BLUE RIDGE ASSOCIATES IN NEUROLOGY

Jill B. Cramer, MD Sarah E. Champion, C-FNP Glenn R. Quarles, Jr. DO

Return Patient Update Form

Please provide any NEW or UPDATED information; leave blank any information that is the SAME.

Patient _____ _____ _____
Last Name First Name Middle Initial

SSN _____ **Date of Birth** _____ **Sex** ☐ M ☐ F

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Other _____

Mailing Address _____

City _____ **State** _____ **Zip** _____

Which contact information would you prefer that we use for the following communication:

	Appointment Reminders	Test Results	Billing Questions	May we leave detailed messages?
Home phone _____	☐	☐	☐	☐
Work phone _____	☐	☐	☐	☐
Cell phone _____	☐	☐	☐	☐
Email _____	☐	☐	☐	☐

Employer Name _____ **Your job title** _____

Emergency Contact Person/Relationship to patient _____
Phone #(s)_____
***Responsible Party (if not patient) Name/ Address/ Phone#(s) for Billing**

_____

_____

Primary Care Physician Name

_____

Referring Physician Name

_____

Do you have Medical Coverage? ☐ yes ☐ no
Primary Cardholder Name(if NOT pt) _____ **Date of Birth** _____
Do you have Prescription Drug Coverage? ☐ yes ☐ no
Please provide copies of your insurance and prescription card(s) at your appointment.

Local Pharmacy Name, Town _____
Mail-in Pharmacy (if applicable) Name _____By signing below, I acknowledge that I understand that insurance is considered a method of reimbursing the patient for fees paid to the physician, but is usually not designed to pay the entire fee. Because the amount paid by insurance companies varies, it is ultimately my responsibility to pay the portion of the bill not paid by my insurance company (unless otherwise restricted by law or an agreement we might have made with the insurer). I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I have received notice of this organization's privacy practices.

Signature: _____ **Date:** _____

Name and title if not patient _____

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Review of Systems

Patient Name: _____ **Today's Date:** _____

Review of Systems: In the past *month*, have you experienced any of the following:

☐ Fevers	☐ Chills	☐ Sweats	☐ Poor appetite	☐ Fatigue
☐ Too sleepy	☐ Trouble sleeping	☐ Feeling ill	☐ Weight gain	☐ Weight loss
☐ Eye pain	☐ Vision loss	☐ Blurry vision	☐ Double vision	☐ Eye irritation
☐ Eye discharge	☐ Light sensitivity	☐ Ear pain	☐ Ringing in ears	☐ Decreased hearing
☐ Nasal discharge	☐ Nosebleeds	☐ Sore throat	☐ Hoarseness	☐ Trouble swallow
☐ Chest pain	☐ Palpitations	☐ Passing out	☐ Easily winded	☐ Leg swelling
☐ Cough	☐ Bloody sputum	☐ Wheezing	☐ Nausea	☐ Vomiting
☐ Diarrhea	☐ Constipation	☐ Stool incontinence	☐ Abdominal pain	☐ Bloody stool
☐ Pain with urination	☐ Blood in urine	☐ Urine incontinence	☐ Back pain	☐ Joint pain
☐ Joint swelling	☐ Muscle cramps	☐ Muscle pain	☐ Muscle stiffness	☐ Skin rash
☐ Itching	☐ Color change	☐ Hair loss	☐ Dry skin	☐ Weakness
☐ Numbness	☐ Seizures	☐ Tremors	☐ Dizziness	☐ Depression
☐ Anxiety	☐ Memory loss	☐ Suicidal thoughts	☐ Hallucinations	☐ Cold intolerance
☐ Heat intolerance	☐ Excessive thirst	☐ Excessive hunger	☐ Frequent urine	☐ Easy bruising
☐ Easy bleeding	☐ Big lymph nodes	☐ Hives	☐ Hay fever	☐ Ongoing infections

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Medication Policy

I, _____, have read, understand, and agree to the following terms regarding medication prescriptions with Dr. Jill Cramer:

1. While Dr. Cramer and Sarah Champion, C-FNP try to accommodate medication refill requests as quickly as possible, be aware medication refills sometimes take several days to process. Please provide at least five (5) business days advance notice for medication refills. The fastest way to process a refill request is to call the pharmacy and ask the pharmacist to forward a faxed or electronic request to Dr. Cramer and Sarah Champion, C-FNP.

2. If you take controlled substances including, but not limited to: codeine, morphine, oxycodone, hydrocodone, tramadol, methylphenidate, dextroamphetamine, diazepam, lorazepam and alprazolam, note that Dr. Cramer and Sarah Champion, C-FNP do NOT typically take over the prescribing of these medications from another physician.

3. Be aware that Dr. Cramer and Sarah Champion, C-FNP participate with the Prescription Monitoring Program. By law, they can review your controlled substance refill habits through this monitoring program. By their policy, Dr. Cramer and/or Sarah Champion, C-FNP will review your prescription refill habits periodically. Any patient found to be receiving prescriptions for controlled medications (see above partial list) from more than one provider will NOT receive further controlled substance prescriptions from Dr. Cramer or Sarah Champion, C-FNP.

4. Early refill requests for controlled medications will NOT be honored.

5. Medication refills cannot be provided for patients who have not been seen in office within 12 months of refill request. Please make sure you have annual appointments with Dr. Cramer if you require ongoing non- controlled prescriptions. For controlled prescriptions, patients must be seen in office a minimum of every six(6) months.

6. For patients who are prescribed controlled substances by Dr. Cramer and/or Sarah Champion, C-FNP, random pill counts and urine drug screens may be performed at or between scheduled office visits. The following situations will result in Dr. Cramer and Sarah Champion, C-FNP no longer prescribing these medications: failure to participate in any requested pill count or urine drug screen; pill count is lower than expected; urine drug screen fails to show the prescribed medications; urine drug screen shows narcotics other than the prescribed medications; or urine drug screen shows any illicit substances.

7. Be sure to update your medication list with Dr. Cramer, Sarah Champion, C-FNP, or Dr. Cramer's assistant, Renee, at each office visit. Also, please advise us of any adverse reactions or allergies to medications you have used previously.

_____ **Date** _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

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Disclosure to Family/Friends

I, _____, hereby authorize release of my medical information to the following people and/or companies:

***If you want nobody else to be able to access your medical information, call for appointments, ask questions regarding your account or medical care, please write "NONE" in the top Name box.**

Name	Relationship to Patient	Phone or Fax # or Email

Other Disclosures (Workers Comp, Disability Rep, etc.)

_____ Date _____

SIGNATURE of PATIENT or GUARDIAN

Name and title if not patient _____

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Consent to Release/Obtain Medical Information

To release the medical information of:

Patient Name:_____

Date of Birth:_____ ***SS#:*** _____

I, the undersigned do hereby authorize and request records ***from***:

_____

_____

To: **Blue Ridge Associates in Neurology at below address/ fax#**

Records to be released:

	YES	**NO**
Discharge Summary	☐	☐
Lab Reports	☐	☐
Substance Abuse Records	☐	☐
History Physical	☐	☐
Office/ Consult Notes	☐	☐
Radiology Reports / Films or Disc	☐	☐
Psychiatric Records	☐	☐
Operative Reports	☐	☐
Emergency/Outpatient	☐	☐
EKG/EEG/ECHO/EMG/Stress	☐	☐

Other (Specify)_____

Treatment Date (s):_____

This disclosure is for the purpose of: Medical Care ☐ Claims Processing ☐ Legal ☐ Other_____

I understand that:

- By signing this authorization, I am giving the healthcare entity permission to disclose confidential health records.
- My treatment, payment, enrollment or eligibility for benefits will NOT be conditioned on signing this authorization.
- I may withdraw or revoke this authorization in writing at any time. Withdrawal of this authorization does NOT affect any disclosure of protected health information made prior to the receipt of written notice of revocation by the custodian of the health records.
- There is potential that information may be re-disclosed by the recipient and no longer protected by law.
- A copy of this authorization and a notation concerning the person or agencies to whom disclosure was made shall be included in the original health records.
- The healthcare entity may impose a reasonable fee for copies of records in accordance federal and state law
- This authorization will automatically expire one year after the day below.

SIGNATURE:_____ **DATE:**_____

(Signature of Patient/Parent/Legal Guardian/Representative)

_____

(Relationship to Patient)

_____ Date:_____

(Signature of Witness)

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