NYU Langone MEDICAL CENTER

Faculty Group Practice Patient Demographic Form

Patient Information

Name (Last, First, MI)			Email address	
Street Address		City	State	Zip
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐		Cell Phone ( ) Preferred ☐	
SSN	Date of Birth	Gender ☐ Male ☐Female	Marital Status □ Single □ Married □ Divorced □ Widowed □ Separated □ Partner □ Other	
Race	Ethnicity	Preferred Language	Country of Origin	

Financially Responsible Party

Is patient responsible party/guarantor? ☐Yes☐No(If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
Occupation	Employer	Email Address	Date of Birth
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐	

Emergency Contact

Name	Relationship to Patient
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	Cell Phone ( ) Preferred ☐

Referral Info

Referring Physician's Name	Physician Phone/Fax (if known) ( )
Physician Address	

PCP Info

Primary Care Physician's Name (Check if same as Referring Physician above☐)	Physician Phone/Fax (if known) ( )
Physician Address	

Insurance Information

Primary Insurance Company	Policy #	Group #		
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)			
Subscriber's Social Security #	Gender ☐ Male ☐Female	Date of Birth	Employer of Subscriber	Work Phone ( )
Secondary Insurance Company	Policy #	Group #		
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____	Name of Subscriber (if other than patient)			
Subscriber's Social Security #	Gender ☐ Male ☐ Female	Date of Birth	Employer of Subscriber	Work Phone ( )

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: _____/_____/_____

Guarantor Signature (if other than patient):_____ Date: _____/_____/_____

HEALTH INFORMATION EXCHANGE, CARE EVERYWHERE AND HEALTHIX CONSENT FORM

In this Consent Form, you can choose whether to allow the health care providers listed on the NYU Langone Medical Center Health Information Exchange ("NYULMC HIE") website http://health-connect.med.nyu.edu/ ("HIE Participants") and non-NYU health care providers who may request access to your medical records for purposes of current treatment ("Care Everywhere Providers") to obtain access to your medical records through a computer network operated by the NYULMC HIE. In order for a Care Everywhere Provider to know that information may be available through the NYULMC HIE, you must tell them that you were/are a patient of an HIE Participant and that such information may be available upon request. This can help collect the medical records you have in different places where you get health care, and make them available electronically to the providers treating you.

You may also use this Consent Form to decide whether or not to allow employees, agents or members of the medical staff of NYU Hospitals Center to see and obtain access to your electronic health records through Healthix, which is a Health Information Exchange, or Regional Health Information Organization (RHIO), a not-for-profit organization recognized by the state of New York. This can also help collect the medical records you have in different places where you get healthcare, and make them available electronically to the providers treating you. This consent also gives your permission for any NYU Langone Medical Center program in which you are a patient or member, to access your records from your other healthcare providers authorized to disclose information through Healthix. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749**.** Upon request, your provider will print this list for you from the Healthix website.

YOUR CHOICE WILL NOT AFFECT YOUR ABILITY TO GET MEDICAL CARE OR HEALTH INSURANCE COVERAGE. YOUR CHOICE TO GIVE OR TO DENY CONSENT MAY NOT BE THE BASIS FOR DENIAL OF HEALTH SERVICES.

The NYULMC HIE and Healthix share information about people's health electronically and securely to improve the quality of health care services. This kind of sharing is called ehealth or health information technology (health IT). To learn more about ehealth in New York State, read the brochure, "Better Information Means Better Care." You can ask your health care provider for it, or go to the website www.ehealth4ny.org.

PLEASE CAREFULLY READ THE INFORMATION ON THE FACT SHEET BEFORE MAKING YOUR DECISION.

Your Consent Choices. You can fill out this form now or in the future. You have the following choices:
Please check Box 1 or 2:

☐ **1. I GIVE CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access ALL of** my electronic health information through the **NYULMC HIE** and **I GIVE CONSENT to ALL employees, agents and members of the medical staff of NYU Hospitals Center to access ALL of** my electronic health information through **HEALTHIX** in connection with any of the permitted purposes described in the fact sheet, including providing me any health care services, including emergency care.

☐ **2. I DENY CONSENT to ALL of the HIE Participants listed on the NYULMC HIE website and Care Everywhere Providers to access** my electronic health information through the **NYULMC HIE** or **HEALTHIX** for any purpose, *even in a medical emergency*.

NOTE: UNLESS YOU CHECK THE "I DENY CONSENT" BOX, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. IF YOU DON'T MAKE A CHOICE, the records will not be shared except in an emergency as allowed by New York State Law.

_____ Print Name of Patient	_____ Patient Date of Birth
_____ Signature of Patient or Patient's Legal Representative	_____ Date
_____ Print Name of Legal Representative (if applicable)	_____ Relationship of Legal Representative to Patient (if applicable)

NYULMC HIE, Care Everywhere and Healthix
Fact Sheet

Details about patient information in the NYULMC HIE, Care Everywhere and Healthix and the consent process:

1. **How Your Information Will be Used**. Your electronic health information will be used by the HIE Participants and Care Everywhere Providers only to:
   - Provide you with medical treatment and related services.
   - Check whether you have health insurance and what it covers.
   - Evaluate and improve the quality of medical care provided to all patients.

Unless otherwise permitted by State and Federal law and if permitted by Healthix, your electronic health information shall be disclosed, accessed and used by NYULMC healthcare insurance plans only to:

- Provide Care Management Activities. These include assisting you in obtaining appropriate medical care, improving the quality of healthcare services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- Provide Quality Improvement Activities. These include evaluating and improving the quality of medical care provided to you and all NYULMC patients and members.

NOTE: The choice you make in this Consent Form does NOT allow health insurers to have access to your information for the purpose of deciding whether to give you health insurance or pay your bills. You can make that choice in a separate Consent Form that health insurers must use.

2. **What Types of Information About You Are Included**. If you give consent, the HIE Participants and Care Everywhere Providers may access ALL of your electronic health information available through the NYULMC HIE and all employees, agents and members of the medical staff of NYU Hospitals Center may access ALL of your electronic health information available through Healthix. This includes information created before and after the date of this Consent Form. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may relate to sensitive health conditions, including but not limited to:

• Alcohol or drug use problems	• Mental health conditions
• Birth control and abortion (family planning)	• HIV/AIDS
• Genetic (inherited) diseases or tests	• Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance ("Information Sources"). These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other ehealth organizations that exchange health information electronically. A complete list of current HIE Information Sources is available from NYU Hospitals Center or your HIE Participant health care provider, as applicable. You can obtain an updated list of Information Sources at any time by checking the NYULMC HIE website **http://health-connect.med.nyu.edu/. You can contact the NYULMC HIE Privacy Officer by writing to: NYU Langone Medical Center, Privacy Officer, One Park Ave, 10th Floor, New York, NY 10016 or calling: 212-263-8488. A complete list of current Healthix Information Sources is available from Healthix and can be obtained at any time by checking the Healthix website at http://www.healthix.org or by calling Healthix at 877-695-4749.**

4. **Who May Access Information About You, If You Give Consent.** Only these people may access information about you: doctors and other health care providers who serve on the medical staff of an approved HIE Participant or Care Everywhere Provider who are involved in your medical care; health care providers who are covering or on call for an approved HIE Participant or Care Everywhere Provider's doctors; designated staff involved in quality improvement or care management activities; and staff members of an approved HIE Participant or Care Everywhere Provider who carry out activities permitted by this Consent Form as described above in paragraph one.

5. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call one of the HIE Participants or Care Everywhere Providers you have approved to access your records; visit the NYULMC HIE website: http://health-connect.med.nyu.edu/ or call the NYS Department of Health at 877-690-2211. If at any time you suspect that someone should not have seen or gotten access to information about you has done so through Healthix, call Healthix at: 877-695-4749; or visit Healthix's website: http://www/healthix.org; or call the NYS Department of Health at 877-690-2211.

6. **Re-disclosure of Information.** Any electronic health information about you may be re-disclosed by an HIE Participant or Care Everywhere Provider to others only to the extent permitted by state and federal laws and regulations. This is also true for health information about you that exists in a paper form. As stated in #2 above, if you give consent, ALL of your electronic health information, including sensitive health information will be available through the NYULMC HIE and Healthix. Some state and federal laws provide special protections for some kinds of sensitive health information, including related to: (i) your assessment, treatment or examination of a health condition by certain providers; (ii) HIV/AIDS; (iii) mental illness; (iv) mental retardation and developmental disabilities; (v) substance abuse; and (vi) predisposition genetic testing. Their special requirements must be followed whenever people receive these kinds of sensitive health information. The NYULMC HIE, Healthix and persons, including Care Everywhere Providers, who access this information through these health information exchanges must comply with these requirements.

7. **Effective Period**. This Consent Form will remain in effect until the day you withdraw your consent or until such time the NYULMC HIE ceases operation, or until 50 years after your death, whichever is later.

8. **Withdrawing Your Consent**. You can withdraw your consent at any time by signing a Withdrawal of Consent Form and giving it to NYU Hospitals Center or one of the other HIE Participants, as applicable. You can also change your consent choices by signing a new Consent Form at any time. You can get these forms on the NYULMC HIE website http://health-connect.med.nyu.edu/. Once completed please fax to 917-829-2085 or submit to your provider.

   Note: Organizations, including Care Everywhere Providers, that access your health information through the NYULMC HIE and/or Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to withdraw your consent, they are not required to return it or remove it from their records.

9. **Refusing to Check a Box (make a choice).** Unless you check the "I DENY CONSENT" box, New York State law allows the people treating you in an emergency to get access to your medical records, including records that are available through the NYULMC HIE. If you do not make a choice, the records will not be shared except in an emergency as allowed by New York State Law.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form after you sign it**.**

11. **Risks of Denying Consent**. If you deny consent for HIE Participants and Care Everywhere Providers to access your information through the NYULMC HIE and Healthix, your healthcare providers may not be able to access critical health information about you, obtained during a prior encounter, in a timely manner.

NYU Langone and Electronic Medical Recording – Privacy and Security with Epic

Frequently Asked Questions

What is an Electronic Medical Record?

An electronic medical record (EMR) is a secure, paperless record of a patient's medical history, including past and present symptoms and diagnoses, lab results, scans, treatments, and prescriptions. NYU Langone is employing an EMR called Epic that will lead to a new level of integrated care within the medical center and its affiliates. The system will improve the quality of our patient care, give you a new level of access to your medical information, and provide better access to our staff.

Who gets access to my electronic information?

Just as when your medical information was stored on paper, only licensed professionals that require access to your information to better treat you will see your records. Every healthcare provider that shares or uses information through the NYU Langone Medical Center Health Information System must obey strict security and privacy rules.

What does NYU Langone do to make certain that my information is secure?

The EMR is stored in an encrypted and highly secure network.

Also, NYU Langone takes patients' privacy very seriously, and we will be conducting random and unannounced audits to make sure that there are no violations of use of the new electronic system. If anyone ever is found to be viewing information that they should not be accessing, they will be subject to termination of their employment.

Are there any improvements to my health information privacy?

In fact, there are improvements to privacy and security through the EMR. With an electronic record, NYU Langone can track the opening of your record, so we would quickly be able to determine if there was ever any suspicious activity – an improved security measure from paper charts.

Why do I have to sign a release form?

The release form is standard practice for newly implemented EMRs, and your signature indicates that you are aware of the new system and that your information is being stored electronically.

Is my information still protected by HIPAA regulations?

Yes, just as it was prior to an EMR, your information is protected by HIPAA regulations and state and federal laws that keep it confidential.

Epic

NYU Langone MEDICAL CENTER

NYU Langone Medical Center
Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I have received a copy of NYU Langone Medical Center's Notice of Privacy Practices.

By providing my email address, I consent (agree) to receiving notifications, including breach notifications, through the Medical Center's secure email messaging system.

Patient Name: _____

Personal Representative Name (if applicable): _____

Personal Representative's Authority (ex: parent, guardian, health care proxy): _____

_____

Email Address: _____

Signature: _____ **Date:** _____

Effective as of 05/23/2013.

NYU Langone Medical Center
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Follows the Privacy Practices in this Notice?
All employees, medical and dental staff, trainees, students, volunteers, and agents of NYU Langone Medical Center must follow these practices. This includes NYU Hospitals Center, the NYU School of Medicine, and our Faculty Group Practices.

Our Commitment to Your Privacy
NYU Langone Medical Center ("NYULMC") is committed to maintaining the privacy of your health information in all formats (electronic, paper or verbally). We keep your health information in a secure (safe) electronic health record. We will only use or disclose (share) your health information as described in this notice.

How We May Use and Share Your Health Information with Others?
We may use and share your health information for treatment, payment, and health care operation purposes.

- We may use and share your health information with other health care providers who are treating you or with a pharmacy that is filling your prescription;
- We may use and share your health information with your health insurance plan to get pre-approval for your treatment or to collect payment for health care services; or
- We may use and share your health information to run our business, to evaluate practitioner or provider performance, or to educate health care professionals.

We may share your health information with business associates who are helping us collect payment for services or other business operations. All of our business associates are required to protect the privacy and security of your health information.

We may use and share your health information to contact you about health-related benefits and services or to fundraise for the benefit of NYULMC. You have the right not to receive fundraising communications and should email developmentoffice@nyumc.org or call 212-404-3640 or 1-800-422-4483 (toll free).

We may also use and disclose your health information for the following reasons:

- For public health activities (for example, to report injuries, diseases, births and deaths to a public health official authorized to receive such information);
- For workers' compensation or similar programs that provide benefits for work-related injuries;
- To alert appropriate authorities about victims of abuse, neglect, or domestic violence; if we reasonably believe that you have been a victim of such abuse, neglect, or domestic violence, we will make every effort to get your permission before sharing this information. However, in some cases we may be required or authorized to act without your permission;
- For oversight by government or private agencies that review health care organization's practices to ensure safety and quality activities;
- For monitoring products which may need repair or are being recalled (for example, to satisfy FDA requirements);
- For research studies where health records are analyzed (when it cannot be done through the normal authorization procedures) and approved by our institutional privacy board. This is done through a special process that makes sure that the research may only be a small risk to your privacy and that researchers keep your information confidential and secure; for preparing for

research, such as writing a research proposal or recruiting possible subjects; or, in the unfortunate event of your death, for research solely on information about people who have died;
- To create and disclose de-identified (does not have your name, SS#, etc.) health information or limited data sets that do not have direct identifiers about you;
- For judicial and administrative proceedings (for example, a court order);
- For law enforcement purposes (for example, to identify or find a suspect or missing person, or to report a crime that occurred on or off our property);
- To coroners, medical examiners, or funeral directors as necessary to do their jobs;
- To organizations that handle organ, eye or tissue donation, or transplantation;
- To avoid a serious threat to health or public safety;
- For specialized government functions;
- Incidental uses and disclosures (for example, if a patient or staff member overhears a discussion in our Emergency Department even when reasonable steps were taken to keep your information confidential); and
- As otherwise required or allowed by local, state or federal law.

If you give us permission, we may use or share your health information for:
- Our patient directory;
- Members of our Chaplaincy Services Department, such as a priest or a rabbi;
- To family or friends involved in your care;
- Payment for your care;
- A disaster relief agency for purposes of notifying your family or friends where you are and what your status is in an emergency situation.

Uses and disclosures of your health information that involve psychotherapy notes, marketing, payments from a third party, or any other use or disclosure not described in this notice or required by law will only be made with your written authorization (permission). You have the right to withdraw (take back) your authorization, except when we have already relied on it, by contacting our privacy official provided below.

Additional privacy protections may apply if we are using or sharing sensitive health information, such as HIV-related information, mental health information, alcohol or drug abuse treatment information and genetic information. For example, under New York State Law, confidential HIV-related information can only be shared with persons allowed to have it by law, or persons you have allowed to have it by signing a specific authorization form.

What Rights do you have About Your Health Information?
Although your health record is the property of NYULMC, you have the right to:

- Request restrictions on how we use or share your information for treatment, payment, and health care operations, and how we may share it with your family and friends. We are not required to agree to your request, except when you pay for services out-of-pocket, in full and request us not to share the health information with your health insurance plan.

- Request confidential communications of your health information.

- Review and copy health information in your medical and billing records upon written request. If you request an electronic or paper copy of your health information, one will be provided to you within 3 to 10 days of your request. You may be charged no more than .75¢ per page for paper copies. For electronic copies, we may also charge you a reasonable fee for using electronic media.

- Request amendment (changes) to information in your medical and billing records. You must make your request to change, in writing and provide a reason for the request. We are not required to agree to your request, but will let you know in writing, and state a reason, when we do not agree. If we agree, your suggested amendment will be added to your record.

- Receive an accounting of disclosures. An "accounting of disclosures" is a report that identifies certain other people or organizations to which we have disclosed your health information without your authorization. (See the section on "We may also use and disclose your health information for the following reasons" for an explanation of who might be included.) You have a right to receive one accounting of disclosures every 12 months without charge; however, we may charge you for the cost of providing any additional accounting in the same 12-month period.

- Name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information of minors (children under 18 years old) unless the minors are permitted by law to act on their own behalf. There may also be exceptions to this per individual state law.

- Ask for and be given a paper copy of this notice.

- Request additional privacy protections with respect to your electronic medical record.

Requests must be made in writing to the privacy official or appropriate doctor's office or hospital department. For more information or to get a designated request form, please contact the privacy official provided below.

What are Our Duties about Your Health Information and this Notice?
We are required by federal and state law to keep the privacy and security of health information that may tell your identity. If there is a breach of privacy that compromises your identifiable health information, we will notify you in writing or by email.

We are required to provide you with a copy of this notice and agree to the terms of this notice. We reserve the right to change the terms of this notice; the revised notice will be effective for all health information that we keep. We will post any revised notices on our public website at www.nyumc.org and in admitting or waiting room areas. You may also request a paper copy of the revised notice at the time of your next visit.

If you have any questions about this notice or believe your privacy rights have been violated, please contact us at:

Internal Audit, Compliance & Enterprise Risk Management
One Park Avenue, 3rd Floor, New York, NY 10016, Attention: Privacy Manager
212-263-8488 or 1-877-PHI-LOSS
compliance.help@nyumc.org

You may also contact the Secretary of the United States Department of Health and Human Services. We will not retaliate or take action against you for filing a complaint.

REQUEST FOR ACKNOWLEDGMENT
An acknowledgement form will be printed for you to sign during your registration process. By signing the Notice of Privacy Practices Acknowledgment Form, you are confirming that you have received a copy of this notice.

This notice is effective as of 05/23/2013.

NYU Langone MEDICAL CENTER

Summary of Faculty Group Practice Financial Policies

Thank you for choosing NYU Langone Medical Center for your medical care. We appreciate that you have entrusted us with your health care and we are committed to providing you with the best patient care possible.

Because healthcare benefits and coverage options have become increasingly complex, we have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your proposed treatment and in answering questions related to submitting your insurance claim for reimbursement.

Your health insurance policy is a contract between you and your health insurance company or your employer. Please note it is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, pre-certifications, pre-authorizations, limits on outpatient charges, and any requirements for specific physicians, labs and/or hospitals to use. You should be knowledgeable of any deductibles, copayments, and/or coinsurance. This applies to all payors regardless of whether or not our physicians participate.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of- pocket fees, and coverage limits.

PLEASE KEEP THESE POLICIES FOR FUTURE REFERENCE

Insurance Coverage

Please provide us with your current insurance plan information at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy or scan and keep on file for our records.

Please be aware of and provide any required referrals or authorizations in advance of the appointment or service. If you do not provide these before care is provided, you will be responsible for the cost of the care. When in doubt, contact your plan directly for clarification.

Our doctors belong to many insurance plans but participation differs by doctor. Before your appointment, please be sure your doctor is in-network and the services are covered under your plan. If your doctor is out-of-network, you will be billed for the costs of care. We will help you find out if you have out-of-network benefits and submit a claim to your plan on your behalf. Refer to our out-of-network policy below for more details.

Please let us know at any time if you do not want us to submit a claim to your plan.

Address Change

It is important that we have your correct address information on file. Please advise us anytime there is any change to your address, telephone or other contact information.

Co-payments/Co-insurances/Deductibles

You are expected to pay your co-payment and any co-insurance and/or deductible amounts, if known, at the time of service.

Other Bills

You may receive services at NYU Langone Medical Center such as anesthesia, radiology testing, pathology, or other services. These doctors provide vital services and are involved in your care even though they may not be present at the time and you may not see them face-to-face. There may be additional charges for these services.

In addition, you may receive in-patient or out-patient hospital care at NYU Langone Medical Center. If so, you will receive a hospital bill for those services. Hospital bills are separate from our doctor services. If you have questions, you may contact the hospital billing office at (800) 237-6977.

NYU Langone
MEDICAL CENTER

Payments
Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card *(American Express, MasterCard, Visa and Discover)*. Returned checks are subject to a fee of $20.00. We do not accept traveler's checks.

As a service to our clients, we provide a courtesy [bill pay reminder] call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Non-Medical Fees
Additional fees may apply to the following:

- Returned Checks
- Completion of disability or other forms
- Copying of medical records

Missed Appointments
Generally, NYU FGP requires a 24 hour (1 business day) cancellation notice for most office visits. Procedures and surgeries may require 48 hours (2 business days) or more. Please note that weekends and holidays are not considered business days. If you miss your appointment, or do not cancel with the required notice, additional fees may apply:

- Office Visit: $50
- Second Office Visit $75
- New Patient Visit: $75
- Procedure/Surgery Per Dept Policy

Out-of Network Providers
If the doctor is not in your insurance plan, the following apply:

- Full payment is due at the time of service for routine visits.
- Payment expected on the date of service may be an estimate of your total charges.
- You will be quoted an estimated fee before services/procedures are performed.
- A deposit is required prior to the date of service for elective surgeries and procedures.
- After your appointment, we will submit a claim to your plan for services performed.
- Even if you have out-of-network benefits, you are ultimately responsible for the full fee charged.
- Depending on your plan, payment may be sent to you. If you receive this payment, you must reimburse NYU Faculty Group Practice immediately.

Non-Covered Services

Medicare Patients. Medicare may not cover some services your doctor recommends. You will be informed ahead of time and given an Advanced Beneficiary Notice (ABN) to read and sign. The ABN will help you decide whether you want to receive services, knowing you are responsible for payment. You must read the ABN carefully.
Non-Medicare Patients. Any service not covered by your plan are your responsibility and must be paid in full at the time of service or upon receiving a bill.

Refunds
A refund is issued when an overpayment has been identified. If you feel a refund is due, please contact our billing office at (877) 648-2964.

Failure to Pay
If you do not pay your bill, your account may be sent to an outside collection agency. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

Policy and Fee Changes
These policies and fees are subject to change. We will do our best to keep you informed of any modifications.

We know medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to ask any of our Managers for more details or call the billing office at the number listed on your billing statement.

NYU Langone
MEDICAL CENTER

FACULTY GROUP PRACTICE FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

I understand that NYU School of Medicine, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

- **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYU School of Medicine. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

- **FINANCIAL LIABILITY:** I have been provided a copy of the NYU School of Medicine financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYU School of Medicine for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:

    - My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at NYU School of Medicine and I have not obtained such a referral or I receive services in excess of the referral, and/or
    - My health plan determines that the services I receive at NYU School of Medicine are not medically necessary and/or not covered by my Insurance plan, and/or
    - My health plan coverage has lapsed or expired at the time I receive services at NYU School of Medicine, and/or
    - I have chosen not to use my health plan coverage, and/or
    - The physician I see does not participate with my health care plan.

- **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me during my hospital stay or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

    Patient's Medicare Number _____ **Patient Signature** _____

- **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYU School of Medicine; such as, anesthesia, interpretation of cardiac tests, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.

- **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

I have been provided the Faculty Group Practice Patient Financial Policies. I understand the information listed above which has been fully explained to me.

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature **Date**

Form Revised: 6/1/2013

FACULTY GROUP PRACTICE LABORATORY BILLING INFORMATION

Thank you for choosing NYU Langone Medical Center Faculty Group Practice for your medical care. Any laboratory services or specimens provided by NYU are sent to the NYU Langone Medical Center outpatient laboratory for processing. The outpatient laboratory is a hospital service that is billed separately from your physician visit. The NYU Langone Medical Center laboratory participates with most insurance plans; however some plans have a specific laboratory facility preference. You should review your laboratory plan to understand your benefits as services provided may be subjected to hospital coinsurances and deductibles. It is your responsibility to understand your insurance plan benefits and to notify our staff or physicians of your preferred laboratory at each visit. Based on your request we will send your specimen to the laboratory your choice.

Should you have questions our practice staff will either answer your question or direct you to your insurance carrier.

Revised: 10-25-11

NYU Langone
MEDICAL CENTER

The Fresco Institute for Parkinson's and Movement Disorders

In accordance with HIPPA regulations, we are taking your privacy very seriously. To help us better protect your confidential information, please list the name and relationship of all persons that you would allow us to release medical information to.

PATIENT NAME	

Name of the person that you would allow us to release medical information to	**Relationship**	**Telephone No.**

_____ _____

Patient signature Date

Patient phone # _____

NYU Langone MEDICAL CENTER

Pharmacy Information

With the installation of Epic, the new electronic medical record system, at this practice, your doctor is now able to e-prescribe. This means that any prescriptions the doctor may give you today will be automatically routed to the pharmacy of your choice and we will no longer have to provide you with handwritten prescriptions. In addition, when you run out of refills on your medication, the pharmacist can now electronically send renewal requests to this office for approval.
**Note: Controlled medications are not eligible for e-prescribing.

Please complete the information below if you are interested in e-prescribing.

Patient Name: _____

Preferred Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Alternate Pharmacy	
Name of Pharmacy:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	

Laboratory Information

Please indicate by placing a checkmark next to one of the options below to identify your preferred laboratory. Some insurance plans require that covered patients utilize specific laboratories; failure to follow their guidelines can lead to bills that become the patient's responsibility. If you do not know which laboratory to select, please contact your insurance carrier. **If you do not select a laboratory, the practice will default any lab tests to NYU laboratory.**

LabCorp	
Quest Labs	
NYU Lab	
Other External Location	

Please provide name of external location: _____

Patient Name:_____ Date_____

Parkinson's Medications	**TIME**									
INDICATE ONLY THE TIME IN THIS ROW										
Mirapex 0.125mg, 0.25mg, 0.5mg 1mg, 1.5mg										
Mirapex ER 0.375mg, 0.75mg, 1.5mg 3mg, 4.5mg										
Requip 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg, 5mg										
Requip XL 2mg, 4mg, 8mg										
Neupro 2mg, 4mg, 8mg										
Sinemet (carbidopa/levodopa) 10/100, 25/100, 25/250										
Sinemet CR (carbidopa/levodopa sustained release) 25/100, 50/200										
Parcopa 10/100, 25/100, 25/250										
Stalevo (entacapone, carbi-levodopa) 50, 75, 100, 125, 150, 200										
Comtan (entacapone) 200mg										
Tasmar (tolcapone) 100mg, 200mg										
Rytary (carbidopa/levodopa sustained release) 95, 145, 95, 245										
Symmetrel (amantadine) 100mg										
Eldepryl (selegilline HCL) 5mg, **or Emsam patch, or Zelapar** 1.25mg										
Azilect 1mg										
Provigil 100mg, 200mg										
Namenda 5mg, 10mg										

Do you have any allergies or reactions to medication? If yes, please list them:_____

Other medication(s) with dose and frequency:

1. _____ **5.** _____

2. _____ **6.** _____

3. _____ **7.** _____

4._____ **8.** _____

NYU Langone MEDICAL CENTER

The Fresco Institute for Parkinson's and Movement Disorders

New Patient Intake Questionnaire

Name: _____ **Appointment Date:** _____

Address: _____ **Date of birth:** _____ **Age:** ____

_____ **Handedness:** Right Left Ambidextrous

E-mail address: _____ **Accompanied by**: _____

Phone numbers: Home: ( ) _____ **Work / daytime:** ( ) _____

Fax: ( ) _____ **Mobile phone:** ( ) _____

Relative or other contact person:

Name: _____

Phone number: ( ) _____

Another contact person:

Name: _____

Phone number: ( ) _____

What is your preferred pharmacy?

Name/branch #: _____ Address: _____

Phone number: ( ) _____ _____

Who referred you to our center?

Name: _____ Address: _____

Phone number: ( ) _____ _____

Fax number: ( ) _____ Type of Doctor (if relevant): _____

Who is your internist, general doctor, or primary care provider?

Name: _____ Address: _____

Phone number: ( ) _____ _____

Fax number: ( ) _____ Type of Doctor (if relevant): _____

What is the **major neurological problem** that brings you to the office today?

Please describe the story of your illness. What were your first symptoms? What happened next? Did things progress quickly or gradually? What are your current symptoms?

Which medications (if any) have you taken for your condition?

Please circle any symptoms that you have experienced as part of your illness:

Slowness	Stiffness	Tremor	Other abnormal movements
Changes in your voice	Difficulty writing	Clumsiness	Difficulty using your hands
Difficulty walking	Balance problems	Falling down	Bad posture/hunching over
Shoulder pain	Hallucinations	Memory loss	Swallowing difficulty
Weight loss	Anxiety or panic attacks	Depression	Acting out your dreams

Current Medications, Vitamins, and Supplements:

Please list the medication **name**, **dose,** and **timing**.

Examples: Carbidopa-Levodopa 25/100 mg, 2 tablets 5 times daily at 8-12-2-4-8
Melatonin 3 mg tablets, 1 tablet every evening

Past Medical and Surgical History:

What medical problems do you have (or have you had in the past)?
Please include hospitalizations.

Please list all surgeries or accidents that you have had, and the dates.

Allergies:

Are you allergic to any medications, foods, or contrast dye? Y N

What are you allergic to? What is your reaction? _____

_____

Please fill in the table below for your parents:

Name	Current Age (or age at death)	Medical problems (and/or cause of death)	Alive (Y/N)?
Mother:			
Father:			

Please fill in the table below for your brothers & sisters:

Name	Sex	Current age (or age at death)	Medical problems (and/or cause of death)	Alive (Y/N)?
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

Please fill in the table below for each of your children:

Name	Sex	Current age (or age at death)	Medical problems, learning disabilities, or developmental delay?	Alive (Y/N)?
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			
	M F			

Which relative(s) have had the following *(e.g., maternal aunt, paternal grandfather):*

Parkinson's disease _____ Tremor _____

Tics _____ Ataxia or balance trouble _____

Alzheimer's disease _____ Dementia _____

Huntington's disease _____ Dystonia _____

Depression _____ Anxiety _____

"Nervous Breakdown" _____ Schizophrenia _____

Bipolar disorder _____ Obsessive-compulsive disorder _____

Attention Deficit Disorder _____ Seizures _____

Mental Retardation _____ Fragile X Syndrome _____

Autism _____ Cerebral palsy _____

Club Foot _____ Scoliosis/hunchback _____

Alcohol abuse _____ Drug abuse _____

Eating disorders _____ Compulsive gambling _____

Unexplained early menopause _____ Melanoma _____

Other neurological disorders (please specify) _____

Personal and Social History:

Do you smoke? Y N When did you start? _____

Are you a prior smoker? Y N When did you quit? _____

If you have ever smoked: How many packs/day (average) _____ For how many years? _____

How much alcohol do you drink? regularly?

Glasses wine/week _____
Number of beers/week _____
Ounces liquor/week _____

What is the most alcohol that you have ever used

Glasses wine/week _____
Number of beers/week _____
Ounces liquor/week _____

How many cups per **week** do you **currently** use of:

Caffeinated coffee? _____ **Caffeinated** tea? _____ **Caffeinated soda**? _____

Coffee (caffeinated): during my life, I used an average of _____ cups per week for a total of _ years

Tea (caffeinated): during my life, I used an average of _____ cups per week for a total of _ years

Soda (caffeinated): during my life, I used an average of _____ cups per week for a total of _ years

Do you **currently** use recreational drugs? Y N Which one(s)? _____

Have you **ever** used recreational drugs? Y N Which one(s)? _____

Have you ever been exposed to **toxic substances** or **HIV/AIDS**? Y N

If so, which one(s)? _____

Occupation: Current: _____ Name of employer: _____
Former: _____ Former employer: _____

Employment status (circle one): Working full time Working part-time Student
Short-term disability Long-term disability Retired

Highest grade level or degree(s): _____ Number of years of school? _____

Countries of your ancestors? _____ Religion(s) of your ancestors? _____

Marital status (circle one): Single Married Separated
Divorced Widowed Domestic Partner

Spouse's/Domestic partner's name (if any): _____

What is your current height? _____ What was your tallest height? _____

What is your current weight? _____ What was your weight 1 yr ago? _____

How many children do you have? _____ Who lives at home with you? _____

Do you or others think that you spend **too much time** on any of the following?

Shopping (in stores or on the internet) _____	**Y**	**N**	Gambling (including scratch offs) _____	**Y**	**N**
Sorting, cleaning, organizing, or tidying up _____	**Y**	**N**	Having sexual thoughts or behaviors_____	**Y**	**N**
Eating (or craving foods) _____	**Y**	**N**	On the internet or playing video games _____	**Y**	**N**
Pursuing your hobbies_____	**Y**	**N**	Pursuing other specific activities _____	**Y**	**N**

For women only:

Age when menstruation began _____ Age of menopause _____

How many pregnancies? _____ How many births? _____

Other pregnancy outcomes: _____ Have your uterus or ovaries been removed? _____

Have you ever used birth control pills? _____ Have you used hormones after menopause? _____

NYU Langone MEDICAL CENTER

Date: _____

The Fresco Institute for Parkinson's and Movement Disorders

Activities of Daily Living Questionnaire

Choose the statement that best describes how you have been feeling, since your last visit, **because of your neurological problems.**

Please circle only **ONE** ANSWER.

1. Do you ever have forgetfulness or loss of memory (e.g., difficulty remembering names, telephone numbers)?

0 No. I do not have forgetfulness or loss of memory.
1 Yes. I have mild and consistent forgetfulness.
2 Yes. I have moderate memory loss. Sometimes I am disoriented and have difficulty handling complex problems.
3 Yes. I have severe memory loss. At times, I am not sure where I am or what day or time it is.
4 Yes. I have severe memory loss. I usually don't know where I am or what day or time it is. I can't be left alone.

2. Do you have hallucinations? (A hallucination is when you see or hear something that is not really there).

0 No. I do not have hallucinations.
1 No. I do not have hallucinations, but at night I frequently have vivid nightmares.
2 Yes. I have hallucinations, but when I have them, I realize that what is happening is not real and is only imaginary.
3 Yes. I have frequent hallucinations that interfere with my ability to function on a day-to-day basis.
4 Yes. I have so many hallucinations that I am unable to take care of myself.

3. Do you experience depression (e.g., feelings of sadness and hopelessness, tearfulness, poor appetite)?

0 No. I do not experience depression.
1 Yes. I have periods of sadness that are greater than normal, but I am never depressed for more than one week.
2 Yes. I have periods of sadness that are greater than normal; I am sometimes depressed for more than one week.
3 Yes. I have periods of depression where I have difficulty sleeping, loss of appetite or loss of interest in things. These periods last longer than one week.
4 Yes. I have constant depression with difficulty sleeping, loss of appetite or loss of interest. Sometimes I even have suicidal thoughts.

4. Do you have loss of motivation or interest?

0 No. I do not have loss of motivation or interest. I am not more passive than I used to be.
1 Yes. I am more passive than I used to be.
2 Yes. I have loss of interest in activities like going out or socializing with friends.
3 Yes. I have lost interest in even day-to-day activities like getting bathed, getting dressed and going to work.
4 Yes. I am withdrawn and have complete loss of interest in anything.

5. Have you noticed that your speech has changed or do you have problems speaking?

0 No. My speech has not changed.
1 Yes. My speech is mildly affected but I have no difficulty being understood.
2 Yes. My speech is mildly affected and I am sometimes asked to repeat myself.
3 Yes. My speech is severely affected and I am sometimes asked to repeat myself.
4 Yes. My speech is so severely affected that it is hard for others to understand me.

6. Have you noticed that you have too much saliva?

0 No. I do not have too much saliva and I never drool.
1 Yes. I have a slight excess of saliva. Sometimes I drool into my pillow at night.
2 Yes. I have moderately excessive saliva and I occasionally drool during the daytime.
3 Yes. I have markedly excessive saliva and I often drool during the daytime.
4 Yes. I have been drooling so much that I often carry a tissue or handkerchief.

7. Do you have problems swallowing or do you choke on your food?

0 No. I do not have problems swallowing and I do not choke.
1 Yes. I have problems with swallowing but I rarely choke.
2 Yes. I have problems with swallowing and I occasionally choke.
3 Yes. I have problems with swallowing and I have to eat soft food.
4 Yes. I am unable to swallow and must use an NG or gastrostomy tube to eat.

8. Have you noticed a change in your handwriting?

0 No. I do not notice a change in my handwriting.
1 Yes. My handwriting is slightly slow or small.
2 Yes. My handwriting is moderately slow or small but all of the words are readable.
3 Yes. My handwriting is severely affected. Not all of the words are readable.
4 Yes. My handwriting is severely affected. Most of the words are not readable.

9. Do you have slowness or difficulties using utensils or cutting your food?

0 No. I do not have slowness or difficulty cutting my food.
1 Yes. I am a little slow or clumsy, but I am able to feed myself without help.
2 Yes. I am slow or clumsy. I need help cutting some types of food.
3 Yes. Someone must cut my food, but I am still able to feed myself.
4 Yes. I am unable to feed myself. Someone else feeds me.

10. Do you have difficulties with dressing?

0 No. I do not have slowness or difficulty with dressing.
1 Yes. I am a little slow or clumsy, but I don't need any help.
2 Yes. I am slow and sometimes need help buttoning buttons, tying shoelaces or getting my arm into a sleeve.
3 Yes. I need a lot of help getting dressed but I can still do some things on my own.
4 Yes. I am unable to get dressed without assistance.

11. Have you slowed down or are you experiencing problems with bathing, brushing your teeth, combing your hair, or going to the bathroom?

0 No. I am not slow with these activities.
1 Yes. I am a little slow with these activities but I do not need help.
2 Yes. I am slow with these activities and I need help to shower/bathe.
3 Yes. I need help with washing, brushing my teeth, combing my hair and going to the bathroom.
4 Yes. I need help with all these activities and I have a Foley Catheter.

12. Do you have difficulty turning in bed or adjusting the sheets?

0 No. I do not have difficulties turning in bed or adjusting my sheets.
1 Yes. I am a little clumsy or slow with turning in bed and adjusting the sheets but I do not need any help.
2 Yes. I am only able to turn or adjust the sheets with great difficulty.
3 Yes. I am able to start turning but am unable to do it without help.
4 Yes. I am not able to turn in bed or adjust the sheets without help.

13. Do you have problems with falling?

0 No. I do not fall.
1 Yes. I rarely fall.
2 Yes. I occasionally fall but less than once per day.
3 Yes. I fall an average of once per day.
4 Yes. I fall an average of more than once per day.

14. Do you have freezing while you are walking? (Freezing is when you are unable to walk for a few seconds because your feet 'stutter' or seem stuck to the ground).

0 No. I do not have freezing.
1 Yes. I have been freezing when I walk but this rarely happens **OR**
Yes. Sometimes when I first start to walk I have been freezing.
2 Yes. I occasionally have freezing when I walk.
3 Yes. I frequently have freezing when I walk. I occasionally fall because of the freezing.
4 Yes. I frequently have freezing when I walk. I frequently fall because of the freezing.

15. Has your walking changed? Is it difficult to walk?

0 No. My walking and my arm swing have not changed.
1 Yes. I do not swing my arms and I tend to drag my legs.
2 Yes. I have a moderate amount of difficulty with walking but usually don't need assistance.
3 Yes. I have severe problems with walking and usually need assistance.
4 Yes. I can't walk at all, even when someone tries to help me.

16. Do you have visible tremor anywhere in your body?

0 No. I do not have a visible tremor.
1 Yes. I have a slight visible tremor, which is infrequently present.
2 Yes. I have a moderate amount of tremor. The tremor bothers me.
3 Yes. I have a severe amount of tremor and it interferes with many activities.
4 Yes. I have a severe tremor and it interferes with most activities.

17. Do you have numbness, tingling, discomfort or aching that you would attribute to your Parkinson's disease (or other movement disorder)?

0 No. I do not have numbness, tingling, discomfort or aching that I attribute to my Parkinson's disease (or other movement disorder).
1 Yes. I do have occasional numbness, tingling, discomfort or aching that I attribute to my Parkinson's disease (or other movement disorder).
2 Yes. I frequently have numbness, tingling or aching that I attribute to my Parkinson's disease (or other movement disorder).
3 Yes. I frequently have painful sensations that I attribute to my Parkinson's disease (or other movement disorder).
4 Yes. I have excruciating pain that I attribute to my Parkinson's disease (or other movement disorder).

In the following table, please circle the number that fits you best.

How well do you perform chores and other daily activities such as preparing food, eating, dressing, washing, and using the toilet?

100% = Completely independent. Able to do all chores without slowness, difficulty, or impairment. Essentially normal. Unaware of any difficulty.

90% = Completely independent. Able to do all chores with some degree of slowness, difficulty, and impairment. Might take twice as long. Beginning to be aware of difficulty.

80% = Completely independent in most chores. Takes twice as long. Conscious of difficulty and slowness.

70% = Not completely independent. More difficulty with some chores. May take three to four times as long. Must spend a large part of the day with chores.

60% = Some dependency. Can do most chores, but exceedingly slowly and with much effort. Errors are made, and some chores are impossible.

50% = More dependent. Help needed with half of chores. Slower. Difficulty with everything.

40% = Very dependent. Able to assist with chores, but can do few alone.

30% = With effort, can occasionally do a few chores alone, or at least begin them alone. Much help is needed.

20% = Can't do any chores alone. Can be a slight help with some chores. Severe invalid.

10% = Totally dependent, helpless. Complete invalid.

0% = Bedridden, with loss of control of swallowing, bowels, and/or bladder function.

PD NMS QUESTIONNAIRE

Name: ..... Date: ..... Age: .....

Centre ID: Male ☐ Female ☐

NON-MOVEMENT PROBLEMS IN PARKINSON'S

The movement symptoms of Parkinson's are well known. However, other problems can sometimes occur as part of the condition or its treatment. It is important that the doctor knows about these, particularly if they are troublesome for you.

A range of problems is listed below. Please tick the box 'Yes' if you have experienced it **during the past month.** The doctor or nurse may ask you some questions to help decide. If you have **not** experienced the problem in the past month tick the 'No' box. You should answer 'No' even if you have had the problem in the past but not in the past month.

Have you experienced any of the following in the last month?

	Yes	No
1. Dribbling of saliva during the daytime	☐	☐
2. Loss or change in your ability to taste or smell	☐	☐
3. Difficulty swallowing food or drink or problems with choking	☐	☐
4. Vomiting or feelings of sickness (nausea)	☐	☐
5. Constipation (less than 3 bowel movements a week) or having to strain to pass a stool (faeces)	☐	☐
6. Bowel (fecal) incontinence	☐	☐
7. Feeling that your bowel emptying is incomplete after having been to the toilet	☐	☐
8. A sense of urgency to pass urine makes you rush to the toilet	☐	☐
9. Getting up regularly at night to pass urine	☐	☐
10. Unexplained pains (not due to known conditions such as arthritis)	☐	☐
11. Unexplained change in weight (not due to change in diet)	☐	☐
12. Problems remembering things that have happened recently or forgetting to do things	☐	☐
13. Loss of interest in what is happening around you or doing things	☐	☐
14. Seeing or hearing things that you know or are told are not there	☐	☐
15. Difficulty concentrating or staying focussed	☐	☐
16. Feeling sad, 'low' or 'blue'	☐	☐
17. Feeling anxious, frightened or panicky	☐	☐
18. Feeling less interested in sex or more interested in sex	☐	☐
19. Finding it difficult to have sex when you try	☐	☐
20. Feeling light headed, dizzy or weak standing from sitting or lying	☐	☐
21. Falling	☐	☐
22. Finding it difficult to stay awake during activities such as working, driving or eating	☐	☐
23. Difficulty getting to sleep at night or staying asleep at night	☐	☐
24. Intense, vivid dreams or frightening dreams	☐	☐
25. Talking or moving about in your sleep as if you are 'acting' out a dream	☐	☐
26. Unpleasant sensations in your legs at night or while resting, and a feeling that you need to move	☐	☐
27. Swelling of your legs	☐	☐
28. Excessive sweating	☐	☐
29. Double vision	☐	☐
30. Believing things are happening to you that other people say are not true	☐	☐

All the information you supply through this form will be treated with confidence and will only be used for the purpose for which it has been collected. Information supplied will be used for monitoring purposes. Your personal data will be processed and held in accordance with the Data Protection Act 1998.

Developed and validated by the International PD Non Motor Group
For information contact: susanne.tluk@uhl.nhs.uk or alison.forbes@uhl.nhs.uk