Deborah R. Syna, M.D.
Board Certified Physician
Movement Disorders and Peripheral Neurology
Electromyography and Nerve Conduction Studies
Botulinum Toxin Therapy

Dear New Patient:

We want to extend our personal greetings and a very warm welcome to Northwest Neurological Specialists, PC. Dr.Syna and our staff are committed to doing everything possible to provide you with excellent neurological care and also make your first visit as pleasant and informative as possible.

Appointment Date:_______________ Appointment Time:_________________

Please use the following checklist to ensure you are well prepared for your first appointment:

- **New Patient Registration Forms**
  - Please complete to the best of your knowledge
- **Current Medication List**
  - Please include medication Name, Dose and Frequency
- **Insurance Cards**
  - We will need your cards when you arrive in order to bill your insurance
  - Workers compensation claims require a claim #, date of injury, claim address/adjuster
  - If your insurance requires a referral we will need a copy of this or we will need to reschedule your appointment
  - We will bill your **motor vehicle accident insurance** as a courtesy (with claim #, date of injury, claims address and adjuster) but payment in FULL is expected at time of service. There is a $300.00 deposit due at the time of service regardless of personal injury protection coverage and or private insurance. Our clinic will not be able to facilitate an appointment if PIP is closed or exhausted.
- **Films with Report**
  - Please bring any films and reports, pertaining to the condition for which you have been referred, with you to your appointment (may include MRIs, CT scans, etc.)
- **48 Hour Cancellation Policy**
  - Please note that our office policy requires 48 hours notice if you will not be able to attend your appointment
  - Without notice, we may bill you a No Show Fee of up to $25.00

Your evaluation will take approximately an hour, unless otherwise noted by our staff, and you are encouraged to arrive 10 minutes prior to your scheduled appointment time. We have included a map to our office and plenty of parking is available for your convenience.

Please do not hesitate to contact our office if you have any questions. We look forward to meeting you!

1585 SW Marlow Ave, Suite 110
Portland, OR 97225
Voice: 503-291-1422
Facsimile: 503-297-8129
www.portlandneurology.com

DEBORAH R. SYNA, M.D.

Physician
NORTHWEST NEUROLOGICAL SPECIALISTS, P.C.
1585 SW Marlow Ave., Ste. 110
Portland, Oregon 97225
Phone: (503) 291-1422

Date: ______________ Referring Physician: ______________________________ Phone #:______________ Fax #: ____________

Family Physician (if different):______________________________ Phone #:______________ Fax #: ____________

Pharmacy ______________________________ Phone #:______________ Fax #: ____________

Patient's Name: Last First Middle	Sex	Birth: Mo. Day Yr.	Age
Mailing Address: Street or P.O. Box	City	State	Zip
Phone: Home Work	Patient SS#	Occupation	Employer
Spouse's Name: Last First Middle		Birth: Mo. Day Yr.	
Spouse's Address: Street or P.O. Box	City	State	Zip
Spouse's Phone: Home Work			
Financially Responsible Person - for Dependent Children	Relationship to Patient	Phone: Home Work	
Mailing Address: Street or P.O. Box	City	State	Zip

Industrial Injury?	Auto Accident?	Other Accident?
No Yes Date ______________	No Yes Date ______________	No Yes Date ______________
In an Emergency, Contact: Name		Phone: Home Work

Primary Insurance to be billed	Secondary Insurance	
Insurance Mailing Address		
City	State	Zip
Policy Holder Name:	Last	First
Policy or ID #		
Group #	Group Name	Union Local #

I hereby authorize Deborah R. Syna, M.D. to furnish insurance carriers with any information concerning my illness and medical care necessary to secure insurance benefits.

I also assign medical payments from my insurance, including major medical benefits, to Deborah R. Syna, M.D.

I understand that I am financially responsible for all charges by my physician whether or not paid for by insurance and guarantee payment of the bill in full within 90 days of receipt.

Signature ______________________________ Date

DEBORAH R. SYNA, M.D.

Physician
Northwest Neurological Specialists, P.C.

Date ___________

Full Name ___________ Where born ___________
Occupation ___________ How long in this type of work? ___________
If industrial injury, give dates and type of injury ___________
Referred by ___________
Primary Care Provider ___________ Ethnicity ___________
Race ___________
Language ___________

REASONS FOR SEEKING NEUROLOGICAL EVALUATION

FAMILY HISTORY	IF LIVING		IF DECEASED		Has any blood relative ever had: (please check)
	Age	Health	Age at Death	Cause	
Father					Cancer
Mother					Sugar Diabetes
Brother or Sister:					Heart Disease
1.					High Blood Pressure
2.					Mental Illness
3.					Seizures
4.					Arthritis
5.					Migraine Headaches
Spouse					Parkinson's Disease
Children					Stroke
1.					Convulsions, epilepsy
2.					Paralysis
3.					Alzheimer's Disease
4.					Multiple Sclerosis
5.					Muscle Disease
					Neuropathy

PERSONAL HISTORY OF YOUR PAST ILLNESSES: Please circle illnesses you have had and add the date(s).

Rheumatic fever ___________
Heart disease ___________
or heart murmur ___________
High blood pressure ___________
Stomach ulcers ___________
Other intestinal problems ___________
Anemia ___________
Kidney disease ___________
Lung condition ___________
Tuberculosis ___________
Pneumonia ___________
Anorexia/Bulimia ___________

Thyroid disease ___________
Venereal Disease ___________
Asthma, hay fever ___________
Eye disease ___________
Arthritis ___________
Blood disorder ___________
Liver disease, jaundice ___________
Stroke ___________
Epilepsy ___________
Migraine headaches ___________
Diabetes ___________
Miscarriages ___________

Cancer ___________
Nervous Breakdown/Emotional Strain ___________
____
Skin trouble ___________
Alcoholism, drug habit ___________
Broken bones ___________
Head injury ___________
Neck problems ___________
Low back problems ___________
Other ___________
Blood clots ___________
Neuropathy ___________

ARE YOU ALLERGIC TO ANY MEDICATIONS? yes____ no ____
If yes, please list medications, and the reaction you had to them:

____
____
____

ANY OTHER INFORMATION YOU THINK IS IMPORTANT ___________
____
____

Form #110496 • 9/11

Name: ______________________________ Date: ______________

SYSTEM REVIEW

Present weight______________ Weight 1 year ago ______________ Weight 5 years ago______________

Fevers ______________
Shortness of breath ______________
Chest pain ______________
Nausea, vomiting______________
Abdominal pain ______________
Unusual bleeding or bruising______________
Difficulty swallowing______________
Snoring/Apnea______________
Rash ______________
Change in bowels ______________
Urinary urgency, loss of control ______________
Trouble with sexual performance______________
Joint aches ______________
Tolerance if heat, cold ______________
Double vision ______________
Fainting Spells______________
Sore muscles ______________
Large glands ______________
Trouble sleeping ______________
Palpitations ______________
Numbness / tingling______________
Weakness ______________

OPERATIONS AND HOSPITALIZATION - PLEASE PRINT:

	Date	Surgery or reason for hospitalization	Where	Doctor
1.				
2.				
3.				
4.				
5.				
6.				

Have you ever been advised to have any surgical operation which has not been done? If yes, please explain ______________

____

X-RAYS

Have you ever had x-rays or MRI's of

Chest______________ Date______________ Normal or abnormal ______________
Skull______________ Date______________ Normal or abnormal ______________
Neck ______________ Date______________ Normal or abnormal ______________
Low back ______________ Date______________ Normal or abnormal ______________
Angiogram______________ Date______________ Normal or abnormal ______________
Myelogram______________ Date______________ Normal or abnormal ______________

SOCIAL

M_____ W ____ S_____ D ____ How long?
Previous marriages:______________
Any problem with marriage? ______________
Educational level: Grade School______yrs. High School _____ yrs. College _____yrs. Other ______________
Any problems with job? ______________
Previous occupations: ______________
When did you come to this region? ______________
Former regions of residence:______________
Recent travel outside United States ______________

HABITS

Do you use: Cigarettes______ packs per day. Never smoked, Former Smoker, Unknown Cigars _____ Pipe ____
Coffee_____ cups per day Tea_____ cups per day
Regular exercise
Have you ever used any experimental drugs? Marijuana _____ LSD_____ Speed _____ Heroin ____
Others ______________
How much alcohol do you consume in one week? ______________
Have you ever used alcohol or medication excessively? ______________

Reviewed with patient Date______________ Signature ______________

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MEDICATIONS: PLEASE LIST ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICINES, HERBAL, NUTRITIONAL SUPPLEMENTS, EYE DROPS, INHALERS, ETC...CROSS OUT MEDICATION NAME IF NO LONGER TAKING. IF YOU ARE UNABLE TO COMPLETE THIS FORM, PLEASE BRING A CURRENT MEDICATION LIST.

NAME:________________________________ DOB:____________________

DATE STARTED	NAME OF MEDICINE	DOSE,UNIT,MG	DIRECTIONS	REASON

ACKNOWLEDGMENT AND CONSENT

I understand that Dr. Deborah Syna and Northwest Neurological Specialists, P.C. (referred to below as "This Practice") will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area *and available on the website at*

WWW.NNS.Neurohub.Net

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that This Practice is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices.

By:______________________________ Date:______________
(Patient)

-OR-

By:______________________________ Date:______________
(Patient representative)

Description of Representative's Authority:______________________________

9155 SW Barnes Rd #531
Portland OR 97225
(503) 291-1422

Northwest Neurological Specialists, P.C.
Deborah R. Syna, Physician

Welcome to my office. My practice is limited to neurology, the field of brain, muscle, nerve and spinal cord disorders. My staff and I are here to help you obtain the care you need, in a pleasant and efficient manner. We are happy to answer any questions you might have, and wish to explain our billing procedures outlined below.

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by Northwest Neurological Specialists, P.C. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing, unless other financial arrangements are made. Established patients with a delinquent balance may be asked for payment at the time of service.

- Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral from your Primary Care Provider (PCP) to see another physician it is your responsibility to obtain a referral/authorization prior to your appointment.

- Appointments will be **cancelled** if the authorization/referral is not received within **48 hours** of your appointment.

Insurance Billings: We will bill your primary insurance carrier, and as a courtesy, bill your secondary insurance if necessary. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit.

Medicare: We maintain participating provider status for Medicare. Although we bill Medicare as your primary insurer, you may be responsible for billing your supplemental insurance. Note: Medicare may be able to bill your supplemental insurance, please contact them at 1-800-326-0238.

Oregon Welfare & Oregon Health Plan: Please bring your current medical card with you to each appointment. If you are restricted to a primary care physician by Oregon's Medical Assistance Program or Washington's Department of of Social and Health Services, you must obtain a referral from them.

Check Returned: It is our office policy to charge a $25.00 fee for checks that are returned.

Authorization to Release Information:

I have read and I accept this policy for my testing and/or treatment with Northwest Neurological Specialists, P.C. In obtaining payment for services, I authorize my healthcare provider to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim.

If I have been referred by, or am being referred to, another healthcare provider, I authorize my provider or my provider's staff to release my clinical information to this provider for continuing care.

I also assign Northwest Neurological Specialists, P.C. all payments for medical expenses resulting from my care. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I HAVE RECEIVED A COPY OF THIS INFORMATION.

Patient Name (print) ____________ Patient Signature ____________ Date ____________

IF PATIENT IS UNDER THE AGE OF 15 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING

Patient is ______ year(s) of age or is unable to sign because: ____________

Signature ____________ Relationship to Patient ____________ Date ____________

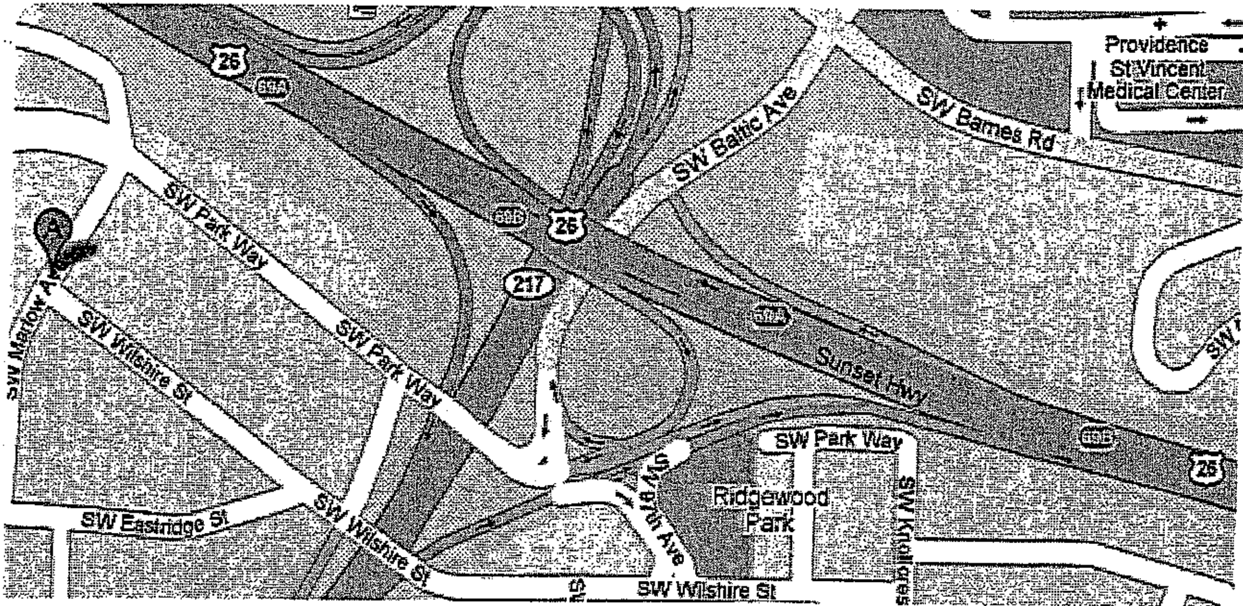
Sign below if you do not wish to authorize the Release of Information clause, and therefore wish to pay for costs of all treatment and services personally at the time of service:

Signature of Guarantor ____________ Date ____________ Signature of Patient ____________ Date ____________

Northwest Neurological Specialists, P.C.

1585 SW Marlow Avenue
Suite 110
Portland, OR 97225

Phone (503)291-1422 Fax (503)297-8129



Directions to our office:

From Downtown Portland: Take Hwy 26 West and exit Barnes Rd/Park Way. Go Left on SW Baltic Ave, Right on SW Park Way and Left on SW Marlow Ave.

From Washington (North): Take I-5 south to I-405 south across the bridge. Take the Beaverton/Hwy 26 west exit. Continue on Hwy 26 for 6 miles and take Exit 69B Barnes Road/Park Way. Turn Left on SW Baltic Ave, Right on SW Park Way and Left on SW Marlow Ave.

From Southern Oregon: Take I-5 North to Hwy 217. Take Hwy 217 North towards Beaverton/Sunset Hwy for 6 miles. Take US-26 E toward Portland/Cedar Hills. Take a slight Right at SW 97th Ave, Right at SW Wilshire St and Right on to SW Marlow Ave.

From the Oregon Coast: Take Hwy 26 East to exit 69B toward Barnes Rd/Cedar Hills. Keep left as loop begins and take slight left on to Park Way. Turn Left on SW Marlow Ave.

From Eastern Oregon: Take I-84 West to I-5 South and stay in the left lanes going towards Beaverton. Cross the bridge and take exit 1-D to Hwy 26 West. Continue on Hwy 26 for 6 miles and take Exit 69B Barnes Road/Park Way. Turn Left on SW Baltic Ave, Right on SW Park Way and Left on SW Marlow Ave.