

**NEUROLOGISTS**

James J. Anthony, MD  
Dolly A. Boughaba, MD  
James P. Farrell, MD  
John H. Feibel, MD  
Maureen Li, MD, PhD  
Brian N. Maddux, MD, PhD  
J. Todd Perkins, MD  
Robert L. Reed, MD  
Marvin H. Rorick III, MD  
Michael Schmerler, MD  
Colin M. Zadikoff, MD

**Appointment Line**  
**(513) 612-1111**

**Mt. Auburn**

111 Wellington Place, LL  
Cincinnati, OH 45219

Direct: (513) 241-2370  
Fax: (513) 241-6053

**Montgomery**

10550 Montgomery Rd. Ste 33  
Cincinnati, OH 45242

Direct: (513) 936-5360  
Fax: (513) 984-6808

**Northern Kentucky**

320 Thomas More Parkway  
Crestview Hills, KY 41017

Direct: (859) 341-4266  
Fax: (859) 344-5076

**Mt. Airy**

2450 Kipling Ave. Ste 103  
Cincinnati, OH 45239

Direct: (513) 681-4880  
Fax: (513) 681-4609

**Anderson**

8000 Five Mile Rd. Ste 330  
Cincinnati, OH 45255

Direct: (513) 624-6031  
Fax: (513) 624-0029

Appointment Date \_\_\_\_\_

Appointment Time \_\_\_\_\_

Dear \_\_\_\_\_

Welcome to Riverhills Neuroscience. You are scheduled to see Dr. Robert Reed for a neurological evaluation at our 111 Wellington Place location. We hope this letter will help prepare you for your visit.

The enclosed questionnaire will be reviewed when you are seen. One of us and/or Dr Reed will ask you about your problem ("take a history"). Please present this information in as much detail as you can. A friend or family member may assist you with this.

Your neurological exam may consist of the following: 1) an evaluation of your mental function, 2) a walking and balance exam, 3) an evaluation of your vision, 4) testing strength and reflexes, 5) a brief medical exam. We emphasize certain aspects of the examination depending on your problem. You will be asked to change into a gown for the examination, but you will keep your underclothes on.

If you have had any studies completed (blood tests, X-Rays, CT scans, MRI scans, EMGs, EEGs) please bring copies of the reports with you. If you have had an MRI or CT scan performed, we will need to review your actual CD or films at the time of your visit. It is best to pick up the CD (or films) at the facility where they were completed and bring them with you on the day of your exam. We will review and discuss your tests at the time of your exam. We may order additional studies depending on our findings. Following completion of the studies, you may need to see us again to discuss the results and a treatment program.

Upon arrival at our office, please check in at our front desk. Our office hours are Monday through Friday from 8:30 a.m. until 5:00 p.m. You can reach us at (513) 241-2370 (option 3). If you have not already done so, please call our appointment line to register and provide health insurance information at (513) 612-1111.

Note: Wheelchairs are available at the reception desk to safely transport patient in/out of our office.

We look forward to meeting you.  
Sincerely,

Rhonda Cortright  
Registered Medical Assistant

Sandy Hunt  
Medical Assistant

# New Patient Questionnaire

**Patient Name** \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_

Physician \_\_\_\_\_

Phone \_\_\_\_\_

Date of appointment \_\_\_\_\_

Emergency contact \_\_\_\_\_

You are:  Right handed  Male  
 Left handed  Female

**\*\*List your allergies in this box:**

Or check this box if you have no known allergies

**Who referred you?** (internist, family practitioner, etc)

**What pharmacy do you use?**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, ST ZIP: \_\_\_\_\_

City, ST ZIP: \_\_\_\_\_

Phone #: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Check here if you do NOT want reports sent to your primary doctor or your referring doctor(s).

**What problem brings you to the doctor today?**

\_\_\_\_\_  
 \_\_\_\_\_

**How long have you been bothered by this problem?** \_\_\_\_\_

**Please rate your pain on a scale of 0 to 10** (0 = no pain, 10 = worst possible pain) \_\_\_\_\_

**What other doctors have you seen, related to your current problem?** \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**What tests have you had, related to your current problem?**

	When	Where
<input type="checkbox"/> MRI scan (image of brain, neck, or back)	_____	_____
<input type="checkbox"/> CT scan (image of brain, neck, or back)	_____	_____
<input type="checkbox"/> EMG (electrical test of nerves and muscles)	_____	_____
<input type="checkbox"/> EEG (brain wave test)	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

**Social and Occupational Information:**

Living situation:

- Assisted living
- House, condo, or apartment
- Nursing care facility
- Retirement/indep't living
- Shelter
- Other: \_\_\_\_\_

Marital status:

- Divorced
- Married
- Separated
- Single
- Widowed

Who lives with you at home: (check all that apply)

- Alone
- Child(ren)
- Friends
- Grandchild(ren)
- Parent(s)
- Sibling(s)
- Spouse

Home safety issues: check if

- You have concerns about safety in your home
- You are (or have been) in an abusive relationship
- Other \_\_\_\_\_

Tobacco:

- Never smoked
- Current smoker:  
Packs per day \_\_\_\_\_
- Former smoker:  
Stop date: \_\_\_\_\_
- Smokeless tobacco

Alcohol:

- Never used
- Current user:  
Amount: \_\_\_\_\_
- Former user:  
Stop date: \_\_\_\_\_

Drug use:

- Never used
- Current user:  
Type/How often? \_\_\_\_\_
- Former user:  
Stop date: \_\_\_\_\_

Check if:

- You have tried unsuccessfully to quit smoking
- You have ever been told (or you know) you have a problem with alcohol
- You have ever been told (or you know) you have a problem with drug use (including prescription medications)

Occupation:

- Current occupation: \_\_\_\_\_
- Retired date: \_\_\_\_\_
- Unemployed or laid off date: \_\_\_\_\_
- Disabled date: \_\_\_\_\_

Check if:

- You are involved in a lawsuit
- This visit is related to a disability
- This visit is related to a work injury
- This visit is related to an auto accident

Please provide details (including attorney address and any claim information) in this space, if applicable.

---

---

---

---

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

### Your Past Medical History and Ongoing Medical Conditions

(Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Headache                           | <input type="checkbox"/> Kidney disease          |
| <input type="checkbox"/> Bleeding disorder            | <input type="checkbox"/> Head injury                        | <input type="checkbox"/> Liver disease           |
| <input type="checkbox"/> Cancer<br>(state type) _____ | <input type="checkbox"/> Heart disease                      | <input type="checkbox"/> Migraines               |
| <input type="checkbox"/> Dementia                     | <input type="checkbox"/> High cholesterol                   | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Seizures                |
|   | <input type="checkbox"/> Irregular heartbeat                | <input type="checkbox"/> Stroke                  |

Please list other conditions or illnesses if they are not shown above:

_____	_____	_____
_____	_____	_____
_____	_____	_____

### Hospitalizations

reason	when	where

For additional space, use reverse side of this page.

### Surgical Procedures

procedure	when

For additional space, use reverse side of this page.

### Medical Conditions in Your Family Members

Check all boxes that apply

	mother	M Gr mother	M Gr father	father	P Gr mother	P Gr father	brother	sister	other
Alive (A) or Deceased (D)									
Age									
Arthritis									
Bleeding disorder									
Cancer (type: _____)									
Dementia									
Diabetes									
Heart Disease									
High Cholesterol									
Hypertension (high blood pressure)									
Migraines									
Multiple Sclerosis									
Seizures									
Stroke									
Other _____									
Other _____									
Other _____									

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

# Medication List

Please list and bring all medications you are currently taking to your appointment.

- ▶ Include over-the-counter medications, dietary supplements, etc.
- ▶ Attach extra page if needed

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Please list below any medications you have STOPPED TAKING within the last two years

	NAME	DOSE	FREQUENCY	REASON	SINCE
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Please check Yes or No to ALL below

### Constitutional

- | Yes                      | No                       |                                 |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive daytime sleepiness    |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fevers                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Low energy                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble <i>getting</i> to sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble <i>staying</i> asleep   |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight gain                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss                     |

### Eyes

- | Yes                      | No                       |                |
|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision  |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of vision |

### Ears, Nose, Mouth, and Throat

- | Yes                      | No                       |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sense of smell |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss           |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in your ears   |

### Cardiovascular and Respiratory

- | Yes                      | No                       |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Palpitations        |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |

### Gastrointestinal

- | Yes                      | No                       |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea     |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn    |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea       |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting     |

### Bladder & Sexual Function (Genitourinary)

- | Yes                      | No                       |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Discomfort and burning      |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control     |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of desire for sex      |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopause (women)           |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble with erection (men) |
| <input type="checkbox"/> | <input type="checkbox"/> | Urgency to urinate          |

### Skin

- | Yes                      | No                       |                         |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Change in hair or nails |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in skin color    |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Rash                    |

### Neurological

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Falling down                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches                                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Incoordination                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Involuntary movements or jerking           |
| <input type="checkbox"/> | <input type="checkbox"/> | Lightheaded or dizzy                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness/fainting/passing out |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizure or convulsion                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinning or vertigo                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremor                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble speaking                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble walking                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble swallowing                         |

### Musculoskeletal

- | Yes                      | No                       |                        |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Back pain              |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain or swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle pain or cramps  |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain              |

### Endocrine

- | Yes                      | No                       |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heat or cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased thirst         |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of hair             |

### Memory, Thinking, Mood, Psychiatric

- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depressed mood                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Hallucinations (seeing or hearing things) |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory loss                               |

### Hematologic (blood) and lymphatic

- | Yes                      | No                       |                           |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Slow to heal after cuts   |

### Allergic and Immune

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic reaction to medicine or x-ray dye |

**SIGN  
HERE**

Signature of patient

Date

Signature of person completing form  
(if not patient)

Date



# Patient Financial Policy

Thank you for choosing Riverhills Neuroscience to provide your neurologic health care needs. We are dedicated to providing you with quality medical care and we value our relationship with you. The following information details our patient payment and administrative services policies.

## Patient Payment Policy

### Insured Patients

Patients are expected to pay their full co-pay and any balance due at the time of service. Failure to pay your full co-pay and balance due at the time of service will result in your being assessed a \$15.00 Service Fee. I understand that Riverhills Neuroscience may verify insurance coverage and benefits prior to services being rendered and that any out of pocket expenses, to include but not limited to co-payments, co-insurance, deductibles and non-covered services, will need to be paid at the time services are rendered. You will receive a statement for any balance due. If there is an overpayment a refund to you will be issued in a timely manner. Insured patients are responsible for charges incurred, regardless of whether their insurance company pays or not.

### Self Pay Patients

For self pay patient office visits, the typical charge is \$200 to \$530 depending on the level of service. The standard amount to be paid at the time of service is \$200. If a procedure is to be performed during the visit, an additional estimated amount for that service is due at the time of service. You will receive a statement for any balance due. If there is an overpayment a refund to you will be issued in a timely manner.

If you find yourself in a position of financial hardship and are unable to comply with the Patient Payment Policy, please speak with a member of our billing staff to discuss payment plans and options moving forward. Understand that you are responsible for all charges incurred. Failure to comply will result in your account being sent to a collection agency.

## Administrative Services Policy

Riverhills Neuroscience physicians will, on occasion, provide administrative services to patients. These services are non-covered services that are not billed to any insurance policy. The list of services does not include “medically necessary treatments” or other “covered” expenses. The following table outlines administrative services that may be provided and the corresponding fee associated with such services. We will expect prompt payment at the time the service is requested.

Disability Placard	\$10.00
Disability Form	\$35.00
Life Insurance Form	\$35.00
FMLA Form	\$35.00
Narrative Report	\$500.00
Functional Capacity Report	\$100.00
Service Form (Duke, Cincinnati Bell, etc.)	1 <sup>st</sup> form @ no charge, each additional form @ \$35.00
Medical Records	No charge for first copy of medical records. Additional requests will be charged the allowable charge per page based on Ohio Law at the time of the request.



# Patient Consent and Financial Responsibility

I authorize Riverhills Neuroscience to submit claim(s) to my health insurance carrier(s) and their agents, whether private or governmental, for all services rendered by Riverhills Neuroscience physicians or other providers involved in my care. I authorize Riverhills Neuroscience to act on my behalf in pursuing and appealing benefit determinations by my insurance carrier. I hereby authorize, request and direct my health insurance company or third party payer of record to release my pharmaceutical history and to pay directly to Riverhills Neuroscience.

I also authorize Riverhills Neuroscience to release all medical, psychiatric, psychological and/or other pertinent information to my health insurance carrier(s) and their agents in order to collect any claim(s) for payment, and to any physician or provider involved in my care, including healthcare professionals not employed by Riverhills Neuroscience to whom I am referred for my care or who have referred me to Riverhills Neuroscience for care. This information may also be released to any third-party payers, benefit administrators and guarantors for payment of services, verification of benefits, to determine necessity and appropriateness of services, for authorization of services, to process claims for benefits and/or hearings or appeal processes regarding payment for treatment expenses, including, but not limited to, Medicaid's hearing and appeal process.

Lastly, my information may be released to any outside entity, under an obligation of confidentiality that may be performing a review of records to assure compliance with applicable laws and accreditation requirements or to assure quality treatment or to determine my eligibility to enroll in a clinical trial. This may include the information regarding diagnoses, drug and/or alcohol related conditions and psychiatric and psychological conditions.

By signing below, I accept and acknowledge financial responsibility to Riverhills Neuroscience for services rendered and I assign insurance benefits to Riverhills Neuroscience for services rendered.

### PAYMENT UP FRONT

I understand that in accordance with law, as well as many participation agreements with third-party payers, Riverhills Neuroscience does not waive, fail to collect, or discount co-payments, deductibles, coinsurance, or other patient financial responsibility. I understand that Riverhills Neuroscience may verify insurance coverage and benefits prior to services being rendered and that any out of pocket expenses, to include but not limited to co-payments, co-insurance, deductibles and non-covered services, will need to be paid at the time services are rendered. I agree to pay a \$15.00 "Service Fee" for failure to pay my full co-pay and balance due at time of service. I further agree to pay Riverhills Neuroscience a \$24.00 "No Show Fee" for failure to provide 24 hours notice for a missed office appointment or \$100.00 for a missed procedure appointment.

### INSURANCE FOLLOW-UP

I understand that I am responsible for charges incurred regardless of whether my insurance pays or not.

### PAST DUE BALANCES

I understand that any balance not paid upon receipt of an initial statement is considered past due and will be subject to interest at the rate of 7% per annum. I understand that past due balances will be placed with a professional collection agency and reported to a credit bureau. I will be responsible for collection fees, interest, attorney fees, and other cost incurred. *I also understand that if I have a past due balance, I may not be able to schedule appointments and/or may be discharged from the practice.*

I understand that the information contained in this form will be used when submitting claims for payment and I certify that such information is correct. I permit a copy of this authorization to be used in place of the original and the use of "signature on file" on all claims submissions. I understand that I am responsible for notifying Riverhills Neuroscience of any pre-certifications, referrals or co-payments required by my insurance company.

**I reviewed the Patient Financial Policy and understand and agree to the terms.**



**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_



# Important

To assist us in providing the best patient care, please **bring** all of your medications with you to every visit with your physician.

We need to keep an accurate record of the medicines you are **currently** taking.