Kitaj Headache Center LLC
Affiliated with Griffin Hospital
Madeleine B. Kitaj, M.D.
Southford Medical Center
30 Quaker Farms Road
Southbury, CT 06488
Phone: 203.262.8430
Fax: 203.262.8441

2 Croton Point Ave
Croton-on-Hudson, NY 10520
Phone: 914.862.0880
Fax: 914.862.0879

www.KitajHeadacheCenter.com

Dear Patient:

Welcome to Kitaj Headache Center, LLC!

As part of your neurological evaluation, we will be discussing your current and past neurological symptoms. Your first visit will last approximately 1 hour**. Please take the time to complete the enclosed demographics and questionnaires prior to your initial visit.**

If your insurance requires a referral it is <u>your</u> responsibility to obtain it prior to your visit. Payment or co-pays are <u>DUE</u> at the time of your visit. Please bring in your insurance card as we must scan it. We will also need to scan your driver's license so please bring it with you. If you do not have a driver's license, please bring in some form of identification (preferably a photo ID). This is to protect you from an increase in identity theft and insurance fraud.

We accept CASH, CHECKS, AMERICAN EXPRESS, MASTER CARD, VISA and DISCOVER for payments or co-payments. This includes HSA accounts. Because of the increasing credit card cost to this office, if your co-pay is $20.00 or less we prefer payment be made in cash or by check. If necessary, however, we will accept a credit card for these lower co-pay amounts.

Be advised that this office does not accept Medicaid (or Husky).

We look forward to seeing you.

Sincerely,

Madeleine B. Kitaj, M.D.
Director

No show policy for initial and follow up visits, payment of deductibles, co-pays and co-insurance, and payment if non-coverage or payment made directly to insured or applied to insured's out of network deductible. Certain items are not covered by insurance and will be charged directly to you. These include, but are not limited to, forms filled out by this office, and reports and letters written by Dr. Kitaj:

1. **No shows:**

There is a financial impact on this office if patients fail to keep their scheduled appointments. They leave a time-slot empty that is impossible to fill at the last minute. In an attempt to defray this cost this office, as is the case with many other medical offices, has created a No Show policy. We must charge for appointments that are not canceled at least 24 **business** hours in advance. Our fees for failure to cancel are as follows: **For an initial visit, $150.00, and for a follow up visit, $50.00**.

2. **Deductibles, co-pays and co-insurance:**

If after receiving an EOB (Explanation of Benefits), an EOP (Explanation of Payment) or an ERA (Electronic Remittance Advice) from your insurer indicating that there is either a co-pay, co-insurance or deductible that remains to be paid, you will be liable for this amount. Similarly, if payment has been paid directly to you or the insured, you will be liable for this amount.

3. **Non-coverage or payment applied to out of network deductible:**

If your insurer determines that you are not covered, or an amount has been applied to the insured's out of network deductible, you will be liable for the amount that this office charges for a self-pay patient.

4. **Balance billing if out of network:**

If this office is out-of-network (non-participating provider) but the insurer has made a payment, or no payment, upon your authorization your credit card will be charged as per the amounts set forth in **Out-of-Network of insurer (balance billing)** in the **Summary of Charges…** below.

5. **Forms filled out by this office, and reports and letters written by Dr. Kitaj:**

For each of these items all of which are time consuming you will be charged $50.00.

To implement these policies this office would like to obtain your credit information (this can be an HSA account). **This is not mandatory, just requested** to simplify future payments**.**

Credit Card#: _____. Exp date: ____ 3 (or 4) digit code:_____

Type of card: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Print name on card: _____.

I have read this policy and agree to its terms and conditions and authorize the Kitaj Headache Center to keep my signature on file and upon my authorization to charge my credit card for the above indicated charges.

_____

Patient's Name

Signature of Patient or Parent/Legal Guardian: _____.

Signature of card holder (if different than above): _____.

Date: _____.

Summary of Charges for which Patient/Guarantor will be Responsible

- **No shows**
- **Deductibles**
- **Co-pays**
- **Coinsurance**
- **Non-coverage by insurer**
- **Out-of-Network of insurer (balance billing)**
- **Payment made directly to insured or applied to insured's out of network deductible. This often occurs if insured has a Point of Service (POS) policy.**

It is patient's/guarantor's/insured's obligation and responsibility to confirm with the insurer that the patient is covered by the insurer reported to the Kitaj Headache Center.

If provider is out-of-network for insurer, or is considered a non-participating provider, patient will be balance-billed:

If a new patient or one who has not been seen for three (3) years or more, the difference between $400 and the amount paid, by the insurer.

If a follow-up patient, the difference between $125 and the amount paid by the insurer.

Additionally, any expense incurred by the Kitaj Headache Center to collect any unpaid balance of the bill, including collection agencies, attorney fees, court costs and other expenses, will be added to the bill if such additional services are required. In the event that any account is turned over for collections, information that is necessary for collection purposes will be forwarded to our professional collection company and to our attorney.

I agree to be responsible for the above charges and that the patient information specified above may be used as indicated.

_____ _____

Patient/Guarantor/Insured Signature **Date**

_____

Print Name

Notice to all Patients (Connecticut and NewYork) – Part I

Important:

It has recently come to our attention that even if we accept your insurance your specific plan may only be good if the physician is In Network: The insurer for these plans does not accept Out-of-Network (OON) providers, alternatively referred to as "non-participating providers. This happens infrequently, but it does happen. **This problem often exists with HMO and EPO plans, but is not limited to these plans.**

Please contact your insurance and make sure that Dr. Kitaj is In Network or is otherwise covered by your plan. If so, obtain a reference number for that call.

Another issue: Some insurance plans require that your primary care physician obtain a referral **from the insurance company** before you can see a specialist. They obtain a referral number that they either give to you to give to us, or transmit it directly to us. It is the patient's responsibility to see if this is the case and if so to ensure that it happens.

Notice to all Patients (Connecticut and NewYork) – Part II

This office does not accept Medicaid or Husky:

Your insurance card might specifically indicate that it is a **Medicaid** or **Husky** plan. Sometimes, however, it might not so indicate. Many insurers offer Medicaid but your insurance card might not spell out that it is in fact a Medicaid plan. For instance, United Healthcare Community Plan is a Medicaid plan. Most insurers have Medicaid plans. Call customer service to find out if your plan is Medicaid.

Notice to All Patients: Risks of Using a Credit Card for Medical Payments

New York State law requires that we inform you of the potential risks involved when using a credit card to pay for medical services. These risks, however, also apply to our patients in Connecticut. Please review the following information before proceeding with your payment.

What You Should Know

1. When you pay for medical services using a credit card, your medical bill is classified as credit card debt rather than medical debt. This change means that by choosing this payment method, you forfeit specific protections normally available for medical debt.
2. By paying with a credit card, you are waiving certain federal and state protections which apply to medical debt and how a practice can seek to collect medical debt. This includes laws which prohibit healthcare providers from seeking to assert a lien on your primary residence or garnishing your wages in connection unpaid medical debt.
3. Medical debts under $500 are generally excluded from credit reports, and paid medical debt is not reported to credit bureaus. However, these exclusions do not apply to credit card debt.
4. Unpaid medical debt typically appears on credit reports only after 12 months, providing time to resolve bills. This delay does not apply to unpaid credit card debt, which may be reported immediately.
5. Medical debt is subject to certain interest rate limits. However, credit card debt does not carry the same protections and may incur higher rates if unpaid over time.

Your Acknowledgment

By choosing to pay with a credit card, you acknowledge that you have read and understand the above risks, and you agree to proceed with this payment method. You are voluntarily waiving the protections typically afforded to medical debt.

Patient Acknowledgment of Credit Card Payment Risks

I have read the information provided above and understand that by paying with a credit card, I am waiving specific protections associated with medical debt. I acknowledge the risks and confirm that I choose to proceed with this payment method.

Patient Name: _____

Signature: _____

Date: _____

Notice to all NewYork Patients

If your current insurance is, or any subsequent insurance plan may be, Anthem Blue Cross, Blue Cross Blue Shield, EmblemHealth, GHI or MagnaCare.

EPO, PPO/EPO or HMO:
For any EPO or HMO we are considered "out-of-network" and your office visit will not be covered. You have two choices you can either be seen in NY as a private patient for which you will be charged $400 for an initial visit and $125 for a follow up visit. Alternatively, you can be seen as a CT patient where your insurance (except for any co-pay and/or deductible) **may** cover you. You should call your insurance to confirm that **New York patients seeing Dr. Kitaj in Connecticut** will be covered.

PPO, POS or PPO/POS:
We are constantly plagued with mixed signals. Sometimes we are paid for services rendered to patients with PPO, POS or PPO/POS plans and at other times requests for reimbursement for such patients are denied or they are considered to be "out-of-network" and/or are determined to have large deductibles.

There are two possibilities. The first is to call your plan to see if Dr. Kitaj is "in-network" **for patients seeing her in New York**. If you are told "Yes", then get a reference number for the call. If at a later date you are denied coverage this may provide some leverage to help reverse this decision. If Dr. Kitaj is considered "out-of-network" then, if covered at all, there may be a large deductible. Again, find out and get a reference number for the call.

If Dr. Kitaj is out-of-network in New York but you nonetheless decide to see her in New York: If for whatever reason the insurer fails to reimburse this office for services rendered for you, you will be responsible for paying the following amounts: For the initial office visit, $400, and for any follow-up visits, $125. If there is a partial payment you will be responsible for the balance.

The second possibility is to see Dr. Kitaj at her Connecticut office in Southbury, CT where this problem may not exist. But please confirm her status in Connecticut.

In some instances, such as with EmblemHealth, we are usually considered out-of-network. There are also other insurers for which we may be considered out-of-network. In which case please see our **Out-of-Network (balance billing)** policy under **Summary of Charges…** on a preceding page.

I agree to the above and understand that I will be liable for any payments that my insurance company fails to make.

_____

Patient's Name

_____ _____

Signature of Patient or Parent/Legal Guardian (relationship to patient) **Date**

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Patient Name:_____

Address:_____

City/State/Zip:_____

Home Phone #_____**Cell phone #**_____ **Work Phone #**_____

D.O.B.:_____

Email: _____.

Emergency Contact, Relationship, Phone:_____

Policy Holder Name:_____**D.O.B**._____**Relation**_____

Primary Insurance Carrier:_____

Address of Insurance Carrier:_____

Phone # of Primary Insurance:_____

ID #: _____**Group #:**_____

Secondary Policy Holder Name:_____**D.O.B**._____**Relation**_____

Secondary Insurance Carrier:_____

Address of Secondary Insurance:_____

Phone # of Secondary Insurance:_____

ID #:_____**Group #:**_____

Primary Care Physician:_____**Phone**:_____**Fax**:_____

Referring Physician:_____ **Phone**:_____**Fax**:_____

Pharmacy:_____ **Phone:**_____

Do you agree that we can send our chart notes to both your referring physician and your PCP and any other physicians whose names you have given to us, and communicate with and any other physician concerning your care and treatment? (Yes or No)

PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Kitaj Headache Center to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below (including family members, physicians – any MD/DO/DC/PhD you have seen in last 3 years).

Name, relationship to patient: _____
Name, relationship to patient: _____
Name, relationship to patient: _____
Name, relationship to patient: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Kitaj Headache Center has acted in reliance upon this authorization. My written revocation must be submitted to Kitaj Headache Center, 30 Quaker Farms Rd., Southbury, CT 06488.

_____

Patient's Name

_____ _____

Signature of Patient or Parent/Legal Guardian (relationship to patient) **Date**

How did you hear about us?_____

All Charges Are Due At Time of Service. If you have a deductible that has not been met we require $175 on your initial visit, and $100 on a follow up paid on account. After we receive payment from insurance any amount that you have overpaid will be refunded.
I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to Kitaj Headache Center, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

_____

Signature of Patient or responsible party **Relationship to patient**

_____

DATE

Kitaj Headache Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Kitaj Headache Center may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Kitaj Headache Center's NOTICE of PRIVACY PRACTICES for a more complete descriptions of such uses and disclosures.

I have the right to review the NOTICE of PRIVACY PRACTICES prior to signing this consent. Kitaj Headache Center reserves the right to revise its NOTICE of PRIVACY PRACTICES at anytime. A revised NOTICE of PRIVACY PRACTICES may be obtained by forwarding a written request to Kitaj Headache Center Privacy Officer at 30 Quaker Farms Road, Southbury CT. 06488.

With my consent, Kitaj Headache Center may call my home (ph#_____) or other designated location (work# _____), (cell ph#_____) and leave a message 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 call pertaining to my clinical care.
___ Please **do not** include laboratory or imaging results in a message.
___ Please **do** include laboratory or imaging results in a message.

With my consent, Kitaj Headache Center may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that Kitaj Headache Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____

Print Patient's or Legal Guardian's Name

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Date:_____

Name of female/male patient:_____

ROS: Please **CHECK all the symptoms that apply to you.**

Constitutional: Have you had significant weight gain of more than 10 pounds over the last year or weight loss of more than 10 pounds other than on a diet____, fatigue___, chills___, sweats____ Have you been on diet pills ____ when ____.
Eyes: Have you had blurry vision___ total vision loss (only with a headache?) ___, double vision ___, eye pain___, feeling of sand in the eye___
Ear/Nose/Throat: Have you had tinnitus (ringing or buzzing in the ears)___, hearing loss___, frequent sore throats___, frequent hoarseness___, post-nasal drip ___, congestion in nostrils ____.
Neurological: Have you had dysarthria (mumbling speech)___, dysphasia (cannot find words, cannot express yourself clearly)___, loss of concentration___, decreased memory___, dysphagia (cannot swallow easily)___, weakness of arms (with or without a headache)___, weakness of legs (with or without a headache)___, dizziness___, room spinning vertigo___, lightheadedness___, falling ___, tremor___
Integumentary: Have you had any rashes___, exudates (weeping sores)___, alopecia (hair loss)___, allodynia (pain on light touch) to hair accessories___, to combing or brushing hair___, to being touched over the neck, shoulders or scalp___
Endocrine: Have you had frequent swollen glands___, cold or heat intolerance___, increased thirst___, increased appetite___, heavy periods ___, multiple periods/month ___
Allergy/Immunology: Have you had seasonal allergies___, food allergies___, positive skin test by an allergist___, frequent infections___, possible exposure to HIV or Hepatitis___
Genitourinary: Have you had bladder urgency___, bladder frequency___, incontinence (urinary accidents)___, hematuria (blood in the urine)___,
Gynecological: Type of birth control_____, any chance of pregnancy now? _____.
Gastrointestinal: Have you had diarrhea___, constipation___, nausea___, vomiting___, abdominal pain___, rectal pain___, rectal bleeding___
Musculoskeletal: Have you had muscle pain___, joint pain___, where is joint pain _____, joint swelling___, neck pain___
Cardiovascular: Have you had ankle swelling___, shortness of breath___, chest pain___, palpitations___
Psychiatric: Have you felt anxiety___, depression___, panic attacks___, irritability___, mood-swings___, thoughts of hurting yourself or others____, experienced childhood abuse ___, PTSD ____. Are you under the care of a psychiatrist or therapist? ____

Reviewed by_____ Date_____

Patient Name:_____

The Migraine Disability Assessment Test (MIDAS)

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS: Please answer the following questions about ALL of the headaches you have had over the last 3 months. Write your answer in the space provided before each question. Write zero if you did not have the activity in the last 3 months.

___ 1. On how many days in the last 3 months did you miss work or school because of your headaches?

___ 2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? (Do not include days you counted in question 1 where you missed work or school.)

___ 3. On how many days in the last 3 months did you not do household work (such as housework, home repairs and maintenance, shopping, caring for children and relatives) because of your headaches?

___ 4. How many days in the last 3 months was your productivity in household work reduced by half of more because of your headaches? (Do not include days you counted in question 3 where you did not do household work.)

___ 5. On how many days in the last 3 months did you miss family, social or leisure activities because of your headaches?

___ Total (Questions 1-5)

___ A. On how many days in the last 3 months did you have a headache? (If a headache lasted more than 1day, count each day.)

___ B. On a scale of 0 - 10, on average how painful were these headaches? (where 0=no pain at all, and 10=pain as bad as it can be.)

Scoring: After you have filled out this questionnaire, add the total number of days from questions 1-5 (ignore A and B).

MIDAS GRADE	DEFINITION	MIDAS SCORE
I	Little or no disability	0-5
II	Mild disability	6-10
III	Moderate disability	11-20
IV	Severe disability	21+

PHQ-9 Patient Questionnaire

Nine symptom checklist

Patient Name: _____ Date: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling/staying asleep, sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
9. Thoughts that you would be better off dead or of hurting yourself in some way.				

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10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Generalized Anxiety Disorder Questionnaire (GAD-7 Anxiety Scale)

Over the Last 2 weeks, how often have you been bothered by any of the following problems?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Feeling nervous, anxious or on edge	○ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
3. Worrying too much about different things	○ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	○ 0	○ 1	○ 2	○ 3
5. Being so restless that it is hard to sit still	○ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
7. Feeling afraid as if something awful might happen	○ 0	○ 1	○ 2	○ 3

8. If you checked off any problems on this questionnaire so far, how difficult have these problems made if for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
○ 0	○ 1	○ 2	○ 3

Scoring Guidelines

Guidelines for Interpretation for GAD7

Score	**Risk Level**	**Intervention**
0	No to Low risk	None, rescreen annually
5	Mild	Provide general feedback, repeat GAD7 at follow up
10	Moderate	Further Evaluation Recommended and referral to mental health program
15+	Severe	Further Evaluation Recommended and referral to mental health program

Spitzer RL, Kroenke K, Williams JB, et al; A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7. GAD-7

If the total score is 10 or more, this could indicate a clinically significant problem and should trigger referral to a mental health program or enrollment in the Mental Health Integration Program.

Patient Name:_____

THE 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 = would never dose
1 = slight chance of dosing
2 = moderate chance of dosing
3 = high chance of dosing

SITUATION	**CHANCE OF DOSING**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g a theater or a meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3