Foothills Neurology, P.C.

4530 East Muirwood Drive ▪ Suite 111 ▪ Phoenix, Arizona ▪ 85048 **480.961.2365 Fax 480.961.2382**

Welcome to **Foothills Neurology, P.C.** Thank you for choosing our office to provide your medical care.

DIRECTIONS: Our office is located in **AHWATUKEE**, ½ mile **West** of **I-10** off of **Chandler Blvd**. We are located directly behind the Urgent Care/Ahwatukee Foothills Health Center.

From **I-10** go **West** on **Chandler Blvd.** to **46th Street**, take a left (south) on **46th Street**, turn **Right** on **Muirwood Drive**. Turn **Right** into the Medical Professional Plaza, our office will be on the **West** side.

4530 E. MUIRWOOD DRIVE Suite 111
PHOENIX, AZ 85048
480.961.2365

OFFICE HOURS: Monday – Friday: 8:00 a.m.-5:00 p.m.
Every other Saturday: 8:00 a.m.-4:00 p.m.

FIRST VISIT: **We ask that you come to your office visit at least *10 minutes* early with the enclosed information completed. If you have had any recent X-rays, CT Scans, MRI's or MRA's that relate to your problem, please bring them with you for the doctor to review during your visit.**

PAYMENT: *We ask that you come prepared to pay any **co-payment** your insurance plan requires at the time of your visit.*
Payments can be made by Cash or Credit Card (Visa, MasterCard or Discover).
We no longer accept personal checks.

Patients are responsible for making sure that Dr. Stuart Hetrick is *in network* with your insurance provider as office visits and procedures are billed under his name. We verify benefits and eligibility, *but we do not verify* that we are in each individual network.

We look forward to being a partner in your health care and providing you with friendly, personal and quality health care

Stuart J. Hetrick & Foothills Neurology Staff

Stuart J. Hetrick, D.O.
Timothy Visser, N.D.
Susan Hawrylkiw, FNP

Scot Fechtel, M. D.
Melinda Preston, Psy-NP
Amber McLouth, P.A.
Robin Adamson, P.A.

Ajo Joy, M.D.
Mary Diedrich, P.T.
Padma Mahant, M.D.

Foothills Neurology, P.C. Patient Registration

4530 E. Muirwood Drive Suite 111, Phoenix, AZ 85048 (480) 961-2365 Fax (480) 961-2382

Patient Name: _____ **Date**: _____

Street Address: _____ **S.S. #** _____

City, State, Zip: _____ **Date of Birth**: _____

Home: (_____)_____

circle one Gender: M F Minor: Yes or No _____ married _____single

Parent name (if patient is a minor) _____ _____divorced _____widowed

Employer: _____

Work Phone: (_____)_____

Other Phone, Mobile or Pager: (_____)_____

Your Pharmacy: Phone: ( )

Emergency Contact: _____ Relation: _____

Address: _____

City, State, Zip: _____ Phone: (____)_____

Family Doctor: _____ Phone: (____)_____

His / Her Address: _____ Fax: (____)_____

City, State, Zip: _____

Referring Doctor: _____ Phone: (____)_____

Address: _____ Fax: (____)_____

Primary Insurance: _____ Effective Date: _____

Address: _____ Group #_____

City, State, Zip: _____ I.D. # _____

Secondary Insurance: _____ Effective Date: _____

Address: _____ Group #_____

I.D. #_____

If the Patient is Not the Primary Insured

Name of primary insured_____ SS #_____

Employer Name: _____ Date of Birth: _____

By signing this document I indicate that all information given is accurate and true.

Patient Signature_____ Date_____

CO-PAY $

Foothills Neurology, P.C. Financial Responsibility

4530 E. Muirwood, Suite 111, Phoenix, AZ 85048 (480) 961-2365 Fax (480) 961-2382

Patient Name_____

I understand a $20 charge will be made for broken appointments unless 24-hour notice is given

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. Your insurance company determines insurance benefit payments. I understand I will be responsible for the portion not covered by my insurance.

I understand I will pay my co-pay at the time of my visit.

I understand there is a $25 charge for a Non-Sufficient Funds (NSF) check.

I understand that I must make an appointment for all forms to be filled out by the Physician (e.g. Disability, FMLA, etc.), and that there is a minimum $50 charge for a dictated letter.

I understand that Foothills Neurology *does not* accept liens, worker's compensation or MVA/auto claims and I am responsible for any insurance claims denied for such. If my medical insurance denies or takes back any monies provided, I understand I am responsible to pay all claims in full in a timely manner.

I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

Due to the large amount of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.

Patients are responsible for making sure that Dr. Stuart Hetrick is *in network* with your insurance provider. We verify insurance eligibility, *but we do not verify* that we are in each individual network.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days of the billing date. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize my insurance company to make payment directly to: Foothills Neurology, P.C.

Signature of patient (or parent / guardian)_____

Print Name _____ **Date**_____

Foothills Neurology, P.C. Privacy Notice

4530 E. Muirwood Drive Ste. 111, Phoenix, Arizona 85048 (480) 961-2365

I have received the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Foothills Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Foothills Neurology upon request.

FAXES: When expedient, I authorize the transmittal of my records by FAX to doctors, pharmacies, insurance companies, or upon my request. I understand that transmission by FAX, by its very nature, is not confidential.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Foothills Neurology and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

MESSAGES:

Y ____N_____ It is ok to leave a message on my home voice mail #: _____

Y ____N _____ It is ok to leave a message on my work voice mail #: _____

Foothills Neurology, P.C. NCS/EMG History Form

Stuart Hetrick, DO 4530 E. Muirwood Drive, Suite 111, Phoenix, AZ 85048

Name: _____ **Date of appointment:** _____

What is the main problem you are having this test for? _____

DO YOU HAVE A PACEMAKER or DEFIBRILATOR? _____YES _____NO

IF YES WHAT BRAND & TYPE? _____

Phone number of the manufacturer on your wallet card_____
(Please bring this card with you the day of the test)

DO YOU HAVE A HEART VALVE REPLACEMENT? _____YES _____NO

IF YES WHAT KIND? _____
(Antibiotics may be needed after this test just as if you went to the dentist)

HAVE YOU EVER BEEN TOLD THAT YOU HAVE A HERNIATED DISK? _____YES _____NO

IF YES WAS IT YOUR NECK OR LOW BACK? _____
Did you have surgery for the disk? _____

What *MEDICINE* are you taking now?

-
-
-
-
-
-

DO YOU HAVE ANY OF THESE MEDICAL PROBLEMS?

___Diabetes	**___Neuropathy**
___High Blood Pressure	**___Carpal Tunnel**
___Heart Disease	**___Pinched Nerve**
___Bleeding Disorder	**___Sciatica**

Do you have any other problems for which you have been seeing a Doctor on a regular basis?

_____
Stuart Hetrick, D.O.

Foothills Neurology, P. C. Electromyogram
4530 E. Muirwood Drive • Suite 111 • Phoenix, AZ • 85048 (480) 961-2365 Fax (480) 961-2382

EMG (Electromyography) and Nerve Conduction Study

An **EMG** or electromyogram is a test that measures the activity of the nerves and muscles. The **EMG** will take less than an hour to perform and you may continue your normal activities before and after the test. **Please let the doctor know at the start of testing if you have a pacemaker, are on blood thinners or have bleeding problems.**

IF YOU HAVE A PACEMAKER WITH A DIFIBRILATOR

1) We can still do the test, but in some cases it would be best to have the defibrillator portion turned off during the procedure to avoid accidental discharge.
2) Please call us and let us know the manufacturer and type of device before your visit so we can ensure we have the proper equipment and information on how to temporarily disable the defibrillator function if needed.

An **EMG** may be helpful in diagnosing:

- Muscle weakness or paralysis
- Sensory problems, such as numbness, tingling or pain
- Nerve damage or injury

Before arriving for your **EMG** it is important that you:

- Do not apply lotions or oils to your hands or arms if we are testing your arm(s)
- Do not apply lotions or oils to your feet or legs if we are testing your leg(s)
- Deodorant is ok
- Remove large jewelry from hands or feet, such as watches, bracelets, anklets or large rings
- Wear short sleeves for an **EMG** of the arm(s)
- Wear or bring shorts or a skirt for an **EMG** of the leg(s)

An **EMG/Nerve Conduction Study** involves two parts:

1. Electrical pulses - During the test several nerves will be stimulated by an electric stimulator and recorded. If a nerve is damaged these electrical impulses may be slow.

2. Tiny Needles – A small acupuncture like needle may be inserted into several muscles to listen for electrical activity. No electricity is used with the needles. Damaged muscles sound different than healthy muscles. The physician will determine if needle testing is required.

After the Test

Most people do very well with this test. Most leave saying it was not as bad as they imagined. You may have a small bruise where the needles were inserted that may last for a week or more. If pain persists longer than two days, you may apply ice or heat.
Call our office at (480) 961-2365 if you experience any unusual problems.

Stuart J. Hetrick, DO Scot Fechtel, MD Ajo Joy, MD
Susan Hawrylkiw, FNP Ambert McLouth, PA-C Robin Adamson, PA-C