Name					
Address				City	
State		Zip Code		Phone	

PCP

Name					
Address				City	
State		Zip Code		Phone	

GUARANTOR #1

Last Name					
First Name				Middle Initial	
Street Address	If the same leave it blank			City	
State		Zip Code		Phone	
Date of Birth		SS #		Sex	☐ M ☐ F
Guarantor Employer					
Employer's Address				City	
State		Zip Code		Phone	

INSURANCE #1

Insurance Carrier			
Policy Holder			
Relationship to the Insured			
Policy #		Group #	

GUARANTOR #2

Last Name					
First Name				Middle Initial	
Street Address	If the same leave it blank			City	
State		Zip Code		Phone	
Date of Birth		SS #		Sex	☐ M ☐ F
Guarantor Employer					
Employer's Address				City	
State		Zip Code		Phone	

INSURANCE #2

Insurance Carrier			
Policy Holder			
Relationship to the Insured			
Policy #		Group #	

Is your illness related to worker's compensation or no fault? Yes ☐ No ☐ If yes, please contact receptionist.

WORKERS COMPENSATION / NO-FAULT

WORKERS COMPENSATION

Were you injured on the job? Yes ☐ No ☐					
Carrier Case #:					
WBC#					
Carrier ID #					
Date of Injury					
Employer's Name					
Carrier					
Address					
Contact		Phone			
Attorney					
Address					
City		State		Zip Code	

NO-FAULT

Were you in an auto accident? Yes ☐ No ☐					
Authorization provided?					
No-Fault Case #					
File #					
Date of Injury					
Policy Holder					
Carrier					
Address					
Contact		Phone			
Attorney					
Address					
City		State		Zip Code	

I hereby authorize Epilepsy & Neurophysiology Medical Consulting, P.C. and/or Epilepsy and Neurophysiology Medical Consultants, P.A. to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to the provider. I understand that I am responsible for any part of the charges that are not covered by my medical insurance.

Patient's Signature: _____ Date: _____/_____/_____

NORTHEAST REGIONAL
EPILEPSY GROUP

ENMC PC/PA

PATIENT NAME: _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to: EPILEPSY & NEUROPHYSIOLOGY MEDICAL CONSULTING PC, and/or EPILEPSY AND NEUROPHYSIOLOGY MEDICAL CONSULTANTS, PA and its PHYSICIANS. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ Date: _____
Signature (Patient or Legal Guardian)

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize EPILEPSY & NEUROPHYSIOLOGY MEDICAL CONSULTING PC, and/or EPILEPSY AND NEUROPHYSIOLOGY MEDICAL CONSULTANTS, PA and its PHYSICIANS to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company(ies) and/or physicians.

_____ Date: _____
Signature (Patient or Legal Guardian)

MEDICAL APPEAL

I authorize to EPILEPSY & NEUROPHYSIOLOGY MEDICAL CONSULTING, PC and/or EPILEPSY AND NEUROPHYSIOLOGY MEDICAL CONSULTANTS, PA and its PHYSICIANS to pursue a written appeal to my insurance carrier on my behalf.

_____ Date: _____
Signature (Patient or Legal Guardian)

ELIGIBILITY WAIVER

I understand that my eligibility for coverage by (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from (name of physician). If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

_____ Date: _____
Signature (Patient or Legal Guardian)

REFERRAL WAIVER

I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral within two days, I understand that I am responsible for paying for the services I am requesting.

_____ Date: _____
Signature (Patient or Legal Guardian)

NORTHEAST REGIONAL
EPILEPSY GROUP

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THE ORGANIZATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.

Northeast Regional Epilepsy Group is required by law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this notice of our privacy policies.

USES AND DISCLOSURE:

Treatment:
We may use your information to provide or coordinate your care. We may disclose all or any portion of your health information to any of our Physicians, Registered nurses, Technologists, other consulting or referring physicians, pharmacists and to any other employees who have a legitimate need for such information to provide or coordinate your care.

Payment:
We may release your information to determine coverage by an insurer for our services, and for billing and claims processing. The information may be released to any other organization involved in the payment of your bill. This information may include copies or excerpts of your PHI that is necessary to receive payment.

Routine Operations:
We may use and disclose your information during routine operation of the practice. An example of routine operation would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorneys or consultants working for the practice. These entities are called "Business Associates". We require our Business Associates to treat your information in the same manner that we do.

Regulatory Agencies:
We may disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

Law Enforcement/litigation:
We may disclose your information for valid law enforcement purposes as required by laws or in response to a court order or subpoena.

Public Health:
We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

Worker's Compensation:
We may release your information to Worker's Compensation agencies in the event that your illness or injury may be related to your work

Military/Veterans:
If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

As Otherwise Required:
We may disclose your information in any situation in which such disclosure is required by law (for example: child or domestic abuse)

Prohibited Uses:
We will not disclose your information to persons outside the practice for purposes other than treatment, payment or healthcare operations with out your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at any time in the future and we will honor that request.

YOUR RIGHTS RELATED TO YOUR PERSONAL HEALTH INFORMATION:
Although all records concerning your treatment here are the property of our office, you have certain rights concerning this information as follows:

Right to Confidentiality:
You generally have the right to inspect and receive a copy of your health information from us, unless that is restricted by law or your physician. You will need to pay for copies of any records we provide.

Right to Amend:
You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your medical record.

Right to Accounting:
You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment or routine operation of this practice.

Right to Request Restrictions:
Changes to this Notice:
We will abide by the terms of this notice currently in effect. However, we reserve the right to change the terms of this notice at any time. Any new notice provisions will be effective for all health from the time that the changes are effective within our office.

Effective Date of this Notice: June 1, 2003
You have the right to request restrictions on certain uses and disclosures of this health information. We will abide by these requests to the extent that we are able.

Right to Revoke Authorization:
You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance on your original authorization.

Right to Complain:
You have the right to formally complain about our handling of your health information. You may contact Dr. Lancman at the number listed below. (If you complain, we will not retaliate against you in any way)

For more information regarding this privacy policy please contact Northeast Regional Epilepsy Group at (914) 428-9213 or (201) 343-6676.

NORTHEAST REGIONAL
EPILEPSY GROUP

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I, _____, hereby acknowledge that I have received and reviewed the "Notice of Health Information Privacy Practices" which describes the uses and disclosures that can be made of my personal health information for treatment, payment and routine health care operations.

_____ _____

Signature of patient or representative Date

_____

Print name of signer

_____

If representative, specify relationship

Please return THIS PAGE ONLY to the receptionist.

NORTHEAST REGIONAL
EPILEPSY GROUP

Northeast Regional Epilepsy Group

To Our Patients:

As you are aware, there are very strict government mandated rules concerning patient health information, confidentiality and release of information. In our continuing efforts to improve patient care and communication, our practice can offer you additional ways to receive information, with your signed authorization, concerning your care and treatment. In addition, a copy of our 'Privacy Policy' is posted in our waiting room and given to all of our patients.

If there are any others persons (family members/friends/health care professionals) with whom we may discuss or to whom we may release information please list them here:

☐ **No One**

Name:	Relationship:
1 _____	_____
2 _____	_____
3 _____	_____

I understand that I may revoke or change this authorization at any time in writing.

Signature _____ Date _____

Print Name _____

NORTHEAST REGIONAL
EPILEPSY GROUP

IMPORTANT INFORMATION FOR PATIENTS 16 YEARS OF AGE OR OLDER

One of the most uncomfortable discussions that doctors and nurses have with patients with epilepsy involve restriction of driving because a driver's license may seem essential to your independence. Although most state laws about driving and epilepsy are now less restrictive than they were many years ago, these laws were written to lessen the chance of harm to self or others resulting from having a seizure while driving.

Therefore, every state regulates driver's license eligibility for people with epilepsy. As a driver's license holder, it is your responsibility to know the regulations in your state. The most common requirement is that you must be seizure free for a certain period of time before you can be allowed to drive.

Although physicians can offer an opinion on your ability to drive safely, the department of motor vehicles makes the final decision. In some states, the physician can offer such an opinion if your seizures do not interfere with consciousness or control of movement. You may be able to continue driving if your seizures occur only at certain times, especially during sleep or if you always have an aura that would warn you to pull off of the road before a seizure begins.

If you are still having seizures, do not hide it from your doctor in order to keep your driver's license. Not reporting seizures makes it impossible for your doctor to treat your epilepsy effectively. The doctor may be able to prevent more seizures from occurring by making a small change in the dosage of your anti-seizure medicine, for instance, but that would not happen if the doctor did not know it was necessary. Inadequate treatment can lead to more seizures and the result may be that you or someone else may be injured. If your seizures are well controlled, use your driving privileges as a reason to take good care of yourself. If you always take your anti-seizure medicines as prescribed, get enough sleep, limit your alcohol consumption, and visit your doctor regularly, you will be more likely to be able to continue driving safely and legally.

Below is a brief description of the laws governing driving in our practice area:

NEW JERSEY:

- You must be seizure free for one year.
- Exceptions may be granted by the Neurological Disorder Committee.
- Periodic medical updates are required after licensing every six months for the first two years, thereafter annually.
- Your doctor must report recurrent convulsive seizures, recurrent periods of unconsciousness, or impairment or loss of motor coordination due to epilepsy, when the condition persists or recurs despite medical treatment.
- DMV appeal of license denial must be filed within 30 days.

- A person is disqualified from driving a commercial motor vehicle if he/she has an established medical history or diagnosis of epilepsy or any other condition which is likely to cause a loss of consciousness or loss of ability to control a commercial motor vehicle. Submitting a false CDL application is a federal offense.
- NJ Motor Vehicle Commission: 609-292-6500
- NJ Medical Review Unit: 888-486-3339

NEW YORK:

- You must be seizure free for one year.
- A person is disqualified from driving a commercial motor vehicle if that person has a medical history of epilepsy, has a current clinical diagnosis of epilepsy or is taking antiseizure medication.
- Doctors are not required to report epilepsy.
- Exceptions may be granted by the DMV's Medical Review Board.
- Periodic medical updates are required after licensing if determined by the DMV.
- DMV appeal of license denial must be filed within 30 days.
- NYS DOT for commercial licensing: 518-457-1010 OR 1016
- Medical Review Unit: 518-474-0774

PENNSYLVANIA:

- You must be seizure free for six months.
- Doctors are required to report epilepsy.
- Your physician will be required to complete a medical report stating that your seizures are controlled and send that report to the Pennsylvania Department of Transportation.
- The department may waive the seizure-free requirement upon request by the person's physician in the following situations:
    - You have a strictly nocturnal pattern of seizures or a pattern of seizures occurring immediately upon awakening that has been established for at least 2 years immediately preceding your application.
    - You experience a specific prolonged aura accompanied by a sufficient warning and this pattern has been established over a period of at least 2 years immediately preceding your application or suspension.
    - Your seizures had previously been controlled and the subsequent seizure or seizures occurred as a result of a prescribed change or removal from medication while under the supervision of a licensed physician.
    - Your seizures had been previously controlled for 6 or more months and the subsequent seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion, metabolic imbalance or nonrecurring trauma.

- Motor Vehicle Commission: 800-932-4600
- Medical Review Unit: 717-787-9662

CONNECTICUT:

- There is no set seizure-free period.
- Doctors are not required to report epilepsy.
- Periodic medical updates are required after licensing if determined by the DMV.
- DMV appeal of license denial must be filed within 30 days.
- Motor Vehicle Commission: 800-842-8222 or 800-263-5700
- Medical Review Unit: 860-263-5223I have read the above information and all questions have been answered to my satisfaction.

_____

Print Name

_____

Signature

_____

Date

NORTHEAST REGIONAL
EPILEPSY GROUP

Cultural/Language/Visual/Auditory Factors Affecting Care

Cultural/Linguistic needs are defined *as the identification of language barriers, visual and or auditory deficits, as well as cultural and religious customs that may impede the provider and or staff's ability to provide the patient's medical benefits.*

We ask that you please use the space below to list any of factors that may be classified as such:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

By signing below I acknowledge that I have disclosed any factors that may affect my medical care.

_____ _____
Patient Name Date

_____
Patient/ Guardian Signature

NORTHEAST REGIONAL EPILEPSY GROUP

Patient Form – New Patient

Name: _____

DOB: _____ **Age:** _____

Gender: ☐ Male ☐ Female

Referring Physician Name and Address:

_____

_____

_____

Primary Care Physician Name and Address:

_____

_____

_____

Date: _____

Allergies: _____

Handedness: ☐ Right ☐ Left ☐ Ambidextrous ☐ Unknown
(using both hands)

Reason for visit:

Find out if I have seizures
Be treated for seizures
Stop seizure medications
Be evaluated for surgery
Other (please explain) _____

_____

Please describe your events:

_____

_____

Seizure Risk Factors (Check all that applies and describe):

Problems during your mother's pregnancy with you _____
Problems during your birth _____
Problems immediately after you were born _____
Meningitis / Encephalitis _____
Convulsions with fevers _____
Severe head trauma _____
Loss of consciousness _____
Learning disability _____
Delay in language/motor development _____
Brain surgery _____
Stroke _____

Previous Testing:

Test	When	Where
MRI brain		
CT Scan		
PET Scan		
SPECT Scan		
Routine EEG		
Video-EEG Monitoring		
Ambulatory EEG		
Other tests		

Do you have a Vagus Nerve Stimulator? Yes No Since when? _____

Have you ever been on ketogenic diet? Yes No When? _____

Did you have epilepsy surgery? Yes No Specify: _____

Patient Name: _____

Current Seizure Medications

Medication	Morning Dose	Afternoon Dose	Evening Dose	Since When?

Previous Seizure Medications **When and why was it stopped?**

ACTH/Steroids _____
Ativan (Lorazepam) _____
Carbatrol (Carbamazepine) _____
Depakene (Valproate) _____
Depakote (Valproate) _____
Depakote ER (Valproate) _____
Diamox (Acetazolamide) _____
Diastat (Diazepam) _____
Dilantin (Phenytoin) _____
Frisium (Clobazam) _____
Gabitril (Tiagabine) _____
Keppra (Levetiracetam) _____
Klonopin (Clonazepam) _____
Lamictal (Lamotrigine) _____
Lyrica (Pregabalin) _____
Mysoline (Primidone) _____
Neurontin (Gabapentin) _____
Phenobarbital _____
Phenytek (Phenytoin) _____
Rufinamide (Banzel) _____
Sabril (Vigabatrin) _____
Tegretol (Carbamazepine) _____
Tegretol XR (Carbamazepine) _____
Topamax (Topiramate) _____
Trileptal (Oxcarbazepine) _____
Valium (Diazepam) _____
Vimpat (Lacosamide) _____
Zarontin (Ethosuxamide) _____
Zonegran (Zonisamide) _____

Social History:

Tobacco: Yes No How much: _____
Alcohol: Yes No How much: _____
Drugs: Yes No Specify: _____
Driving: Yes No

Education: _____
Current Job: _____

Date of last menstrual period:_____
Planning pregnancy: Yes No

Patient Name: _____

Family History: (Indicate diseases present in your family. F: Father, M: Mother, S: Sister, B: Brother, C: Cousin, O: Other)

____ High Blood Pressure	____ Diabetes	____ Kidney Stones	____ Stroke	____ Brain Surgery
____ Heart Disease	____ Cancer	____ Depression	____ Seizures	____ Liver problems
				____other

Past Medical / Surgical History (Check all that applies):

High Blood Pressure	Stroke	Miscarriages	Appendix	Prostate	Cancer: _____
Heart Disease	Migraine	Kidney disease	Gall bladder	C-Section	Psychiatric problems
Diabetes	Sleep apnea	Kidney stones	Hernia	Breast surgery	Other: _____
Ulcer	Asthma	Liver disease	Hysterectomy	Brain Surgery	_____

Review of Symptoms: (Check all that applies)

General Health
- Tiredness
- Fevers
- Night sweats
- Weight gain
- Weight loss

Visual System
- Blurred vision
- Double vision
- Decreased vision
- Eye pain
- Eye redness
- Visual hallucinations
- Visual loss

Auditory System
- Hearing loss
- Ringing
- Dizziness

Skin
- Large moles
- Rash
- Hair loss

Gastrointestinal
- Belly pain
- Diarrhea
- Constipation
- Loss of appetite
- Black stools
- Blood in stools
- Nausea
- Vomiting

Respiratory
- Chronic cough
- Shortness of breath
- Coughing blood

Cardiovascular
- Chest pain
- Ankle swelling
- Palpitations

Musculoskeletal
- Joint paint
- Joint swelling
- Joint stiffness
- Muscle pain

Head and Neck
- Nasal congestion
- Neck pain
- Neck stiffness
- Seasonal allergies
- Sinus pain
- Gum problems

Genitourinary
- Blood in urine
- Difficulty urinating
- Pain during urination
- Trouble holding urine
- Waking up at night to urinate
- Erectile dysfunction
- PMS

Psychiatric
- Anxiety
- Depression
- Panic attacks
- Irritability
- Inner sadness
- Loss of usual pleasures
- Aggression
- Restlessness

Sleep Symptoms
- Daytime sleepiness
- Daytime fatigue
- Frequent awakenings
- Difficulty falling asleep
- Difficulty staying asleep
- Snoring
- Leg movements in sleep
- Restless legs
- Sleep talking
- Sleep walking

Neurological
- Headache
- Trouble walking
- Unsteadiness
- Poor coordination
- Memory difficulties
- Concentration problems
- Difficulty finding words
- Difficulty speaking
- Numbness
- Tingling
- Weakness
- Shaky hands

Other: _____

Do you have any questions/concerns that you want to be addressed on today's visit?

_____

_____

_____

Signature: _____ Date: _____

NORTHEAST REGIONAL
EPILEPSY GROUP

Social Questionnaire

These questions are intended to better understand and meet your social and emotional needs.

Name: _____ **Date:** _____

1) Age:

- ❑ I am 21-27
- ❑ I am 28-35
- ❑ I am 36-42
- ❑ I am 43-50
- ❑ I am 50+

2) Relationship Status:

- ❑ I am single
- ❑ I am married
- ❑ I am separated
- ❑ I am divorced
- ❑ I have a significant other/partner

3) Living Arrangements:

- ❑ I live alone
- ❑ I live with my spouse/partner
- ❑ I live with my partner and child/children
- ❑ I live with my parents
- ❑ Other

4) Working Status:

- ❑ I work full-time/part-time
- ❑ I am a student
- ❑ I am a homemaker
- ❑ I cannot find employment
- ❑ I am not well enough to work

5) Communication:

- ❑ I speak on the phone with friends/relatives on a daily basis
- ❑ I speak on the phone with friends/relatives weekly basis
- ❑ I speak on the phone with friends/relatives on a monthly basis
- ❑ I do not speak on the phone with friends/relatives
- ❑ I do not have access to a telephone

6) Computer:

- ❑ I utilize the computer to socialize/communicate with friends/relatives on a daily basis
- ❑ I utilize the computer to socialize/communicate with friends/relatives on a weekly basis
- ❑ I utilize the computer to socialize/communicate with friends/relatives on a monthly basis
- ❑ I do not utilize the computer to socialize/communicate with friends/relatives
- ❑ I do not have access to a computer or the necessary skills to use a computer

7) Computer Usage:

- ❑ I am on the computer for 0-7 hours per week
- ❑ I am on the computer for 8-15 hours per week
- ❑ I am on the computer for 16-23 hours per week
- ❑ I am on the computer greater than 24 hours per week
- ❑ I do not have access to a computer or the necessary skills to use a computer

8) When I am on the computer, I socialize on:

- ❑ Facebook, Twitter (please circle all that apply)
- ❑ Epilepsy Blogs, Forums, Chat rooms (please circle all that apply)
- ❑ Dating Websites
- ❑ I do not socialize on the computer
- ❑ Other (i.e. Shespeaks.com)

9) Time with Friends:

- ❑ I see friends in person on a weekly basis
- ❑ I see friends in person on a monthly basis
- ❑ I see friends in person on a yearly basis
- ❑ I do not see friends in person
- ❑ I do not have friends

10) Time with Relatives:

- ❑ I see relatives in person on a weekly basis
- ❑ I see relatives in person on a monthly basis
- ❑ I see relatives in person on a yearly basis
- ❑ I do not see relatives in person
- ❑ I do not have any relatives

11) Time with Co-Workers:

- ❑ I socialize with my co-workers on a daily basis
- ❑ I socialize with my co-workers on a weekly basis
- ❑ I socialize with my co-workers on a yearly basis
- ❑ I do not socialize with my co-workers
- ❑ I do not work

12) I like to be alone:

- ❑ Always
- ❑ Most of the time
- ❑ Sometimes
- ❑ Only when I do not feel well
- ❑ Never

13) When I have free time I like to:

- ❑ Go to the movies, sporting events or a restaurant
- ❑ Watch TV, Read, or Play on the Computer
- ❑ Exercise or be outdoors
- ❑ Invite friends/family over to socialize
- ❑ Sleep or do nothing

14) The following factor prevents me from socializing:

- ❑ Social stigma (i.e. People are not comfortable being around someone with seizures)
- ❑ Not being able to drink alcohol
- ❑ Not being able to drive
- ❑ Side effects from my medications
- ❑ I am not limited in my ability to socialize

15) I prefer to socialize with:

- ❑ Anyone
- ❑ Other people with Epilepsy
- ❑ People who do not have Epilepsy but know about my condition
- ❑ People who do not have the condition and do not know about my condition
- ❑ I do not want to socialize

16) I would most benefit from:

- ❑ An on-line support group/educational program
- ❑ A telephone support group/educational program
- ❑ A support group in office/hospital
- ❑ An outing with other epilepsy patients
- ❑ Volunteering to help others with seizures