PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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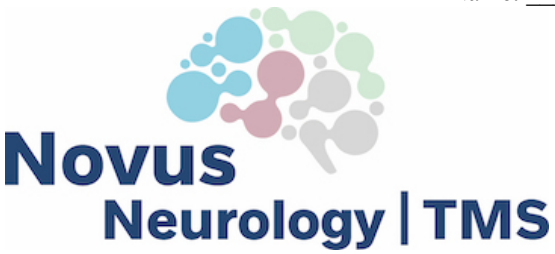
A2663B 10-04-2005

Name: _____ DOB: _____



PERSONAL INFORMATION

Patient: _____ Birthdate: _____ Gender: _____
Last First Middle

Address: _____Social Security #: _____

City: _____ State: _____ Zip: _____ Email: _____

Home # _____ Cell # _____

Employer: _____ Phone # _____

Next of Kin/Spouse: _____ Phone#: _____ Work#: _____

Referring physician: _____ Primary Care Physician: _____

Person responsible for bill (if not the patient): _____ Phone#: _____

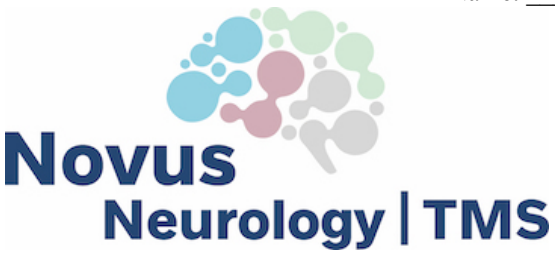
Race: Check one	**Ethnicity:** Check one	**Preferred Language**: Check one
___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ Native Hawaiian ___Other Pacific Islander ___White ___ More than one race	____ Hispanic or Latino ____ Non-Hispanic or Latino	____ English ____ German ____ Spanish ____ Other_____

ACCIDENT INFORMATION

Is visit accident related? **Yes** or **No** If yes, accident date? _____

Work related? **Yes** or **No** If yes, accident date? _____

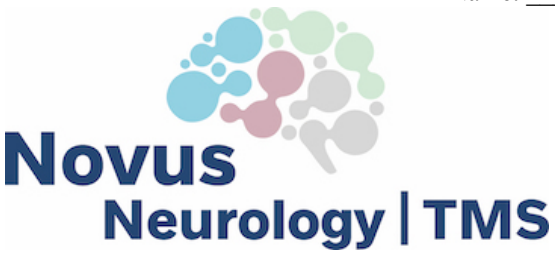
Name: _____ DOB: _____



INSURANCE INFORMATION

PRIMARY: _____	SECONDARY: _____
Policyholder: _____	Policyholder:_____
Policyholder's Birthdate _____/_____/_____	Policyholder's Birthdate _____/_____/_____
Relationship of Patient: Spouse Child Other	Relationship of Patient: Spouse Child Other

Name: _____ DOB: _____



Financial Policy

We, Novus Neurology & TMS, attempt to provide the best care possible for our patients. Sometimes certain services or procedures and exams are not covered in whole or in part by insurance policies. You are expected to pay for all such services not paid by your insurance company.

We agree to file the necessary claims with your insurance company when we are furnished sufficient information to do so.

PAYMENT AGREEMENT

I acknowledge and agree that I am fully responsible for payment of all charges for any services rendered to me, my spouse, and my dependent children by Novus Neurology & TMS, and their associates and for payment of any balance not paid by insurance. I further reaffirm and agree to pay all previously incurred and unpaid charges and for future charges rendered to myself and my family I also agree to pay all reasonable collection costs, including a reasonable attorney's fee of one third of the unpaid principal balance due on my account in the event my account is placed with an attorney for collection. I waive any right I may have according to the Constitution and Laws of the State of Alabama, or any other state, to claim exemptions as to personal property as to this obligation.

COMMUNICATION REGARDING MY ACCOUNTS

Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any services and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

ASSIGNMENT OF BENEFITS

I hereby authorize Novus Neurology & TMS, and their associates to furnish information to insurance carriers concerning services and treatment rendered to myself and my dependents; and I hereby assign to Novus Neurology & TMS all payments for such services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance.

Patient Signature: _____ Date: _____

Patient Name (print): _____

Guarantor (if not patient): _____ Date: _____

Name: _____ DOB: _____

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Release of Health Information

I authorize Novus Neurology & TMS to release all necessary medical information requested by my health insurance carrier, Medicare, or any other third-party payers.

I authorize Novus Neurology & TMS to release all medical information to my referring physician and my primary (family) physician.

I authorized Novus Neurology & TMS to contact Medicare, Blue Cross Blue Shield, Medicaid, or any other health plan administrator to obtain all pertinent financial information concerning coverage and payments under my policy.

I direct Medicare, Blue Cross Blue Shield, Medicaid, or any other health plan administrator to release such information to Novus Neurology & TMS

I authorize the access and release of confidential patient information by Novus Neurology & TMS for purposes of photocopying the information in response to properly authorized requests for copies of patients' medical records

If you anticipate the need for anyone else (spouse, family members, close friend, etc) to have access to this information please complete the information below:

Name _____ Relationship_____ Phone_____

Name _____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

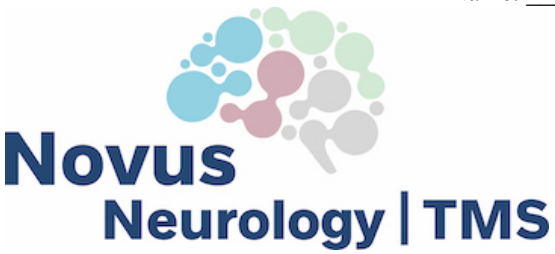
I authorize Novus Neurology & TMS Physician's and staff to leave detailed information on my voice mail if I am unavailable to speak with them directly. [] Yes [] No

Phone number(s) approved for detailed messages: _____

I fully understand and ***accept*** the term of this consent.

Patient Name signature: _____ Date: _____
Patient Name print: _____

Name: _____ DOB: _____



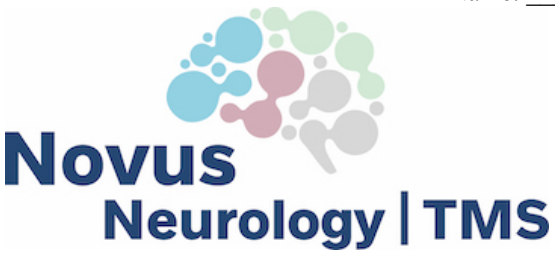
Notice of Privacy Practices Acknowledgment

I have received a copy of the Novus Neurology & TMS Notice of Privacy Practices, which includes electronic access to medication history. I understand that Novus Neurology & TMS has the right to change its Notice of Privacy Practices from time to time and that I may contact Novus Neurology & TMS at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____

Patient Name (print) _____

Name: _____ DOB: _____



PAST MEDICAL HISTORY

Please list all your and your family's medical problems below

Patient	Mother	Father	Brother/Sister	
____	_____	____	____	Stroke
____	_____	____	____	Seizures/Epilepsy
____	_____	____	____	Alzheimer's disease
____	_____	____	____	Multiple sclerosis
____	_____	____	____	Myasthenia gravis
____	_____	____	____	Parkinson's disease
____	_____	____	____	Carpal Tunnel Syndrome
____	_____	____	____	Restless Legs Syndrome
____	_____	____	____	Neuropathy
____	_____	____	____	Migraine
____	_____	____	____	Sleep apnea
____	_____	____	____	Insomnia
____	_____	____	____	Depression
____	_____	____	____	Anxiety
____	_____	____	____	Bipolar
____	_____	____	____	ADHD
____	_____	____	____	OCD
____	_____	____	____	Schizophrenia
____	_____	____	____	High blood pressure
____	_____	____	____	Heart attack or Heart Disease
____	_____	____	____	Heart failure
____	_____	____	____	High cholesterol
____	_____	____	____	Atrial fibrillation
____	_____	____	____	Diabetes mellitus
____	_____	____	____	Thyroid problems
____	_____	____	____	Kidney stones
____	_____	____	____	Ulcer
____	_____	____	____	Hepatitis
____	_____	____	____	Irritable bowel syndrome
____	_____	____	____	Emphysema/COPD
____	_____	____	____	Asthma
____	_____	____	____	Kidney failure
____	_____	____	____	Cancer
____	_____	____	____	Arthritis
____	_____	____	____	Lupus
____	_____	____	____	Other_____
____	_____	____	____	Other_____

Name: _____ DOB: _____

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Past Surgical History (Please list all surgeries including tonsillectomy, cataracts, etc.)

1._____
2._____
3._____
4._____
5._____

Prior Hospitalizations

Please list all hospitalizations: If none, indicate here: ____ **NO**

Date	**Reason**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Immunizations

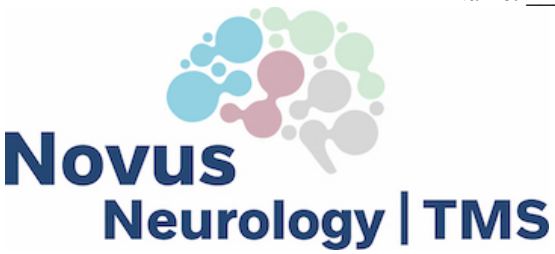
When was your last flu vaccination? _____

Have ever had a Pneumonia vaccination? **Yes or No** **If yes, when?** _____

ALLERGIES (Please list all allergies to medications such as penicillin, etc)

_____
_____
_____

Name: _____ DOB: _____

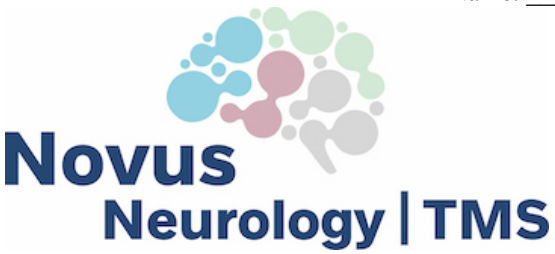


PRESENT MEDICATIONS

(Please list all prescription and non-prescription drugs)

Medication	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Name: _____ DOB: _____



Social History

Marital Status: ____Married ____Single ____Divorced ____Widowed

Children: ____Yes ____No If yes, list ages_____

Do you work outside the home? ____Yes ____No
If yes, what is your job? _____
If you are retired, what was your job? _____

What level did you complete in school? _____

Tobacco Use: (check all that apply)
____Never smoked
____ Smoker How many years have you smoked? _____
____Current everyday smoker
____Current some day smoker
____Cigarettes How many packs per day do you smoke? _____
____Pipes How many per week? ____
____Cigars How many per week? ____

____Former smoker Years smoked? _____ Years stopped? _____
____Smokeless Tobacco (please choose which type of smokeless tobacco used)
_____Chewing tobacco ____Snuff Number of cans per week? ___
____Recently quit tobacco use
____Remotely quit tobacco use
____Would like to quit
____Never tried to quit
____Tried to quit unsuccessfully

Do you drink alcohol? __Yes __No How many drinks do you have
- during a usual 24-hour weekday? ____
- during a usual 24-hour weekend day? ___

How many cups of caffeinated coffee or tea or cola do you drink per day? _____

Do you use:
Intravenous drugs: ____No ____Yes, last used _____
Cocaine: ____No ____Yes, last used _____

Name: _____ DOB: _____

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Please check Yes or No for each item:

Yes No

Constitutional
___ ___ Weight gain (in the last 6 months)
___ ___ Weight loss (in the last 6 months)
___ ___ Fatigue

Sleep
___ ___ Sleepiness
___ ___ Unrefreshing sleep
___ ___ Snoring
___ ___ Stop breathing during sleep

Eyes
___ ___ Vision loss (blindness)
___ ___ Double vision
___ ___ Rapid change in vision

Respiratory
___ ___ Chronic cough
___ ___ Wheezing
___ ___ Cough up blood

Cardiac
___ ___ Chest pain
___ ___ Shortness of breath with exercise
___ ___ Rapid pounding heartbeat

Gastrointestinal
___ ___ Frequent constipation
___ ___ Frequent diarrhea
___ ___ Blood in stool

Urinary
___ ___ Urinary incontinence
___ ___ Decreased urine flow
___ ___ Frequent urination at night

Yes No

Emotional/Psychiatric
___ ___ Depression
___ ___ Frequent or severe anxiety
___ ___ Hallucinations

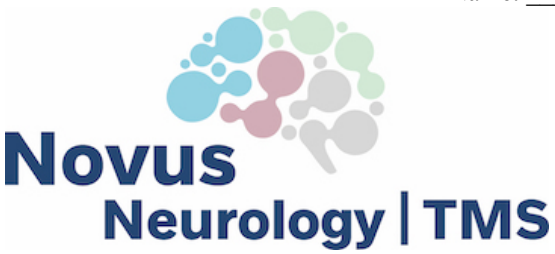
Hematologic
___ ___ Easy bruising or bleeding
___ ___ Frequent infections
___ ___ Low blood counts

Endocrine
___ ___ Heat intolerance
___ ___ Cold intolerance
___ ___ Excessive thirst

Musculoskeletal
___ ___ Joint pain
___ ___ Back pain
___ ___ Neck pain

Neurological
___ ___ Seizures
___ ___ Dizziness
___ ___ Memory loss
___ ___ Headache
___ ___ Weakness
___ ___ Loss of grip strength
___ ___ Numbness or tingling in the hands
___ ___ Numbness or tingling in the feet

Name: _____ DOB: _____



2201 Jack Warner Parkway
Tuscaloosa, AL 35401
Phone: (205) 523-5618 / Fax: (205) 462-7125

Dear Patient,

Please complete the attached information legibly and bring it with you to your appointment along with your **insurance card(s)** and **photo ID**. If you are currently without insurance, you will be expected to pay $150 and at the time of check in for your initial visit and $75 for each follow-up visit. Payment is due at time of your visit.

If your insurance is one that requires a primary care physician referral (ex: Medicaid, BCBS BEG policy, etc.) you will need to obtain it prior to your office visit or you will be rescheduled.

Please ensure that your primary care physician or referring physician has sent **ALL** necessary medical records. Also, if you have had a **recent MRI or CT please bring a copy with you to your appointment**. If you fail to bring these films, you may be asked to reschedule your appointment.

Please note: If you are more than 15 minutes late for your appointment, you may be asked to reschedule. **There will be a $50 charge added to your account for cancelling less than 24 hours from your appointment time. And testing will be $150. Charge.**

If you have any questions please call our office for assistance.

Sincerely,
Dr. Timothy Prestley and Staff

Name: _____ DOB: _____

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PLEASE KEEP FOR YOUR RECORDS

Phone Number: (205) 523-5618

The following important information will help you when dealing with **Novus Neurology & TMS:**

A. Communicate with our office online through your patient portal. Simply provide your email address when you check-in for your appointment.

- Request an appointment
- Ask a Nurse
- Request a refill
- Requests records
- Ask a billing question

B. The following are common tests ordered by our neurologists and the normal amount of time you can expect to wait for results:

- MRI and CT: 10 business days
- Spinal tap: 10 business days
- Lab work: 5 business days
- EEG: 10 business days
- Driver's Test: 3 weeks
- EMG / NCV: 5 business days
- FORMS: 10 business days

Because test results are evaluated together, our office will not call you until **ALL** results are back.

Please do not call multiple times in the same day for refills or test results as this will not speed up the process