



## Comprehensive Neurology and Sleep Medicine, P.A.

### **Konrad Bakker, MD**

Board Certified in Neurology  
and Sleep Medicine

### **Navid Mostofi, MD**

Neurologist  
Neurophysiologist

### **Sarah Layman, PA-C**

NCCPA Certified  
Physician Assistant

Welcome to Comprehensive Neurology and Sleep Medicine (CNSM). We are glad you have selected CNSM and are committed to providing quality patient services. We look forward to seeing you. This letter outlines the contents of the welcome packet and details about our practice.

We strive to continually offer you individual patient attention and patient/caregiver education and support. To help us provide you the best care possible, we ask that you provide accurate background information and familiarize yourself with our office policies. In this packet you will find:

- **Patient Information Form** – basic contact and insurance information
- **New Patient Medical History Form** – complete medical history to provide us with context for your current condition
- **CNSM Policies** – important office policies to review and sign-off
- **Appointment Checklist** - items to complete for or bring to your first appointment
- **Sleep Questionnaire** (sleep patients only) – list of questions to be completed before your first appointment to help assess and treat your condition
- **Authorization** – place for you to specify which aspects of your care we can discuss with whom

During your initial appointment you will be interviewed and examined by one of our neurologists, Dr. Konrad Bakker or Dr. Navid Mostofi, or by our experienced physician assistant, Sarah Layman, PA-C. The providers at CNSM are experienced in a range of neurological disorders including epilepsy, Parkinson's disease, multiple sclerosis, migraine headaches, neuropathy, carpal tunnel syndrome, Alzheimer's disease, etc. We are also experienced in sleep medicine including sleep apnea, insomnia and restless leg syndrome.

Our highly-respected team looks forward to working with you and making sure that you are fully involved with all aspects of your care. **To help us better serve you, please bring a list of your symptoms and a list of previous medical providers you have seen for this condition. Please also arrange for records from your previous providers to be sent to our office prior to your visit.**

If you have any questions or want to learn more, please see our website ([www.myneurologypractice.com](http://www.myneurologypractice.com)) or contact our office at 301-694-0900.

**Patient Information Sheet**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Patient's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Home Phone (    ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Cell Phone (    ) \_\_\_\_\_

Gender M \_\_\_ F \_\_\_ DOB \_\_\_\_\_ Marital Status \_\_\_\_\_ Work Phone (    ) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Parent/Spouse's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Work Phone (    ) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone (    ) \_\_\_\_\_

How did you hear about us? Friend Family member Internet Advertisement Physician name: \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (    ) \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Other Doctors You See Regularly \_\_\_\_\_

Name /Address of Your Pharmacy \_\_\_\_\_

\_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY Ins Co** \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**SECONDARY Ins Co** \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group# \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Relationship to Subscriber \_\_\_\_\_ Subscriber's DOB \_\_\_\_\_

Subscriber's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION & AUTHORIZATION TO PAY PROVIDER**

I hereby authorize Comprehensive Neurology & Sleep Medicine to release any information requested from the insurance company with respect to claims and bills as the provider of the services rendered. I hereby authorize payment from the insurance to be sent directly to Comprehensive Neurology and Sleep Medicine for services rendered. I understand that I am financially responsible for the charges that are not covered or considered not medically necessary by the insurance.

Signature \_\_\_\_\_ Date: \_\_\_\_\_



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### Appointment Checklist

Thank you for entrusting care to us. To provide you with the best service and be responsive to your needs, I suggest you bring the following to your first appointment:

- Completed paperwork from this packet
- Insurance card(s), also any required insurance referrals
- Photo ID
- A list of your previous medical providers, especially if they are neurologists or sleep specialists, and arrange for records from those providers to be sent to our office prior to your appointment.
- Test results such as MRIs, CT scans, lab work, EEGs and sleep studies.
- A written list of all medications you are currently taking, including strengths and dosages.
- A diary of your symptoms and a list of your questions that you would like to address with the provider.

At all future visits, you will be asked to fill out a patient update sheet before seeing your provider. This sheet assists us in assessing your progress and in determining your treatment plan.

We at Comprehensive Neurology and Sleep Medicine, P.A. appreciate the opportunity to care for you, and we welcome you again to our practice.

Konrad W. Bakker, M.D.  
Medical Director



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### Office Policies

Please review the following and sign at the bottom:

#### **MEDICATION REFILLS:**

We request that you allow 24 hours to process your prescription refill request.

We generally provide enough medication to last between appointments, but if you run out of a medication before your next scheduled appointment, your medical condition needs to be re-assessed and a follow-up visit is in order.

Pain medications for migraines or pain syndromes are prescribed not more than 30 per month to prevent rebound headaches/ addiction/ habituation, etc. If you lose a prescription and/or pill bottle, we will not under any circumstances prescribe more during that 30-day period.

#### **URGENT CARE VISITS:**

If you need to be seen sooner than your next scheduled appointment, for reasons such as a change in your health status, new symptoms, pressing concerns, or forms that need to be filled out quickly, we recommend that you contact us to schedule an urgent care visit. We will make every attempt to accommodate you.

#### **MISSED APPOINTMENTS:**

If you miss an appointment without giving a 24-hour notice, you may be charged a \$25.00 no-show fee. If you miss an appointment more than once without notifying us 24 hours in advance, you may be discharged from the practice.

#### **NOTE TO REFERRING PHYSICIAN:**

At the time of your visit, a letter is dictated and sent to your referring physician and any other physician you would like copied on your behalf. You will also receive a copy of this letter.

We at Comprehensive Neurology and Sleep Medicine appreciate the opportunity to care for you.

**PLEASE SIGN THAT YOU HAVE READ THE ABOVE:**

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### Authorization

I, \_\_\_\_\_, give Comprehensive Neurology and Sleep Medicine, P.A. (CNSM) permission to discuss the following:

\_\_\_\_\_ Diagnosis, prognosis, and/or treatment information

\_\_\_\_\_ Test results

\_\_\_\_\_ Scheduling information

\_\_\_\_\_ Billing and/or insurance information

\_\_\_\_\_ Other: (please specify) \_\_\_\_\_

With the following people:

\_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

My preferred method to be contacted during daytime hours is:

E-mail, my address is: \_\_\_\_\_

Daytime phone, my number is: \_\_\_\_\_

An additional number is: \_\_\_\_\_

I give Comprehensive Neurology and Sleep Medicine permission to leave a message at the above phone number(s) and/or email address.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: This form must be complete in order to ensure the confidentiality of our patients' medical records.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

REASON FOR TODAY'S VISIT \_\_\_\_\_

**YOUR MEDICAL HISTORY**

	Yes	No		Yes	No
Rheumatic fever, heart disease	_____	_____	Arthritis, Rheumatism	_____	_____
Bone or joint disease	_____	_____	Neuritis, Neuralgia	_____	_____
Bursitis, sciatica, back pain	_____	_____	Polio, Meningitis	_____	_____
Syphilis	_____	_____	Anemia, Jaundice	_____	_____
Tuberculosis	_____	_____	Diabetes	_____	_____
Cancer	_____	_____	High Blood Pressure	_____	_____
Blackouts	_____	_____	Epilepsy, seizures	_____	_____
Migraine headaches	_____	_____	Nervous breakdown	_____	_____
Asthma	_____	_____	Broken bones	_____	_____
Concussion; head injury	_____	_____	Skin rashes	_____	_____
Glaucoma	_____	_____			

**YOUR ALLERGIES**

	Yes	No		Yes	No
Penicillin	_____	_____	Tetanus	_____	_____
Sulfa	_____	_____	Other drugs	_____	_____
Aspirin	_____	_____			
Codeine, Morphine	_____	_____	Foods	_____	_____
Mycins, Other antibiotics	_____	_____	Other (pollen, etc)	_____	_____

If you have an allergy, please list the symptoms you experience. \_\_\_\_\_

**MEDICATIONS:** Please list all of the medications that you currently take. Include the medications that you take on an "as needed" basis.

NAME OF DRUG	DOSE OF PILL	HOW MANY PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FAMILY HISTORY**

	FATHER	MOTHER	SIBLINGS	CHILDREN
Age	_____	_____	_____	_____
Living/dead	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Multiple sclerosis	_____	_____	_____	_____
Nervous breakdown	_____	_____	_____	_____
Migraine headache	_____	_____	_____	_____
Memory loss	_____	_____	_____	_____
Tremor or shaking	_____	_____	_____	_____
Mental retardation	_____	_____	_____	_____
Heart problems	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Cancer	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____
Other (explain)	_____	_____	_____	_____

**SOCIAL HISTORY**

Are you married/divorced/single/separated? If married, since when? \_\_\_\_\_

Do you have children? Y/N How many live at home with you? \_\_\_\_\_

Occupation \_\_\_\_\_

How often do you drink alcohol? Never, Rarely, \_\_\_ per day/week/month

Do you use tobacco? Y/N \_\_\_ packs per day since \_\_\_\_\_ (quit date \_\_\_\_\_)

How often do you drink caffeine? Never, Rarely, \_\_\_\_\_ per day  
 Do you use sleeping pills? Y/N Do you use sedatives/tranquilizers? Y/N  
 Do you sleep well? Y/N How many hours per night? \_\_\_\_\_ Do you feel rested? Y/N  
 Have you been treated for alcoholism? Y/N Have you been treated for drug abuse? Y/N  
 Do you exercise? Y/N If so how? \_\_\_\_\_  
 Is your spouse in good health? Y/N If no, describe \_\_\_\_\_

**YOUR SURGICAL HISTORY**

If yes, please provide the approximate date.

	Yes	No	Date		Yes	No	Date
Tonsils	_____	_____	_____	Appendix	_____	_____	_____
Hysterectomy	_____	_____	_____	Gallbladder	_____	_____	_____
Vasectomy	_____	_____	_____	Brain	_____	_____	_____
Disc surgery	_____	_____	_____	Other surgery	_____	_____	_____
Cesarean	_____	_____	_____	Transfusion	_____	_____	_____
Other, nonsurgical hospitalization _____							

**REVIEW OF SYSTEMS: Do you have/feel:**

	Yes	No		Yes	No
Eye disease/injury	_____	_____	Chest pain	_____	_____
Vision loss	_____	_____	Shortness of breath	_____	_____
Ear disease/injury	_____	_____	Palpitations/heart flutter	_____	_____
Fainting spells	_____	_____	Extreme daytime fatigue	_____	_____
Convulsions/seizure	_____	_____	Kidney disease	_____	_____
Paralysis	_____	_____	Trouble urinating	_____	_____
Dizziness	_____	_____	Numbness, part of body	_____	_____
Stomach ulcer	_____	_____	Headaches, frequent/severe	_____	_____
Liver disease	_____	_____	Change in appetite	_____	_____
Tick bites	_____	_____	Dry eyes/mouth	_____	_____
Depression	_____	_____	Anxiety	_____	_____
Memory loss	_____	_____	Difficulty concentrating	_____	_____
Jittery/jumpy	_____	_____	Nasal congestion (chronic)	_____	_____

**YOUR TESTS**

	Yes	No	Date	Result
Chest X-ray	_____	_____	_____	_____
Neck X-ray	_____	_____	_____	_____
Back X-ray	_____	_____	_____	_____
CT Neck/Back	_____	_____	_____	_____
CT Head/Brain	_____	_____	_____	_____
MRI Neck/Back	_____	_____	_____	_____
MRI Head	_____	_____	_____	_____
Myelogram	_____	_____	_____	_____
EKG (heart)	_____	_____	_____	_____
EEG (brain)	_____	_____	_____	_____
EMG/NCV	_____	_____	_____	_____
Sleep study	_____	_____	_____	_____
Other	_____	_____	_____	_____



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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

Effective Date: April 14, 2003

I have been given a copy of the Notice of Privacy Practices and I understand that I can ask questions about how my protected health information (PHI) will be used. I know that I can contact the Secretary of the Department of Health and Human Resources if I have further concerns.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Account Number