NEUROVERSION
Break the cycle of pain

Patient Registration Form

PATIENT INFORMATION: (Please print) Date: _____/_____/_____

Last name: _____ First name: _____ MI: _____

Preferred name (if applicable): _____ SS#: _____-_____-_____

Sex: ☐ Male ☐ Female ☐ Transgender Age: _____ DOB: _____/_____/_____

Marital status: ☐ Married ☐ Divorced ☐ Partner ☐ Single ☐ Widowed

Home phone: _____ Work phone: _____ Cell phone: _____

Best number to contact: ☐ Home ☐ Work ☐ Cell Can we leave message: ☐ Yes ☐ No

E-mail address: _____

Physical address (line 1): _____

Physical address (line 2): _____

City: _____ State: _____ Zip code: _____

☐ Mailing address is same as physical address

Mailing address (line 1): _____

Mailing address (line 2): _____

City: _____ State: _____ Zip code: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Not employed

If not-employed, is this due to present medical condition: ☐ Yes ☐ No

Occupation: _____

Employer: _____

PLEASE COMPLETE THE FOLLOWING THREE SECTIONS AS PER GOVERNMENTAL HEATH CARE REGULATIONS

Race (Please check all that apply):

□ American Indian □ Alaska Native □ Native Hawaiian □ Black or African American
□ Asian □ White □ Other Pacific Islander □ More than one race
□ Other □ Decline to specify

Ethnicity (Please check one):

□ Hispanic or Latino □ Non-Hispanic or Latino □ Decline to specify

Preferred language:
□ English □ Spanish □ Other

Do you require an interpreter: ☐ Yes ☐ No

HEALTH CARE PROVIDERS:

Referring physician: _____ Phone number: _____

Location: _____

Primary care physician: _____ Phone number: _____

Location: _____

INSURANCE INFORMATION:

Primary insurance: _____ ID #: _____ Group #: _____

Ins. address: _____ Phone number: _____

Subscriber's name: _____ Subscriber's DOB: _____/_____/_____

Subscriber's employer: _____

Secondary insurance: _____ ID #: _____ Group #: _____

Ins. address: _____ Phone number: _____

Subscriber's name: _____ Subscriber's DOB: _____/_____/_____

Subscriber's employer: _____

Is this visit related to an accident: ☐ No ☐ Yes, workers compensation ☐ Yes, auto accident ☐ Yes, other

If YES, the following information must be provided:

Is there an open claim related to this? ☐ Yes ☐ No

Date of injury: _____/_____/_____ Claim #: _____

Adjuster's name: _____

Adjuster's phone number: _____ Adjuster's fax number: _____

Employer (workers comp): _____

PHARMACY INFORMATION:

Preferred local pharmacy: _____

City: _____ Phone number: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Relationship to patient: _____

Home phone: _____ Work phone: _____ Cell phone: _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

□ Referring doctor □ Friend □ Self
□ Newspaper □ Internet □ Other _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign):

I hereby authorize Neuroversion to furnish information to insurance carriers concerning my illness and/or treatments. I assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____/_____/_____

Notice of Privacy Practices for Protected Health Information

This notice describes how your Protected Health Information (PHI) may be used and disclosed and how you can get access to this information. Please review it carefully.

Neuroversion takes the privacy of your health information seriously. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

We are required by law to maintain the privacy of your health information and provide you with this Notice of Privacy Practices. We will act according to the terms of this Notice. We are required to notify you if we cannot accommodate a requested restriction or request and accommodate your reasonable request regarding methods to communicate health information to you. We reserve the right to change this Notice of Privacy Practices and to make any new practices effective for all Protected Health Information that we keep. Any changes made to the Notice of Privacy Practices will be prominently displayed, available at our offices and posted on our website (www.neuroversion.com).

The clinic is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. We will attempt in good faith to obtain your signed Acknowledgement that you were offered a copy of this Notice to use and disclose your confidential medical information for the following purposes.

Treatment Purposes:

- A medical assistant or scribe obtains treatment information about you and records it in a health record
- During the course of your treatment, the provider determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Payment Purposes: We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information to them about you and the care given. **Exception: If you have paid a visit in full and have requested the information not be shared with your insurance carrier, we will not disclose that particular visit. **

Health Care Operations: We obtain services from our insurers or other business associates such as quality assessment and improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, and legal services. We will share information about you with such insurers or business associates as necessary to obtain these services.

Other Disclosures and Uses: Examples of other types of disclosures and uses of your PHI are listed below (note that this is not an exhaustive list). If you would like additional information on these, please contact us.

- Communication with family
- Notification of persons responsible for your care
- FDA, related to adverse events
- Threat to health or safety
- Law Enforcement as required by law; Judicial proceedings
- Abuse & Neglect
- Public Health
- Health Oversight to agencies for health oversight activities

We will not sell your PHI without written authorization. We will not use your PHI for marketing purposes without your written authorization. Patients do have a right to 'opt out' of such marketing information. Except where required by law, we will not disclose your psychotherapy notes without your written authorization. Other uses and disclosures, besides those identified in this Notice, will be made only with your written authorization and you may revoke the authorization as stated under "Your Health Information Rights."

NEUROVERSION

Your Health Information Rights

The health and billing records we maintain are the physical property of the clinic. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our clinic – we are not required to grant the request, but we will comply with any request granted.
- Request a restriction on disclosures of medical information to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full? – we must comply with this request.
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our clinic. Access to your health records will not include information to which your access is restricted by law. We may charge a reasonable fee for providing a copy of your health records or a summary of those records at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Electronic copies are also available on CD or through the patient portal.
- Appeal or denial of access to your protected health information, except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our clinic. We may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not a part of the health information kept by or for the clinic;
    - Is not a part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.
- Request the communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our clinic.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our clinic. An accounting will not include uses and disclosures for treatment, payment, or operations; disclosures made to you or made at your request; disclosures made pursuant to an authorization signed by you; to family members to friends relevant to that person's involvement in your care or in payment for such care. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve month period.
- Revoke authorizations that you made previously to use or disclose information by delivering written revocation to our clinic, except to the extent information or action has already been taken.
- You have the right to be notified of any breach of your information that occurs.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our Chief Operating Officer (Kristen Washburn) at 907-290-1683.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our COO. You may also file a complaint with the Department of Health and Human Services (DHHS). We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Updated 1/15/2020

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____/_____/_____

I, _____, acknowledge and agree that I have been offered a copy of Neuroversion's Clinic Privacy Practices.

Signature: _____ Date: _____/_____/_____

Relationship to Patient (if unable to sign): _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained for the following reasons:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please specify):

_____

_____

_____

_____

_____

Employee name (Please print): _____ Initials: _____

NEUROVERSION
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Financial Agreement

Patient Name: _____ DOB: _____/_____/_____

Patients are responsible for any and all charges incurred resulting from treatment provided at Neuroversion. As a service to our patients, Neuroversion will file claims with most insurance carriers directly; however, you are primarily responsible in full for your balance and for all services rendered. Please be aware that the contractual agreement is between yourself and your insurance company, not the physician's office. It is your responsibility to call and verify you coverage, know your benefits and know if authorization is required prior to scheduling your appointment. In cases where we participate with your insurance as a preferred provider; deductibles, co-pays, and co-insurance payments are due in full and expected at the time of service. All quotes given by our billing department for services, co-pays, co-insurance, etc. are estimates only. We accept money orders, personal checks, and cash, Visa, MasterCard, and Discover as payment options.

Collection Procedure

For any surgery center procedures, you will receive two statements; one for the professional physician service, Luke Liu, MD and one for the ambulatory surgery center facility. These separate statements conform to current standards of billing practices within the healthcare industry. For clinic visits, you will receive only one statement from Neuroversion. If you have a urine drug screen, you should expect to see a bill and/or an explanation of benefits from the lab company as well. You will receive monthly statements which will reflect the total amount owing on your account until a payment has been received. If your account does not clear in a timely manner and you have not supplied requested information to our billing department, your account will be turned over to a third party collection agency. To prevent this from happening, we ask that you keep in communication and comply with our billing department in regards to your account.

It is your responsibility to update Neuroversion with any insurance changes prior to a scheduled appointment.

All billing questions are to be directed to our billing department.

We will process patient charges as follows:

Self-Pay/No Insurance

A $250.00 non-refundable deposit is required at the time of scheduling a New Patient Consultation. Future appointments will be given a 20% discount and payment is due in full at the time services are rendered.

Medicare

Neuroversion is a participating provider of Medicare. All Medicare supplemental insurances will be filed. Patients are responsible for their deductibles, co-pays, and co-insurance payments which are due in full at the time services are rendered.

Commercial Insurance

As a courtesy to you, we will file your primary and secondary insurance. It is your responsibility to verify your benefits if authorization is required for our participation with you insurance company prior to your appointment. You must provide correct insurance billing information, along with a copy of your insurance card(s) at your appointment. Patients are responsible for the full balance on their accounts.

Workers Compensation

The injury must have been reported to your employer, reported to the workers compensation carrier, and approved for coverage prior to your appointment. You will need to provide us with the name of the workers compensation carrier, billing address, adjustor's name and phone number, claim number, and date of the injury. Verification must be received prior to you appointment(s). It is your responsibility to verify if authorization has been received.

No Show Policy

Neuroversion requires a 24 hour cancellation notice for all scheduled appointments not kept or the patient may be charged a $25.00 fee for the missed appointment. Insurance does not cover this charge.

Returned Check Policy

You will be charged a $25.00 fee on all returned checks regardless of the reason.

I understand that by signing this Financial Agreement form, I agree to all the above (regardless of insurance status). I am ultimately responsible in full for all charges and balances on my account(s) for all services rendered, to Neuroversion. A copy of this agreement will be provided upon request.

Signature: _____ Date: _____/_____/_____
(Parent or guardian if minor.)

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New Patient Medical Summary
Long Haul Covid-19 (A)

Name: _____ DOB: _____

When were you diagnosed with COVID-19: _____

Have you been vaccinated for COVID-19: □ Yes □ No

If yes, which vaccine did you receive:	□ Pfizer	□ Moderna	□ Johnson & Johnson
Date of 1st injection:			
Date of 2nd injection:			

□ Other vaccine: _____
Date(s): _____

Rate the following symptoms for *when you actively had COVID-19* (circle one): 0 – did not have, 10 – most severe

Fatigue:	0	1	2	3	4	5	6	7	8	9	/10
Difficulty breathing:	0	1	2	3	4	5	6	7	8	9	/10
Shortness of breath:	0	1	2	3	4	5	6	7	8	9	/10
Cough:	0	1	2	3	4	5	6	7	8	9	/10
Chest pain:	0	1	2	3	4	5	6	7	8	9	/10
Memory problems:	0	1	2	3	4	5	6	7	8	9	/10
Problems concentrating:	0	1	2	3	4	5	6	7	8	9	/10
Headache:	0	1	2	3	4	5	6	7	8	9	/10
Muscle pain:	0	1	2	3	4	5	6	7	8	9	/10
Fast heartrate:	0	1	2	3	4	5	6	7	8	9	/10
Pounding heartbeat:	0	1	2	3	4	5	6	7	8	9	/10
Loss/change of smell:	0	1	2	3	4	5	6	7	8	9	/10
Loss/change of taste:	0	1	2	3	4	5	6	7	8	9	/10
Anxiety:	0	1	2	3	4	5	6	7	8	9	/10
Depression:	0	1	2	3	4	5	6	7	8	9	/10
Fever:	0	1	2	3	4	5	6	7	8	9	/10
Dizziness when standing:	0	1	2	3	4	5	6	7	8	9	/10
Sleep problems:	0	1	2	3	4	5	6	7	8	9	/10
Worsened symptoms after physical activities:	0	1	2	3	4	5	6	7	8	9	/10
Worsened symptoms after mental activities:	0	1	2	3	4	5	6	7	8	9	/10
Altered menstrual cycle (leave blank if N/A):	0	1	2	3	4	5	6	7	8	9	/10

Other symptom(s): _____

_____

Were you hospitalized? □ Yes □ No
If yes, where: _____

If yes, what date(s): _____

Were you given any medications: □ Yes □ No

If yes, what medication(s): _____

What other therapies have you tried: _____

_____

_____

Rate the following symptoms prior to *COVID-19* diagnosis (circle one): 0 – did not have, 10 – most severe

Fatigue:	0	1	2	3	4	5	6	7	8	9	/10
Difficulty breathing:	0	1	2	3	4	5	6	7	8	9	/10
Shortness of breath:	0	1	2	3	4	5	6	7	8	9	/10
Cough:	0	1	2	3	4	5	6	7	8	9	/10
Chest pain:	0	1	2	3	4	5	6	7	8	9	/10
Memory problems:	0	1	2	3	4	5	6	7	8	9	/10
Problems concentrating:	0	1	2	3	4	5	6	7	8	9	/10
Headache:	0	1	2	3	4	5	6	7	8	9	/10
Muscle pain:	0	1	2	3	4	5	6	7	8	9	/10
Fast heartrate:	0	1	2	3	4	5	6	7	8	9	/10
Pounding heartbeat:	0	1	2	3	4	5	6	7	8	9	/10
Loss/change of smell:	0	1	2	3	4	5	6	7	8	9	/10
Loss/change of taste:	0	1	2	3	4	5	6	7	8	9	/10
Anxiety:	0	1	2	3	4	5	6	7	8	9	/10
Depression:	0	1	2	3	4	5	6	7	8	9	/10
Fever:	0	1	2	3	4	5	6	7	8	9	/10
Dizziness when standing:	0	1	2	3	4	5	6	7	8	9	/10
Sleep problems:	0	1	2	3	4	5	6	7	8	9	/10
Worsened symptoms after physical activities:	0	1	2	3	4	5	6	7	8	9	/10
Worsened symptoms after mental activities:	0	1	2	3	4	5	6	7	8	9	/10
Altered menstrual cycle (leave blank if N/A):	0	1	2	3	4	5	6	7	8	9	/10

Rate the following symptoms AFTER *COVID-19* (circle one): 0 – did not have, 10 – most severe

Fatigue:	0	1	2	3	4	5	6	7	8	9	/10
Difficulty breathing:	0	1	2	3	4	5	6	7	8	9	/10
Shortness of breath:	0	1	2	3	4	5	6	7	8	9	/10
Cough:	0	1	2	3	4	5	6	7	8	9	/10
Chest pain:	0	1	2	3	4	5	6	7	8	9	/10
Memory problems:	0	1	2	3	4	5	6	7	8	9	/10
Problems concentrating:	0	1	2	3	4	5	6	7	8	9	/10
Headache:	0	1	2	3	4	5	6	7	8	9	/10
Muscle pain:	0	1	2	3	4	5	6	7	8	9	/10
Fast heartrate:	0	1	2	3	4	5	6	7	8	9	/10
Pounding heartbeat:	0	1	2	3	4	5	6	7	8	9	/10
Loss/change of smell:	0	1	2	3	4	5	6	7	8	9	/10
Loss/change of taste:	0	1	2	3	4	5	6	7	8	9	/10
Anxiety:	0	1	2	3	4	5	6	7	8	9	/10
Depression:	0	1	2	3	4	5	6	7	8	9	/10
Fever:	0	1	2	3	4	5	6	7	8	9	/10
Dizziness when standing:	0	1	2	3	4	5	6	7	8	9	/10
Sleep problems:	0	1	2	3	4	5	6	7	8	9	/10
Worsened symptoms after physical activities:	0	1	2	3	4	5	6	7	8	9	/10
Worsened symptoms after mental activities:	0	1	2	3	4	5	6	7	8	9	/10
Altered menstrual cycle (leave blank if N/A):	0	1	2	3	4	5	6	7	8	9	/10

PCFS A.

Can you live alone without any assistance from another person?	□ Yes	□ No
Are there duties/activities at home or at work which you are no longer able to perform yourself?	□ Yes	□ No
Do you suffer from symptoms, pain, depression or anxiety?	□ Yes	□ No
Do you need to avoid or reduce duties/activities or spread these over time?	□ Yes	□ No

PCFS B.

How much are you currently affected in your everyday life by COVID-19?
Please indicate which <u>one</u> of the following statements applies to you.

- □ I have no limitations in my every life and no symptoms, pain, depression or anxiety related to the infection.
- □ I have negligible limitations in my everyday life as I can perform all usual duties/activities, although I still have persistent symptoms, pain, depression or anxiety.
- □ I suffer from limitations in my everyday life as I occasionally need to avoid or reduce usual duties/activities or need to spread these over time due to symptoms, pain, depression or anxiety. I am, however, able to perform all activities without any assistance.
- □ I suffer from limitations in my everyday life as I am not able to perform all usual duties/activities due to symptoms, pain, depressions or anxiety. I am, however able to take care of myself without any assistance.
- □ I suffer from severe limitations in my everyday life: I am not able to take care of myself and therefore I am dependent on nursing care and/or assistance from another person due to symptoms, pain, depression or anxiety.

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	□	□	□	□
Feeling down, depressed, or hopeless	□	□	□	□
Trouble falling or staying asleep, or sleeping too much	□	□	□	□
Feeling tired or having little energy	□	□	□	□
Poor appetite or overeating	□	□	□	□
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	□	□	□	□
Trouble concentrating on things, such as reading the newspaper or watching television	□	□	□	□
Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	□	□	□	□
Thoughts that you would be better off dead or of hurting yourself in some way	□	□	□	□

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem?
□ Yes □ No
If YES, when? _____

Have you ever considered suicide?
□ Yes □ No
If YES, when? _____

GAD-7

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	□	□	□	□
Not being able to stop or control worrying	□	□	□	□
Worrying too much about different things	□	□	□	□
Trouble relaxing	□	□	□	□
Being so restless that it is hard to sit still	□	□	□	□
Becoming easily annoyed or irritable	□	□	□	□
Feeling afraid, as if something awful might happen	□	□	□	□

If you checked off any problems above, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficulty

The following questions are about your sleep:

Do you have trouble falling asleep or staying asleep?

□ Yes, falling asleep □ Yes, staying asleep □ No

When in bed, do you experience uncomfortable sensations in your arms or legs? □ Yes □ No

If yes, do the sensations go away if you move your legs? □ Yes □ No

Do you snore? □ Yes □ No

Have you been evaluated or treated for snoring? □ Yes □ No

If yes, how/when: _____

_____

What time do you generally go to sleep at night? _____

How long does it take you to fall asleep? _____

Do you sleep during the day/take naps? □ Yes □ No

If yes, how often, how long and what time(s): _____

PROMIS

Over the last 7 days…

	Never	Rarely	Sometimes	Often	Always
How often did you feel tired?	□	□	□	□	□
How often did you experience extreme exhaustion?	□	□	□	□	□
How often did you run out of energy?	□	□	□	□	□
How often did your fatigue limit you at work (include work at home)?	□	□	□	□	□
How often were you too tired to think clearly?	□	□	□	□	□
How often were you too tired to take a bath or shower?	□	□	□	□	□
How often did you have enough energy to exercise strenuously?	□	□	□	□	□

Current Medications

List ALL medications that you currently take. Include name, dosage, frequency, and prescriber (if known). Examples include anticoagulants (blood thinners), blood pressure medication, supplements, vitamins, topicals (creams), CBD products, etc.

Name	Dose	Frequency	Prescriber

MEDICAL HISTORY

Please check all current and past medical problems that apply to you:

□ High blood pressure □ Diabetes □ Kidney disease
□ Asthma or wheezing □ Seizure or epilepsy □ Stroke/TIA
□ Heart attack □ Chest pain □ Bleeding problems
□ Chronic cough □ Arthritis □ Peripheral vascular disease
□ Liver disease
□ Cancer, please specify: _____

Status: □ Active □ In remission *Current treatment:* □ Chemotherapy □ Radiation therapy □ N/A

□ Other: _____

SURGICAL HISTORY

Please list past surgeries. If you run out of room, please provide a separate list:

Type/Name of Surgery	Date (approximate)

ALLERGIES

Please list all known drug allergies. If you run out of room, please provide a separate list:

Medication/Drug	Reaction
□ Contrast dye	

Have you *ever* been hospitalized? □ Yes □ No

If YES, please provide brief description of when, where, and what for: _____

_____

_____

FAMILY HISTORY

Please select/list all medical problems that affect family members:

Father:

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

Mother:

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

Brother(s):

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

Sister(s):

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

Other family member(s): _____

□ Heart disease □ Hypertension □ Diabetes mellitus □ Cancer □ Substance abuse □ Mental illness

□ Other _____

□ **Adopted** □ **Family history unknown**

SOCIAL HISTORY

Are you a:

□ Nonsmoker □ Former smoker, date quit: _____ □ Current smoker

Living arrangements:

□ Alone □ Spouse/partner □ Friends □ Children □ Other

Highest education level achieved:

□ Graduate or professional training (degree obtained)
□ College graduate (degree obtained)
□ Partial college training
□ High school diploma
□ GED or trade-technical social graduate
□ Partial high school (10th through 12th grade)
□ Partial junior high school (7th through 9th grade)
□ Elementary school (6th grade or less)

Review of Systems

Over the last 2 weeks, have you had any of the following symptoms:

General/Constitutional:

□ Change in appetite □ Chills □ Fatigue □ Fever □ Headache
□ Lightheadedness □ Night sweats □ Sleep disturbance □ Weight gain □ Weight loss
□ No symptoms

Allergy/Immunology:

□ Cough □ Rash □ Sneezing □ No symptoms

Ophthalmologic:

□ Blurred vision □ Eye problems □ No symptoms

ENT:

□ Dry mouth □ Nosebleed □ Ringing in the ears □ No symptoms

Endocrine:

□ Cold intolerance □ Diabetes □ Difficulty sleeping
□ Excessive sweating □ Heat tolerance □ Hot flashes
□ No symptoms

Respiratory:

□ Asthma □ Breathing problems
□ Shortness of breath at rest □ Shortness of breath with exertion
□ No symptoms

Cardiovascular:

□ Chest pain at rest □ Chest pain with exertion □ High blood pressure
□ Irregular heartbeat □ Swelling in hands/feet □ No symptoms

Gastrointestinal:

□ Abdominal pain □ Blood in stool □ Change in bowel habits □ Constipation
□ Decreased appetite □ Diarrhea □ Difficulty swallowing □ Nausea
□ No symptoms

Hematology:

□ Bleeding problems □ No symptoms

Genitourinary:

□ History of kidney stones □ Difficulty urinating □ Kidney problems
□ No symptoms

Musculoskeletal:

□ Arthritis □ Back problems □ Carpal tunnel □ History of gout □ Joint stiffness
□ Leg cramps □ Muscle aches □ Painful joints □ Swollen joints □ Weakness
□ No symptoms

Peripheral Vascular:

□ Blood clots in legs □ Cold extremities
□ Decreased sensation in extremities □ Pain/cramping in legs after exertion □ No symptoms

Skin:

□ Discoloration □ Hair changes □ Itching □ Nail changes □ No symptoms

Neurologic:

□ Balance difficulty □ Difficulty speaking □ Fainting □ Loss of strength

□ Memory loss □ Pain □ Stroke □ No symptoms

Psychiatric:

□ Auditory hallucinations □ Visual hallucinations □ Depressed mood

□ Loss of appetite □ Psychiatric condition □ Suicidal thoughts

□ No symptoms

To the fullest of my knowledge, I have accurately and truthfully completed my health history.

Signature: _____ Date: _____

Dear COVID Long-hauler,

Congratulations on receiving your first stellate ganglion block injection, and thank you for completing several questionnaires regarding your symptoms before you received treatment.

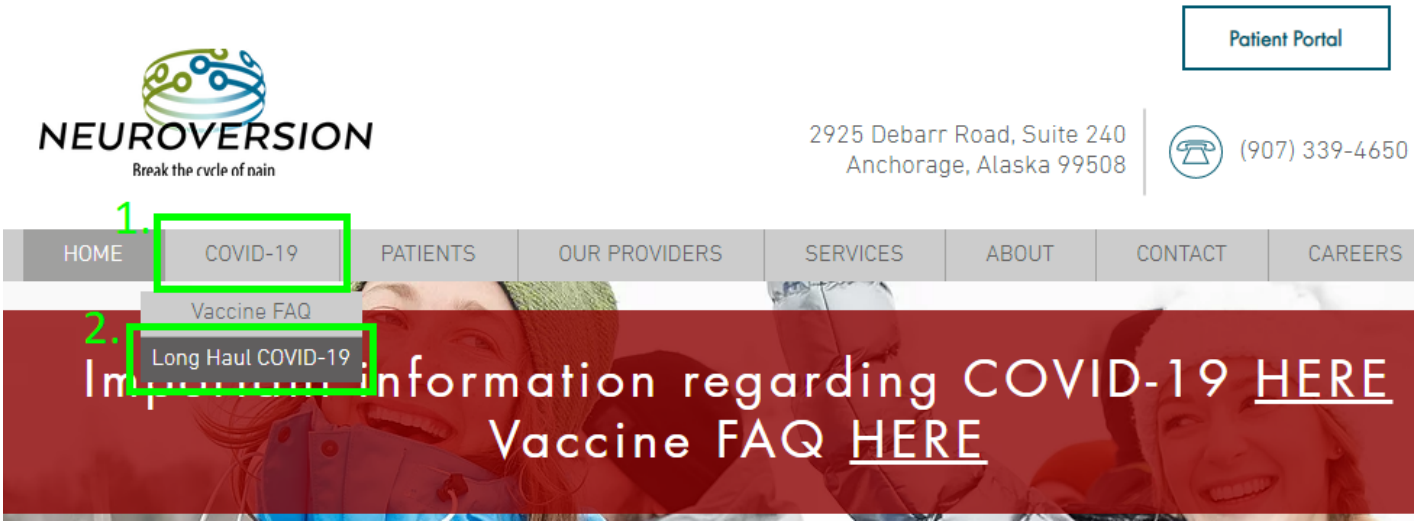
In order to track your progress, we ask that you complete the same questionnaires at our HIPAA-compliant online portal according to the schedule below. If you are unable to complete these forms online, please inform our staff so that we can provide you with paper copies to fill out and return to us.

Please complete the questionnaire tomorrow (1 day after your first injection).

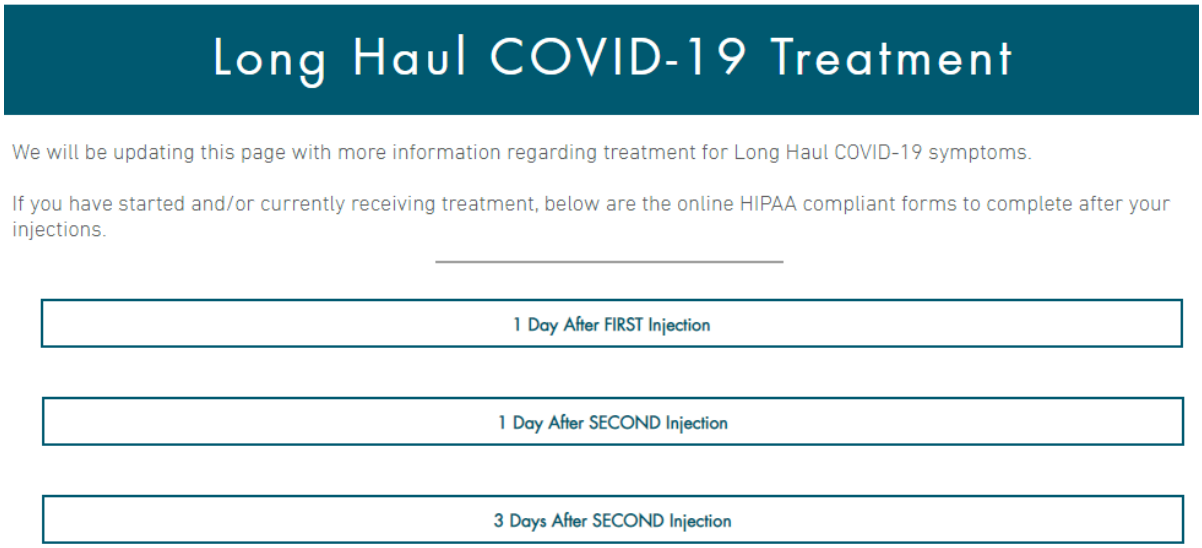
After you receive your 2nd stellate ganglion block injection, please complete the questionnaire on days 1, 3, 5, 7, and 14, then at 1, 2, and 3 months (relative to your 2nd injection date).

To access these forms you can go directly to: www.neuroversion.com/longhaulcovid19

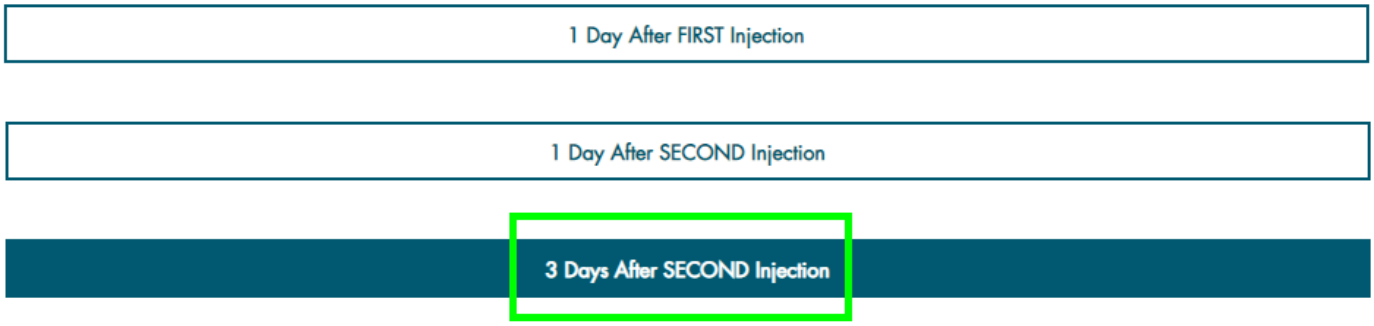
Or, go to our home page, www.neuroversion.com. Then navigate to our Long Haul COVD-19 page:



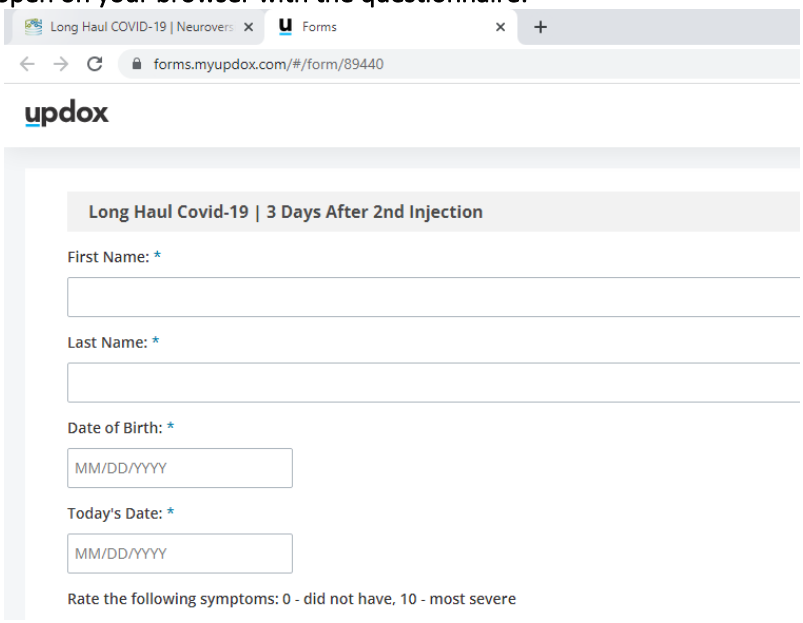
Here you will find online questionnaires:



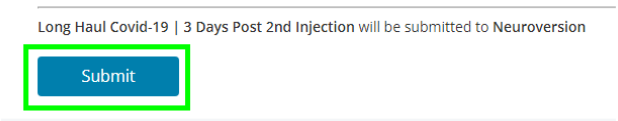
Select the appropriate questionnaire:



A new window or tab will open on your browser with the questionnaire:

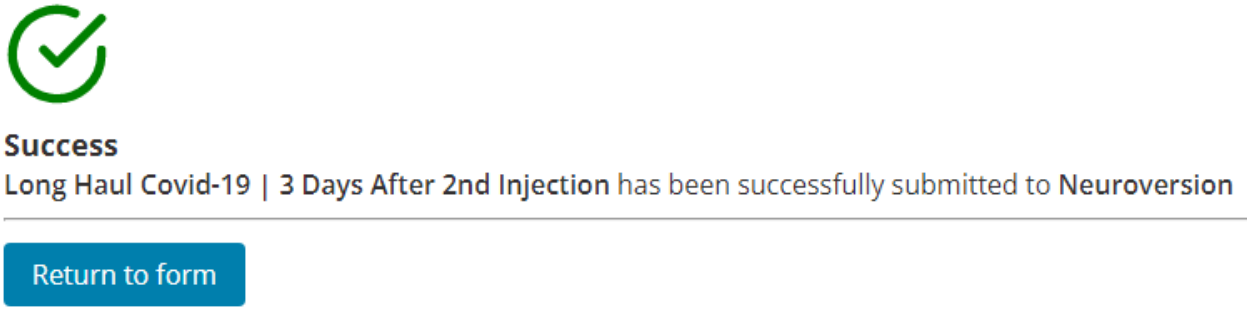


You will be required to complete every field on the form, and provide a signature. Once you have completed the form, click on the submit button:



You will not be able to submit the form if a required field is missing.

Once you click on the submit button, wait until the page refreshes to indicate success:



<u>You have now successfully completed and submitted your questionnaire. Thank you for giving us the opportunity to improve your treatment!</u>