East TN Neurology, LLC – Dr. Subroto Kundu

****** INFO & ADDITIONAL INFO SECTION *****

Name: _____ **SS#:** _____

Birthdate: _____ **Sex:** ____ **Marital Status:** _____ **Race:** _____ **Ethnicity:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home: _____ **Cell:** _____ **E-mail:** _____

Primary Care Dr. Name: _____ **Phone:** _____

Employer Name: _____ **Full Time - Part Time**

Student: Yes / No **Highest Level of Education Completed:** _____

Spouse Name: _____ DOB: _____ SSN# _____

Spouse Address (if different than above): _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ E-mail: _____

Emergency Contact Name and Relationship: _____ _____

Pharmacy - Name, Address & Phone:

_____

QUESTIONS: (If relevant make a note in Patient Info box under insurance)

If we are not able to leave a message on your answering machine for appointment, test results & general medical – Please let us know here : _____

Are you residing in a nursing facility? ____ **Are you under house arrest ?** _____

Are you seeing us related to an accident or injury? ___ **Are you Workers Comp Patient** ___

If your answer is YES to any of above, provide further details name, address, where etc:

_____

Do you prefer we TEXT or CALL for appointment reminder. Phone number :---------->

_____

Height _____ Weight _____

Your Signed Name: _____ **DOB:** _____ **Date:** _____

G. In Connection with Judicial and Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court as expressly authorized by such order or in response to a subpoena.

H. In the Event of a Serious Threat to Health or Safety

We may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe that such use or disclosure is necessary to prevent an imminent threat to your health or safety or to the health or safety of the public.

III. Uses and Disclosures Permitted Without Authorization, but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your care or related to your care. We can also disclose your information in connection with trying to locate or notify a family member or others involved in your care concerning your location, condition, or death.

You may object to these disclosures. If you do not object to these disclosures, in the exercise of our professional judgement, that it is in your best interest for use to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures Which You Authorize

Other than stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

A. The Right to Inspect and Copy Your Protected Health Information

You may inspect and obtain a copy of your protected health information for as long as we maintain such information. To inspect or copy your medical information, you must submit a written request to the office of Dr. Subroto Kundu. If you request a copy of your information, we may charge you a fee for the costs incurred by complying with your request.

B. The Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information

You may ask us, in writing, not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request, in writing, that we not disclose your health information to family members involved in your care. Your request must state the specific restriction requested.

VI. Complaints

You have the right to express complaints to Dr. Subroto Kundu and to the Secretary of Health and Human Services if you believe your privacy rights have been violated. We encourage you to express any concerns that you may have regarding the privacy of your information.

Print Name_____

Signature_____

Date_____ Relationship To Patient _____

List of People Authorized to access your Medical Information.

_____ _____

_____ _____

_____ _____

East TN Neurology, LLC – Dr. Subroto Kundu

****** PROGRESS NOTES- CHIEF COMPLAINT *****

Describe your Chief Problem or Complaint:_____

_____

_____

Have you ever seen a Neurologits in the past ? Explain who and why?

_____

Current Medications: (provide printout or copy of list, if you have one)

Medication	Strength	Dosage Instructions	How long in Use

MEDICAL HISTORY (Circle if any problems related to the following):

Anemia:___ Arthiritis:____Allergies:_____Acute Infections:___ Dizziness:_____

Parkinsons:_____ Fibromyalgia:_____ Head Injury:____Cerebral Palsy:____ Vertigo: ___

Asthma:_____ Hypertension:____ VeneralDisease:___ Anxiety:_____ Fatigue:_____

Shaking:____Fainting:_____ Memory Loss:____ Headaches___ Migraines:____ MS:____

Seizures:____ Balance Problems:____ Attention Probems:____Alzheimers:_____

Bladder Control Problems: _____ Bladder Infections:_____ Bleeding Tendency: _____

Cancer: _____ Meningitis:___ Lupus:____ Back Pain:____ Foot Pain:____ Sleep:_____

Convulsions:_____Spasms:_____ Thyroid Issue:_____ Depression:___ HIV/AIDS:____

Cholesterol:_____ Heart Issues:_____ LymeDisease:_____Diabetes:____

Your Signed Name: _____ DOB: _____ Date:_____

Patient Name: _____ SSN: _____ DOB: _____

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I. Uses and Disclosures of Protected Health Information

Dr. Subroto Kundu may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless Dr. Subroto Kundu has obtained your authorization or the use or disclosure otherwise permitted by the HIPAA Privacy Regulations or State law. Disclosures of your protected health information for the purposes described in this Notice may be made in writing, orally, or by facsimile. Communications to you may be made by mail, facsimile, or by telephone.

A. Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes.

B. Payment

Your protected health information will be used, as needed, to bill and collect payment for your health care services.

C. Operations

We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of Dr. Subroto Kundu and to provide quality care.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for the following reasons:

A.When Legally Required.

We will disclose your protected health information when we are required to do so by any Federal, State, or local law.

B. When There are Risks to Public Health.

We may disclose your protected health information for the following reasons:

To prevent, control, or report disease, injury, or disability as permitted by law

To report vital events such as birth or death as permitted by law

To conduct public health surveillance, investigations, and interventions as permitted or required by law

To notify a person when exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law

C. To Report Abuse, Neglect, or Domestic Violence

We may notify government authorities if we believe the patient is a victim of abuse, neglect, or domestic violence.

D. To Conduct Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections, licensure or disciplinary actions; or other activities necessary.

E. For Workers Compensation

F. For Law Enforcement Purposes

We may disclose your protected health information to a law enforcement official for law enforcement purposes.

East TN Neurology, LLC – Dr. Subroto Kundu

Please List all ALLERGIES: If NONE circle here : NONE

_____

_____

Please List all SURGERIES & HOSPITALIZATIONS with Dates:

_____

_____

Please List all HOSPITALIZATIONS with Dates:

_____

_____

Family History :

(Circle One) Mother is - Alive / Deceased Father is - Alive / Deceased

If applicable enter M. F, S, C, PGM, MGM, PGF or MGF for each disease.

(M = Mother **** F = FATHER *** S = Siblings, *** C= Child *** PGF = Paternal Grandfather ***

MGF = Maternal Grandfather*** PGM = Paternal Grandmother ***MGM = Maternal Grandmother ***)

Hypertension:_____ **Diabetes:**_____ **Cancer:**_____ **MS:**_____

Heart Disease:_____ **Stroke:**_____ **Seizure:**_____

Tremor:_____ **Parkinson's:**_____ **Peripheral Neuropathy:**_____

Memory Loss/Dementia: _____ **Muscle Weakness:** _____**Depression:**_____

Myopathy:_____ **Headache:**_____ **Migraine:**_____

Number of Siblings: Brothers_____Sisters_____

No. of Children: Sons_____ Daughters_____

Use of Tobacco: Never :__ Former: ___Current packs/day:_____ , Like to quit: _____ Y/N

Use of Alcohol: Never :__ Rarely: ___ Moderate:___ Daily:___

Use of Drugs: Never:___ or Type & Frequency:_____

Your Signed Name: _____ DOB: _____ Date:_____

Patient Name:_____SSN:_____ DOB: _____

East TN Neurology, LLC - Office Policies

Authorization to treat and bill for services

- I authorize Dr. Kundu and his staff to treat my medical condition (s) and to bill my insurance company for services rendered.
- I authorize Dr. Kundu and his staff to release my medical information to other physicians, my insurance company or pharmacy if necessary to ensure that I receive quality medical care and to obtain payment for services and/or medications.
- I authorize Dr. Kundu and his staff to release and receive information regarding my prescription history in order to further treat my condition.

_____Initial

Authorization to treat patients under the age of 18

- I authorize Dr. Kundu and his staff to treat my minor child in my absence for this visit and for all future visits. I understand that I may call and speak to a member of the doctors staff directly if I have questions regarding the treatment and care of my minor child.

_____	_____	_____
Signature of parent/guardian	Relationship to patient	Date

Financial and Billing Policy

- I authorize Dr. Kundu and his staff to bill and seek payment from my insurance company for services rendered to me.
- I understand that I am responsible for payment of co-pay, co-insurance, and/or deductible amounts at the time of service.
- I understand that I am responsible for my bill if my insurance does not cover the charges for any reason.
- I understand that I am responsible for obtaining the necessary referrals (if required) from my primary care physician for services. If I do not obtain necessary referrals I must either reschedule my appointment or pay for the services at the reduced benefit level as stated by my insurance plan.
- I understand that any balance due after insurance are my responsibility and that balance due to Dr. Kundu may be subject to a billing fee or having interest applied if my balance is not paid within 30 days.
- I understand that there is $35.00 fee for returned checks Payment for returned checks must be made by credit card, money order or cash within 30 days. Returned checks that are not paid after 30 days may be referred to a collection agency and collected to the fullest extent allowed by Tennessee law.
- I understand that if my account is referred to a collection agency for nonpayment, I will be responsible for the total amount of my bill plus collection/attorney fees.

_____Initial

Office Policy

- I consent to Dr. Kundu and his office to keep pictures of myself on file.
- I consent to Dr. Kundu and his office, video recording evidence related to medical conditions for use in professional and educational purposes.
- I understand that there may be a $20.00 assessed for missed appointments cancelled without 24 hours notice and a $50 fee missed diagnostic testing appointments.
- I understand that prescription refills will not be authorized unless I have been seen by the Doctor within the past 60 days unless otherwise discussed with the staff or Dr. Kundu, also there is a 24 hour turn around on all prescription refills. Prescriptions will not be called in.
- I have read, understand and have been offered a copy of the patient privacy policy as mandated by the Federal Government HIPPA regulations (privacy act).

_____Initial

_____	_____	_____
Signature of Patient	Social Security Number	Date

_____	_____	_____
Signature of parent/guardian	Relationship to patient	Date

East TN Neurology, LLC – Dr. Subroto Kundu

REVIEW OF SYSTEMS

General		
Weakness	yes	no
Fatigue	yes	no
Weight Gain/Loss	yes	no
Fever	yes	no
Insomnia	yes	no

Gastro-Intestinal		
Appetite Changes	yes	no
Bowel Habit Change	yes	no
Diarrhea	yes	no
Indigestion	yes	no
Constipation	yes	no
Blood in Stool	yes	no
Pain in Abdomen	yes	no

Genitourinary		
Difficulty Urination	yes	no
Erectile Dysfunction	yes	no
Irregular Periods	yes	no
Heavy Periods	yes	no
Prostate Problems	yes	no
Blood in Urine	yes	no
Kidney Stones	yes	no

Endocrine		
Diabetes	yes	no
Thyroid Disorder	yes	no
High Cholesterol	yes	no
Menopause	yes	no
Excessive Hair Loss	yes	no

Respiratory		
Asthma	yes	no
Trouble Breathing	yes	no
Shortness of Breath	yes	no
Cough/Sputum	yes	no
Blood in Cough	yes	no

Cardiovascular		
Syncope	yes	no
Heart Disease	yes	no
High Blood Pressure	yes	no
Swelling of Feet	yes	no
Palpitations	yes	no

Musculoskeletal		
Arthritis	yes	no
Back Pain	yes	no
Carpal Tunnel	yes	no
Muscle Weakness	yes	no
Under Pain Management ?	yes	no

Hematology		
Anemia	yes	no
Abnormal Bruising	yes	no
Abnormal Bleeding	yes	no
Glands /Lymph Nodes	yes	no
Thyroid	yes	no

Psychiatric		
ADD/ADHD	yes	no
Anxiety	yes	no
Depression	yes	no
Eating Disorder	yes	no
Hallucinations	yes	no
Suicidal Thoughts	yes	no
Irritability	yes	no
Bipolar	yes	no
Seeing a Psychiatrist ??	yes	no

Allergy/Immunology		
Allergies	yes	no
Immune Disorders	yes	no
Hives	yes	no
Food Allergies	yes	no
Seasonal Allergies	yes	no
Skin Rashes/Reactions	yes	no

Your Signed Name: _____ DOB: _____ Date:_____

East TN Neurology LLC, 3555 Keith St., NW Cleveland TN 37312

Pain Management Treatment Agreement

PATIENT NAME: _____ **DOB:** ____/____/_____

Since other treatments have not been successful in controlling pain, the providers at East TN Neurology LLC (ETN-N) have decided to treat you with short term or long-term opioids, to all allow you to improve your social and professional activities, heretofore hampered by chronic pain. This decision is subject to your unconditional agreement to uphold the following commitments on your part, that you will:

1. NOT use any illegal substances, illicit drugs, street drugs or alcohol, while taking the prescribed medication.
2. Will NOT be involved in any sale, illegal possession, diversion or transport of any controlled substances like narcotics, sleeping pills or nerve pills.
3. Agree to obtain drug screening blood or urine tests, as requested by my physician.
4. Agree to obtain all prescriptions of opioids from ONE physician only, and NOT attempt to fill prescriptions from other providers while under treatment at this office.
5. Agree to using only one pharmacy identified here for filling opioids and other restricted drugs; Indicate this pharmacy is:_____
6. Agree to periodic follow up as indicated at any scheduled visit, and make the best effort to keep all scheduled appointments. Also agree to call the office and reschedule an appointment if unable to keep it, notifying the office at least 24 hours in advance. Be aware we may cancel all future visits fora "No Show" of a scheduled appointment.
7. Agree to allow this office to communicate with other physicians and pharmacists regarding the plans of pain management.
8. Agree to keep the prescription and the pills in safe custody, and agree that this office is under no obligation to provide duplicate prescriptions for claims made for STOLEN OR LOST prescriptions or pills, including losses from theft, fires or other hazards. **Initial:**___
9. **FEMALE PATIENTS:** Agree to certify that you are NOT pregnant at the initiation of treatment, and that appropriate birth control methods are being followed to prevent pregnancy for the duration of opioid therapy treatment.
10. Understand that treatment with opioids may carry risks of adverse effects and dependency.
11. Understand that further treatment at this office will be discontinued immediately if:
    a. I give away, sell or misuse the prescribed medications
    b. I use other people's medications or illegal substances, recreational drugs
    c. I disrespect or harass any member of the office staff
    d. I do not keep my visits
12. Bring prescription bottles to the office within 24 hours when a random pill count is requested.

I have read and understand this agreement. I have all my questions answered satisfactorily, and I have been offered to have this contract read to me if need be.

Print Name: _____ Date: ____/____/_____

Signed: _____ Witnessed: _____