The Herman & Walter Samuelson Children's HOSPITAL AT SINAI
a LifeBridge Health center

EDWARD S. GRATZ, M.D.
YUVAL SHAFIR, M.D.

Division of Pediatric Neurology
Sinai Hospital of Baltimore
Michel Mirowski
Medical Office Building
5051 Greenspring Avenue Suite 202
Baltimore, MD 21209
Tel 410 601 8300 Fax 410 601 8227

SINAI LOCATION

Date: _____

Dear Parents/ Guardian,

We would like to take a moment to welcome your child as a new patient of Pediatric Neurology at the Herman and Walter Samuelson Children's Hospital at Sinai. Your child is typically treated by the same physician, who knows the medical history and family background information. This continuity of care contributes to more positive health care outcomes. We value the critical role that parents play in keeping their children healthy. As a key member of our health care team, you have access to all members of your child's team and participate in making all decisions about your child's care. Your family will benefit from a very personal approach to care, similar to the experience of visiting a physician in a private practice.

Prior to your child's visit, please fax or mail medical records including: x-rays, lab tests, growth charts, office notes pertaining to the visit, and documentation of any ED visits or hospitalizations in the past 3 months. Our fax number is 410-601-8227. Please ensure our office receives your child's medical records at least 48 hours prior to the scheduled appointment. We ask that you **arrive fifteen minutes prior to or on time for the appointment or the appointment is subject to be rescheduled** to complete the registration process. If you are unable to keep your child's appointment kindly give 24 hours notice. We look forward to meeting you and your child.

_____ has an appointment with _____

on _____ at_____ am/pm at the _____ location.

☐ Sinai Hospital Michel Mirowski Medical Office Building (main office)
5051 Greenspring Avenue, Suite 202 Baltimore, Maryland 21209

What to Bring with You:

The completed registration packet	**Referral from your pediatrician (if applicable)**
Insurance cards	**A list of medications and questions you may have for the physician.**
Photo Identification	If your child is old enough, help him or her to add to the list too
Co-Payment	Books, games, snacks, formula, diapers, change of baby clothes or other necessities.

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Patient Policies

We've found the following policies to be helpful in providing each of our patients with the best possible service. Your cooperation is appreciated.

Primary Care Referrals:
If your insurance carrier requires a referral from your primary care physician, please send your completed referral forms to us prior to your appointment. Patients cannot be seen without the appropriate referral.

Co-Payments:
Co-payments are due at the time of your scheduled appointment.

Methods of Payment:
We accept cash, checks, MasterCard, Visa and Discover. We do not accept American Express.

Delays:
Please call if you are running late. Patients arriving after their scheduled appointment time will be asked to reschedule. If our office is responsible for a delay, your session will be completed in its entirety.

No-Shows
Patients may be charged for missed appointments without a 24 hour cancellation notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees should be paid before scheduling subsequent appointments.

Cancellations:
If you are unable to keep an appointment, please contact the office at least 24 business hours prior to your scheduled appointment time. We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other patients that could benefit from this appointment slot.

Forms Completion:
There is a $25 fee for completing forms for school, disability, camp etc.

If you have any questions regarding this information contact our office at 410-601-8300. We look forward to meeting you and your child.

Directions to Sinai Location

Sinai Pediatric Neurology is now located in the Michel Mirowski Medical Office Building
5051 Greenspring Avenue
Suite 202 Baltimore, MD 21209

From the North
From Pennsylvania and northern Baltimore suburbs, take I-83 South. At junction with I-695 (Baltimore Beltway), enter I-695 heading West (Pikesville direction). Re-enter I-83 South at Exit 23. Proceed for approximately 3 miles and take Exit 10B, Northern Parkway.

From the West
From Howard County and points west, head east on I-70 or on I-795 to I-695 East (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway.

From the East and Northeast
From Towson, Harford County, and points farther north, take I-95 South to Exit 64, I-695
West (Baltimore Beltway, Towson direction). Take Exit 23 onto I-83 South (Jones Falls Expressway). Proceed for approximately 3 miles and take Exit 10B, Northern Parkway. Head west on Northern Parkway.

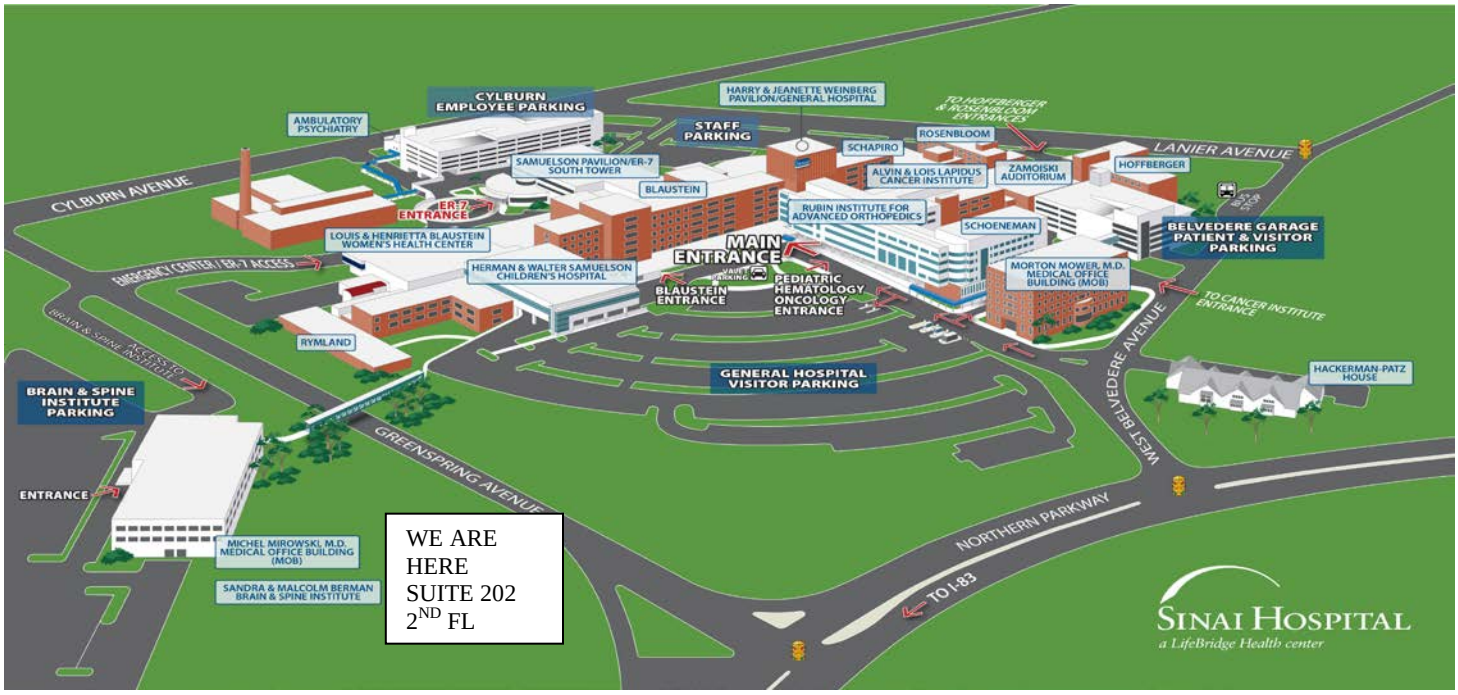
From the South
From the DC, MD, VA area, take I-95 North into downtown Baltimore via the I-395 Exit. Turn RIGHT at W. Pratt Street. Turn LEFT at S. President Street, which becomes I-83N/Jones Falls Expressway. Take I-83 North approximately 6 miles to Exit 10B, Northern Parkway West.

DIRECTIONS FROM NORTHERN PARKWAY TO MIROWSKI BUILDING
Proceed 0.6 miles up Northern Parkway and turn left at the stoplight onto Greenspring Avenue. Shortly after you pass under a footbridge across Greenspring Avenue, make the very first left into the driveway that leads up the hill to the parking lot. The driveway entrance is directly across from the Emergency Room (ER7) entrance and is marked by a blue sign pointing to the Mirowski Office Building and the Brain & Spine Institute.

DIRECTIONS FROM THE HOFFBERGER BUILDING TO THE MIROWSKI BUILDING
From the Belvedere Garage turn right onto West Belvedere Avenue, turn right onto Northern Parkway.

Please note the office is on the 2nd floor suite 202 of 5051 Greenspring Avenue. Please expect to pay for parking. Parking is located in front of the building.

MAP OF BUILDINGS AT SINAI LOCATION



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IMPORTANT REMINDER CHECKLIST

PLEASE **ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT**
TO COMPLETE THE REGISTRATION PROCESS

□ Call the PCP's office to have records sent
(*Last office note, growth chart, labs or related test faxed to (410) 601-8227)*

□ Call us 48 hours prior to confirm records were received or at least 24 hours in advance if you need to cancel or reschedule

□ **B**ring the **COMPLETED** New Patient Packet

□ Bring your state/government issues photo id, patient's insurance card(s), patient's referral and/or co-pay, if required by insurance. It is the parents responsibility to obtain a referral to cover the appointment date.
(We accept Master Card, Visa, Discover, Cash & Checks)

□ Call us if your phone #, address or insurance changes.

Please expect to pay for parking as there is a **fee for parking** on the main parking lot as well as in the garage. *(This applies to the Sinai location only)*

*****If medical records are not received prior to the appointment, the appointment is subject to being canceled or postponed.*****

DIVISION OF PEDIATRIC NEUROLOGY REGISTRATION FORM

Background Information

Welcome to our office. In order to facilitate your child's evaluation, we'd appreciate you providing us with the following information:

Date of appointment: _____ Provider: ☐ Edward Gratz, MD ☐ Yuval Shafrir, MD

Child's full name: _____ Date of Birth: _____

Nickname? _____ Male : ☐ Female: ☐

Name of your child's primary care physician/pediatrician: _____

Physician's Address: _____

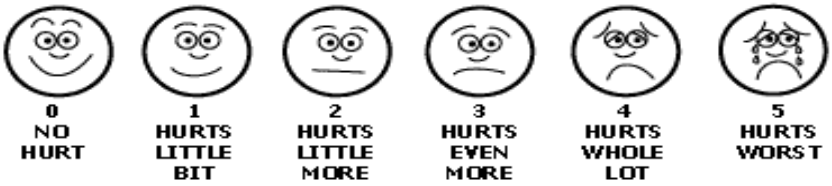
Phone # _____ Fax # _____

Who referred you to our office (if different from physician above)? _____

Name and phone number of your preferred pharmacy: _____

Why are you coming to see us today? _____

PAIN ? ☐ Yes ☐ No



Has your child had any medical tests performed due to this condition (X-rays, blood, urine, EEG tests, etc.)? ☐ Yes ☐ No

If yes, when/where? _____

Medical History

Medical problems or health concerns:

1. _____
2. _____
3. _____
4. _____

Prior hospitalizations (Reason/Date/Location):

1. _____
2. _____

Prior surgeries or outpatient procedures (Surgery name/Date/Location):

1. _____
2. _____

Please list any known medication, food, or other allergies: _____

DIVISION OF PEDIATRIC NEUROLOGY REGISTRATION FORM cont.

Birth History:

Any problems with pregnancy, labor, or delivery? _____

Child's birth weight: _____ Gestational age: _____ weeks

Any medical problems during first month of life?_____

Social History:

Who lives at home with your child?_____

Any pets at home?_____

Has your child traveled outside the U.S. in past 6 months?_____

Home drinking water source: _____

Current grade in school: _____

How many school days were missed due to illness in the past year? _____

For what illness(s)? _____

Any unusual stresses at home or school? _____

Has your child been diagnosed with any of the following? Please check all that apply.

□ Asthma	□ ADHD/ ADD
□ Heart Murmur	□ Anxiety
□ Anemia	□ Depression
□ Diabetes	□ Other: _____

Review of Systems:
Please check the box below if your child has experienced any of the following in the past three months:

General	□Chills	□Fatigue	□Irritability	□ Weight loss or gain	□ Fever
Skin	□ Rashes	□ Jaundice	□ Other:		
Eyes	□ Vision problems:	□ Other:			
Ear, nose, throat	□ Hearing loss	□ Nasal discharge	□ Strep throat	□ Mouth sores	□ Oral thrush
	□ Other				
Chest	□ Wheezing	□ Chest pain	□ Coughing	□ Other	
Hematology	□ Bleeding problems	□ Bruises easily	□ Other		
Genitourinary	□ Bed wetting	□ Painful urination	□ Dark colored urine	□ Other	
Musculoskeletal	□ Joint pain	□ Joint stiffness	□ Joint swelling	□ Fractures	□ Other
Neurological	□ Headache	□ Loss of consciousness	□ Seizures	□ Dizziness	□ Other

Current age of patient's: Mother _____ Father _____ Siblings _____ _____ _____ _____ _____ _____

Current Medications:

Medication name	Dose	Frequency (How often it is given)

DIVISION OF PEDIATRIC NEUROLOGY REGISTRATION FORM cont.

Name of MOTHER or female guardian _____	***Name of FATHER or male guardian*** _____
Date of Birth:	***Date of Birth:***
S.S.No.:	***S.S.No.:***
Home Address:	***Home Address:***
Home Phone:	***Home Phone:***
Cell Phone:	***Cell Phone:***
E-Mail Address:	***E-Mail Address:***
Employer:	***Employer:***
Position Held:	***Position Held:***
□ Full Time □ Part-time	□ Full Time □ Part-time
Business Phone:	***Business Phone:***
BEST NUMBER TO CONTACT BEFORE 5:00PM *HOME* ☐ *CELL* ☐ *BUSINESS* ☐	***BEST NUMBER TO CONTACT BEFORE 5:00PM*** *HOME* ☐ *CELL* ☐ *BUSINESS* ☐
BEST NUMBER TO CONTACT AFTER 5:00PM *HOME*☐ *CELL* ☐ *BUSINESS* ☐	***BEST NUMBER TO CONTACT AFTER 5:00PM*** *HOME*☐ *CELL* ☐ *BUSINESS* ☐

Is your child covered under more than one insurance policy? ☐ Yes ☐ No

Person responsible for bill □ Mother □ Father □ Guardian/Other (Specify):_____

Primary insurance co. name: _____Policy No. _____

Insurance co. address _____

Group Name _____ Group No. _____ Effective date _____

Subscriber name _____ Relationship to patient _____

Secondary insurance co. name: _____Policy No. _____

Insurance co. address _____

Group Name _____ Group No. _____ Effective date _____

Subscriber name _____ Relationship to patient _____

X_____ (Patient or Guardian/Date)

X_____ (Office Official Witness/Date)

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DOCUMENTATION REQUEST

Sinai Hospital of Baltimore Faculty Practice Providers are dedicated to preserving your privacy and personal health information. We are requesting Patient Medical Documentation for the doctor to review prior to their appointment in order to provide the finest medical care possible. Thank you for your assistance.

Date: _____ Appointment Date: _____

To: _____
_____
_____

Patient Name: _____
DOB: _____ Sex: _____
Address: _____
_____
_____

The above named patient is presently being treated by one of our Pediatric Neurology physicians. In order to complete our evaluation of this patient, we need the following…

Information Requested:

_XX_ Discharge Summary, Progress notes
_XX_ Pathology Report, History and Physical , x-rays, EEG test results ect.
_XX_ Consultation/Evaluations, Lab Reports
_XX_ Genetic Testing Information, Psychological Testing
_XX_ Outpatient Clinic Records, Records of any ED visits or hospitalizations in the past 3 months
_XX_ Other *Anything that would assist in understanding why referred to the Pediatric Neurologistt*

Please send the requested information to:

Sinai Pediatric Neurology
Michel Mirowski Medical Office Building
5051 Greenspring Avenue, Suite 202
Baltimore, MD 21209
Phone: 410-601-8300 Fax 410-601-8227

_____ _____
Patient or Legal Guardian *Witness*

_____
Date

If the records are not received prior to the appointment, the appointment is subject to being postponed until records are obtained

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DIVISION OF PEDIATRIC NEUROLOGY PATIENT AUTHORIZATION FORM

Sinai Hospital of Baltimore Faculty Practice Providers are dedicated to preserving your privacy and personal health information. Our employees are trained in the proper handling of your medical and financial records. We are requesting this Patient Authorization in order to continue to provide the finest medical care possible. Thank you for your assistance.

I authorize **Sinai Pediatric Neurology** to:
(Dept/Division)

1. Call my home and/or work to remind me of upcoming appointments; in the event I am not there, leave a message on an answering machine.
2. Send reminder notices for upcoming appointments or when it is time to schedule an appointment.
3. Call my home or work and leave a message to contact the office. Make and/or receive calls from pharmacies on my behalf, including prescriptions. By FAX.
4. Update my personal demographic information either on the phone or in the office at the time of my appointment.
5. At my request, I give permission to discuss my personal health with the designated person(s) below:

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

_____ _____
Name *Relationship*

I have read and agree to the above policies.

_____ _____
Patient Name (print) *Date*

Signature of Patient/Guardian

LIFEBRIDGE HEALTH
NOTICE OF PRIVACY PRACTICES:

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *LifeBridge Health Notice of Privacy Practices*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

I acknowledge receipt of the *LifeBridge Health Notice of Privacy Practices*.

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

PATIENT ACCT #: _____