Malcolm Roland, MD   Megan Edwards, DO
Penny Burcham, FNP   Anita Thomas, FNP   Shavonne Doyle, GNP
2908 South Lamar Blvd. Oxford, MS 38655 - (662)281-0112 (ph) - (662)281-0943 (fax)
http://oxfordneurologyclinic.com

OUR POLICIES:

-***IF YOU DO NOT CONFIRM YOUR APPOINTMENT WITHIN 48 HOURS IN ADVANCE IT WILL BE CANCELED AND ANOTHER PATIENT SCHEDULED. THIS IS DUE TO OUR EXTENSIVE WAITING LIST***

- MEDICATION REFILLS ARE HANDLED DURING OFFICE VISITS. Discuss your prescriptions with the nurses and your physician each time you come in, and keep track of the number of refills available at your pharmacy. On the rare occasion that a refill is needed without an office visit, your pharmacy must fax the request. Our FAX number for that is 1-(662)-281-0943. It usually takes several days to process requests for medication refills, and they are only handled during business hours. No refills are handled after hours.

- If you leave a message for the nurses, they will make every attempt to return calls within 24 hours. Please do not leave duplicate messages.

- Our office charges a $25 fee for completing forms or letters. We do not complete disability forms, your primary care physician will need to complete the forms for you. With proper authorization, we will send your medical records to the physician of your choice or to your case manager.

-Our office charges $50 no show fee if you do not give a 24 hr notice of canceling your appointment.

- You are required to pay your insurance co-pay at the time of visit. If you do not have insurance then you are expected to pay in full at the time of your visit. If you are unable to make these payments, we will be happy to reschedule your appointment. If you have insurance and you have a balance of more than $100 you must pay that in full at your visit. Failure to pay these balances may result in blocked appointments and not being able to see the physician.

- **IF YOU THINK YOU ARE HAVING A MEDICAL EMERGENCY, CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM.**

Signature below is an acknowledgement that you have received this notice:

SIGNATURE OF PATIENT/ LEGAL GUARDIAN   DATE

PATIENT INFORMATION:

Last Name: ______________________First: ____________________Middle: _______

DOB: _________________________ Age: ___________ Sex: M_____ F_____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Address: ____

City: _________________________ State:______________ Zip:________________

SSN #:______________________ Email Address: ______________________________

Home: (______)_____________ Cell: (_____)_____________ Work: (____)____________
Preferred number: Home______ Cell_______ Work_______

Employer/Occupation (if applicable):____
Employment Status: ☐ Full-time ☐ Part-time ☐ Not Employed
☐ Student ☐ Disabled ☐ Retired

Primary Care Physician:_______________________ Phone: ______________________

HIPAA/Emergency Contacts:

Name:_____________________________Name:_________________________________

Primary Phone #: _____________________Primary Phone#:_________________________

Other Phone #: _______________________Other Phone#:____________________________

Relationship to Patient: _________________Relationship to Patient:_____________________

____ I authorize the disclosure of my protected health information to this person ____ I authorize the disclosure of my protected health information to this person

Other person(s) I would like to authorize access to my protected health information:
Name & Relationship to Patient:

____

I, the undersigned, assign insurance benefits directly to Oxford Neurology/Oxford Neuromuscular. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

____

SIGNATURE OF PATIENT/ LEGAL GUARDIAN **DATE**

Social History:

Use of:

Tobacco: ☐No ☐Yes How many packs per day?_______How many years?_____ ☐Quit

Alcohol: ☐No ☐ Yes How much do you drink daily? ______How many years?____ ☐ Quit
Have you ever drank heavily or abused alcohol? ☐ No ☐ Yes

Caffeine: ☐No ☐ Yes How much do you drink daily? _____________ How many years?

Have you ever used any illicit substances? ☐ No ☐ Yes Type:_______________________

Pharmacy Information: ***PLEASE BRING YOUR MEDICATIONS TO EVERY VISIT!***

Type: ▢ Local ▢ Mail-Order ▢ Specialty Name:_____________________________________

City/State/Zip:_______________________________Phone: (______)_______________________

LIST ANY ALLERGIES:____

▢ **I have no medicine allergies**

Family History:

Dementia/
Alzheimer's: ___No ___Yes *Relationship:* ___Parent ___Grandparetns ___Silbling ___Child

Stroke/TIA: ___No ___Yes *Relationship:* ___Parent ___Grandparents ___Sibling ___Child

Epilepsy/
Seizure: ___No ___Yes *Relationship:* ___Parent ___Grandparents ___Sibling ___Child

Multiple
Sclerosis: ___No ___Yes *Relationship:* ___Parent ___Grandparents ___Sibling ___Child

Parkinsons
Disease: ___No ___Yes *Relationship:* ___Parent ___Grandparents ___Sibling ___Child

Migraines: ___No ___Yes *Relationship:* ___Parent ___Grandparents ___Sibling ___Child
*Other:*____

Past Medical History:

Please check the box if you have or had any of the following:

Aneurysm ▢	Hypertension ▢	Restless leg ▢
Asthma ▢	GERD ▢	Seizures ▢
Cancer ▢	Headaches ▢	Spine Disorder ▢
Depression ▢	Heart Disease ▢	Stroke ▢
Dementia ▢	Multiple Sclerosis ▢	Thyroid Disease ▢
Diabetes ▢	Meningitis ▢	Brain or Spinal Cord Tumor ▢
Fibromyalgia ▢	Neuropathy ▢	Other:
High Cholesterol▢	Parkinson's Disease ▢	

Past Surgical History:

Please check the box if you have or had any of the following:

Appendectomy ▢	Gastric Bypass ▢	Tonsillectomy ▢
Back Surgery ▢	Gastric Sleeve ▢	Other:
Brain Surgery ▢	Heart Surgery ▢	
C-Section ▢	Hysterectomy ▢	
Carpal Tunnel Release ▢	Lapband ▢	
Chemo/Radiation ▢	Neck Surgery ▢	
Cholecystectomy ▢	Sinus Surgery ▢	

Review of Systems:

Are you experiencing any of the following symptoms?

Sleep:

▢ Problems going to sleep
▢ Problems staying asleep
▢ Loud snoring
▢ Excessive daytime sleepiness
▢ Falling asleep when you shouldn't
▢ Legs moving restlessly

Respiratory:

▢ Shortness of Breath
▢ Chronic cough

Genitourinary:

▢ Urinary Incontinence
▢ Increased urinary frequency
▢ Up all night going to bathroom
▢ Frequent Urinary Tract Infections
▢ Change in color of urine

Gastrointestinal:

▢ Nausea
▢ Vomiting
▢ Abdominal pain
▢ Hemorrhoids
▢ Change in color of stool
▢ Incontinence of bowels
▢ Diarrhea
▢ Constipation

Hematologic/Lymphatic:

▢ Anemia
▢ Easy bleeding
▢ Swollen Lymph nodes

Psychiatric:

▢ Depression
▢ Anxiety
▢ Drug/alcohol addiction
▢ Suicidal thoughts

Integumentary:

▢ Rash
▢ Sores
▢ Lumps

Neurological:

▢ Loss of smell/taste
▢ Facial weakness
▢ Poor concentration
▢ Memory problems
▢ Difficulty walking
▢ Numbness
▢ Headaches
▢ Passing out
▢ Slurred Speech
▢ Difficulty swallowing
▢ Loss of ability to speak properly
▢ Loss of ability to eat properly
▢ Loss of ability to write properly
▢ Unexplained spells
▢ Tremor/shaking

Cardiovascular:

▢ Palpitations
▢ Racing of the heart
▢ Chest pain
▢ Swollen extremities

Eyes:

▢ Blurred vision
▢ Double vision
▢ Loss of vision
▢ Droopy Eyelids

Ears/Nose/Throat:

▢ Deafness
▢ Ringing in ears
▢ Ear Pain
▢ Mouth Pain

Endocrine:

▢ Intolerance to hot/cold
▢ Uncontrollable Blood Pressure
▢ Thyroid Problems

Musculoskeletal:

▢ Joint Pain
▢ Swelling in hands
▢ Swelling in feet
▢ Stiffness
▢ Weakness of muscles
▢ Muscle shrinkage

Constitutional Symptoms:

▢ Fever
▢ Chills
▢ Weight loss
▢ Weight gain

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Name:______________________________D.O.B:___/___/____SSN#______________

Address:____

City:___________________________State:__________Zip:______________________

To be filled by the physician's office:
____ I authorize the release of the following health information:

Name of Physician/Dr. Office:____
____
____

▫ All Records ▫ Radiology Results ▫ Lab Results

I understand that:
- By signing this form I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
-If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. The Oxford Neurology Clinic shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information will be requested.
-Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
-A copy of this signed form will be provided upon request.
-This authorization expires on: ___/___/____ (if date not completed / one year after signed)

Signature below completes authorization for the release of your private medical information

____
SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

THE OXFORD NEUROLOGY CLINIC

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Welcome to Oxford Neurology!

New Patient Packet

Thank you for choosing Oxford Neurology for your neurological care! Please mail this packet to us at the address listed below before the date of your visit!

APPOINTMENT DATE:

APPOINTMENT TIME:

Please arrive 30 minutes prior to your appointment to complete the registration process.

LOCATION: 2908 South Lamar Blvd. Suite 100
Oxford, Mississippi 38655

HOURS: M-F:8am-4pm (Closed for lunch 12pm-1pm)
Sat & Sun: CLOSED

WHAT TO BRING TO YOUR APPOINTMENT:

- Photo I.D.
- Insurance card(s)
- All medication bottles (prescribed and/or over the counter/herbal supplements)
- **All recent testing (MRI, CT, etc.). bring the printed report AND the images scanned to a CD.**

CANCELLATION POLICY:

For any reason you can not make your appointment, please call (662) 281-0112 at least 48 hours in advance to cancel or reschedule, if not you will be charged $50.

HAVE QUESTIONS?

Feel free to call our scheduling department at 1(662) 281-0112 with any questions relating to this packet.

IF YOUR APPOINTMENT IS NOT CONFIRMED 48 HOURS IN ADVANCE YOUR APPOINTMENT WILL BE CANCELLED AND ANOTHER PATIENT SCHEDULED

CONSENT FORM FOR TEXT MESSAGING REMINDERS

I give permission to receive text messages from Oxford Neurology Clinic or others acting on Oxford Neurology's behalf. As part of this consent, you represent and warrant the following:

(1) The Oxford Neurology Clinic or others acting on their behalf may send text messages in various formats and with various contents, including but not limited to, text messages about appointment reminders.
(2) You are the owner or authorized user of the mobile phone number identified below. You will notify us immediately if you are no longer the owner or authorized user of the mobile phone number identified below.
(3) You are solely responsible for any message and data charges associated with such text messages.

If You do not wish to receive text messages from the Oxford Neurology Clinic or others acting on their behalf, You should not sign this form.

______________________________ ______________________

Printed Name Date of Birth

____

Signature

____

Mobile Phone Number