New Patient Welcome Packet

Welcome to Neurological Associates of Albany, P.C.!

Research & Clinical Offices

Our Email: research@naaresearch.com

www.neurologicalassociatesofalbany.com

760 Madison Ave
Albany, New York 12208
PH# 518.449.2662
FAX# 518.449.1342

Our Services

- Clinical Neurology & Research related to memory impairment
- Patient/Family Education programs for community organizations
- Appointments for the treatment of memory disorders/Alzheimer's Disease
- Lifestyle Tips for Brain Health & Wellness
- No cost Memory Testing
- Alzheimer's and Neurological Research with Cutting Edge Treatment Options

Clinic Patients:

Please remember to also bring with you to your visit all of the following:

- Photo ID
- Current Insurance Card(s)
- List of all current medications ~ names, dosages and frequencies
- Name, address and telephone number of your primary care provider
- Names, addresses and telephone numbers of all currently treating physicians
- Copies of all available, pertinent medical records
- Copies of your Health Care Proxy & Durable Power of Attorney and any/all other such documents that you may have for inclusion in your record
- Please come prepared with your co-pay that is due at the time of service
- In order to serve you better, prior to coming to our office for a visit, please complete all of the attached new clinic patient paperwork and bring the completed forms with you to your appointment.
- If you have records from your primary care physician, please bring them with you as well

***Please note there is off street parking to the side and the rear of the building**

Research Patients:

Our History:

Doctor Richard Holub, M.D., is a leader in the field of in Neurology specializing in Research for Alzheimer's disease, cognitive impairment and memory disorders. For over 30 years Dr. Holub and his staff have been providing care and alternative research treatment options for persons suffering from these serious health concerns.

If you are interested in learning more about our research programs - a no cost phone or in person consultation with a research coordinator can be made by calling 518.426.0575. If you are a research patient you will hear directly from one of our research staff who will work with you and Dr Holub for your office visits

Our Expertise

Personalized care and research alternative treatments for individuals and families dealing with the challenges of Dementia, Alzheimer's disease, cognitive disorders and other memory disorders.

We provide a safe, confidential environment while providing excellent care. We encourage physical activity and provide tips for decisions to support brain health. We focus on the individual needs of our patient with a true understanding of the complex issues in dealing with memory or other neurological disorders related to memory. We make many choices in our lives but aging is not one of them and we are here to help!

Alzheimer's disease causes memory loss, behavior & personality changes and a decline in thinking abilities. It impacts many individuals, their families & is a growing major health concern. Please feel free to contact us to explore options that are available.

There are no cost treatments & alternatives that include

- Imaging and other scans
- Cutting edge therapies
- Extensive cognitive testing

NEUROLOGICAL ASSOCIATES OF ALBANY P.C.

♦ *Richard F. Holub, MD* ♦

760 Madison Avenue
Suite 1
Albany, NY 12208

Phone (518) 449-2662
Fax (518) 449-1342
Research (518) 426-0575

MEDICAL NEUROLOGY DIVISION
Clinical Neurology
Electromyography
Electroencephalography

CLINICAL RESEARCH DIVISION
Treatment Trials in
Alzheimer's Disease
Multiple Sclerosis

NAME: ______________________________

An appointment has been scheduled for you at Neurological Associates of Albany, PC, and the office of Dr. Richard Holub.

Your appointment Day, Date and Time

____

Please bring with you:

INSURANCE CARDS, YOUR CO-PAY AND YOUR MEDICATIONS. (BRING YOUR MEDICINE BOTTLES INCLUDING SUPPLEMENTS) Dr. Holub requests to see the medication bottles which have names, milligrams strength and dosages, schedule of taking the medications and who prescribes them for you.

CANCELLATION AND NO-SHOW APPOINTMENTS CAUSE INCONVENIENCE NOT ONLYTO THE PHYSICIAN, BUT TO THE OTHER PATIENTS WHO NEED ACCESS TO TREATMENT

Each no-show will be assessed a $50 fee and will be billed to the patient. If it is necessary for you to cancel your scheduled appointment, we require that you give us 48 hour. If and appointment is cancelled within a 24 hour period, this may result in a $50 cancellation fee that will be billed to the patient.

RICHARD HOLUB, MD ______________________
NEUROLOGICAL ASSOCIATES OF ALBANY ______________________

Neurological Associates of Albany, PC

Permission to Discuss or Have Access Your Care and Health Information Form

(Please Print legibly)

Patient Name: ____

Date of Birth: ____

I, ______________________, authorize Neurological Associates of Albany to speak with my designee____________________________________, about any matter pertaining to my care and records.

Name of Designee: ______________________________

Phone Number of Designee: ______________________________

Address of Designee: ______________________________

What is the relationship of this person to you? (Son, Daughter, Spouse, friend, POA, other)

Patient signature: ______________________________

Date: ______________________________

NOTE:

It is the patient's responsibility, not Neurological Associates of Albany, to keep this authorization up to date. This form will be updated at the time of each of your office visits at Neurological Associates of Albany

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

Patient Demographics

Name:______________________________ Date of Birth:______________

Address:____

____

Phones: Daytime:______________ Work:______________ Cell:______________

S.S.#______________ Emergency Contact: ______________ Phone:______________

Are you: ( ) Retired ( ) Disabled ( ) Student ( ) Working: ___ Full Time ___ Part Time

Employer: ____

Referring Physician (the Doctor who is referring you to Neurological Associates)

Name: ______________________________ Specialty ______________

Address:______________________________ Phone:______________

Who is your Primary Care Physician (PCP) if different than Referring Physician

Name: ______________________________ Specialty ______________

Address:____

Phone:______________________ Fax:______________________

Health Insurance Information

Primary Insurance:______________________________ ID #______________

Group #: ______________ Subscriber: ( ) Self Spouse ______________

Secondary Insurance:______________________________ ID #______________

Group #: ______________ Subscriber: ( ) Self Spouse ______________

Assignment of Benefits

I hereby authorize Neurological Associates of Albany, P. C. to release Protected Health Information (PHI) as necessary to provide medical care and expedite claims processing and payment from third party payors on my behalf. I hereby assign to Neurological Associates of Albany, P. C. where applicable, all payments for medical services provided, tot to exceed stated charges. A photographic copy of this authorization shall be as valid as the original. I certify that the information given above is complete and accurate to the best of my knowledge.

Signed:______________________________ Date:______________

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

♦ Richard F. Holub, MD ♦

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MEDICAL NEUROLOGY DIVISION
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Alzheimer's Disease
Multiple Sclerosis

Patient Name: ______________________ Date of Birth: __________

Authorization of PHI
Protected Health Information

This authorization allows Neurological Associates of Albany, P.C. (NAA) to leave minimum information on my phone or answering machine, as well as fax information on my behalf to:

A. Another Physician's office, Hospital or Nursing Home.
B. Physiatrist, Physical Therapy, Home Health Services Provider.
C. Laboratory, Pharmacy or Surgical Supply facility.
D. Insurance Company or Third-Party Payor.
E. X-ray or MRI facility.
F. Motor Vehicle or other Governing Bureau for renewal of licensure.
G. Other ______________________
H. Self/Patient or Health Care Proxy ______________________

I understand that Neurological Associates of Albany, P.C. (NAA) will disclose only a minimum amount of my Protected Health Information (PHI) necessary for my treatment, coordination of care, payment for services provided or health care operations.

Signature below is an acknowledgement that I have received a copy of the Neurological Associates of Albany HIPAA Notice of Privacy Practices.

This authorization shall begin at time of signing and shall be effective indefinitely unless revoked in writing by the patient/signee.

By signing this authorization, I fully understand and accept the terms as listed above.

______________________ ______________________
PATIENT SIGNATURE DATE

______________________ ______________________
Legal Guardian/Power of Attorney DATE

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

Patient History Questionnaire

Patient: ______________________ Date of Birth: ______________ Date: ______

Chief Complaint:

(Please describe the purpose of this visit and what you hope to achieve from it)

____

____

____

____

____

History of Present illness:

What problems are you experiencing?

____

____

What part/parts of the body does this problem affect? ______________________

How long have you had this problem? ______________________

How often does this problem occur? ______________________

Does the problem occur at a particular time of the day? If so, When? ______________________

How long does the problem last? ______________________

How severe is the problem (0-10)? Does it affect your activities of daily living? If yes, how?

____

____

Does anything make it go away? If yes, what? ______________________

Does anything make the problem worse? If yes, what? ______________________

List tests you may have had for this condition? (Ex: Labs, MRI, CT scan, EMG, EEG)

____

List all prior treatments or surgeries for this condition:

____

How much pain have you had in the past week? (0 being no pain, 10 being the worst) __________

Do you have a living will, Health Care Proxy, Do Not Resuscitate (DNR) or Medical Power of Attorney in place? __________ (if yes, please provide the office with a copy for our records).

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

Patient History Questionnaire

Patient ______________________________ Date of Birth __________

Social History

Age ________ Height ______ Weight ________ Are you a twin? Yes __ No____

Single _______ Married ______ Widowed _____ Separated _____ Divorced ____

Are you: _____ Left handed _______ Right handed

Do you live: Alone ___ Spouse ___ Room or Housemate ___ Parent/Siblings____

Assisted Living Community ___ Rehab Facility ___ Skilled Nursing Facility

What is your highest level of Education? ______________________________

What is/was your occupation? ______________________________

Where do or did you work? ______________________________

What is/was your position there? ______________________________

Smoking History: ___ Never ___ Currently a smoker ___ History of smoking

Packs per day _____ for ______ year? Age Started? ____ Age/Year Stopped? ____

Alcohol Consumption? What type? ______________

Current Medications(use additional sheet if required)

DRUG	DOSE	FREQUENCY	PRESCRIBED BY	INDICATION

Any Allergies or Adverse Reactions to Medications? If yes, please list medication and Reaction.

____

____

Name: ______________________ Date of Birth: ______________

Medication Name	Dose	How taken	Prescribed by:	Indication

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

Patient History Questionnaire – Family History

Patient ______________________________ Date of Birth __________

	Father	Mother	Father's parents	Mother's parents	Brothers & Sisters	Children	Notes
Arthritis							
Bleeding Disorder							
Cancer							
Dementia							
Epilepsy/Seizure							
Heart Disease							
Hypertension							
Kidney Disease							
Lupus							
Multiple Sclerosis							
Diabetes							
Neuropathy.							
Stroke							
Thyroid Disease							
ALS							
Muscular Dystrophy							
Migraine H/A							
Parkinson's							
Alzheimer's							

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

Patient History Questionnaire Past Medical History

Patient ____ Date of Birth __________

Please list all medical problems/diagnosis you currently have or have had:

Medical Problems/Conditions **Approximate Date Diagnosed or Treated**

____

____

____

____

____

____

____

____

____

____

Please list all the surgeries you have had, with approximate date:

Surgery **Date**

____

____

____

____

____

____

____

Have you ever had a problem with anesthesia? NO YES, if so, what medication and what complication ____

If Diabetic, do you monitor blood sugars? ______ Usual Range of readings? ______________

Do you know what your most recent Hemoglobin A1c was and when? ______________

Do you have a **PACEMAKER** or **DEFIBRILLATOR** implanted? ( ) YES ( ) NO

NEUROLOGICAL ASSOCIATES OF ALBANY, P.C.

Patient ______________________________ Date of Birth__________

Review of Systems Patient History Questionnaire
Please check box if you have currently or have had a history of:

GENERAL	EARS NOSE THROAT	CARDIOVASCULAR	HEMATOLOGIC AND ENDOCRINE
Altered Taste or Smell	Balance Problems	Angina	Diabetes
Change in Appetite	Dizziness	Chest pain/pressure	Other endocrine disorder
Weight gain or loss	Ringing in ears	Fainting spells	Sickle cell disease
Fatigue	Hearing loss	Heart murmur	Thyroid Disorder
Unable to sleep	Nose bleed	High blood pressure	Enlarged lymph nodes
Excessive sleepiness	Sinus disease	Low blood pressure	HIV Exposure/ AIDS
Snoring	Difficulty swallowing	Leg swelling	Anemia
Skip breathing in sleep	Dry mouth	Shortness of breath	Miscarriages
Unexplained Fever		Heart failure	Blood disorder
Cancer	EYES		
Chemotherapy	Blurred Vision	GASTROINTESTINAL	RESPIRATORY
Radiation	Double vision	Abdominal pain	Emphysema
	Glaucoma	Constipation	Asthma
RENAL FAILURE	Cataracts	Diarrhea	COPD
Kidney failure	Dry eyes	Hepatitis	Tuberculosis
Urine frequency	Macular degeneration	GI bleed	Chronic cough
Incontinence, urine		Hiatal hernia	
Sexual dysfunction	PSYCHIATRIC	Ulcer	MUSCULOSKELETAL
	Anxiety	Vomiting/nausea	Joint replacement
Skin/Integumentary	Panic Attacks	Liver failure	Low back pain
Open wound/sore	Depression	Incontinence, bowel	Joint pain
Skin rash/bruising	Trouble concentrating	Crohn's disease	Neck pain
Botox injection		Malabsorption	Joint swelling
******************	NEUROLOGICAL	REVIEW OF SYSTEMS	******************
Confusion	Difficulty concentrating	clumsiness	Trouble swallowing
Facial numbness/tingling	Difficulty chewing	Drooling	Headaches
Hallucinations	Difficulty tasting	Hoarseness	Vertigo/dizziness
Memory problems	Difficulty smelling	Tingling sensations	Loss of muscle bulk
Personality change	Loss of words	Muscle twitching	Poor balance
Seizure	Speech difficulty	Restless legs	Poor coordination
Paranoia	numbness	Loss of sensation	Abnormal Gait

Please add details or explanations if checked:

____

____

____

Patient: ____

Rx Insurance Coverage ( ) Yes ( ) No ( ) 30 day ( ) 90 day supply

Local pharmacy: ______________________________ Phone : ____________

Mail order: ______________________________ Phone : ____________

ALLERGIES or MEDICATION INTOLERANCES

Medication name & adverse reaction:

____

____

____

____

____

____

LIST OF DOCTORS

NAME	SPECIALTY	ADDRESS	PHONE #

Neurological Associates of Albany, P.C.

WHAT IS AN ELECTROENCEPHALOGRAM (EEG)?

An EEG measures brain waves. Brain cells give off very small amounts of electricity that are amplified and recorded by means of a machine called the electroencephalograph. The test is begun by pasting metal discs to the patient's scalp which are connected by wires to the machine. The electroencephalograph machine then picks up the electrical brain waves from the metal discs. The machine amplifies and records the brain waves on paper, much in the same way that a high fidelity record player amplifies vibrations from a record's surface and transforms them into sound. Electrical activity from at least eight areas of the brain is measured at the same time.

The test will identify the nature and location of any brain cell over activity. This is very helpful to the doctor in diagnosing and treating many conditions.

The machine has no real affect on the person whose record is being taken and the electrode paste used to connect the metal discs is easily removed with water.

The test is usual performed by a medical technician and takes approximately one hour after which the patient is asked to wait in the waiting room until the results are processed. After that the patient will see the doctor.

Please come with clear hair (no hair products of any kind- hairspray, gel, etc.). The visit will take between two and three hours. Bring a good book and maybe a snack.

NEUROLOGICAL ASSOCIATES OF ALBANY

760 MADISON AVE

ALBANY, NY, 12207

CLINIC 518-449-2662 RESEARCH 518-4260575

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

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

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

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

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

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement,

coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

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

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

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

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

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

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Provided By HCSI

Effective as of April 14, 2003