

CENTER NEUROLOGY, P.C.

JOSEPH N. SABA, M.D.

Neurology, EEG, EMG, Evoked Potentials

Certified Diplomate, American Board of Neurology and Psychiatry (Neurology)
Certified Diplomate, American Board of Neurology of CLinical Neurophysiology and Qualification in EEG
Certified Diplomate, American Board of Independent Medical Examiners (ABIME)
Certified Diplomate and Senior Disability Analyst, American Board of Disability Analysts
Fellow, American Academy of Disability Evaluating Physicians
Fellow for Life, Royal Society of Medicine (Great Britain)

PLEASE FILL IN ALL FORMS COMPLETELY BEFORE YOUR SCHEDULED APPOINTMENT

PLEASE PRINT CLEARLY. You are welcome to bring one adult with you to the exam room.

However, children are not allowed unless they are being treated. Please bring all Meds on each visit and previous Records including Xrays.

Picture I.D. is required. Copays are due at time of service.

If your health insurance requires prior authorization, please obtain the authorization prior to your appointment.

If you were in an automobile accident, be sure to bring your insurance card along with the adjuster's name, phone number, claim number and police report.

If this is a worker's compensation injury, we will need the name of your worker's comp insurance company, adjuster's name, phone number and claim number before appointment time for approval or denial to treat. We will verify all information in the office. Please remember that your insurance company has a list of approved physicians for worker's compensation injuries and we may not be one of them. You may want to check ahead of time to make sure we are an approved physician with your insurance company.

If you are represented by an attorney, fill in all blanks on the 5th page and have your attorney sign the forbearance agreement BEFORE your first visit.

You are scheduled to see Dr. Saba on _____ at _____. Please arrive by _____.

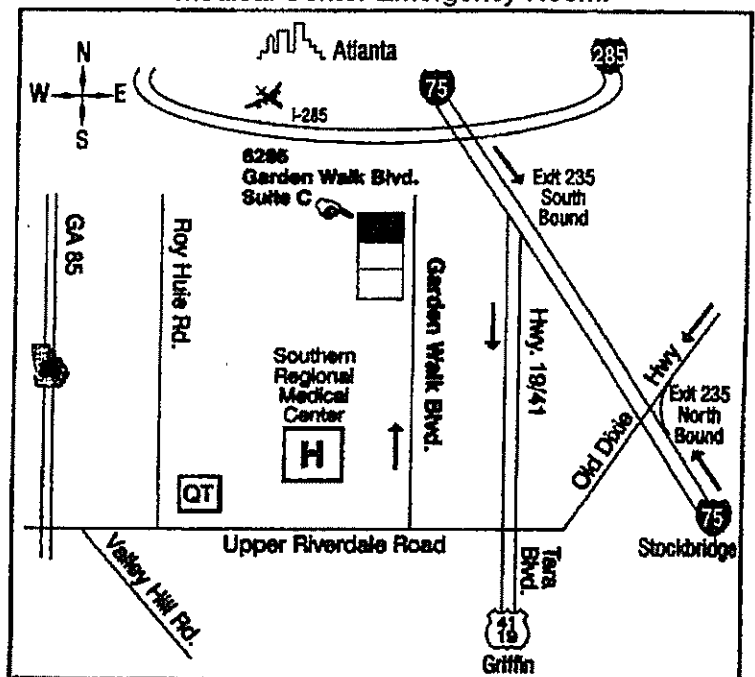
Please be on time. If you need to reschedule your appointment, would you please call at least 24 hours in advance. (Phone: 770-996-1352). No calling and no showing for an appointment will result in a \$74.00 rescheduling fee. Please note that insurance verification can be time consuming. You may want to allow 1 to 2 hours for your first visit. If you are more than 15 mins late we may have to reschedule your appointment.

We are located in Clayton County, South of the Airport and I-285 loop, and very close to Southern Regional Medical Center Emergency Room.

DIRECTIONS • Use only these directions

South on I-75, take Jonesboro/Griffin exit 235. Turn right at the 1st traffic light onto Upper Riverdale Road. Go to the 3rd traffic light and turn right onto Garden Walk Blvd. We are 1/2 mile down the street on the left, past Southern Regional Hospital Emergency Room.

North on I-75, take the Old Dixie Hwy. exit 235. Turn left off exit then turn right at the first traffic light crossing over Tara Blvd. onto Upper Riverdale Road. Go to the 3rd traffic light and turn right onto Garden Walk Blvd. We are 1/2 mile down the street on the left.



Please fill in completely

PATIENT'S NAME	MARITAL STATUS					DATE OF BIRTH	AGE	SS#	
	S	M	W	*D	*SEP				
MAILING ADDRESS	CITY AND STATE					ZIP CODE	HOME PHONE# ()		
ADDRESS OF RESIDENCE IF DIFFERENT FROM ABOVE	CITY AND STATE					ZIP CODE	CELL # ()		
EMPLOYER	OCCUPATION				HOW LONG EMPLOYED?	BUS PHONE # ()			
EMPLOYER'S STREET ADDRESS	CITY AND STATE					ZIP CODE			
SPOUSE OR PARENT'S NAME	SS#				DATE OF BIRTH				
SPOUSE OR PARENT'S EMPLOYER	OCCUPATION				HOW LONG EMPLOYED?	BUS PHONE # ()			
EMPLOYER'S STREET ADDRESS	CITY AND STATE					ZIP CODE			
NAME AND ADDRESS NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU	CITY AND STATE					ZIP CODE	HOME PHONE # ()		
PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE & ZIP CODE					HOME PHONE# ()			
MEDICAL INSURANCE (SUCH AS BC BS - MEDICARE, ETC.)									
PRIMARY INSURANCE:									
ADDRESS:					CONTRACT #		GROUP#		
SECONDARY INSURANCE:									
ADDRESS:					CONTRACT #		GROUP#		
WERE YOU INJURED ON THE JOB? _____ DATE _____				ADJUSTER NAME:			ADJUSTER'S PHONE # ()		
INSURANCE COMPANY:				ADDRESS:					CLAIM #
WAS THIS AN AUTO ACCIDENT? _____ DATE OF ACCIDENT _____				ADJUSTER NAME:			ADJUSTER'S PHONE # ()		
YOUR AUTO INSURANCE CARRIER:				ADDRESS:					CLAIM #
AUTO INSURANCE ADDRESS:				ADDRESS:					PHONE # ()
ATTORNEY'S NAME (IF ANY)				ADDRESS:					PHONE # ()
REFERRING PHYSICIAN'S NAME				ADDRESS:					PHONE # ()

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Center Neurology to submit claims and to furnish complete information to insurance carriers concerning my condition, treatments and services rendered.

I hereby instruct, request and direct my insurance carrier or its intermediaries to issue payment directly to Center Neurology.

I understand that I am personally and fully responsible for any amount not covered by insurance.

I hereby authorize photocopies of this form to be valid as the original.

I hereby acknowledge having been informed of my privacy rights.

I hereby acknowledge having reviewed the Notice of Center Neurology's Privacy Policy prior to signing this consent.

Date _____

Signature _____

NEW PATIENT MEDICAL HISTORY

Name _____ Date of Birth _____

Do You Have Any of the Following:

	Yes	Some	No
A) Headaches _____			
B) Neck Pain _____			
C) Shoulder Joint Pain and Which Side is Worse _____			
D) Arm or Finger Numbness, Tingling or Weakness and Which Side is Worse _____			
E) Upper or Mid Back Pain _____			
F) Low Back Pain _____			
G) Leg Pain or Numbness and Which Side is Worse _____			
H) Knee Joint Pain and Which Side is Worse _____			
I) Loss of Bowel or Bladder Control _____			
J) Any Sexual Difficulties _____			

K) Family History (Circle correct answer please):

Diabetes:	Y	N
High Blood Pressure:	Y	N
Stroke:	Y	N
Seizures:	Y	N
Heart Disease:	Y	N
Migraine:	Y	N
Alzheimers:	Y	N

Are you here for a traumatic injury? _____ Date of injury? _____

Any Other Significant Neck or Back Conditions Requiring Treatment (before or since the traumatic injury in question?)

Did You See a Doctor? _____ Who _____ What Year _____

PLEASE ANSWER THE FOLLOWING:

1. If Accident or Injury, Please Give Date and Describe: _____

2. Were You Taken to the Emergency Room? _____ Where? _____ By Car or Ambulance?
3. Have You Been Hospitalized for This Injury? _____
4. What Kind of Work Do You Perform? _____
5. Give Date(s) Out of Work or Disabled as a Result of This Injury? _____
6. How Many Days or Weeks in Total Have You Lost from Work? _____

5. HAVE YOU EVER HAD ANY OF THE FOLLOWING DONE?

- A) Myelogram _____
- B) CAT Scan or MRI _____
- C) Back or Neck Surgery _____ When _____ Where _____
- D) Epidural Nerve Block _____
- E) Tens Unit Used and does it help? _____
- F) Physical Therapy or Chiropractic _____

6. MEDICAL/SURGICAL HISTORY:

A) Please Bring with You All of Your Medicine Bottles on Every Visit and Please List Here All of Your Medicine:

B) Please Describe Any Medical Problems Such as Diabetes, High Blood Pressure, Migraines, Ulcers, Heart Condition, Asthma, Seizures, Strokes, Cancer, Anemia, Prostate, Surgery, Etc. _____

C) Please List Any Medication Allergies or Intolerance: _____

D) Average Amount You Smoke in a Day or a Week _____

E) Average Amount of Alcohol - Beer You Drink in a Week or Month _____

D) Estimated Height _____ Estimated Weight _____

FOR FEMALES ONLY

A) Are You on Birth Control? _____ Hormones? _____

B) Could you possibly be pregnant? _____

C) Have You Had a Hysterectomy? _____ Partial _____ Complete _____

D) Have You Had a Tubal Ligation? _____

E) Are You Breast Feeding? _____

REVIEW OF SYMPTOMS:

(Circle any symptoms that you have had)

- weak and tired • fevers • chills • night sweats • weight loss • weight gain #lbs _____
- headaches • blurred vision • halos around lights • ear pain • ear discharge • nosebleeds
- sore throat • difficulty swallowing • stiff neck • decreased motion to neck • thyroid trouble
- chest pains (they feel like _____ and _____ makes the come on.)
- ankle swelling • shortness of breath • cough • coughing up blood • wheezing • nausea
- vomiting • diarrhea • constipation • black or bloody stool • bright red blood per rectum
- pain on urination • discharge • female trouble • muscle pains • weakness • wasting
- joint pains • swelling • stiffness • seizures • fainting spells • tics • weakness • dizziness
- Any bleeding tendencies/disorders? • Do you urinate too much? YES/NO
- Are you thirsty too often? YES/NO • Does cold weather bother you? YES/NO
- Does hot weather bother you? YES/NO

HEMATOLOGY:

- Easy bruising Y / N

GENITOURINARY:

- Urinary incontinence Y / N • Difficulty Urinating Y / N

GENERAL:

- Weight change Y / N • Loss of appetite Y / N • Recurrent fevers Y / N • Fatigue Y / N
- Night Sweats Y / N

DERMATOLOGY:

- Rash Y / N

NEUROLOGY:

- Headache Y / N • Tingling Y / N • Seizures Y / N • Dizziness Y / N • Tremors Y / N
- Weakness Y / N • Back Pain Y / N • Neck Pain Y / N • Snoring/Daytime Sleepiness Y / N
- Gait/Balance Problems Y / N • Memory Problems Y / N • History of Sleep Apnea Y / N

OPHTHALMOLOGY:

- Blurring of Vision Y / N

ENT/RESPIRATORY:

- Hearing Loss Y / N

CARDIOLOGY:

- Chest Pain Y / N • Palpitations Y / N • Leg Swelling Y / N • Dizziness Y / N
- Shortness of Breath Y / N

GASTROENTEROLOGY:

- Nausea/Vomiting Y / N • Difficulty Swallowing Y / N

PSYCHOLOGY:

- Depression Y / N • Sleep Disturbances Y / N • Anxiety Y / N

SURGICAL HISTORY:

FORBEARANCE AGREEMENT

Attorney Name _____
Address: _____

Phone: _____

From: Center Neurology, P.C.
Joseph N. Saba, M.D.
6285 Garden Walk Boulevard, # C
Riverdale, Georgia 30274

Patient Name: _____ SSN: _____
(Please Print)

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of my examination, diagnosis, treatment, prognosis and related information in regard to the accident in which I was involved on or about _____.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as maybe due and owing the above doctor for medical services rendered me both by reason of this accident and by reason of any other bills that are due by me to the above doctor's office, and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said doctor. Further, I hereby give a lien on my case to said doctor against any and all proceeds of any settlement, judgement, or verdict which may be paid to you, my attorney, or me as the result of the injuries for which I have been treated, or injuries in connection therewith. While said lien is not a lien against me, the patient, or any other property or any other assets of mine, and is not evidence of my failure to pay a debt, in the event that no settlement, judgement, or verdict is reached in my favor, I understand and agree that, in any event, I remain personally liable for all bills associated with services rendered me by the above doctor. I agree this assignment is irrevocable.

I further agree that any dispute between my doctor and myself as regards the amount of my bill shall be discussed at the time of treatment and I shall not make claim that the bills were excessive or that I do not agree to make payment of the charges unless I have given written notice at the time of the treatment. Should a dispute arise I authorize my attorney or doctor to file whatever type of action with the proper court to declare or interplead the matter for a judge to determine who is the rightful recipient of any escrowed funds. I further agree that I will not insist that my attorney release any funds to me which are withheld for my doctor bills without prior approval of my doctor or a court ruling.

I fully understand that I am directly responsible to said doctor for all medical bills submitted by the said doctor for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his forbearance of payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict which I may eventually recover said my medical expenses.

Dated: _____ Patient Signature: _____

THE UNDERSIGNED being ATTORNEY(S) of record for the above patient do(es) hereby agree to observe all the terms of the above agreement and agrees to withhold such sums from any settlement, judgement, award or verdict as may be necessary to adequately protect said doctor above named including cooperating with the doctor to file whatever interpleader or declaratory action as is necessary to protect the doctor, the client and the attorney from any ethical or legal violations.

Dated: _____ Attorney Signature: _____

CENTER NEUROLOGY, P.C.

Joseph N. Saba, M.D.

6285 Garden Walk Blvd., Suite C • Riverdale, GA 30274 • Phone:(770) 996-1352 • Fax (770) 991-0850

Authorization for Use/Disclosure of Protected Health Information

I hereby request and authorize Center Neurology, P.C. to receive medical records as described below.

Patient's Full Name _____ SSN: _____

Maiden/Other Name: _____ Telephone Number (Home): _____

Date of Birth: _____ Telephone Number (Work): _____

Current Address: _____

I further request and authorize use or disclosure of the medical records checked below to (please provide name and address or class of persons):

This Authorization applies to the information checked below for the following date or dates of service: _____

The information used/disclosed pursuant to this authorization will not include psychotherapy notes (meaning detailed notes kept by your psychiatrist or psychotherapist), but may include other detailed mental health information, HIV/AIDS information and/or information regarding alcohol or substance abuse.

- History and Physical Report
Consultation Reports
Discharge Summary Reports
Radiology Reports
Operative Report
Laboratory Test Results
Emergency Room Record
Entire Medical Record*

* Entire Medical Record includes all items not in bold print.
** An abstract of the record includes the History/Physical Report, Operative, Consultation and Discharge Summary Reports, and diagnostic test results.

I understand that the information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of the information and may then no longer be protected by the federal privacy regulations. I understand that unless otherwise limited by state or federal regulations, I may revoke this Authorization at any time by presenting my revocation in writing except to the extent that the entity identified above has taken action in reliance on this Authorization.

I further understand that this Authorization is valid for a period of 90 days from today's date and will expire at that time unless another date is written here:

Patient's or Legal Representative's Signature Please Print Name Today's Date

As Legal Representative, my relationship to the patient is _____. Any document outlining such authority should be attached. The patient is unable to sign because _____. There may be fees for provision of any or all requested information.

This use or disclosure is for marketing function for which Center Neurology receives direct or indirect remuneration from a third party.