

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

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 your responsibility to obtain it prior to your visit. Payment or co-pays are DUE 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 CASH, CHECKS, MASTER CARD, VISA and DISCOVER for payments or co-payments.

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 before any appointment can be made.

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

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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).

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 HIPPA 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, 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 or 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 1 day, 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.

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:

SITUATION	CHANCE OF DOSING				
	0	1	2	3	
	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	