



851 Corporate Drive, Suite 110
Lexington KY 40503
Phone: 859-263-2222
Fax: 859-263-0020
Email: info@horizonheadache.com
www.horizonheadache.com

Adult Demographics Form

Patient Information

Title _____ Last Name _____

First Name _____ M.I. _____

Gender _____ Date of Birth _____ Social Security Number _____

Address _____ City/State _____

Zip Code _____ Home phone _____ Cell Phone _____

Work Phone _____ Driver's License Number _____

Email Address _____

Preferred Contact Method _____ Preferred Time of Day _____

Marital Status _____ Current Employment Status _____

Occupation _____ Employer _____

Employment Address _____

City/State _____ Zip Code _____

Spouse's Name (Last, First, M.I.) _____

Spouse's Current Employment Status _____ Occupation _____

Spouse's Employer _____

Responsible Party for Payment

Responsible Party for Payment: [] Patient [] Spouse [] Other

Please fill out the following for the Responsible Party below if different than from above.

Responsible Party (Last, First, M.I.) _____

Title _____ DOB _____ SSN _____ Gender _____

Address _____ City/State _____

Zip Code _____ Home phone _____ Cell Phone _____

Email Address _____ Work Phone _____

Marital Status _____ Current Employment Status _____

Occupation _____ Employer _____

Employment Address _____

City/State _____ Zip Code _____

Insurance Information

Name of primary insurance (enter "NA" if self-pay) _____

Name of Insured (Last, First, M.I.) _____

Name of Policy Holder (Last, First, M.I.) _____

Primary Insurance State _____ Policy Holder's Relationship to Patient _____

Insurance ID number _____

Insurance Group number _____

Policy Effective Dates _____

Name of secondary insurance (enter "NA" if self-pay) _____

Name of Insured (Last, First, M.I.) _____

Name of Policy Holder (Last, First, M.I.) _____

Primary Insurance State _____ Policy Holder's Relationship to Patient _____

Insurance ID number _____

Insurance Group number _____

Policy Effective Dates _____

Emergency Contact Information

Emergency Contact Name _____

Emergency Contact Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Physician Information

Referring Physician Name _____

Referring Physician Practice Name _____

Practice Address _____

City/State _____ Zip Code _____ Phone _____

Primary Care Physician Name (if different from Referring Physician)

Primary Physician Practice Name _____

Practice Address _____

City/State _____ Zip Code _____ Phone _____

How did you hear about Horizon Headache Center?

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Horizon Headache Center of any changes in the above information.

PATIENT SIGNATURE

DATE



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Medical History Intake Form

The following questions relate to your general health. The details of this form will only be reviewed by your physician and nurse. Please bring this form to your first appointment.

Headache History

How long have you had headaches? _____

Have you ever been hospitalized for headaches? _____

If so, please list most recent location and dates of hospitalization:

Have you gone the emergency room for headache treatment? _____

If so, please list most recent location and dates of emergency room visits:

At least once a week, do you miss school, work, or social activities because of your headaches? _____

Please list outpatient physician that you have seen for your headaches in the past five years. Include their practice name, specialty, location, and approximate dates you were under care.

How many days in the past month did you have a headache? _____

Health Condition:

YES

NO

Details/Dates of your condition

LUNGS:

Pneumonia requiring hospitalization

Tuberculosis

Asthma

COPD/Emphysema

GASTROINTESTINAL:

Peptic Ulcer Disease

GERD/Acid Reflux

Liver problems

Kidney Problems

Irritable Bowel Disease

Chronic Constipation

Crohn's Disease or Ulcerative Colitis

URINARY SYSTEM:

Kidney Disease/Renal insufficiency or failure

Kidney Stones

Interstitial Cystitis

Recurrent UTI

Pyelonephritis/Kidney Infection

FEMALE GYN:

Abnormal Pap Smear

Sexually Transmitted Disease

MALE SYSTEM:

Prostate cancer

Benign Prostate Hypertrophy

MUSCULOSKELETAL:

Chronic Back Pain

Shoulder problems

Injury to any joint/bone

Osteoarthritis

Osteoporosis

RHEUMATOLOGY:

Fibromyalgia

Health Condition:	YES	NO	Details/Dates of your condition
Rheumatoid Arthritis			
Other inflammatory arthritis			
SLE (Lupus)			
Scleroderma			
PSYCHIATRIC:			
Depression			
Bipolar/Mania			
Schizophrenia/schizoaffective disorder			
Psychiatric disorder requiring hospitalization			
Suicidal thoughts or attempts			
NEUROLOGIC:			
Headaches/Migraines			
Stroke/Mini Stroke (TIA)			
Seizures			
Brain aneurysm			
Multiple Sclerosis			
Other neurologic condition			
HEME/ONCOLOGY:			
Cancer or Tumor			
Anemia			
Blood clots/ Clotting disorders			

Please list any other medical conditions you have been diagnosed with in your lifetime that was not included above:

Please list all medications you have tried in the past for your headaches:

Medication	Dose	Frequency	Dates you took this med	Why it was discontinued

Family History:

Do headaches, other neurological disorders, or heart problems run in your family? If so, please explain who and what they have/had?

Please describe any health condition that your mother father or siblings have/had?

Relative	Living or Deceased	Health Conditions
Mother		
Father		

Neuroimaging

Have you had a CAT scan, EEG, or MRI of your head and neck in the past 3 years?

Yes

No

If so, please bring the report to your initial visit.

Review of Systems

(Please circle YES to any of the following you may have experienced in the past 3 months and use the remarks section below to explain)

GENERAL

Fever, chills, night sweats	YES	NO
Weight change more than 10 lbs.	YES	NO
Overwhelming fatigue	YES	NO

EYES

Temporary vision changes	YES	NO
Permanent vision changes	YES	NO
Blurry vision	YES	NO
Seeing spots or lines of light	YES	NO
Pain in eyes	YES	NO
Increased/Decreased Tearing	YES	NO
Double Vision	YES	NO

HEENT

Scalp Tenderness	YES	NO
Ear pain	YES	NO
Ringing in the ears	YES	NO

Review of Systems, continued

Hearing loss	YES	NO
Vertigo (feeling like the room is spinning)	YES	NO
Pain or numbness in face	YES	NO
Problems with speech or slurred speech	YES	NO
Sore throat	YES	NO
Nasal Congestion	YES	NO
Sinus pain or pressure	YES	NO

CARDIOVASCULAR

Chest pain	YES	NO
Racing heart rate or irregular heart beat	YES	NO
Pain in legs with walking	YES	NO

LUNGS

Cough	YES	NO
Shortness of breath	YES	NO

ABDOMEN

Abdominal Pain	YES	NO
Nausea/Vomiting	YES	NO
Heartburn	YES	NO
Diarrhea/Constipation	YES	NO
Pain or trouble with swallowing	YES	NO
Blood in stool	YES	NO

FEMALE

Abnormal menses	YES	NO
Pelvic pain	YES	NO
Recent pregnancy	YES	NO

GU

Trouble with urinary stream	YES	NO
Pain with urination	YES	NO
Frequency of urination	YES	NO
Erectile dysfunction (males)	YES	NO

Review of Systems, continued

SKIN

Rash	YES	NO
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PSYCH

Feeling sad or down	YES	NO
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Feeling anxious or worried	YES	NO
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Poor sleep	YES	NO
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Feeling overwhelmed	YES	NO
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Difficulty concentrating	YES	NO
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Mood swings	YES	NO
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NEUROLOGIC

Weakness in arms, legs, or face	YES	NO
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Loss of consciousness	YES	NO
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Memory problems	YES	NO
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Numbness or tingling	YES	NO
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Seizure	YES	NO
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Poor balance	YES	NO
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Tremor	YES	NO
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MUSCULOSKELETAL

Muscle pain	YES	NO
-------------	-----	----

Low back pain	YES	NO
---------------	-----	----

Neck pain	YES	NO
-----------	-----	----

Shoulder pain	YES	NO
---------------	-----	----

Other joint pain, stiffness, or swelling	YES	NO
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Review of Systems Remarks (if YES to any of the above, please specify below):



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Consent for Treatment Form

I hereby give my permission for Horizon Headache Center, PLLC to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered to my satisfaction. I understand that I may decline treatment at any time

SIGNATURE (Parent/Guardian)

DATE

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to Horizon Headache Center, PLLC to release information to my insurance company, employer, attorney, workers compensation carrier, physician/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Horizon Headache Center, PLLC.

SIGNATURE (Parent/Guardian)

DATE

AUTHORIZATION FOR PAYMENT OF BENEFITS:

I authorize Horizon Headache Center, PLLC to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although Horizon Headache Center, PLLC will help verify and assist me in understanding my benefits, it is ultimately my responsibility and I will not hold Horizon Headache Center, PLLC responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, and are due and payable by me.

SIGNATURE (Parent/Guardian)

DATE



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Cancellation/No –Show Policies

The cancellation / no-show policy is enforced for the following reasons:

1. We rely heavily on our schedule to maintain a high standard of care.
2. By giving appropriate notice to the facility, we are able to offer your appointment slot(s) to other patients.
3. Repeated cancellations and no-shows will slow your progress and likely prevent you from experiencing optimal outcomes from treatment.

NO-SHOW POLICY

If you do not cancel your appointment in accordance with the cancellation policy and/or fail to show for your scheduled appointment, a \$30 no-show fee will be charged to your account. This fee will be charged for each appointment missed on the same day. This fee will not be waived for any reason, so please do not ask.

CANCELLATION POLICIES

Appointments must be cancelled a minimum of 12 hours prior to your scheduled appointment time. Failure to cancel your appointment by this deadline will result in a no-show fee charged to your account. If you arrive more than 20 minutes past your appointment time, you may be asked to reschedule. If you are asked to reschedule, the no-show fee will be charged to your account.

REPEATED CANCELLATIONS

Optimal outcomes from treatment can only be achieved if you take responsibility in your care and are compliant with scheduled appointments. Repeated cancellations may result in discharge for noncompliance.

These policies are strictly enforced to assure you receive the care you deserve and achieve your treatment goals. We pride ourselves in providing the highest quality of care possible. Please help us maintain this level of care by making your time here a priority.

A copy of this policy will be provided to you upon request.

Patient Signature (Parent/Guardian if under 18)

Date

HORIZON HEADACHE CENTER, PLLC
NOTICE OF PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Horizon Headache Center, PLLC and its entities. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Horizon Headache Center. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Office Manager, Horizon Headache Center, 851 Corporate Drive, Suite 110, Lexington KY 40503.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke the authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosure for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and other professionals involved in your care will use information in your medical record and information you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Options: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved in Your Care: With your written agreement, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to the Office Manager, Horizon Headache Center, 851 Corporate Drive, Suite 110, Lexington KY 40503.

Other Uses and Disclosures:

We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls
- To your employer when we have provided healthcare to you at the request of your employer
- To a government oversight agency conducting audits, investigations, or civil or criminal proceedings
- Court or administrative ordered subpoena or discovery request
- To law enforcement officials as required by law to report wounds and injuries and crime
- If you are a member of the military, we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU MAY HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:**Access to Your Personal Health Information**

You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the Office Manager. You are entitled to one free copy of your personal health information. If you request additional copies, you may be charged a nominal fee for copying and postage.

Amendments to Your Personal Health Information

You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the Office Manager.

Accounting for Disclosures of Your Personal Health Information

You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the Office Manager. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or healthcare operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such notice to the Office Manager.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing to the Office Manager, Horizon Headache Center, 851 Corporate Drive, Suite 110, Lexington KY 40503. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Office Manager, Horizon Headache Center, 851 Corporate Drive, Suite 110, Lexington KY 40503; Phone 859.263.2222.

PATIENT SIGNATURE (Patient/Guardian if under 18)

DATE

The Migraine Disability Assessment Test

The **MIDAS** (Migraine Disability Assessment) questionnaire was put together to help you measure the impact your headaches have on your life. The information on this questionnaire is also helpful for your primary care provider to determine the level of pain and disability caused by your headaches and to find the best treatment for you.

INSTRUCTIONS

Please answer the following questions about ALL of the headaches you have had over the last 3 months. Select your answer in the box next to each question. Select zero if you did not have the activity in the last 3 months. Please take the completed form to your healthcare professional.

- _____ 1. On how many days in the last 3 months did you miss work or school because of your headaches?
- _____ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)
- _____ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?
- _____ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)
- _____ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?
- _____ Total (Questions 1-5)

What your Physician will need to know about your headache:

- _____ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1 day, count each day.)
- _____ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10=pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS Grade	Definition	MIDAS Score
I	Little or No Disability	0-5
II	Mild Disability	6-10
III	Moderate Disability	11-20
IV	Severe Disability	21+

If Your MIDAS Score is 6 or more, please discuss this with your doctor.