HORIZON HEADACHE CENTER
an integrative, non-narcotic approach to headache management

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

Pediatric Demographics Form

Patient Information

CHILD'S NAME

Last Name_____

First Name_____ M.I. _____

Gender _____ Date of Birth _____ Social Security Number _____

Name of Responsible Adult _____ Relation _____

Address _____

City/State _____ Zip Code _____

Home phone _____ Cell Phone _____

Email Address_____

Parent's Work Phone _____ Parent's Driver's License # _____

Preferred Contact Method _____ Preferred Time of Day _____

Occupation _____ Employer _____

Employment Address_____

City/State _____ Zip Code _____

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 (Parent/Guardian if under 18) 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? _____

Past Medical/Surgical History

Have you ever been diagnosed with any of the following health conditions:

Health Condition:	YES	NO	Details/Dates of your condition
EYES:			
Glaucoma			
Retinal Artery Occlusion			
Retinal Migraine			
Cataracts			
Near or far sighted			
Other eye problems			
HEENT:			
Recurrent Ear Infections			
Chronic Sinusitis			
Seasonal Allergies			
NECK:			
Thyroid Problems			
Neck Injury/Pain			
DENTAL:			
Wisdom Teeth Removal			
Root canal			
TMJ disorder			
Bruxism (teeth grinding)			
Orthodontic device (braces)			
CARDIAC:			
Heart attack/Stent placement/Bypass Surgery			
Congestive Heart Failure			
Atrial Fibrillation			
Abnormal heart beat			
Heart murmur			
High Blood Pressure			
High Cholesterol			
Diabetes, specify type:			

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			
PYSCHIATRIC:			
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 any surgeries you have had in your lifetime:

_____

_____

_____

_____

_____

_____

Medications

Please list medications you are currently taking:

Medication	Dose	Frequency	Date Started	Condition being treated

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
PSYCH		
Feeling sad or down	YES	NO
Feeling anxious or worried	YES	NO
Poor sleep	YES	NO
Feeling overwhelmed	YES	NO
Difficulty concentrating	YES	NO
Mood swings	YES	NO
NEUROLOGIC		
Weakness in arms, legs, or face	YES	NO
Loss of consciousness	YES	NO
Memory problems	YES	NO
Numbness or tingling	YES	NO
Seizure	YES	NO
Poor balance	YES	NO
Tremor	YES	NO
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

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 carding 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