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. Hyperhidrosis 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? _____

Is this due to an accident? ___Y ___N ___Don't know **Is a legal case pending?** ___Y ___N ___Maybe

Age _____

PLEASE LEAVE THIS BOX BLANK

Have you had any Tests done already? (e.g., MRI, Cat scan, EMG, X-rays, Ultrasound, etc...)

Test / X-Ray	Approximate Date Done	Result

***ALLERGIES*: Do you have any allergies to any medicine?** _____

What *MEDICINE* or *DRUG STORE PRODUCTS* are you taking?

Name of Medicine	Dosage	Times per Day	For What	Approx. Date Started
•				
•				
•				
•				
•				
•				

Have you stopped any medicine recently or used other medicine in the past for this problem?

Do you take birth control pills, patch or implant? Y N What?_____

PAST MEDICAL HISTORY **Do you have any other medical problems such as:**

Yes	No		Yes	No		Yes	No	
___	___	diabetes	___	___	ulcers	___	___	heart problem
___	___	kidney problem	___	___	hepatitis	___	___	stroke
___	___	thyroid problem	___	___	cancer	___	___	arthritis
___	___	fibromyalgia	___	___	seizures	___	___	asthma/emphysema
___	___	TMJ	___	___	depression	___	___	anxiety
___	___	lung disease	___	___	high cholesterol	___	___	headache
___	___	eye disease	___	___	osteoporosis	___	___	chronic pain in:
___	___	anemia	___	___	high blood pressure			___back ___neck ___other

Have you had any other surgeries, hospitalizations or other medical problems? If so list them:

Do you have any other problems for which you have been seeing a *doctor* or *chiropractor* on a regular basis?

FAMILY HISTORY

Do you have any family members with similar problems as you? Y N

Do you have any family members with?

brain tumor	**N**	**Y**	**who?**	stroke	**N**	**Y**	**who?**
seizures	**N**	**Y**	**who?**	heart attack	**N**	**Y**	**who?**
headaches	**N**	**Y**	**who?**	aneurysm	**N**	**Y**	**who?**

SOCIAL HISTORY:

Do you use tobacco? Y N How much? _____

Do you drink alcohol? Y N How much? _____

What is your occupation or major daytime activity? _____

If you are pregnant or thinking of getting pregnant please check here: ☐

(ROS) Do you have any other symptoms that you feel are important but have not already mentioned?

___fever/chills	___blurred vision	___double vision	___jaw pain with chewing
___chest pain	___eye pain	___trouble urinating	___difficulty swallowing
___palpitations	___constipation	___diarrhea	___shortness of breath
___joint pain	___stomach pain	___trouble sleeping	___numbness/tingling
___nose bleeds	___dizziness	___swollen glands	___**other (please explain)**

What part of your body sweats too much?

- ☐ Arm pits
- ☐ Hands
- ☐ Feet
- ☐ Face or head
- ☐ All over
- ☐ Just one spot _____
- ☐ Other _____

Do other people (friends, family or others) notice that you sweat too much?

- ☐ No
- ☐ Yes

How long has the excessive sweating been going on?

- ☐ 2-3 months
- ☐ 3-6 months
- ☐ over 6 months

Do you know why you sweat too much?

- ☐ No
- ☐ Yes if yes, why? _____

Do you sweat excessively on

- ☐ Both sides of your body?
- ☐ Just one side of your body?

Does your excessive sweating impair your daily activities in any way?

- ☐ No
- ☐ Yes how? _____

Does your excessive sweating occur:

- ☐ Constantly?
- ☐ Multiple times a day?
- ☐ Once a day or so?
- ☐ 1-2 times per week?
- ☐ less than once a week?

At what age did you first start experiencing excessive sweat? _____

Do you have a parent, sibling or child who sweats like you do?

- ☐ No
- ☐ Yes who? _____

Do you sweat during sleep?

- ☐ No
- ☐ Yes

My excessive sweating is: (please choose the most appropriate response)

_____ Never noticeable and never interferes with my daily activities.

_____Tolerable but sometimes interferes with my daily activities.

_____ Barely tolerable and frequently interferes with my daily activities.

_____ Intolerable and always interferes with my daily activities.

focal visible sweating >6 months w/o apparent cause with (3 or more): B/L; impairs daily activity; > 1 episode/week; onset <25; + fam hx; ceases during sleep.