CHC

Coastal Headache Clinic

Phone (910) 238-2050
Fax (910 238-2310
1715 Country Club Rd, Ste B
Jacksonville NC 28546

REGISTRATION FORM

Date:			Primary Care Provider:	
Last name: First: Middle:			PHARMACY NAME:	
Email address (for patient portal):	Home phone number: Mobile phone number:	Date of birth:	Age:	Sex: M F
Street address:	City:	State / Zip code:		
Social security number:	Occupation / Employer:			

INSURANCE INFORMATION

PRIMARY Insurance (please circle):

BCBS Medicare Medicaid United Healthcare Medcost Cigna Tricare Aetna Self-Pay Other:

Subscriber name:	Subscriber social security number:	Subscriber DOB:

Relationship to subscriber (please circle): Self Spouse Child Other

SECONDARY Insurance (please circle):

BCBS Medicare Medicaid United Healthcare Medcost Cigna Tricare Aetna Self-Pay Other:

IN CASE OF EMERGENCY

Emergency contact person:	Relationship:	Phone number:	Second phone number:

I confirm that the above information is true and accurate to the best of my knowledge. I authorize my insurance benefits to be paid directly to Coastal Headache Clinic and I understand that I am financially responsible for any balance. I authorize Coastal Headache Clinic or my insurance company to release any information required to process my claim.

_____ _____

Patient signature (or guardian signature) *Date*

CHC

Coastal Headache Clinic

Phone (910) 238-2050
Fax (910 238-2310
1715 Country Club Rd, Ste B
Jacksonville NC 28546

2024 Patient Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Full payment is due at the time of service unless your health insurance carrier has made prior arrangements. For your convenience we accept cash, checks or credit cards (i.e.; VISA, Mastercard, Discover and American Express)

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect this copayment when you arrive for your appointment. If your insurance requires a referral, it is your responsibility to provide the referral to our office prior to seeing the physician. If unable to provide the referral prior to the visit payment in full will be required at the time of the visit.
- If you have Medicare, PART B only, you are responsible for your Medicare deductible and your 20% of the charges at the time of service.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of the service.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- COASTAL HEADACHE CLINIC charges a $50.00 fee for failure to cancel your appointment within 24 hours of your scheduled appointment time; payment of this fee will be required prior to scheduling subsequent appointments. Three or more missed appointments may result in discharge from care.

Signature:_____ Date: _____

Witness:_____ Date: _____

CHC

Coastal Headache Clinic

Phone (910) 238-2050
Fax (910 238-2310

1715 Country Club Rd, Ste B
Jacksonville NC 28546

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____



COASTAL HEADACHE CLINIC

Compassionate Headache and Migraine Care

Authorization to Disclose Protected Health Information

The undersigned authorizes

Name / Facility_____

Fax:_____

to release my health information as noted below:

****All sections must be completed in order for request to be processed****

PATIENT INFORMATION			
Patient Full Name:		Date of Birth:	
Patient Address:		Other names:	
City:	State:	Zip Code:	Phone:

RELEASE INFORMATION TO ****this section must be completed****

Coastal Headache Clinic
1715-B Country Club Road
Jacksonville, NC 28546
Phone: (910) 238-2050
Fax: (910) 238-2310

PURPOSE OF REQUEST: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other_____

INFORMATION TO BE RELEASED ****this section must be completed****

☐ Office Notes ☐ Labs ☐ Operative notes ☐ Diagnostic Reports ☐ Treatment Notes

Specify Date(s) of Service: _____

Other (please specify):_____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. *_____ *(Please initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. *If I do not specify, the authorization will expire in 1 year.*
4. If the requester or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can ask for a copy of this form after I sign and date it.



PLEASE CONFIRM THAT YOU HAVE FILLED OUT THIS FORM IN ITS ENTIRETY – IF THIS FORM IS INCOMPLETE, OR IF PROTECTED INFORMATION IS NOT RELEASED, WE MAY BE UNABLE TO FULFILL THIS REQUEST.

Signature*:_____ Date:_____

**For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

CHC

Coastal Headache Clinic

HEADACHE ASSESSMENT FORM

Name:	**Date:**

How old were you when your headaches started?

Was there any specific event that occurred prior to the start? If so, please explain (head injury, illness, etc):

Describe your headache pain: **(Please circle all that apply)**

Throbbing Pulsing Squeezing Sharp Stabbing Dull Pressure Achy

Where does the pain occur during most of your headaches / migraines?

(Please circle all that apply)

Right side of head Left side of head Both sides Entire head Forehead Behind eyes

Temple(s) Top of head Jawline Back of head Neck/shoulders

Please circle any additional symptoms associated with your headaches / migraines:

Nausea Vomiting Dizziness Light sensitivity Sound sensitivity Smell sensitivity

Fatigue Brain Fog Irritability Numbness/tingling Weakness Loss of focus

Loss of appetite Confusion Stiff neck Blurred vision Vision loss

Speech changes Visual aura prior to onset of head pain

How many days per month do you experience headache pain? **(Please circle)**

1-4 days 4-14 days 15-20 days 20 or more days Daily

How many days PER MONTH is the headache / migraine pain severe? **(Please circle)**

1-4 days 4-14 days 15-20 days 20 or more days Daily

How long does each headache / migraine last? **(Please circle)**

8 hours or less 8-24 hours 24-48 hours 3 days or longer

CHC

Coastal Headache Clinic

HEADACHE ASSESSMENT FORM

Name:	Date:

Please circle any of the following that you feel may contribute to or trigger your headaches / migraines:

Stress Caffeine Weather changes Trigger foods Bright lights Loud noises
Sexual activity Undersleeping Oversleeping Hormone changes Exercise Alcohol
Exertion Skipped meals Dehydration Strong odors /perfumes Cigarette smoke
Screens/Reading Driving at night Fatigue

Have you had any imaging of your head or neck done (if so, when)?

MRI head MRI neck CT head CT neck X-ray

What is your current treatment plan / routine for prevention / rescue treatment?

Rx meds Over the counter meds Rx and OTC meds Massage Ice / Heat
Chiropractic Acupuncture Rest in dark, quiet room Sleep

What are your goals for migraine treatment? (Please circle all that apply)

Decreased pain overall Less frequent attacks Decreased severity Less medication use
Decreased missed work Increased time with family and friends Increased exercise tolerance
Less irritability Decreased fatigue Increased focus and productivity

Please feel free to list any additional goals for treatment:

Please list all medications you are currently taking:

MEDICATION ALLERGIES:

PREFERRED PHARMACY:

PHARMACY ADDRESS:

CHC

Coastal Headache Clinic

HEADACHE ASSESSMENT FORM

Name:	Date:

Please circle any of the following medications that you have tried (even if they were not specifically for migraines or headaches):

IBUPROFEN	TYLENOL	EXCEDRIN	ADVIL/ALEVE	GOODY OR BC PWDR
PROPRANOLOL	METOPROLOL	ATENOLOL	LABETALOL	VERAPAMIL
TOPAMAX	GABAPENTIN	DEPAKOTE	ZONEGRAN	LAMICTAL
AMITRIPTYLINE	NORTRIPTYLINE	ZOLOFT	PROZAC	LEXAPRO
EFFEXOR	CYMBALTA	PRISTIQ	CELEXA	WELLBUTRIN
IMITREX	MAXALT	RELPAX	TREXIMET	ZOMIG
NARATRIPTAN	ELETRIPTAN	FROVATRIPTAN	BUTALBITAL	DHE / MIGRANAL
AIMOVIG	AJOVY	EMGALITY	QULIPTA	VYEPTI
BOTOX	XEOMIN	DYSPORT	NERVE BLOCKS	TRIGGER POINT INJ
NURTEC	UBRELVY	ZAVZPRET	REYVOW	CAMBIA
MAGNESIUM	COQ10	RIBOFLAVIN	MULTIVITAMIN	B12
BENADRYL	ZOFRAN	PHENERGAN	REGLAN	TORADOL

HIT-6™
(VERSION 1.1)

HEADACHE IMPACT TEST™

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

To complete, please circle one answer for each question.

1. When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very Often Always

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never Rarely Sometimes Very Often Always

3. When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very Often Always

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never Rarely Sometimes Very Often Always

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very Often Always

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very Often Always

Patient Name:_____ Date of Birth:_____

Date:_____