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 take a copy of 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 <u>CASH</u>, <u>CHECKS</u>, <u>MASTER CARD</u>, <u>VISA</u> and <u>DISCOVER</u> for payments or co-payments. This includes HSA accounts. We do not accept American Express.

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:

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) 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, this office will charge this amount to the credit card that we have on file.

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

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

No charge will be made to your credit card except in the limited situations indicated above.

To implement these policies it is necessary for us to obtain your credit information (this can be an HSA account) before any appointment can be made. **Please note American Express not accepted**.

Credit Card#: _____. Exp date: _____ 3 digit code:_____

Type of card: ☐ Visa ☐ MasterCard ☐ Discover

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 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): _____.

Email: _____. Date: _____.

Summary of Charges for which Patient/Guarantor will be Responsible

- **No shows**
- **Deductibles**
- **Co-pays**
- **Coinsurance**
- **Non-coverage by insurer**
- **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

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 NewYork Patients

If your insurance is Blue Cross Blue Shield and your plan is either POS or PPO/POS, continue reading. Otherwise just skip this page.

We are constantly plagued with mixed signals from Blue Cross Blue Shield. Sometimes we are paid for services rendered to patients with POS plans 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 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 you decide to see Dr. Kitaj we must have a credit card and email on file for you in the event that you are denied coverage or the insurance determines that you have a deductible. If for whatever reason BCBS fails to reimburse this office for services rendered for you, you will be responsible for paying the following amounts: For the initial office visit, $300, and for any follow-up visits, $125.

The second possibility is to see Dr. Kitaj at her Connecticut office in Southbury, CT where this problem does not exist.

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.:_____

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 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

<u>For New York patients only</u>!

The consent form which follows this page enables this office to obtain your patient information from other physicians who are in a Health Information Exchange Organization such as HealtheConnections. This allows us to have at our disposal past office notes from other physicians, and lab and imaging results. We strongly suggest that you check the checkbox **"1. I GIVE CONSENT".**

Kitaj Headache Center, LLC

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/.

The choice I make on this form will NOT affect my ability to get medical care. The choice I make on this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency*.

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through HealtheConnections and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through HealtheConnections. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems	HIV/AIDS
Birth control and abortion (family planning)	Mental Health conditions
Genetic (inherited) diseases or tests	Sexually Transmitted diseases

   If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from HealtheConnections. You can obtain an updated list at any time by checking HealtheConnections website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access, who carry out activities permitted by this form, as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through HealtheConnections for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the HealtheConnections website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as HealtheConnections ceases operation (or until 50 years after your death, whichever occurs first). If HealtheConnections merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through HealtheConnections while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form**.**

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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

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