HEAD TO HEAD CONSULTANTS, PA

Patient Name: _____, _____
Last First
Address: _____
City: _____ State: _____ Zip Code: _____
Tel. No. (H): _____
Work: _____
Cell No.: _____
E-mail address: _____ Fax Number: _____
Date of Birth: _____ Age: _____

Male: _____ Female: _____

Single: Married: Divorced: Widowed:

Employed By: _____
Occupation: _____
City: _____ State: _____
Telephone: _____
E-mail address: _____ Fax Number: _____

Are your injuries sustained from a motor vehicle accident: Yes ( ) No ( ) Explain:

Are your injuries sustained from a sports-related accident: Yes ( ) No ( ) Explain:

Are your injuries sustained from a Workers' Compensation case: Yes ( ) No ( ) Explain:

Are you currently involved in litigation: Yes ( ) No ( ) Explain:

Referral Source:_____

Primary Care Physician: _____
Address: _____
Tel No.: _____

Emergency Contact: _____ _____ _____
Name Relationship Telephone No.

HEAD TO HEAD CONSULTANTS, PA
PAYMENT POLICY

Explanation of Payment Policy: I understand that Head to Head Consultants does not participate with any insurance companies and that it is my responsibility to pay my bill at the time of provision of services. I understand that I am ultimately responsible for the balance of my account.

Signed: _____

_____ _____
Name Date

HEAD TO HEAD CONSULTANTS, PA
ADULT PATIENT INFORMATION FORM

Patient Name: _____, _____ Date of Appointment: _____
Last First

Review of Systems: Are you presently experiencing any of the following symptoms (please check if yes):

____Fever
____Weight Loss
____Loss of Sleep
____Fatigue
____Loss of Vision
____Blurred Vision
____Double Vision
____Shortness of Breath
____Chest Pain
____Palpitations
____Decreased Hearing
____Ringing in the Ears
____Vertigo (Room Spinning)
____Lightheadedness
____Dizziness
____Loss of or Excessive Appetite
____Nausea
____Vomiting
____Tremor
____Paralysis
____Poor Balance
____Seizures
____Restless Legs
____Attention and Concentration Problems
____Memory Loss
____Depression
____Anxiety
____Hallucinations
____Agitation
____Phobias
____Headache
____Stress

Past Medical History (please check if yes):

____Diabetes
____High Blood Pressure
____Heart Attack

____Angina
____Stroke
____Fainting
____Cancer
____Epilepsy
____Infections
____High Cholesterol
____Concussion/Brain Injury
Other: _____

Do you smoke cigarettes: No ( ) Yes ( ) How many ( )

Do you drink alcohol? No ( ) Yes ( ) How much and how often _____

Do you use recreational drugs? No ( ) Yes ( ) How much and how often _____
_____

Family History (please check if yes):
____High Blood Pressure
____Diabetes
____Seizure Disorder
____Migraines
____Depression
____Anxiety
____Attention-Deficit/Hyperactivity Disorder
____Learning Disability
____Bipolar Disorder
____Psychosis
Other (please explain): _____

Do you have any allergies: No ( ) Yes ( ) Please explain_____

What do you hope to gain from this consultation/evaluation: _____

HEAD TO HEAD CONSULTANTS, PA
CONCUSSION HISTORY FORM

Patient Name: _____, _____
Last First
Date of Birth: _____

Date of Concussion	Nature of Injury	Symptoms	Duration

HEAD TO HEAD CONSULTANTS, PA
MEDICATION LOG SHEET

Patient Name: _____, _____ Date of Birth: _____
Last First

Known Allergies: _____

Current Medications	Strength/Dose	Prescribed By

NOTICE OF PRIVACY PRACTICES

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

Head to Head Consultants has an obligation to maintain the privacy of Protected Healthcare Information (PHI) and provide individuals with notice of our legal duties and privacy practices when requested.

Federal law provides that we may use your medical information or disclose your medical information to obtain the following:

- Payment for our services (i.e., submission of your diagnosis which you will send to your insurance company)
- Health care operations (i.e., audits by our bookkeeper and accountants)
- When required for public health purposes to avoid health or safety threat
- When required by an agency such as the Department of Health
- When required by law and judicial or administrative proceedings
- When required for law enforcement purposes

Your have the right to:

- Request restrictions on certain uses or disclosures described above; however, we are not required to agree to such restrictions.
- Obtain copies of your neuropsychological information.
- Request an accounting of any disclosures we make of your medical information with the exception of disclosures we make to you, or in order to carry out treatment, payment, or health care operations.

We may contact you by mail or phone to remind you of appointments or to provide information about treatment unless you instruct us otherwise. We may leave a message for you on your answering machine or with any person who answers the phone at your residence. If you have a preference please check below:

____Home
____Work
____Cell

The people listed below have my permission to speak to the doctor or the office with regard to my treatment: _____

_____

My signature below represents that I have read this notice of privacy practices.

_____
Signature

_____ _____
Name **Date**

HEAD TO HEAD CONSULTANTS, PA,
OUR FINANCIAL POLICY

Thank you for choosing us to provide your neuropsychological healthcare. The following is the statement of our financial policy which we require that you read and sign prior to your office visit. Payment is due at time of service. Partial payment will only be accepted if prior arrangements have been made prior to your initial visit.

- Once a payment plan is arranged, payments must be made consistently or the balance will be considered delinquent and may be subject to finance charges or eventually turned over to our collection agency.
- Delinquent accounts will be subject to monthly billing charges until the account is settled in full.
- Our cancellation policy – we require 48 hours notice for all cancelled appointments or your account will be charged for a portion of the time that has been set aside for the appointment. Please be aware that this charge is your responsibility and is not covered by your insurance.
- In addition, there will be a charge for all no-shows.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above financial policy and understand and agree to the terms as stated above.

_____
Signature

_____ _____
Name **Date**