WELCOME TO THE
ALZHEIMER'S DISEASE RESEARCH & TREATMENT CENTER
NEUROLOGICAL ASSOCIATES OF ALBANY

760 Madison Avenue
Suite 1
Albany, NY 12208
Phone (518) 449-2662
Fax (518) 449-1342

Hours of Operation:
Mon-Thur – 8:30 am - 4:30 pm
email: info@naaresearch.com

Our Services:

- Alzheimer's Disease Research and other research programs related to memory impairment.
- Clinical Neurology for Memory Disorders.
- Patient/Family Education programs for community organizations.
- No Cost Memory Screens.

Clinical Neurology 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 be sure to ask if you qualify for one of our recent clinical trials.

***Please note there is off street parking to the side and the rear of the building. Many of the spaces are labeled Neurological Associates of Albany.**

***Directions to our office can be found on our website:**
www.neurologicalassociatesofalbany.com

2/2020

WELCOME TO THE
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Research Patients involved in clinical trials:

Our History:

Doctor Richard Holub, M.D., is a leader in the field of 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 518-449-2662 and ask to be connected with a member of our research staff. 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 and personality changes and a decline in thinking abilities. It impacts many individuals, their families and is a growing major health concern. Please feel free to contact us to explore options that are available.

There are no cost treatments and alternatives that include:

- Imaging
- Cutting edge research
- Extensive cognitive testing

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MEDICAL NEUROLOGY DIVISION
Clinical Neurology-Memory Disorders

CLINICAL RESEARCH DIVISION
Alzheimer's Disease Research

NAME: _____ **DATE OF BIRTH:** _____

An Appointment has been scheduled for you at Alzheimer's disease Research & Treatment Center – Neurological Associates of Albany.

Your appointment Day, Date and Time:

Please complete this packet prior to your scheduled appointment and email it to:
info@naaresearch.com
Or you may also fax it to: 518-449-1342

We strongly recommend you make a copy for yourself and bring it with you to your scheduled appointment.

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, milligram strengths and dosages, schedule of taking the medications and who prescribes them for you.

CANCELLATION AND NO-SHOW APPOINTMENTS CAUSE INCONVENIENCE NOT ONLY TO 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 hours. If an appointment is cancelled within a 24 hour period, this may result in a $50 cancellation fee that will be billed to the patient.

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MEDICAL NEUROLOGY DIVISION
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CLINICAL RESEARCH DIVISION
Alzheimer's Disease Research

Patient Name: _____ Date of Birth: _____

Authorization of PHI
Protected Health Information

This authorization allows Alzheimer's disease Research & Treatment Center-Neurological Associates of Albany 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. **Any other family member**_____
H. Self/Patient or Health Care Proxy_____

I understand that Alzheimer's disease Research & Treatment Center-Neurological Associates of Albany 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 Alzheimer's disease Research & Treatment Center-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

ALZHEIMER'S DISEASE RESEARCH & TREATMENT CENTER
NEUROLOGICAL ASSOCIATES OF ALBANY

Patient History Questionnaire

Patient name: _____Date of Birth: _____ Date: _____

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/s? Age Started? _____ Age/Year Stopped? ____

Alcohol Consumption? _____

What type? _____

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Patient Demographics

Name: _____ Date of Birth: _____

Address: _____

Phones: Daytime: _____ Work: _____ Cell: _____

S.S. #_____ **Emergency Contact:** _____ Phone: _____

Primary Contact for Medical/Appointments: _____ Phone: _____

Are you: ( ) Retired ( ) Disabled ( ) Student ( ) Working:_____ Full Time_____ Part Time_____

Employer:_____

Who is your Primary Care Physician (PCP) 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 Alzheimer's disease Research & Treatment Center-Neurological Associates of Albany 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 Alzheimer's disease Research & Treatment Center-Neurological Associates of Albany where applicable, all payments for medical services provided, not 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:** _____

ALZHEIMER'S DISEASE RESEARCH & TREATMENT CENTER NEUROLOGICAL ASSOCIATES OF ALBANY

Patient Medication List

Patient name: _____ Date of Birth: _____ Date: _____

Medication Name	Dose	Frequency/How taken	Prescribed by:	Indication

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NEUROLOGICAL ASSOCIATES OF ALBANY

Patient name: _____ Date of Birth: _____

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

Medical Problems or Conditions **Approximate Dates Diagnosed and Treated**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Surgery **Where** **Date**

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever had a problem with anesthesia? NO____ YES ____, if so what was the complication:

_____

If Diabetic, do you monitor blood sugars? _____ Usual Range of your readings? _____

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

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

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Patient: _____ Date: _____ Date of Birth: _____

Name of Caregiver: _____ Relationship: _____

Please provide the following information about the patient:

Patient's marital status: ____Married ____ Single _____Divorced ____Widow

Highest level of education completed_____ Degree(s)_____

Past and/or current employment (if retired, what did they do for a living?)

Occupation: _____

Year retired: _____ _____Not retired Current employer _____

Military Service _____

Current Living Situation:

____ Own home

____ Rental

Lives With:

_____ Alone Has support ___Y ___ N ___Family

_____ Spouse/Child ____ Pd.Care ____ Caregiver

____ Other: _____

____Assisted Living Facility: _____

____Independent Living Community: _____

____Nursing Care Facility: _____

How long at this address? _____yr./mos

Please be as specific as possible: provide examples of Past History:

____Stroke ____Other please state: _____

Memory problems first noted: _____ years or _____months ago?

Changes in memory have been: ___gradual _____ or abrupt?

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NEUROLOGICAL ASSOCIATES OF ALBANY

Patient: _____ Date of Birth: _____

Is your memory getting? ____better _____worse ____or staying the same

What did you first notice or what concerned you initially?

_____

Were there any changes in medications or significant stressors at the time? If so what?

_____

_____

_____

_____

Memory in the last six months:	YES	NO
Forgetting recent events/conversations	____	_____
Repeats statements/questions	____	_____
Problems remembering old/events	____	_____
Often asks "How do I know him/her?	____	_____

Language/Speech: in last six months:

Word-finding problems	_____	_____
Speech Hesitations	_____	_____
Loses conversational train of thought	_____	_____
Others have difficulty understanding	_____	_____

Mood/Behavior:

Socially withdrawn	_____	_____
Lost interest in people or activities	_____	_____(if Yes, please describe/examples)
Depressed mood	_____	_____
Agitation/anxious/angry outbursts	_____	_____
Irritable/frustrated	_____	_____
Seeing or hearing things not there	_____	_____
Believe thing happened but did not	_____	_____

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Patient: _____ Date of Birth: _____

Daily Functions:	**Independent**	**Needs Help**	**Cannot Do**	**Never Did**
Managing Medication	_____	_____	_____	_____
Managing Finances/Bills	_____	_____	_____	_____
Use household appliances	_____	_____	_____	_____
Dress	_____	_____	_____	_____
Eating	_____	_____	_____	_____
Bathing	_____	_____	_____	_____
Using toilet/bathroom needs	_____	_____	_____	_____
Hygiene/Grooming	_____	_____	_____	_____

Driving:

Is patient driving now? ____ Yes ____ No

Have License? ___Yes __No

Are you concerned about your driving? ___Yes ___No explain:

Is anyone in your family concerned about your driving? ___Yes ___No explain:

Orientation:

Acts confused in familiar places? ___Yes ____No

Needs directions to familiar places? ___Yes ____No

Sleep:

Problems with sleep? ___ Yes ___No

Needs Meds to sleep? ____Yes ___No

Name of med: _____

Gait: (Check all that apply)

___falls last six months **____Poor balance** **___Unsteady on feet**

___Uses cane **____Walker** **___Wheelchair**

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Patient name: _____ Date of Birth _____

	Father	Mother	Father's parents	Mother's parents	Brother's & 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							

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MEDICAL NEUROLOGY DIVISION
Clinical Neurology-Memory Disorders

CLINICAL RESEARCH DIVISION
Alzheimer's Disease Research

NAME: _____ **Date of Birth:** _____

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

Local pharmacy: _____ **Phone:** _____

Mail Order: _____ **Phone:** _____

ALLERGIES or MEDICATION INTOLERANCES

Please list any Allergies or Adverse Reactions to Medications:

_____

_____

_____

_____

_____

_____

_____

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Alzheimer's Disease Research

LIST OF YOUR DOCTORS

Patient Name: _____ **Date of Birth:** _____

NAME	SPECIALTY	ADDRESS	PHONE

ALZHEIMER'S DISEASE RESEARCH & TREATMENT CENTER
NEUROLOGICAL ASSOCIATES OF ALBANY

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 & ENDOCRINE	
Reduced Taste or Smell		Balance Problems		Angina		Diabetes	
Loss of Appetite		Dizziness		Chest pain/pressure		Thyroid disorder	
Weight Gain		Ringing in ears		Fainting spells		Other endocrine disorder	
Weight Loss		Hearing loss		Heart Murmur		Anemia	
Fatigue		Difficulty swallowing		High blood pressure		Blood Disorder	
Unable to sleep		Dry Mouth		Low blood pressure		Enlarged lymph nodes	
Excessive sleepiness				Leg swelling		HIV exposure/AIDS	
Snoring				Shortness of breath			
Skip breathing in sleep				Heart Failure			
Unexplained Fever		**EYES**		**GASTROINTESTINAL**		**RESPIRATORY**	
Cancer		Blurred Vision		Abdominal pain		Emphysema	
Chemotherapy		Double Vision		Constipation		Asthma	
Radiation		Glaucoma		Diarrhea		COPD	
RENAL FAILURE		Cataracts		Hepatitis		Tuberculosis	
Kidney failure		Dry eyes		GI bleed		Chronic cough	
Urine frequency		Macular degeneration		Hiatal hernia		**MUSCULOSKELETAL**	
Incontinence, urine		**PSYCHIATRIC**		Ulcer		Joint pain	
		Anxiety at times		Vomiting/nausea		Joint swelling	
SKIN/INTEGUMENTARY		Panic attacks		Liver failure		Spinal back pain	
Open wounds/		Depression		Incontinence, bowel		Joint replacement	
Skin rash/easy bruising				Crohn's disease			
				Malabsorption			

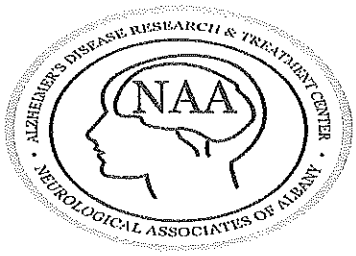
***THIS FORM MUST BE COMPLETED AT EVERY OFFICE VISIT FOR EVERY PATIENT**

ALZHEIMER'S DISEASE RESEARCH & TREATMENT CENTER
NEUROLOGICAL ASSOCIATES OF ALBANY

Patient: _____ **Date of Birth:** _____

**********		**NEUROLOGICAL**		**REVIEW OF SYSTEMS**		**********	
Memory problems		Paranoia		Choking		Clumsiness	
Confusion		Hallucinations		Trouble swallowing		Headaches	
Loss of words		Restless legs		Hoarseness		Vertigo/Dizziness	
Difficulty concentrating		Difficulty smelling		Tremor		Seizure	
Speech difficulty		Difficulty tasting		Poor balance		Numbness & tingling	
Personality change		Drooling		Abnormal gait			

Please add details or explanations if checked:



Richard Holub, MD, is the President and Director of The Research & Neurology Center of the Alzheimer's disease & Research Treatment Center, Neurological Associates of Albany.

Dr. Holub earned his BA in Biology from Rutgers University and his medical degree from Georgetown University School of Medicine. He completed his internship in Internal Medicine and his residency in Neurology at Albany Medical Center Hospital.

The Research & Neurology Center is staffed with well trained and qualified research and clinical professionals who provide Alzheimer's disease research and clinical neurology services. The Research and Neurology Center has a panel of over 4, 000 patients diagnosed with Alzheimer's disease, Mild Cognitive Impairment or other forms of Dementia.

Dr. Holub has conducted clinical trials and clinical neurology for over 30 years. During his career, he has conducted over 130 successful Alzheimer's disease clinical trials and that work has played a significant role in the investigation of all 5 drugs currently approved by the FDA for the treatment of Alzheimer's disease.

Dr. Holub's focus is on Alzheimer's disease, Memory Disorders, current research initiatives and Brain Health.

Alzheimer's disease Research & Treatment Center
Neurological Associates of Albany, PC

Caring for the needs of patients, families and the community for over 30 years

The following are some of the frequently asked questions we receive in relation to our clinical research studies:

QUESTION:

What is a research study about?

ANSWER:

A research study or also called a clinical trial is a study that helps determine whether a new treatment or medication is safe and effective. Other trials can also evaluate which older treatments produce the best results. Advances in treatments can only be accomplished through clinical trials. As more people volunteer to participate, trials are completed more rapidly and new treatments become more quickly available.

QUESTION:

Should I participate in a clinical research study?

ANSWER:

A decision to take part in a research study is completely voluntary. The decision should not be made without a full knowledge of what is involved; such information is provided in the informed consent process when detailed explanations are provided by the research study team and the physician, who is called the principal investigator. When you choose to take part in a clinical trial, it may or may not improve your health. A clinical trial offers patients a way to gain access to promising newer drugs or treatments that are otherwise not available. If you decide to participate, you will be cared for by a team of dedicated health professionals, who are interested in your health and well-being. One of the most important reasons to join a clinical trial is to help advance what is known about new treatments and potentially improve outcomes for yourself and others. Clearly, there is potential benefit for you as the research participant, and also with potential benefit to future generations.

QUESTION:

Why should I participate in a research study?

ANSWER:

A decision to participate in a research study may result in helping yourself or helping others with the same condition or illness. Research studies may also give you access to new treatments that are not available outside the clinical research program. Frequently it is found, that patients in clinical trials demonstrate better health regardless of which treatment they are given compared to patients who are not in such clinical trials. This is because participation in a clinical trial is associated with frequent medical examinations and testing, such that the patient's general medical health is well evaluated and assessed, which often leads to an improvement in the overall health of the patient.

QUESTION:

What happens after a clinical trial is over?

ANSWER:

The research team works with you and will stay in contact with you and will let you know about the trials findings and conclusions if you are interested. They may offer to continue to provide information about your health, either through surveys or actual health examinations. This is in addition to the regular care provided by your doctor after you have completed the study.

QUESTION:

Who can participate in the clinical trial?

ANSWER:

Each clinical research study defines who is eligible to participate. Each trial must include only patients that fit specific criteria for that study (also known as eligibility criteria). Some examples of eligibility criteria might include: age, gender, diagnosis, stage of illness, list of current ongoing illnesses, medications and treatments.

QUESTION: How long do clinical trials last?

ANSWER:

The length of every clinical trial varies depending upon what is being studied. Participants are informed about how long the study will last before they join the study.

QUESTION:

Does a participant's medical information remain confidential during and after a study?

ANSWER:

Yes, all information remains confidential both during and after a study. Access to personal information is usually available to the investigator and research team conducting the clinical study. In some circumstances, the Institutional Review Board overseeing the research study, and/or the sponsor of the research, will have access to personal medical information but keep it confidential. However, no one is authorized to release the information without a written consent from the participant. This is explained more specifically in the consent process that participants are provided before study participation.

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www.neurologicalassociatesofalbany.com
518.449.2662 CLINIC
518.426.0575 RESEARCH
760 MADISON AVENUE
ALBANY, NEW YORK 12208

- **Call today for an appointment at our clinic for the treatment of neurological disorders, memory disorders and Alzheimer's disease - 518.449.2662**

- **Our clinical research team is also available for no cost phone consultations or in office cognitive testing for you, a loved one or friend, call 518.426.0575 to learn more**

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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 effect 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 usually 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 clean 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.