Consultants in Epilepsy & Neurology, PLLC

Robert Wechsler, M.D., Ph.D., FAAN

Jessica Bishop, PA-C, MPAS

Enclosed please find registration and medical history forms. Please complete, sign and date these and scan back to **cen_admin@icloud.com**. If you are unable to scan this document back, you may mail to the address below.

It is important that we obtain past medical records related to your visit with Dr. Wechsler. Please contact any providers that have treated you for this condition and request that they send copies of your records to the address or fax below. If you have had an MRI, CT or EEG, please contact the facility where these were performed and ask them to send a copy to our office. If these tests were performed at St. Luke's Regional Medical Center it is not necessary as we are able to access these via the network.

It is very important, and your responsibility, to check with your insurance(s) to verify your insurance benefits for this visit, including whether or not your insurance requires a referral or authorization to see Dr. Wechsler. If a referral or authorization is required and we have not received it by the time of your visit, it may be necessary to reschedule your appointment. If you need assistance with this, please contact our office prior to your visit. We will gladly bill your insurance company.

Please bring your insurance card(s), identification card, and all of your medications with you to your appointment, including any medications/supplements taken for other purposes.

We are located at 1499 West Hays Street on the corner of 15th and Hays Street, downtown Boise. There is parking available in the front.

Please feel free to contact us if you need any assistance completing these forms or have any other questions pertaining to your visit. We look forward to meeting you and participating in your health care. You may also visit our website at www.idahoepilepsy.com for more information and directions to our office.

Sincerely,
Robert T. Wechsler, M.D. & Staff.

1499 W Hays Street Boise, ID 83702 (208)275-8585 Fax (208)275-8586
WWW.IdahoEpilepsy.com

Consultants in Epilepsy & Neurology, PLLC
Robert T. Wechsler, M.D., Ph.D.,FAAN
Jessica Bishop, MPAS, PA-C
PATIENT REGISTRATION

Please print all information below.

PATIENT: THIS SECTION REFERS TO THE PATIENT ONLY.

NAME: LAST | FIRST | MIDDLE INITIAL | EMAIL ADDRESS:

ADDRESS (STREET, APT. NO))

CITY | STATE | ZIP

HOME PHONE:
CELL PHONE:
CONSENT TO TEXT APPT. REMINDERS? Y OR N

DOB:

SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NO.

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ OTHER

REFERRING PHYSICIAN: | PRIMARY CARE PHYSICIAN:

PHARMACY: | PHARMACY PHONE #

BILL TO: PLEASE COMPLETE IF PERSON RESPONSIBLE FOR BILL IS OTHER THAN ABOVE PATIENT.

NAME: | RELATIONSHIP TO PATIENT:

ADDRESS (STREET, APT. NO., CITY, STATE, ZIP)

HOME PHONE:

EMERGENCY CONTACT: LIST SOMEONE OTHER THAN ONE LIVING IN YOUR HOME, I.E. GRANDPARENT, RELATIVE, NEIGHBOR.

NAME: | ADDRESS:

PHONE NO.: | RELATIONSHIP TO PATIENT:

INSURANCE INFORMATION:

Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier supply information of all carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION, PRE-ADMISSION APPROVAL OR REFERRAL, IT IS YOUR RESPONSIBILITY TO INFORM US.

PRIMARY	SECONDARY
PRIMARY CARRIER NAME	SECONDARY CARRIER NAME
ADDRESS	ADDRESS
CITY, STATE, ZIP CODE	CITY, STATE, ZIP CODE
SUBSCRIBER NAME / DOB:	SUBSCRIBER NAME / DOB:
RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER	RELATIONSHIP TO PATIENT ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER
POLICY/ I.D. NO.	POLICY/ I.D. NO.
GROUP NO.	GROUP NO.

I hereby authorize Consultants in Epilepsy & Neurology to submit a claim to my insurance carrier or the intermediaries for all services rendered by Dr. Robert Wechsler and direct my insurance carrier or its intermediaries to issue payment check(s) directly to Consultants in Epilepsy & Neurology, PLLC.

I hereby authorize Consultants in Epilepsy & Neurology, PLLC to release all information necessary regarding services rendered to my insurance company and referring physician.

SIGNATURE OF PATIENT OR AUTHORIZED PERSON:

DATE SIGN

Consultants in Epilepsy & Neurology, PLLC
Robert Wechsler, M.D., Ph.D., FAAN
Jessica Bishop, MPAS, PA-C

Cancellation & No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

If an appointment is not cancelled at least 24 hours in advance, you may be charged a fifty dollar ($50) fee; this will not be covered by your insurance.

____
Print Patient Name

____
Signature

____
Date

1499 W Hays Street Boise, ID 83702 (208)275-8585 Fax (208)275-8586
WWW.IdahoEpilepsy.com

Consultants in Epilepsy & Neurology, PLLC

Robert Wechsler, M.D., Ph.D., FAAN
Jessica Bishop, PA-C, MPAS

PATIENT FINANCIAL POLICY

INITIAL VISIT

Please provide us with a current copy of your ID and insurance card so that we may bill your insurance for you. If no insurance is available, 50% of your payment is due at time of service. Payment plans are available and must be set up if a balance is past due.

All co-pays are due at time of visit.
We accept cash, checks, and major credit and debit cards.

HEALTH INSURANCE

As a courtesy to our patients, we will bill your insurance company for you. Each insurance company has its own parameters for determining how much they will pay on each claim. You have signed a contract with your insurance company and are responsible for your financial portion of your claims (according to your policy rules). This might be in the form of a deductible, coinsurance amount, or copay.

It is your responsibility to make yourself familiar with your insurance policy. Please contact your insurance company if you have any questions about coverage or whether Dr. Wechsler is covered under your insurance plan. If you find that Dr. Wechsler is not covered by your insurance plan, we are willing to try to become a preferred doctor, but extra time is required and your appointment may be delayed if your insurance is not one that currently allows you to see Dr. Wechsler. If your insurance is out-of-network, you may still be seen if you want to be responsible for charges as a self-pay patient.

PAYMENTS

Unless other arrangements have been agreed upon, all balances are due on receipt of statement. If payment is not received, we reserve the right to refuse future appointments for those with any overdue account balances.

I have read and agree to the above:

_____________________   _____________________

Patient signature   Date

1499 W Hays Street Boise, ID 83702 (208)275-8585 Fax (208)275-8586
WWW.IdahoEpilepsy.com

Consultants in Epilepsy & Neurology, PLLC

Robert T. Wechsler, M.D., Ph.D., F.A.A.N.

1499 W. Hays Street Boise, ID 83702
PHONE: (208) 275-8585 FAX: (208) 275-8586

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Patient: ______________________________________ DOB: ________________________

Address: ____ Phone: ___________________
Street City State Zip

Dates of Service: _____________________ to ________________________

This is to authorize that medical information regarding the above-identified person be released:

From: ____
____
____

REQUESTING: Robert Wechsler, M.D., P.h.D., F.A.A.N.

Purpose or need for records: ____

COPIES OF RECORDS REQUESTED:

_____ Complete Copy of All Records
_____ Physician's Order & Progress Notes
_____ History & Physical
_____ Films (specify_______________)
_____ Emergency Room Record
_____ EEG Report
_____ Laboratory Reports
_____ Operative Reports
_____ Pathology Reports
_____ Slides
_____ X-Ray Report
_____ Discharge Summary
_____ Clinic records pertaining to outpatient treatment of: __________________________________
_____ Other: ____
FOR THE FOLLOWING DATES: ____

RESTRICTIONS AND/OR EXCLUSIONS (if any): _______________________________________
This authorization is valid for six months unless revoked in writing earlier:

_______________________________________ ____________________________
Patient's Signature Date

____ ______________________________
Parent or Guardian (if minor patient) Relationship to Patient

*__NOTE TO RECIPIENT OF INFORMATION:__ This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosures of this information without specific written consent of the patient or legal representative involved.

CONSULTANTS IN EPILEPSY & NEUROLOGY, PLLC

MEDICARE ASSIGNMENT OF BENEFITS

I request that payment of authorized health insurance benefits, including Medicare and Medigap, be made either to me or on my behalf to Consultants in Epilepsy & Neurology, PLLC for services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

____ Date _____________________
Signature of patient or authorized representative.

ASSIGNMENT OF MEDICAL BENEFITS OTHER THAN MEDICARE

I hereby authorize direct payment of medical benefits to Consultants in Epilepsy & Neurology, PLLC/Dr. Robert Wechsler for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I hereby authorize Consultants in Epilepsy & Neurology, PLLC/Dr. Robert Wechsler to release any medical or incidental information that may be necessary for the filing and reimbursement of medical claims.

____ Date ______________________
Signature of patient or authorized representative.

AUTHORIZATION TO USE AND/OR DISCLOSE HEALTH INFORMATION

Consultants in Epilepsy & Neurology, PLLC, Robert Wechsler, MD, PhD, FAAN, and staff are authorized to share information and provide copies of my entire medical records, including all written and oral reports, substantive evaluations of progress, history, diagnosis, prognosis, course of treatment, reports, and attendance and compliance with respect to all care or treatment, including all confidential HIV and AIDS related information, mental health records, drug and alcohol, abuse treatment records, sexual assault and sexual abuse counseling records to my insurance companies, doctors, treating facilities, and my employer in the case of Worker's Compensation, and the following persons.

CHECK ALL THAT APPLY:

( ) Spouse–Name ____

( ) Parents, if over18–Name(s) ____

( ) Children–Name(s) ____

( ) Authorized Representative–Name ____

( ) Other–Name(s) ____

____ Date ____________________
Signature of patient or authorized representative.

I have read and understand the above assignments and authorizations to use/disclose health information about the named patient as described.
These assignments/authorizations remain in effect until revoked by me in writing.

***A copy or facsimile of any or all above signatures is as valid as the original.**

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is import to our professional relationship. Please ask if you have any questions about our fees, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. A PHOTOCOPY OF YOUR INSURANCE CARD(S) WILL BE MADE FOR YOUR FILE.

- **CO-PAYMENTS** – By law we MUST collect your carrier designated co-pay at the time of service. Please be prepared to pay that co-pay at the visit.
- **NON CO-PAY PLANS** – If your plan does not require a co-pay and we participate, we will accept the designated fee**.** You are responsible for any deductible and balance your plan indicates on their explanation of benefits.
- **REFERRALS** – If your plan requires a referral from your primary care physicians it is YOUR responsibility to obtain it prior to your appointment. It is best if you request that your physician fax the referral to our office at (208) 275-8586. If you do not have your referral, you may be required to sign a financial waiver. It is then your responsibility to provide us with the referral as soon as possible. If a referral cannot be obtained from your primary care physician you will be responsible for the charges for the services provided.
- **SELF PAY PATIENT** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We submit all Medicare claims, patients are responsible for the deductible and the 20% co-insurance. Secondary insurance may reimburse for the Medigap deductible and co-insurance.

WE ACCEPT CASH, CHECKS, VISA OR MASTER CARD

THANK YOU for taking the time to review our policies. Please feel free to ask questions or share special concerns with us.

____ ____________________

RESPONSIBLE PARTY SIGNATURE **DATE**

Consultants in Epilepsy & Neurology, PLLC
Robert t. Wechsler, M.D., Ph.D.,FAAN

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for to use and disclose Consultants in Epilepsy & Neurology, PLLC protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Consultants in Epilepsy & Neurology, PLLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Consultants in Epilepsy & Neurology, PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Consultants in Epilepsy & Neurology, PLLC, 1499 West Hays Street Boise, Idaho 83702

With this consent, Consultants in Epilepsy & Neurology, PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Consultants in Epilepsy & Neurology, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Consultants in Epilepsy & Neurology, PLLC may keep my name on a list for future therapy options including but not limited to Clinical Studies.

With this consent, Consultants in Epilepsy & Neurology, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Consultants in Epilepsy & Neurology, PLLC restricts how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Consultants in Epilepsy & Neurology, PLLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Consultants in Epilepsy & Neurology, PLLC may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

___________________________ ___________________
Print Patient's Name Date

____
Print Name of Patient or Legal Guardian, if applicable

Intake History & Systems Review

Reviewed:_______________

Current Medications and Doses **NONE**

____

____

____

Previous Antiepileptic Drug Trials
******Please circle below****** **NONE**

Aptiom (eslicarbazepine)
Ativan (lorazepam)
Briviact (Brivaracetam)
Banzel (rufinamide)
Carbatrol (carbamazepine)
Depakote (valproate)
Dilantin (phenytoin)
Diastat (diazepam rectal)
Epidiolex
Felbatol (felbamate)
Fycompa (perampanel)
Gabatril (tiagabine)
Klonopin (clonazepam)
Keppra (levetiracetam)
Lamictal (lamotrigine)
Lyrica (pregabalin)
Nayzilam (midazolam)
Mysoline (primidone)
Neurontin (gabapentin)
Onfi (clobazam)
phenobarbital
Potiga (exogabine)
Sabril (vigabatrin)
Tegretol (carbamazepine)
Topamax (topiramate)
Tripleptal (oxcarbazepine)
Valium (diazepam tablet)
Valtoco (diazepam nasal spray)
Vimpat (lacosamide)
VNS (vagus nerve stimulator
Xcopri (cenobamate)
Zarontin (ethosuxamide)
Zonegran (zonisamide)

Medication Allergies (ONLY)
Please specify medication and type of reaction.
IF YOU DON'T HAVE ANY ALLERGIES, PLEASE CIRCLE NONE. **NONE**

Medication: ____
Symptoms / Reactions:
Fatigue: ____
Cognitive problems: ____
Mood or behavior change: ____
Rash or hives: ____
Weight Change: ____
Electrolyte abnormality: ____
Hepatic Toxicity: ____
Blood count abnormality: ____
Other: ____

Past Medical History
Please circle all that apply

Seizures Headache Migraine Stroke/TIA MS Dementia Heart disease Hypertension Diabetes

Asthma Thyroid problems Cancer Depression Anxiety Surgeries (describe and list below) Other :

____

____

____

Childhood History and Epilepsy Risk Factors – Please circle yes or no!

History of prematurity or problems at birth: No Yes ____

History of febrile seizures: No Yes____

Developmental or congenital abnormality: No Yes____

Delayed developmental milestones: No Yes ____

Problems in school: No Yes ____

Meningitis or encephalitis: No Yes____

History of coma: No Yes____

Family history of seizures: No Yes____

History of head trauma with loss of consciousness: No Yes______________________________________

Social History of patient

Marital/Family Status: Single Married Divorced

Number of Children: ____

Circumstances at home (i.e. group home, live alone): ____

Level of education: ____

Work Status: Employed Not Employed Student Part Time Full Time

Left or Right Handed (Circle one)

Nature of employment: ____

Disability status: ____

Driving status: ____

History of physical or sexual abuse: ____

Alcohol: Never Past history Style of beverage and number of drinks per day or week:_______________

Tobacco: Never Past history Style of Tobacco and number of packs per day or week:________________

Quit (when): ____________________

Drugs: Never Quit: Style of drugs taken:_______________

Family History

Please circle M or P if family member is Maternal or Paternal when option is given.

	Father	Mother	Child (ren) Specify Male/F emale	Brother	Sister	Uncle	Aunt	Cousin	Grandparents
Epilepsy						M–P	M–P	M–P	M–P
Seizures						M–P	M–P	M–P	M–P
Migraine						M–P	M–P	M–P	M–P
Dementia						M–P	M–P	M–P	M–P
Stroke						M–P	M–P	M–P	M–P
Heart disease						M–P	M–P	M–P	M–P
Hypertension						M–P	M–P	M–P	M–P
Diabetes						M–P	M–P	M–P	M–P
Asthma						M–P	M–P	M–P	M–P
Thyroid problems						M–P	M–P	M–P	M–P
Psychiatric Problems						M–P	M–P	M–P	M–P
Cancer						M–P	M–P	M–P	M–P
Other									

Review of Systems

Circle items of note in the past few months, or circle NONE if there hasn't been any.

General/Constitutional

NONE weight loss weight gain overall good health normal energy excessive heat intolerance cold intolerance excessive sweating fatigue

Other:

Eyes

NONE change in vision double vision tearing blind spots pain glaucoma

cataracts scintillations injury blindness

Other:

Ears/Nose/Mouth/Throat

NONE nose bleeding frequent colds sinus problems discharge dental problems

gum bleeding dentures neck stiffness tinnitus neck tenderness masses in thyroid

change in hearing pain

Other:

Cardiovascular

NONE chest pain palpitations syncope shortness of breath phlebitis swelling feet

hypertension heart murmurs varicosities claudication

Other:

Respiratory

NONE shortness of breath wheezing infections tuberculosis fevers night sweats

Other:

Gastrointestinal

NONE change in appetite swallowing problems indigestion heartburn abdominal pain

nausea vomiting jaundice constipation diarrhea

Other:

Genitourinary

NONE urgency frequency pain hematuria frequent urination kidney stones

infections incontinence change in libido STD irregular periods

Other:

Musculoskeletal

NONE joint pain swelling redness or heat in joints pain in muscles limitation of motion

muscular weakness atrophy cramps

Other:

Skin

NONE rash itching dryness change in texture loss of hair

Other:

Neurological

NONE headaches vertigo lightheadedness convulsions paralysis tremor

incoordination paresthesias memory problems speech problems sensory disturbances

motor weakness ataxia sleep disturbance

Other:

Psychiatric

NONE nervousness emotional problems anxiety depression previous psychiatric care

unusual perceptions hallucinations bipolar disorder psychosis

Other:

Lymphatic/Endocrine

NONE lymph node enlargement tenderness excessive thirst dry skin excessive urination

hormone therapy heat intolerance cold intolerance weight gain weight loss

Other:

Hematological

NONE anemia bleeding tendency previous transfusions Rh incompatibility

Other:

Allergic/Immunologic

NONE allergy to drugs allergy to foods allergy to insects skin rashes trouble breathing

frequent infections autoimmune disease

Other:

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = no chance of dozing

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	__________
Watching T.V.	__________
Sitting inactive in a public place (e.g. theater or meeting)	__________
As a passenger in a car for an hour without a break	__________
Lying down to rest in the afternoon when circumstances permit	__________
Sitting and talking to someone	__________
Sitting quietly after a lunch without alcohol	__________
In a car, while stopped for a few minutes in traffic	__________
Your Total:	__________

The Epworth Sleepiness Scale Key

Total Score	
1-6	Congratulations, you are getting enough sleep.
7-8	Your score is average.
9 and up	Seek the advice of a sleep specialist. This suggests that you may need further evaluation by a physician to determine the cause of your excessive sleepiness and whether you have an underlying sleep disorder.

Name____ Date______________

NDDI-E

Neurological Disorders Depression Inventory for Epilepsy

	Always or Often	Sometimes	Rarely	Never
Everything is a struggle	4	3	2	1
Nothing I do is right	4	3	2	1
Feel guilty	4	3	2	1
I'd be better off dead	4	3	2	1
Frustrated	4	3	2	1
Difficulty finding pleasure	4	3	2	1

Total Score: ______________

BDI-II Suicidal Ideation Screening

Please circle the item that is most correct for you:

0 – I don't have any thoughts of killing myself.

1 – I have thoughts of killing myself, but I would not carry them out.

2 – I would like to kill myself.

3 – I would kill myself if I had the chance.