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

Dear Patients, families and caregivers,

Welcome to the Alzheimer's disease Research and Treatment Center of Neurological Associates of Albany.

Our MISSION is to find a cure for Alzheimer's disease in our lifetime through the pursuit of collaborative research and other treatment options.
Our Method:

- **To raise public awareness regarding Alzheimer's disease and memory disorders through outreach, education and treatment;**
- **To identify new models for care and treatment of Alzheimer's disease through research;**
- **To advocate for patients with memory disorders, as well as to support their families and caregivers.**

Dr. Richard Holub is our President/Principal Investigator and is a graduate of Rutgers University where he earned a Bachelor of Arts in Biology. He received his Doctor of Medicine Degree from Georgetown University. Subsequently, Dr. Holub continued his training in internal medicine and Neurology at the Albany Medical Center Hospital. He is a Diplomat of the American Board of Psychiatry and Neurology, and a member of the American Academy of Neurology; Dr. Holub is board certified. He has served on the boards of the Alzheimer's Association and the Multiple Sclerosis Foundations. Dr. Holub is an active member of ISTAART, the International Society to Advance Alzheimer's Research and Treatment.

Dr. Holub has been engaged in Alzheimer's disease research for over 35 years and has contributed to the development of the first 5 of 6 drugs approved by the FDA, for the treatment of Alzheimer's disease as well as the first Alzheimer's disease amyloid imaging agent, Florbetapir. He has successfully conducted over 134 Alzheimer's disease and memory disorders clinical trials with many returning volunteers.

Our practice is focused on Clinical Trial patients with Alzheimer's disease and other memory disorders. He continues to be actively engaged in cutting edge research in pursuit of medication and treatments to find a cure for Alzheimer's disease, as such we are a research site.

He lectures widely in the Capital Region to community groups on brain health and the importance of clinical trial participation to find a cure for Alzheimer's disease. He feels fortunate to have numerous opportunities to offer both information and hope to those currently dealing with the challenges of memory disorders. Dr. Holub and his team are committed to working with individuals who are also looking to the day when we have a world without Alzheimer's disease.

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Our Core services are:

- Grant sponsored no cost Alzheimer's disease and memory disorders research clinical trials, following FDA guidelines;
- No cost Memory Disorders Pre- Screening;
- Cognitive neurology office visits exclusively for Alzheimer's disease & memory disorders patients.

As our patient you and/or your authorized representative can expect:

- To receive service(s) without regard to age, race, color, sexual orientation, religion, marital status, sex, gender identity, national origin;
- Be treated with consideration, respect and dignity including privacy;
- Be informed of the services available;
- Obtain current information concerning your diagnosis, treatment and prognosis;
- Receive information necessary to give informed consent prior to the start of any nonemergency procedure or treatment or both. Be informed of consequences of not receiving treatment and alternatives for treatment.
- To refuse treatment and be informed of any consequences related to your care and prognosis;
- Privacy and confidentiality of all information and records pertaining to your treatment;
- Designate, in writing, anyone that can give consent on your behalf.

As our patient you and/or your authorized representative are responsible for:

- If you are not able to keep your appointment and do not call our office at 518-449-2662 within 24 hours your appointment will be given to another patient on our waiting list
- If you are more than 15 minutes late for your appointment, we cannot guarantee that you will be seen and your appointment may have to be rescheduled.
- Providing current and accurate information about your condition;
- Providing up to date information about how to reach you and to inform us promptly of any changes to your phone number(s), email address, insurance coverage or address;
- Being on time for your scheduled appointment and if you are not able to keep your appointment, to provide us with at least 24 hours' notice or you may be charged a $25.00 no show fee;
- Being aware of your insurance coverage, co-pay amount and paying your co-pay at the time of service as well as paying for any balance not covered by insurance or other payor;
- Being respectful and responsive to our staff requests about your care needs. Compliance with your care regime as prescribed by your physician and reporting to us any concerns/changes about your inability to comply promptly. Non-compliance with your care regime or any behavior that we consider disruptive to our ability to provide you with care may result in our requesting that you identify another provider to continue with your ongoing care needs;
- Providing feedback or concerns us about your experience without fear of reprisal.

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Preparing for your visit to our office:

If you are a clinical trial participant or if you are coming in for a research memory pre-screen appointment, you will hear directly from one of the research office staff members who will provide you with the specific instructions prior to your visit. The research office is located on the lower level of the building and is accessible by an outside lift (elevator) if needed. The lift is located on the driveway side of the building.
If you are a memory disorders patient in the clinical office which is located on the 1st level, you will need to fully complete this New Patient Welcome Packet. The following will be needed when you arrive for your office visit:

- Photo ID
- Insurance card(s) and your Medicare card (if you are on Medicare)
- A complete list of medications that you are currently taking including over the counter medications/supplements (you should bring in your actual prescription bottles with you)
- Copies of any medical records that you have from your primary care physician or other specialists
- Copies of any healthcare Proxy, Durable Power of Attorney Forms or other advanced directives that you have issued to someone to act on your behalf
- A family member/caregiver must come with you on your visit to our office
- Please come prepared to pay for your co-payment which is collected at the time of your office visit

If your insurance coverage, address or phone number change after you are an established patient it is **very important that you notify us immediately by phone at 518-449-2662 or via email at info@naaresearch.com**

New patients that are initially seen for a non-research assessment will:

- Be evaluated by Dr. Holub;
- Receive a diagnosis;
- Typically be placed on a medication based on their condition;
- Be stabilized on a medication (if any) and have a treatment plan established.
- Then enter a research trial or be referred back to their PCP.

***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
Email: info@naaresearch.com

Patients that are treated for memory disorder may be scheduled for an EEG prior to seeing Dr. Holub during this office visit as this is needed for your evaluation and ongoing care.

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.

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Richard F. Holub, MD

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NEUROLOGY DIVISION
Clinical Neurology-Memory Disorders

CLINICAL RESEARCH DIVISION
Alzheimer's Disease Research

Patient Name: _____ Date of Birth: _____

Authorization for Use and Disclosure of Protected Health Information Form

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 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 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 acknowledgement that I have received a copy of the Alzheimer's disease Research & Treatment Center-Neurological Associates of Albany HIPPA Notice of Privacy Practices.

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

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

Signature of patient: _____ Date: _____

Legal Representative: _____ Date: _____

Records requested will be released to the Alzheimer's Disease Research & Treatment Center – Neurological Associates of Albany- 760 Madison Avenue – Albany – NY – 12208 -Fax: 518-449-1342 -Phone: 518-449-2662

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NEUROLOGY DIVISION
Clinical Neurology-Memory Disorders

CLINICAL RESEARCH DIVISION
Alzheimer's Disease Research

PATIENT DEMOGRAPHIC FORM

Name: _____ Date of birth: _____

Address: _____

Phones: Home: _____ Work: _____ Cell: _____

Social security #: _____ Email address: _____

Emergency contact: _____ Phone: _____

Primary Care Physician: _____

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 valid as the original. I certify that the information given above is complete and accurate to the best of my knowledge.

Signed: _____ Date: _____

MEMORY ASSESSMENT FORM

Patient: _____ Date of Birth: _____ Date: _____

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?

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?

_____

_____

Patient: _____ Date of Birth: _____ Date: _____

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	____	____

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	____	____	____	____

Patient: _____ Date of Birth: _____ Date: _____

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**

Patient name: _____ Date of Birth: _____

PLEASE LIST ALL 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 was it checked last_____

Do you have a PACEMAKER or DEFIBRILLATOR implanted? YES ____ No ____

Have you had a STROKE or other Major Medical event? YES ___ NO ___, if so please explain:

_____

If you have Memory Problems, when did your Memory Problems first start: _____ years or _____ months ago

Were your changes in memory: Gradual _____ or Abrupt _____

Patient Medical & Social History Form

Patient Name: _____ Date of birth: _____

Age	
Height	
Weight	
Are you (circle one)	Working Retired Disabled Student
Smoker? (circle)	Yes No Never
If you smoke how often do you smoke each day?	
Marital Status (circle)	Single Married Widowed Divorced Separated
Handed (circle)	Right Left
Do you live (circle)	Alone With Spouse Roommate Assisted Lvg. Nursing Home Rehab Facility Skilled Nursing
Do you consume alcohol?	Yes No
How often and what do you drink?	
Name of your Primary Care Physician (PCP)	
Date of your last PCP visit	

Patient name: _____ Date of Birth _____

	Father	Mother	Father's parents	Mother's parents	Brother's & Sisters	Children	Notes
Alzheimer's							
Mild Cognitive Impairment							
Dementia							
Parkinson's							
ALS							
Multiple Sclerosis							
Stoke							
Arthritis							
Bleeding disorder							
Cancer							
Epilepsy/Seizure							
Heart Disease							
Hypertension							
Kidney Disease							
Lupus							
Diabetes							
Neuropathy							
Thyroid Disease							
Muscular Dystrophy							
Migraine H/A							

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**

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:

LIST OF YOUR DOCTORS

Patient Name: _____ Date of Birth: _____

NAME	SPECIALTY	ADDRESS	PHONE

Pharmacy Preference and Coverage

NAME: _____ Date of Birth: _____

Rx Insurance Coverage: ___Yes ___No ___30 day supply ___90 day supply ___180 day supply

Local pharmacy name: _____ Phone: _____

Mail Order name: _____ Phone: _____

PLEASE NOTE ANY ALLERGIES TO FOOD OR MEDICATIONS BELOW:

_____

_____

_____

_____

_____

_____

_____

Patient Medication List

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

Medication Name	Dose	Frequency/How taken	Prescribed by:	Indication

Neurological Associates of Albany, P.C.
Richard F. Holub, M.D.
760 Madison Ave
Albany, NY 12208

Research Division

Research Phone # (518) 426-0575 **Research Fax # (518) 426-1190**

MEDICAL RECORDS RELEASE REQUEST

DATE: _____

TO: _____

_____

_____

I hereby authorize and request the above to release my medical records to:

Dr. Richard Holub
Neurological Associates of Albany, P.C.
Research Division
760 Madison Ave
Albany, NY 12208

Patient Name: _____ **DOB:** _____
(Please Print)

Address: _____

_____

Signature: _____