HORIZON
Gastroenterology
& Neurology PC
Sleep & Epilepsy Center

Shameela N. Ahmed, MD
Neurology
Sleep Medicine

WELCOME TO OUR PRACTICE

We appreciate your selection of this practice to provide the gastroenterological services that you desire. Please know that by choosing Horizon Gastroenterology & Neurology, you have chosen quality.

Many insurance companies require a referral from the primary care physician before seeing a specialist. **It is YOUR responsibility to contact your insurance carrier and provide us with a referral if it is required**. If we do not have a referral at the time of service, your visit will be rescheduled. Also, any deductibles or copays not met are the patient's responsibility and will be due at the time of your visit. If you need to know this amount prior to your visit, please do not hesitate to contact our office.

If you are referred by another physician to our practice, please make sure that you have arranged for your medical records to be forwarded to our office. You may also bring them with you to your appointment. This includes any testing or imaging reports that has been done. On the day of your appointment, please bring your referral (if required), your medical records, list of medications with dosages, your insurance card(s), your driver's license and the enclosed forms (completed). Any co-payment that you have is due at the time of service. Please **DO NOT** mail in these forms.

CLINIC POLICIES

- Clinic hours are from 8:00 a.m. to 4:00 p.m. Monday through Thursday and from 8:00 a.m. to 12:30 p.m. on Friday. Please arrive 15 minutes prior to your appointment so your patient information update may be completed.
- Non-emergent telephone calls will be returned as soon as possible
- Prescription refill requests will take 24 to 48 hours to be called in.
- Only persons listed in your chart may be given information regarding your health. This includes test results.
- For all correspondence to include medical records requests and for completions to include but not limited to time off, return to work, and letters of medical necessity will take 48-72 hours to complete.
- For all billing inquiries or account information, please ask to speak with the billing office at 901-821-0338

HORIZON Gastroenterology & Neurology
Our Patients, Our Priority

Name _____ Social Security No. _____
Last First MI

Address _____ Phone No. (_____) _____

City _____ State _____ Zip _____ Secondary No. (_____) _____

Date of Birth _____ Sex (M/F) _____ Race _____ Email _____

County _____ Primary Care _____ Marital Status Single Divorced Married Widowed

Employer _____ **Occupation** _____

Employer Phone No (_____) _____

INSURANCE INFORMATION (Please notify us if your insurance has changed)

Insurance Company _____ I.D No. _____

Group No. _____ Effective Date _____ Specialty Copay Visit: _____

Subscriber _____ Patients Relationship to Subscriber _____
Last First MI

Secondary Insurance_____ I.D. No. _____

Group No. _____ Effective Date _____ Specialty Copay Visit: _____

Subscriber _____ Patients Relationship to Subscriber _____
Last First MI

EMERGENCY INFORMATION

Relative or Friend _____ Relationship _____

Address _____ City _____ State _____ Zip _____ Phone No. (_____) _____

PHARMACY INFORAMTION

Pharmacy _____

Address _____ City _____ State _____ Zip _____

Phone Number (_____) _____ Fax Number (_____) _____

ASSUMPTION OF FINANCIAL RESPONSIBILITY

In order to obtain services from the physicians and staff of Horizon Gastroenterology and Neurology (HGN), the Undersigned agrees as follows:

1. **I consent to treatment by Dr. Muhammad Siddiq or Dr. Shameela Ahmed.**
2. **The undersigned shall be financially responsible for all medical services and supplies provided by any physician, nurse or technician of HGN**
3. **The undersigned hereby assign(s) to HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed all of the undersigned's right, title and interest in and to any insurance proceeds payable for the treatment rendered to the patient and further agree to deliver all checks and drafts received by the undersigned from insurance companies, properly endorsed to HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed.**
4. **HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed is hereby authorized and requested to furnish any insurance company, other third payor, hospital or physician any and all information it may have concerning the patient named above including, but not limited to, medical history, reports, consultations, prescriptions, treatment, including x-rays, and any and all other requested information and/or documentation pertaining to such patient. A photostatic copy of this authorization shall be considered as valid and reflective as the original.**
5. **If more than one person signs below, each is jointly and severally liable with the other. The undersigned executes this agreement for the purpose of inducing HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed to provide medical services and supplies to patient named above.**
6. **This authorization includes the release of information to HGN and/or Dr. Muhammad Siddiq or Dr. Shameela Ahmed.**
7. **Patient is responsible for all fees associated with missed appointments, returned checks, collection fees and/or attorney fees.**

_____ _____ _____ _____
PATIENT'S SIGNATURE **DATE** **RESPONSIBLE PARTY'S SIGNATURE** **DATE**

HORIZON Gastroenterology & Neurology
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PATIENT REPRESENTATIVE IDENTIFICATION FORM

Date: _____

Patient Name: _____ Date of Birth: _____

By law, the HIPAA Privacy Rule prohibits Clinic/Center from disclosing your Protected Health information (PHI) to anyone without your authorization, except for treatment, payment, and health care operations. This rule became effective April 14, 2003.

1. **Please list the names of all persons that you wish to have access to your Protected Health Information (PHI).**

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

2. **Please list the name of the person(s) with whom we can discuss your bill.**

Name: _____ Relationship to Patient: _____

3. **If applicable, please list the name of your Legal Representative.**

Name: _____ Phone Number: (_____) _____

Relationship:

_____ Parent

_____ Guardian

_____ Next of kin

_____ General Power of Attorney

_____ Heath Care Power of Attorney

PLEASE NOTE: In order for us to disclose your PHI, the above representatives must be able to provide two patient identifiers.

_____ _____ _____ _____

Patient's Signature | Date | Patient Representative Signature | Date

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Medical Records Release

_____ _____ _____
Facility Name Phone Number Fax Number

I would like a copy of my medical records released to:

Horizon Gastroenterology & Neurology
FAX TO: 901-840-1085 or 901-837-0183

Patient Name: _____
Date of Birth: _____
S.S. #: _____
Signature _____

Records being requested:

- ER notes
- Clinic notes
- Lab reports
- Referral note
- EEG report
- EMG report
- Imaging (MRI, CT, Ultrasound, etc.)
- Endoscopy report
- Colonoscopy report
- Other: _____

ATOKA
340 Atoka McLaughlin Dr.
Suite C
Atoka TN 38004

MIDTOWN
1325 Eastmoreland
Suite 510
Memphis TN 38104

Phone: (901) 840.1083 ▪ Fax: (901) 840.1085 ▪ horizondoctors.com

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose it.

- We may use and disclose your medical records only for each of the following purposes:
    - Treatment: means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example would be to include a physical examination.
    - Payment: means such activities such as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example would be sending a claim to your insurance company.
    - Healthcare Operations: include business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be internal quality assessment review.

- We may also create and distribute de-identified health information by removing all references to individually identifiable information.

- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.

- Any other uses and disclosures will be made only with your written authorization. You may revoke such an authorization in writing and we are required to honor and abide by that written request except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:
    - The right to request restrictions on certain used and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
    - The right to reasonable requests to receive confidential communications of protected health information form used by alternative means or at alternative locations.
    - The right to inspect and copy your protected health information.
    - The right to amend your health information

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective immediately and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of the notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

By signing here, I acknowledge that I have received a copy of Horizon's Notice of Privacy Practices

Signature: _____ Date: _____

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Gastroenterology

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Name: _____ Date of Birth: _____ Today's Date: _____

Weight gain over the past year? _____ Are you trying to lose weight? ☐ Yes ☐ No

Weight loss over the past year? _____ Meals per day? _____

If you are allergic to any medications, please list what reaction you have. _____

MEDICATION LIST (please list all medications that you are currently taking)

Medication	Dose	Frequency

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Name: _____ Date of Birth: _____ Today's Date: _____

Reason for Visit: _____ Referring MD: _____

ALLERGIES:

☐ None ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Morphine ☐ Latex ☐ Penicillin ☐ Shellfish ☐ Other: _____

MAJOR EVENTS, HOSPITALIZATIONS, SURGERIES:

☐ None
☐ Brain
Reason: _____
☐ Shoulder
☐ Carpal Tunnel
☐ Back
☐ Other:_____
☐ Joint Replacement
☐ Hysterectomy
☐ Stomach
☐ Obesity Surgery
☐ Gallbladder Surgery
☐ Bladder
☐ Cataract Surgery
☐ Colostomy
☐ Appendectomy
☐ Breast
☐ Cardiac Bypass Surgery
☐ Cardiac Valve Surgery
☐ C-Section
☐ Organ Transplant
☐ Splenectomy
☐ Kidney
☐ Adenoidectomy
☐ Ovary
☐ Prostate
☐ Thyroid
☐ Tonsillectomy
☐ Tubal Ligation
☐ Uterus
☐ Problems with Anesthesia
☐ Difficult Intubation of Airway
☐ Sleep Apnea Surgery
☐ Other:_____
☐ Other:_____
☐ Other:_____

MEDICAL PROBLEMS (PAST OR PRESENT)

☐ None
☐ Stroke
☐ Hemiplegia
☐ Parkinson's Disease
☐ Alzheimer's Disease
☐ Migraines
Duration_____
☐ Carpal Tunnel
☐ Epilepsy
☐ Dementia
☐ Lupus
☐ Bell's Palsy
☐ Cerebral Palsy
☐ Multiple Sclerosis
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Cataracts
☐ Chronic Lung Disease
☐ Cirrhosis of Liver
☐ Kidney Failure
☐ Diabetes
☐ Emphysema
☐ Thyroid Problems
☐ Heart Attack
☐ Heart Murmur
☐ High Blood Pressure
☐ Difficulty Making decisions
☐ Memory Problems
☐ Tingling/Numbness
☐ Falling/Poor Balance
☐ Tremors
☐ Seizure
☐ Headaches
☐ Lethargy/Weakness
☐ Dizziness
☐ Fainting
☐ Blurring of Vision
☐ Ringing in Ears
☐ Sinus Problems
☐ Depression
☐ Bipolar Disorder
☐ Schizophrenia
☐ Tension/Stress
☐ Attention Deficit
☐ Anxiety
☐ Loss of Energy
☐ Thoughts of Suicide
☐ Sleep Apnea
☐ Sleep Walking
☐ Sleep Terrors
☐ Fatigue
☐ Snoring
☐ Daytime Drowsiness
☐ Leg Movements
☐ Frequent Naps
☐ Trouble Sleeping
☐ Irregular Heart Beat
☐ High Cholesterol
☐ Polio
☐ HIV/AIDS
☐ Other:_____
☐ Other:_____
☐ Other:_____

SOCIAL HISTORY

MARITAL STATUS:_____ **NUMBER OF CHILDREN:**_____

Who do you live with? _____ What is your highest level of education? _____

ALCOHOL USE:

☐ Never ☐ Less than 2 Days/Week
☐ Daily ☐ Quit Using Alcohol
☐ More than 2 Day/Week How Long? _____

TOBACCO USE:

☐ I use tobacco products Packs per day? _____
☐ I quit using tobacco products Year: _____
☐ I have never used tobacco products

RECREATIONAL DRUG USE:

☐ Never ☐ Quit Date:_____
☐ Yes
Type(s): _____

CAFFEINE:

☐ No ☐ Yes: Cups per day? _____

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Name: _____ Date of Birth: _____ Today's Date: _____

FAMILY HISTORY

	FATHER	MOTHER	CHILD(REN)	BROTHER(S)	SISTER(S)	OTHER (relationship)	
Healthy	☐	☐	☐	☐	☐	☐	
Deceased	☐	☐	☐	☐	☐	☐	
Parkinson's Disease	☐	☐	☐	☐	☐	☐	_____
(age at diagnosis)	_____	_____	_____	_____	_____	_____	
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	_____
(age at diagnosis)	_____	_____	_____	_____	_____	_____	
Dementia	☐	☐	☐	☐	☐	☐	_____
Migraines	☐	☐	☐	☐	☐	☐	_____
Strokes	☐	☐	☐	☐	☐	☐	_____
Epilepsy	☐	☐	☐	☐	☐	☐	_____
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	_____
Arthritis	☐	☐	☐	☐	☐	☐	_____
Ataxia	☐	☐	☐	☐	☐	☐	_____
Cancer	☐	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	☐	_____
Heart Trouble	☐	☐	☐	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	☐	☐	☐	_____
Schizophrenia	☐	☐	☐	☐	☐	☐	_____
ADHD	☐	☐	☐	☐	☐	☐	_____
Mood Disorder	☐	☐	☐	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	☐	☐	☐	_____
Depression	☐	☐	☐	☐	☐	☐	_____
Substance Abuse	☐	☐	☐	☐	☐	☐	_____

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Patient Name: _____ **Date of Birth:** _____

Please check the appropriate blank.

General:
___ Change in Weight
___ Fever
___ Exercise

Neurology:
___ Headaches
___ Head injury
___ Dizzy Spells
___ Falling/Poor balance
___ Fainting Spells
___ Difficulty making decisions
___ Tremors
___ Aching muscles/joints
___Tingling/numbness

Neck:
___ Stiffness/Pain
___ Tenderness
___Lumps

Ophthalmology (Eyes):
___ Wears glasses
___ Worsening eyesight
___ Double vision (diplopia)
___ Eye pain

ENT/Respiratory (Ears/Nose/Mouth):
___ Hearing loss
___ Ringing in ears (tinnitus)
___ Sinus problems
___ Congestion/sneezing (coryza)
___Nose bleeds (epistaxis)
___ Coughing up phlegm or blood (hemoptysis)
___ Dental problems/dentures/TMJ

Cardiology
___ Chest pain (difficult breathing)
___ Wheezing/coughing spells
___ Heart attack/murmur
___ Leg swelling
___ Palpitations

Endocrinology:
___ Excessive Thirst ___ Diabetes

Gastroenterology
___ Change in appetite
___ Difficulty swallowing (dysphagia)
___ Blood in stool
___ Diarrhea
___ Ulcer
___ Vomiting
___ Constipation

Psychology:
___ Depression
___ Tension/Stress
___ Attention deficit
___Loss of energy
___ Thoughts of Suicide

Hematology
___ Bleed/bruise easily
___ Anemia/low blood
___ Blood disease
___ Enlarged glands/nodes

Dermatology (Skin):
___ Rash/Sores/Itching

Genitourinary Female:
___ Difficult urinating
___ Lumps in breast
___ Menstrual irregularity
___ Pelvic Pain

Genitourinary Males:
___ Difficult urinating
___Urinary incontinence

Sleep:
___ Snoring
___ Fatigue
___ Night terrors
___Daytime Drowsiness
___ Leg movements in sleep
___ Frequent Naps
___Trouble Sleeping

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Name: _____ Today's Date: _____

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If your score is 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene, and/or need to see a sleep specialist.

Use the following scale to choose the most appropriate number for each situation:

0 = would ***NEVER*** doze or sleep
1 = ***SLIGHT*** chance of dozing or sleeping
2 = ***MODERATE*** chance of dozing or sleeping
3 = ***HIGH*** chance of dozing or sleeping

Please fill out your answers and see where you stand.

SITUATION	Chance of dozing or sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor vehicle for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped in traffic for a few minutes while driving	
TOTAL SCORE (add the scores up)	

- Do you snore? _____yes _____no
- Do you wake up gasping? _____yes _____no
- Do you wake up several times during the night? _____yes _____no
  Why? (if you answered yes) _____
- Do you move your legs a lot at night? _____yes _____no

ATOKA
340 Atoka McLaughlin Dr.
Suite C
Atoka TN 38004

MIDTOWN
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Suite 510
Memphis TN 38104

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