NeuroScience Associates

Timothy J. Johans, M.D. **Paul J. Montalbano, M.D.** **Michael V. Hajjar, M.D.**
Thomas C. Manning, M.D., Ph.D. **Richard A. Lochhead, M.D.**

Dear Patient:

We look forward to seeing you on _____ at _____

To help us prepare for your visit, please fill out the enclosed patient information form and health history questionnaire and bring the completed forms with you at the time of your appointment. Should you not complete the forms prior to coming to the office we will request that you complete them before being seen by the provider. If this is necessary, please allow extra time before your appointment.

If you have had x-rays taken anywhere other than Saint Alphonsus RMC, St Lukes RMC, or Intermountain Medical Imaging (IMI), please bring them with you to your appointment. If you take any prescription medications, please ask your pharmacist for a list of your current medications and bring it to your appointment.

Our Notice of Privacy Practices can be found on our website at www.idneuro.com. If you would like a paper copy of the Notice of Privacy Practices, please ask the receptionist at the time of your appointment. All healthcare facilities are required to provide you with this notice regarding your rights to your medical record and our duty to manage the information. Please sign and return the acknowledgement form in the new patient packet at the time of your appointment stating you have reviewed the notice.

Also enclosed is a copy of our Financial Policy. Please review so that we may help with any questions you may have prior to your appointment.

Please bring your insurance card with you. Our policy requires a copy of your card to insure that we submit the claim correctly on your behalf. Please be prepared to pay your co-pay at the time of your visit. If you have not met your deductible or do not have insurance coverage, we ask that you pay $275.00 as a deposit for your first visit. First visit fees range between $383.00 and $703.00. Should your insurance plan require a referral authorization for your visit please be sure that your primary care physician provides us with the referral authorization form.

To schedule a visit for a Worker's Compensation injury we require written verification of acceptance by the insurance company responsible for your claim. Please bring the insurance company name and address for submission of your claim. This process will help protect you should your claim be denied and we need to submit a claim to your primary insurance company.

Our website *www.idneuro.com* has maps to all the locations where we provide services.

If you have a question regarding your office appointment please call 367-3500 and ask to speak with the receptionist for the physician you will be seeing. Should you have a medical question please ask to speak to the physician's medical support staff.

Appointments with Dr. Lochhead please ask for Christina.
Appointments with Dr. Johans please ask for Kelly.
Appointments with Dr. Hajjar please ask for Rexene.
Appointments with Dr. Montalbano please ask for Preston.
Appointments with Dr. Manning please ask for Brianna.

Thank you, we look forward to caring for your neurosurgical needs.

6140 W. Curtisian, Suite 400, Boise, ID 83704

Phone: 208.367.3500 | Fax: 208.367.2968

NeuroScience Associates
Talus Professional Plaza

3875 E Overland Rd Meridian ID 83642 (208) 367-3500

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Appointments with Dr. Montalbano please ask for Preston.
Appointments with Dr. Manning please ask for Brianna.

Thank you, we look forward to caring for your neurosurgical needs.

Neuroscience Associates

WWW.IDNEURO.COM

Timothy J. Johans, M.D. Paul J. Montalbano, M.D. Michael V. Hajjar, M.D.
Thomas C. Manning, M.D., Ph.D. Richard A. Lochhead, M.D.

Today's date:	**Primary Care Physician:**	**Referred to clinic by:** Dr.

PATIENT INFORMATION

Patient's Legal Name: (Last) (First) (Middle)	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	**Marital status** (circle one)
Preferred Name:		Single / Mar / Div / Sep / Wid

Ethnicity (circle one)	**Race** (circle one)
Hispanic/Latino : Caucasian : Asian : Other : Unknown	White : Asian : African American : Pacific Islander : American Indian : Other : Unknown

Language (circle one) Arabic : Bulgarian : Central Khmer : Chinese : English : French : German : Haitian : Hebrew : Hindi : Italian : Japanese : Korean : Polish : Portuguese : Russian : Spanish	**Birth date:** / /	**Age:**	**Sex:** ❑ M ❑ F

Mailing address:	**Social Security Number:**	**Home Phone :** ( ) **Cell Phone :** ( )

City:	**State:**	**ZIP Code:** (+4) -	**E-Mail Address:**

Occupation:	**Employer:**	**Employer phone :** ( )

Employer Address:	**City:**	**State:**

If patient is a minor, Responsible party:

Pharmacy:	**Pharmacy Location:**

SPOUSE INFORMATION

Spouse's Legal Name: (Last) (First) (Middle)	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Birth date:** / /	**Sex** ❑ M ❑ F

Occupation:	**Employer:**	**Employer phone:** ( )
Other family members seen here:		

NEAREST RELATIVE NOT LIVING WITH YOU

Name:	**Phone:** ( )
Address:	

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Patient Name:_____ **Date:**_____

PERSONAL INSURANCE INFORMATION			
PRIMARY INSURANCE NAME		SECONDARY INSURANCE NAME	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
POLICY ID NUMBER	GROUP NUMBER	POLICY ID NUMBER	GROUP NUMBER
RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:		RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER:	
POLICY HOLDER'S DATE OF BIRTH		POLICY HOLDER'S DATE OF BIRTH	

WORKER'S COMPENSATION INSURANCE INFORMATION		
WORKER'S COMP INSURANCE CARRIER		
ADDRESS (street-city-state-zip)	PHONE NUMBER	
DATE OF INJURY	TIME OF INJURY	STATE WHERE INJURY OCCURRED
HAVE YOU FILED A WORKER'S COMP CLAIM ☐ YES ☐ NO	CLAIM NUMBER	

LIABILITY INSURANCE INFORMATION	
YOUR LIABILITY CARRIER	OTHER PARTY'S LIABILITY CARRIER
ADDRESS (street-city-state-zip)	ADDRESS (street-city-state-zip)
HAVE YOU FILED A CLAIM WITH A LIABILITY CARRIER ☐ YES ☐ NO	NAME OF OTHER PARTY
CLAIM NUMBER / TIME OF INJURY	CLAIM NUMBER / TIME OF INJURY
STATE /DATE OF INJURY	STATE / DATE OF INJURY

I herby verify that all of the above information is correct to the best of my knowledge and understand that if any information is to change, it is my responsibility to information NSA before any services are provided. Worker Comp and Personal auto medical Insurer is primary payer only for those serviced related to the accident. Liability insurance is primary payer only for those services related to the Liability settlement, judgment or award, a lien will be filed with the Third Party carriers with all liability claims.

Signature_____ Date_____

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Thomas C. Manning M.D., Ph.D. Richard A. Lochhead, M.D.

How the Payment Process Works at NeuroScience Associates

We agree to submit your medical bill for payment to the insurance carrier who is primarily responsible for payment and agree to receive payment directly from the responsible insurance carrier. Responsible insurance carriers may be your personal medical plan or health insurance, your auto or homeowner's liability insurance, your employer's workers' compensation insurance plan, or a third party liability insurance carrier. If your medical plan or health insurance includes a deductible and co-insurance provision, we will bill the patient or guarantor as directed by your plan or policy. Responsibility for payment begins the date services are provided. A billing statement will be sent to advise you of any amounts due.

In cases where a third party liability insurance carrier is involved, such as in an auto accident, a lien may be placed, in accordance with Idaho Code § 45-701, *et seq.*, with the third party liability insurance carrier.

Provisions in our participating provider contracts with health insurance companies request, permit, and, in many instances, direct us to send your bill to the third party liability insurance carrier for full payment before we send it to your medical plan or health insurance for payment. For example, if your treatment was for injuries caused by someone else, we will submit your bill to the other person's insurance company (third party liability insurance carrier) for payment in full, **before** we send your bill to your health insurance to pay. If the total unadjusted amount of your bill is $10,000, for example, we will ask the other person's insurance company to pay the entire $10,000. No health insurance contractual adjustments will be made to your bill prior to submitting it to the other person's insurance company -- we will submit the full, unadjusted amount for payment.

Co-pays, deductibles, limits, and contractual adjustments only apply to bills sent directly to your medical plan or health insurance for payment. They do not apply to bills sent to third party liability carriers for payment.

If you are injured in a work-related accident, we will submit your bill directly to the workers' compensation insurance carrier. If your worker's compensation claim has been properly filed with and accepted by the Idaho Industrial Commission, there will be no charges incurred by you. If your claim is denied or is not paid in accordance with IDAPA 17.02.09, any remaining balance will be your responsibility.

If you have a balance due after all possible insurance carriers have paid, or if you do not have insurance, the following options are offered:

- Online payments at: www.idneuro.com
- Payments by cash, check or credit card;
- Short term internal payment plans not to exceed three (3) months; or
- Long term payment plans through DL Evans Bank for plans beyond three (3) months. These payment plans are administered by DL Evans Bank on behalf of your physician.
- We reserve the right to charge interest on balances over 120 days old from date of service. The fee is assessed annually at 12% or a monthly interest rate of 1%.

Patients with financial constraints should speak to a financial counselor for assistance. We will not deny critical care to anyone due to inability to pay or lack of insurance. If surgery is indicated and a financial hardship is determined, we will assist in obtaining available coverage, such as county assistance or Medicaid.

If you have the ability to pay your bill but refuse to pay under the terms defined above, your account may be turned over to a collection agency.

I have read the information about how the payment process works at NeuroScience Associates. I understand and agree that I am financially responsible for the payment of medical charges incurred on my behalf as outlined above.

Signature:_____ Date:_____

NeuroScience Associates

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Thomas C. Manning, M.D., Ph.D. Richard A. Lochhead, M.D.

Blue Shield Insurance Information

Just a reminder, Dr. Timothy Johans, Dr. Paul Montalbano, Dr. Michael Hajjar, Dr. Thomas Manning, and Dr. Richard Lochhead are currently out-of-network with Blue Shield Insurance. For existing Blue Shield patients, we require a $100.00 payment at the time of your appointment. For new Blue Shield patients, we require a $200.00 payment at the time of your initial appointment; any follow-up appointments, we would require a $100.00 payment. We agree to submit your medical claim for payment to your Blue Shield insurance carrier who is primarily responsible for payment. Blue Shield may pay you directly for the office visit less any co-pays, deductibles and/or co-insurance.

If surgery is required, we agree to submit your medical claim(s) to your Blue Shield insurance carrier. When applicable, a deposit may be required prior to surgery. Blue Shield may pay you directly for all surgery charges and any related claims. These checks are the doctor's property. You will be required to sign the check(s) issued to you directly over to the physician who provided the services to you. You will still be responsible for any co-pays, deductibles, co-insurance, and any balance due.

If you have a balance due after you have signed the Blue Shield check(s) over to us, the following options are offered:

- Online payments at: www.idneuro.com
- Payments by cash, check or credit card;
- Short term internal payment plans not to exceed three (3) months; or
- Long term payment plans through DL Evans Bank for plans beyond three (3) months. These payment plans are administered by DL Evans Bank on behalf of your physician.
- We reserve the right to charge interest on balances over 120 days old from date of service. The fee is assessed annually at 12% or a monthly interest rate of 1%.

Patients with financial constraints should speak to a financial counselor for assistance. We will not deny critical care to anyone due to inability to pay.

If you have the ability to pay your bill but refuse to pay under the terms defined above, your account may be turned over to a collection agency.

I have read the information about how the payment process works for patients with Blue Shield insurance. I understand and agree that I am financially responsible for the payment of all medical charges incurred on my behalf as outlined above.

Signature:_____ Date:_____

NeuroScience Associates

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Thomas C. Manning M.D., Ph.D. **Richard A. Lochhead, MD**

Initial

_____ **Medication Refill Policy**: Pain management during your recovery is very important to us. Careful management of narcotic medication is an essential component of a successful recovery. Therefore, we have implemented the following policy:

- The Physician "on call" will not refill medications. No refills will be given outside of office hours. Office hours are from 9:00am to 5:00pm Monday through Friday.
- Refills must be received between 9:00am and 3:00pm Monday through Friday.
- Refill requests must be received by fax from your pharmacy. Allow 72 hours for refills to be processed, excluding weekends and holidays.
- It is illegal to drive under the influence of drugs or alcohol. **Do not** drive after you take a narcotic prescribed by this office and while you are under the influence of narcotics. Please consult with the provider who wrote the prescription, for each narcotic, to assess when you are legal to drive.

I authorize access to my medication history from any prescriber within SureScripts to assist in preventing adverse drug reactions.

_____ **Medicare Payment Authorization:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Johans, Dr. Montalbano, Dr. Hajjar, Dr. Manning, or Dr. Lochhead. I also further authorize and direct any holder of medical information about me to release such information to the Centers of Medicare and Medicaid Services; formerly the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. This authorization shall remain in full force and effect until revoked in writing by myself. A copy of this authorization shall be as valid as the original.

_____ **Ownership Disclosure:** As a patient of NeuroScience Associates, your physician may order tests, images, and/or schedule procedures to be performed at local hospitals and/or imaging facilities. These include (but are not limited to) MRI's, X-rays, CT scans, laboratory tests, and surgical procedures.

The physicians of NeuroScience Associates have ownership interest in St. Luke's Medical Center, Treasure Valley Hospital and Sage Diagnostic Imaging, locations where you may receive these services. Our providers have privileges at St. Luke's Boise and Meridian, St. Alphonsus Boise and Nampa and West Valley Medical Center. You have the right to have your services performed at any facility of your choosing.

This form is to confirm you have been informed of NeuroScience Associates ownership interest and to inform you of your right to choose the facility where you would like to receive your services.

_____ **Acknowledgement**: I acknowledge that I have reviewed the Notice of Privacy Practices on our website at www.idneuro.com. If a paper copy of the Notice of Privacy Practices is preferred, I will request a copy from the receptionist at the time of my appointment and review it before I sign below.

Signature: _____ Date: _____

Print patient / representative name: _____ Relationship: _____

NSA

NEUROSCIENCE ASSOCIATES

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Michael V. Hajjar, M.D.
Richard A. Lochhead, M.D.
Thomas C. Manning, M.D., Ph.D

FMLA, DISABILITY, MISC. Form Completion Agreement

We are happy to complete forms for you; however, due to the volume of patients who require paperwork to be completed and signed by the provider, we have adopted to the following guidelines to assist in rapid processing of these important forms:

1. All forms are completed in the order they are received. Due to the volume of forms, it may not be possible to complete your form immediately.

2. All patient information must be completed before we can accept the forms, and all pages of of the form need to be provided.

3. Please allow 7 **business days** for completion and plan accordingly.

4. Some forms cannot be completed until your most recent office note has been dictated and transcribed. This may increase the time it takes to complete the form.

5. There is a fee **per form** which must be paid before the forms will be completed.
   - No charge for 1 page (except Activity Restriction form; $25.00 fee)
   - $25.00 for 2-5 pages
   - $50.00 for 6+ pages

6. Payment is the patient's responsibility and will not be submitted to insurance.

7. When forms are completed they will be mailed to the patient's home address unless other arrangements have been made.

8. The authorization for disclosure of protected health information must be signed if forms are to be mailed or faxed to anyone other than the patient.

9. Urgent forms may be completed in 48 business hours at the rate of $50.00 for 2-5 pages and $75 for 6+ pages.

10. **NO FORMS MAY BE GIVEN TO THE PHYSICIAN AT ANY TIME.**

I have read and understand the form Completion Policy.

_____
Print Name

_____ _____
Signature Date

Thank you for your cooperation

6140 Curtisian Ave., Suite 400 ▪ Boise, ID 83704 ▪ Ph (208)367-3500 ▪ Fx (208)367-2968

www.idneuro.com

NeuroScience Associates
PATIENT HEALTH HISTORY

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Patient Height _____ Patient Weight _____

Chief Complaint/ Reason for today's visit? _____

Current problem is the result of a(n): Check all that apply
☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other _____
Date of onset _____

Past Medical History

Please list any medical conditions (i.e hypertension, diabetes, etc) or major injuries:

Surgical History

Surgeries/Hospitalizations	Year	Complications

Have you ever had an antibiotic resistant infection? ☐ Yes ☐ No
If Yes, was it MRSA or VRF? (Please circle)

Have you ever had problems with anesthesia? ☐ Yes ☐ No
Do you take Aspirin? ☐ Yes ☐ No If Yes, how often : _____

Medications

Current Medications **Including Over the Counter**	Dose	Frequency

NeuroScience Associates

Patient Name: _____

ALLERGIES/TYPES OF REACTIONS
Please circle: **Latex** Yes No **Iodine** Yes No **Shellfish** Yes No **Asthma** Yes No

Family Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

SOCIAL HISTORY

Do you have children? ☐ Yes ☐ No How many? _____

Do you live alone? ☐ Yes ☐ No Who lives with you? _____

Do you smoke? ☐ Yes, I've smoked _____ packs of cigarettes per day for _____ years.
☐ Yes, I smoke cigars or a pipe.
☐ No, I have never smoked.
☐ No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

Do you drink alcohol? ☐ No, never (or rarely) ☐ No, but I used to
☐ Yes ☐ Daily ☐ 1 or more times a week ☐1 or more times a month

Are you at risk for AIDS (e.g., sexual orientation, drug abuse, previous blood transfusion)?
☐ No ☐ Yes, please explain _____

☐ Deferred by patient: Signature _____

NeuroScience Associates

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Check button if you currently have any of the following problems:

CONSTITUTIONAL

- ○ Chills
- ○ Fatigue
- ○ Fever
- ○ Weight loss/Weight gain
- ○ Other:

CARDIOVASCULAR

- ○ Chest Pain
- ○ High Blood Pressure
- ○ Edema
- ○ Palpitations
- ○ Other:

REPRODUCTIVE

- ○ Vaginal discharge
- ○ Irregular menses
- ○ Erectile dysfunction
- ○ Penile discharge
- ○ Other:

PSYCHIATRIC

- ○ Anxiety
- ○ Depression
- ○ Insomnia
- ○ Paranoia
- ○ Other:

HEENT

- ○ Dental Problems
- ○ Hearing Loss
- ○ Nasal drainage/Sinus
- ○ Blurred/Double vision
- ○ Glaucoma
- ○ Other:

GASTROINTESTIONAL

- ○ Incontinence
- ○ Change in stool
- ○ Constipation
- ○ Nausea
- ○ Vomiting
- ○ Other:

INTEGUMENTARY

- ○ Redness
- ○ Rash
- ○ Hives
- ○ Skin lesion
- ○ Hair loss
- ○ Other:

METABOLIC/ENDO

- ○ Nipple Discharge
- ○ Heat/Cold intolerance
- ○ Diabetes
- ○ Excessive Thirst
- ○ Excessive Hunger
- ○ Other:

RESPIRATORY

- ○ Chronic cough
- ○ Shortness of Breath
- ○ Wheezing
- ○ Asthma
- ○ Other:

GENITOURINARY

- ○ Urinary frequency
- ○ Urinary incontinence
- ○ Urinary retention
- ○ Painful Urination
- ○ Other:

NEUROLOGICAL

- ○ Dizziness
- ○ Numbness
- ○ Weakness
- ○ Tingling
- ○ Gait disturbance
- ○ Headache
- ○ Memory loss/confusion
- ○ Tremor
- ○ Seizures
- ○ Other:

MUSCULOSKELETAL

- ○ Back pain
- ○ Neck pain
- ○ Joint pain
- ○ Joint swelling
- ○ Muscle weakness
- ○ Other:

HEMATOLOGIC/LYMPH

- ○ Easy bleeding
- ○ Easy bruising
- ○ Other:

IMMUNOLOGIC

- ○ Seasonal allergies
- ○ Food allergies
- ○ Other:

The above information is accurate to the best of my knowledge.

_____ _____

Patient / Guardian Signature Date

Patient Name:_____ DOB:_____

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please check the one box that indicates the statement **which most clearly describes your problem**.

Section 1: Pain Intensity

- □ I have no pain at the moment.
- □ The pain is very mild at the moment.
- □ The pain is moderate at the moment.
- □ The pain is fairly severe at the moment.
- □ The pain is very severe at the moment.
- □ The pain is the worst imaginable at the moment.

Section 2: Personal Care (washing, dressing, etc.)

- □ I can look after myself normally without causing extra pain.
- □ I can look after myself normally but it causes extra pain.
- □ It is painful to look after myself and I am slow and careful.
- □ I need some help but can manage most of my personal care.
- □ I need help every day in most aspects of self-care.
- □ I do not get dressed, was with difficulty and stay in bed.

Section 3: Lifting

- □ I can lift heavy weights without extra pain.
- □ I can lift heavy weights but it gives me extra pain.
- □ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently on the edge of a table.
- □ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- □ I can only lift very light weights.
- □ I cannot lift or carry anything.

Section 4: Walking

- □ Pain does not prevent me walking any distance.
- □ Pain prevents me from walking more than 1 mile.
- □ Pain prevents me from walking more than ½ mile.
- □ Pain prevents me from walking more than 100 yards.
- □ I can only walk using a stick or crutches.
- □ I am in bed most of the time.

Section 5: Sitting

- □ I can sit in any chair as long as I like.
- □ I can only sit in my favorite chair as long as I like
- □ Pain prevents me sitting more than one hour.
- □ Pain prevents me from sitting more than 30 minutes.
- □ Pain prevents me from sitting more than 10 minutes.
- □ Pain prevents me from sitting at all.

Section 6: Standing

- □ I can stand as long as I want without extra pain.
- □ I can stand as long as I want but it gives me extra pain.
- □ Pain prevents me from standing for more than 1 hour.
- □ Pain prevents me from standing for more than 30 minutes.
- □ Pain prevents me from standing for more than 10 minutes.
- □ Pain prevents me from standing at all.

Section 7: Sleeping

- □ My sleep is never disturbed by pain.
- □ My sleep is occasionally disturbed by pain.
- □ Because of pain I have less than 6 hours of sleep.
- □ Because of pain I have less than 4 hours of sleep.
- □ Because of pain I have less than 2 hours of sleep.
- □ Pain prevents me from sleeping at all.

Section 8: Sex Life (if applicable)

- □ My sex life is normal and causes no extra pain.
- □ My sex life is normal but causes some extra pain.
- □ My sex life is nearly normal but is very painful.
- □ My sex life is severely restricted by pain.
- □ My sex life is nearly absent because of pain.
- □ Pain prevents any sex life at all.

Section 9: Social Life

- □ My social life is normal and gives me no extra pain.
- □ My social life is normal but increases the degree of pain.
- □ Pain has no significant effect on my social life apart from limiting my more energetic interests like sports.
- □ Pain has restricted my social life and I do not go out as often.
- □ Pain has restricted my social life to home.
- □ I have no social life because of pain.

Section 10: Traveling

- □ I can travel anywhere without pain.
- □ I can travel anywhere but it gives me extra pain.
- □ Pain is bad but I manage journeys over 2 hours.
- □ Pain restricts me to journeys of less than 1 hour.
- □ Pain restricts me to short necessary journeys under 30 minutes.
- □ Pain prevents me from traveling except to receive treatment.

Patient Signature:_____ Date:_____

Neuroscience Associates

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Paul J. Montalbano, M.D. Michael V. Hajjar, M.D. Richard A. Lochhead, M.D.

Medical Record Release

Patient Name:_____ Date of Birth:_____
(Please print)

Social Security No:_____

Authorization for medical information regarding the above patient to be released.

From:_____
Name

_____
Street Address

_____
City State Zip Phone#

To: _____
Name

_____
Street Address

_____
City State Zip Phone #

Purpose for release _____

Information Requested to be released:

Chart Notes: _____ Hospital records: _____
X-ray films: _____ X-Ray results: _____
Lab results: _____ All Records: _____
Itemized billing:_____

I hereby consent to release the above stated information.

Signature: _____ Date:_____

Relationship to Patient:_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDs virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released.

Signature:_____ Date:_____

Relationship to Patient:_____

This authorization is valid for 180 days and may be revoked at any time by written request.

Date Mailed or Faxed:_____ Date Hand Carried:_____

6140 W Curtisian Ave. Suite 400, Boise, ID 83704 (208) 367-3500 Fax (208) 367-2968

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