Center for Headache Medicine

www.HeadacheMedicine.Info 630.719.0900

Welcome to our practice! We are glad that you chose us. Please take a few moments to fill out and sign the form below and the next two pages. These forms must be signed to see the doctor. If you have any questions please ask, we would be glad to explain any confusing part of this form. Thank you.

PERSONAL INFORMATION

_________________ _______________ ____ **_M/F__** _________________
Last Name First Name M Sex Soc. Sec **Required**
(guardian SS# if under 18)

_________________ ________________ _____ ___________ ____________
Street City State Zip Code Date of Birth

(_____)___________ (____)__________ ________________________________
Cell Phone # Work # Referring Doctor or Doctors

__________________ (_____)___________ _______________ _S/M/D/ Other_
Emergency Contact Emergency Contact # Relationship Marital Status

INSURANCE INFORMATION

Primary Insurance ___________________________ Co-Pay Amt: ________

Is this your insurance? Yes/No

_____________________ ___________________ __________________
If no, Insur. Holder's Name Employer Insur. holder's Birthdate

Secondary Insurance ___________________________ Co-Pay Amt: __________

Is this your insurance? Yes/No

_________________ ___________________ ________________
If no, Insur. Holder's Name Employer Insur. holder's Birthdate

Is this visit due to symptoms from and auto accident or injury at work? Yes/No
Is this visit affected by legal or disability issues? Yes/No

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Congress has reduced payments to physicians for Medicare patients since 2006.

Since reimbursements continue to fall and the costs to practice medicine rises, we either need to reduce the quality of service or reduce costs associated with quality care. We do not want to reduce quality of service. Since **January 2020 we no longer are a Medicare participating provider** and since 2006 we have implemented a policy to help reduce costs by requiring all patients to have a signed credit card authorization on file that will be used to pay for deductibles, co pays and non-insurance covered services (such as prior drug authorizations, missed appointments, duplicate medications or disability forms). By signing below you authorize us to bill any insurance determined deductibles and co pays (as per your Explanation of Benefits) and any non-insurance covered services $150 or less without sending you a separate bill. There are no exceptions to this policy. If you will not or cannot comply with this policy, we will facilitate your transfer to another doctor's care and will continue as your physician for the next 30 days.

We are sorry for any inconvenience this may cause you. If you do accept this policy by signing below but do not keep an updated copy of your credit card on file with us, it will be assumed you are no longer in agreement with this policy. At that time, we will send you a 15-day notice of our intention to terminate care unless you provide a valid credit card within 15 days. By signing below, you also agree that this is adequate notice to terminate doctor patient relationship.

PLEASE PRINT YOUR NAME AND SIGN BELOW:

NAME: ____

I accept the above credit card policy: ________________________ Date: ____________

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By signing the form below you are stating that you understand and agree to the following

1. **The Financial Policy** of this practice is that we provide a service to you at your request and you are responsible to reimburse us for that service at the time of service at the amount that you are billed. These amounts are not arbitrarily determined but are in line with Neurological care provided in this zip code as published by an independent data service. An estimate will be provided either now or at the time of the appointment. The only exception to you paying us at our billed amounts is if we have a contract with your insurer and/or have agreed to a different amount before your visit. We **do not accept Medicare assignment** (it may require you to pay an additional small fee - an estimate will be provided upon request) and are in only BCBS PPO plans. If we are not in your insurance plan network we will bill your insurance first and offer reduced fees if you have large out of pocket expenses as you will be responsible for a larger portion of the bill. Again, we will be glad to provide an estimate of this additional amount.
2. **Payment is due at time of service.** Cash, credit cards and checks are accepted as payment. As a service to our patients we will process your insurance claim or referral to your insurance company. We will make every effort to collect your medical bill from your insurance company for sixty days from the visit date. After that time by signing the below you authorize us to apply the balance of your bill at our discretion to your credit card on file.
3. **Pay your balances on time.** If you receive billing information from your insurance plan regarding the amount you are responsible for, please pay this amount and do not wait for a statement from us. Should we not receive your payment, we will apply your balance to your credit card. Call if you have any questions regarding the amount to pay.
4. **Fee for cancelled appointments.** In consideration of all our patients, there is a fee for canceling appointments without ***one business day notice.*** (NOTE: Our office is closed on Wednesday, Saturday and Sunday. These days are NOT considered business days) This fee increases upon the second occurrence.
5. **Acknowledgement of Privacy Practices.** Upon request, a copy of David S. Larsen M.D. notice of privacy practices will be provided. The notice contains information regarding potential uses and disclosures of my protected health information (as that term is defined under Health Insurance Portability and Accountability Act of 1996 HIPPA) that may be made by the practice, and of my rights and the practice's legal duties with respect to my protected health information.

In the event I fail to pay the balance of my account to David S. Larsen M.D., I hereby agree that David S. Larsen M.D. upon sending my account to a collection agency (which is why we require your Soc Sec number to facilitate this), will cause me to be responsible to pay the fee charged to the practice by the collection agency.

I certify that to the best of my knowledge the information provided is correct. This signature on file is my authorization for the release of any information necessary to process my insurance claim and to any doctor designated by me as actively involved in my medical care. If an insurance claim is filed at my request, I authorize payment to the medical practice of David S. Larsen M.D. benefits otherwise payable to me for the services that I received by this medical practice.

Signature__________________________________ Date______________________

MEDICATION HISTORY FORM **Name: _____________________Date:__________**

Please indicate which medications you have tried W (worked) or N (did not work) & any side effects (SE)

W/ N	SE	Over the Counter	W/ N	SE	Herbal/Vitamins
		Acetaminophen (Tylenol)			Deplin
		Aleve			Feverfew
		Anacin			Gliacin
		Aspirin			Magnesium Oxide
		Aspirin Free Excedrin			Petadolex (butterbur)
		Excedrin Migraine			Vitamin B2 (riboflavin)
		Ibuprofen (Motrin, Advil etc)			CBD
W/ N	**SE**	**Anti Inflammatory**	**W/ N**	**SE**	**Blood Pressure**
		Arthrootec			Atacand (Candesartan)
		Celebrex (Celecoxib)			Atenolol (Tenormin)
		Indocin (Indomethacin)			Benicar
		Mobic (Meloxicam)			Bystolic
		Tvorbex			Inderal (Propranolol)
		Voltaren (Diclofenac sodium)			Losartan
		Zorvolex			Metoprolol (Lopressor, Toprol XL)
					Nadolol (Corgard)
					Verapamil (Calan, Covera HS)
W/ N	**SE**	**Anti Seizure Medications**	**W/ N**	**SE**	**Anti Nausea Medications**
		Depakote			Compazine (Prochloperazine)
		Gabapentin, Gralise (Neurontin)			Phenergan (Promethazide)
		Gabitril			Reglan (Metoclopramide)
		Keppra			Tigan (Trimethobenzamide)
		Oxtellar XR			Zofran (Ondansetron)
		Topamax. Topiramate, Trokendi XR			
		Tripleptal (Oxcarbamezapine)			
		Zonegran			
W/ N	**SE**	**ADD / ADHD**	**W/ N**	**SE**	**Muscle Relaxers**
		Adderall			Baclofen
		Adderall XR			Flexeril (Cyclobenzaprine)
		Concerta			Norflex
		Dexedrine			Parafon Forte (Chlorzoxazone)
		Focalin			Robaxin
		Focalin XR			Skelaxin (Metaxalone)
		Intuniv			Soma (Carisoprodol)
		Ritalin			Zanaflex (Tizanidine)
		Vyvanse			

MEDICATION HISTORY FORM

Please indicate which medications you have tried W (worked) or N (did not work) & any side effects (SE)

W/ N	**SE**	**Prescription Pain Medications**	**W/ N**	**SE**	**Prescription Pain Medications**
		Butrans			OxyContin
		Demerol (Meperidine)			Panlor Acetaminophen/Caffeine/Dihydrocodeine)
		Fentora			Percocet, Percodan, Tylox (Oxycodone)
		Fioricet/Esgic (Butalbital, ASA,Caffeine)			Phrenilin (Butalbital/Acetaminophen)
		Fiorinal (Aspirin/Butalbital/Caffeine)			Sprix Nasal Spray
		Fiorinal w/Codeine/ Fiorinal #3			Stadol Nasal Spray
		Kadian			Toradol (Ketorolac) Tabs, injections
		Lidoderm Patch			Tylenol #3 or #4
		Methadone (Dolophine)			Ultram (Tramadol)/Ultracet
		Morphine IV/IM MsContin, Avinza			Vicodin, Vicoprofen, Lorcet (Hydrocodone), Norco
		Naproxen Sodium (Anaprox, Naprelan, Naprosyn)			Zohydro
		Nucynta			
W/ N	SE	**Headache Medicine**	W/ N	SE	**Headache Medicine**
		Alsuma			Maxalt (Rizatriptan) tab or MLT dissolves
		Amerge (Naratriptan)			Midrin (isomethep/dichloralphen/acet)
		Axert (Almotriptan)			Migranol Nasal Spray DHE, IV IM
		Cafergot Tab, supp, Cafergot PB supp			Prodrin (Similernea)
		Cambia			Relpax
		Ergomar SL			Sumavel Dose Pro
		Frova			Treximet
		Imitrex (Sumatriptan tab/ spray & injections, patch			Zomig
		Ubrelvey			Nurtec ODT
W/ N	**SE**	**Anti Depressant Medications**	**W/ N**	**SE**	**Anti Depressant Medications**
		Brintellix			Paxil (Paroxetine)
		Celexa			Pristiq
		Cymbalta			Prozac (Fluoxetine)
		Desipramine Norpramin)			Remeron (Mirtazapine)
		Doxepin (Sinequan)			Trazodone(Desyrel)
		Effexor (Venlafaxine)			Viibrvd
		Elavil (Amitriptyline)			Vivactil (Protriptyline)
		Fetzima			Wellbutrin (Buproprion)
		Lexapro (Escitalopran)			Zoloft (Sertaline)
		Pamelor (Noratriptylin, Aventvl)			

MEDICATION HISTORY FORM

Please indicate which medications you have tried W (worked) or N (did not work) & any side effects (SE)

W/ N	SE	Anxiety	W/ N	SE	Sleep Medications
		Ativan (Lorazepam)			Ambien
		Buspar (Buspirone)			Belsomra
		Diazepam (Valium)			Lyrica
		Klonopin (Clonazepam)			Lunesta
		Xanax (Alpraxolam)			Rozerem
W/ N	SE	**Monoclonal antibody CGRP**			Savella
		Aimovig			Sinenor
		Ajovy			
		Emgality	**W/ N**	**SE**	**Corticosteroids**
		Vyepti			Decadron
W/ N	SE	**Mood Stablizer**			Prednisone
		Rexulti			Medrol
		Seroquel (Quetiapine), XR			Solumedrol PO,IV
		Lithium (Eskalith, Lithobid)			
		Lamictal (Lamotrigine)			
W/ N	**SE**	**Other Medications/Treatment**	**W/ N**	**SE**	**Miscellaneous**
		Botulinum Toxin (Botox)			Low-Dose Naltrexone
		Trigger point shot			Namenda

What medications worked in the emergency room?

____

____

What medications did not work in the emergency room?

____

____

Migraine Questionnaire Intake 1st visit

Patient Name:_______________________ Date ______________

1. I typically have _____ migraine attacks / episodes per month.

   1 2 3 4 5 6 7+

2. I can usually feel symptoms coming on ____ hours before the migraine attack/episode starts.

   1hr 2 hr 3hr 4hr 5hr 6hr 7hr 8hr 9hr 10hr +

3. My migraine attack/episode typically lasts up to:

   1hr 2 hr 3hr 4hr 5hr 6hr 7hr 8hr 9hr 10hr +

4. On average, it takes me _____ hours after the migraine attack/episode ends to typically feel like myself again.

   1hr 2 hr 3hr 4hr 5hr 6hr 7hr 8hr 9hr 10hr +

5. How many “didn’ts”, missing out on things because of a migraine do you have a month?

   1 2 3 4 5 6 7+

6. During your “didn’ts” what are some of the things you tend to avoid?

   work play meals travel exercise sleep family time special events

7. I ___________take medication at the onset of my migraine symptoms.

   never rarely frequently always

8. How would you describe your overall attitude toward migraines?

   I power through

   I have more good days than bad

   I have as many good days as bad

   I have more bad days than good

   I live in constant dread