MEMORY & MOVEMENT
CHARLOTTE

Patient Welcome Packet

Updated May 17, 2023

MEMORY & MOVEMENT
CHARLOTTE

Welcome

Welcome to Memory & Movement Charlotte (MMC). We are an independent, nonprofit medical practice caring for patients with memory and movement disorders. We communicate closely with each patient's primary care physician and other specialists to ensure coordination of care. MMC operates as a membership practice, allowing us to deliver care utilizing our Time and Attention model. This includes longer appointments to meet the needs of the patient and family, prompt access to the medical team between visits, and ongoing patient and caregiver education and support.

This Patient Welcome Packet has been designed to thoughtfully guide you through the new patient experience so that you feel prepared and comfortable with your MMC team every step of the way. For questions, please contact Katie Benton, Patient Experience Coordinator, by emailing kbenton@mmclt.org or calling (704) 577-3186.

OUR PROMISE TO YOU

We promise to provide every patient with personalized, expert care based on our four guiding principles for patient care – calm, clean, safe, and loved.

We promise to treat every patient with dignity and compassion, seeing the whole person beyond the challenges they may be facing.

We promise to treat every family and caregiver with respect and empathy, as they are valued members of the patient's care team.

Before Your New Patient Visit

MEMORY & MOVEMENT CHARLOTTE

SCHEDULING

How to schedule an appointment

Our goal is to provide you with timely access to appointments when you need them.

At the end of appointments, the nurse or patient services specialist will schedule the next appointment.

Appointments can also be scheduled by sending an appointment request through your online Patient Portal account or calling 704-577-3186.

Prior to an appointment, the patient/caregiver will receive an appointment reminder according to the following schedule:

- 4 days prior – email
- 3 days prior – text
- 2 days prior – automated telephone call

How to cancel and/or reschedule an appointment

MMC's goal is to provide every family the time and attention they require. We reserve an extended time slot on our schedule for each patient appointment. We strongly encourage patients to keep every appointment, as provider schedules are typically full and demand for appointments is very high.

In the event you must cancel an appointment, please do so as early as possible. If you miss or reschedule an appointment without contacting our office at least 48 hours in advance of the appointment time, you will be charged a $50 fee. Please keep in mind that a late cancellation does not allow us time to fill the appointment slot with other patients who are on a waiting list.

We understand that emergencies occur, yet we ask that you make every effort to keep your scheduled appointments. Missed appointments are reviewed on an individual basis.

Things You Should Know

MEMORY & MOVEMENT CHARLOTTE

YOUR MMC MEDICAL RECORDS

We will not share your MMC records without permission to do so. Medical information will be released only under at least one of the following conditions:

- a release form signed by the patient or their Health Care Power of Attorney
- the person requesting access is authorized to receive MMC records on the Care Team Contact List form included in this package
- a court order

New Patient Information

MEMORY & MOVEMENT CHARLOTTE

PATIENT INFORMATION

Patient name:_____ **Date of Birth:**___/___/___ **SS#:**_____

Gender: ☐ Male ☐ Female

Race: ☐ Black/African American ☐ White ☐ Asian ☐ American Indian

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Preferred language ☐ English ☐ Other: _____ **Do you need a translator?** ☐ Yes ☐ No

Home phone: _____ **Mobile phone:**_____ **Email:**_____

Address: _____ ☐ House ☐ Assisted Living

_____ ☐ Apartment/Condo ☐ Memory Care

_____ ☐ 55+ community ☐ Other:_____

If living at home, who else lives with the patient?_____ **Relationship:**_____

If receiving personal care in the home, please check:

☐ Housekeeper ☐ Companion

☐ Errands ☐ Home Health company: _____

☐ Personal Care ☐ Other:_____

PHYSICIAN INFORMATION

Which physician are you seeing? ☐ Dr. Charles Edwards ☐ Dr. Aris Chaconas ☐ Dr. Sanjay Iyer

Were you referred by a physician? ☐ Yes ☐ No

Physician name: _____

Practice: _____ Phone: _____

Address: _____

If not, how did you hear about us?

☐ Friend ☐ Internet

☐ Support Group

☐ Other: _____

What is the main reason you are coming for evaluation?_____

PRIMARY CONTACT

Name:_____ **Relationship to Patient:**_____

Address (if different from patient):_____

Home phone: _____ **Mobile phone:**_____ **Email:**_____

☐ **May we leave a message?** ☐ **May we send texts?**

PLEASE CONTINUE TO NEXT PAGE →

FINANCIAL INFORMATION

Complete this insurance information AND bring ALL insurance cards to your first appointment.

Guarantor (person with financial responsibility): _____

Relationship to patient: _____

Address: _____ Phone: _____

Primary insurance: _____

Member ID: _____ Benefits phone number: _____

Secondary insurance: _____

Member ID: _____ Benefits phone number: _____

MEDICAL CARE TEAM

Pharmacy: _____ Phone: _____

Address: _____

Mail-Order Pharmacy: _____ Phone: _____

Address: _____

Primary Care Provider: _____

Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

Would you like us to share office notes with this practitioner? Circle Yes / No

Neurologist: _____ Last seen: _____

Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

Would you like us to share office notes with this practitioner? Circle Yes / No

Other: _____ Last seen: _____

Clinic Name: _____ Phone: _____

Address: _____ Fax: _____

Would you like us to share office notes with this practitioner? Circle Yes / No

PLEASE CONTINUE TO NEXT PAGE →

MEDICAL HISTORY

> Diagnoses:

- ☐ Memory loss
- ☐ Mild cognitive impairment
- ☐ Alzheimer's Disease
- ☐ Vascular Dementia
- ☐ Dementia with Lewy Body
- ☐ Frontotemporal Dementia
- ☐ Other type of dementia: _____

- ☐ Depression
- ☐ Anxiety
- ☐ Other mental/psychiatric illness: _____

- ☐ Head trauma/Concussion/Traumatic brain injury
- ☐ Loss of consciousness
- ☐ Stroke/Aneurysm
- ☐ Seizure

- ☐ Parkinson's Disease
- ☐ Huntington's disease
- ☐ Tremors
- ☐ Tardive dyskinesia (drug- induced movements)
- ☐ Hemi-facial spasm/blepharospasm
- ☐ Dystonia/spasticity
- ☐ Tourette's syndrome
- ☐ Restless leg syndrome
- ☐ Other movement/neurologic disorder:

_____

- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heart rhythm
- ☐ Congestive heart failure
- ☐ Sleep apnea
  - ☐ Use CPAP
- ☐ Heart Disease, explain:

_____

_____

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lyme's disease
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Cancer, type and year of diagnosis:

_____

_____

PLEASE CONTINUE TO NEXT PAGE →

> Check any of the following medications you have taken for a prolonged time:

☐ Reglan/metoclopromide	☐ Abilify	☐ Haldol
☐ Phenergan/promethazine	☐ Geodon	☐ Invegga
☐ Compazine/prochlorperazine	☐ Risperidone	☐ Zyprexa

> Were you in the hospital or ER in the last year?

☐ Yes ☐ No

Hospital: _____ City: _____

Date: __/__/__ Reason: _____

> Have you had any psychiatric hospitalizations?

☐ Yes ☐ No

Hospital: _____ City: _____

Date: __/__/__ Reason: _____

> Have you had the following tests or imaging studies? If so, please indicate most recent date and location.

☐ EKG __/__/__ at _____	☐ Lab work __/__/__ at _____
☐ Carotid u/s __/__/__ at _____	☐ DaT scan __/__/__ at _____
☐ CT head __/__/__ at _____	☐ PET scan of brain __/__/__ at _____
☐ MRI brain __/__/__ at _____	

SURGICAL HISTORY

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

PLEASE CONTINUE TO NEXT PAGE →

CURRENT MEDICATIONS

Name:_____ Strength: _____

#Tabs: _____ Frequency: _____

Name: _____ Strength: _____

#Tabs: _____ Frequency: _____

Name: _____ Strength: _____

#Tabs: _____ Frequency: _____

Name: _____ Strength: _____

#Tabs: sdfg Frequency: _____

Name: _____ Strength: _____

#Tabs: _____ Frequency: _____

Name: _____ Strength: _____

#Tabs: _____ Frequency: _____

Name: _____ Strength: _____

#Tabs: _____ Frequency: _____

ALLERGIES

Name:_____ Reaction:_____

Name:_____ Reaction:_____

Name:_____ Reaction:_____

Name:_____ Reaction:_____

Name:_____ Reaction:_____

☐ Covid first vaccination ___/___/___ second ___/___/___ booster ___/___/___

☐ Phizer ☐ Moderna ☐ J&J ☐ Phizer ☐ Moderna ☐ J&J ☐ Phizer ☐ Moderna ☐ J&J

☐ Flu shot ___/___/___

PLEASE CONTINUE TO NEXT PAGE →

FAMILY MEDICAL HISTORY

> Relatives

	Age (if living)	Age at death	Major illness/cause of death
Mother			
Father			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
Additional immediate relatives:			

> Please check and indicate which family member has been diagnosed with any of the following:

☐ Alzheimer's disease _____

☐ Vascular dementia _____

☐ Memory problems _____

☐ Parkinson's disease _____

☐ Hungtington's disease _____

☐ Tics _____

☐ Tremors _____

☐ Depression _____

☐ Anxiety _____

☐ Other psychiatric illness _____

PLEASE CONTINUE TO NEXT PAGE →

SOCIAL HISTORY

> Smoking status

☐ Never ☐ Former / Date quit:_____ ☐ Currently

How much did you smoke? _____ packs/day

How many years did you smoke? _____

How much do you smoke?

_____ packs/day

> Alcohol consumption

What is your alcohol consumption?

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

How many times per week do you drink alcohol?

☐ never ☐ 1-2 times per week ☐ 3-4 times per week ☐ 5-7 times per week

How many drinks do you typically have each time? _____

Female: How many days in the past year have you consumed 4 or more drinks? _____

Male: How many days in the past year have you consumed 5 or more drinks? _____

Have you ever been counseled for unhealthy alcohol use? ☐ Yes ☐ No

> Illicit Or recreational drug use

☐ None ☐ Occasional ☐ Moderate ☐ Heavy

Illicit or recreational drugs used: _____

> Diet

☐ Regular

☐ Mediterranean

☐ Cardiac

☐ Diabetic

☐ Other: _____

Do you:

Have any dietary restrictions? ☐ Yes ☐ No

_____

Follow a low-salt diet? ☐ Yes ☐ No

Follow a fluid restriction? ☐ Yes ☐ No

> Exercise

☐ None

☐ Occasional

☐ Moderate

☐ Heavy

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days? _____

How many minutes on average did you exercise each day? _____

What types of sporting/exercise activities do you participate in? _____

PLEASE CONTINUE TO NEXT PAGE →

FAMILY

☐ Married Spouse name: _____

☐ Single

☐ Divorced

☐ Widow/Widower

Number of living children:

_____ sons _____ daughters

Names: _____

_____

Number of deceased children:

_____ sons _____ daughters

Names: _____

_____

EDUCATION

> **Highest grade completed:**

☐ High school or GED

☐ College

☐ Master's Degree

☐ Doctoral Degree Professional

☐ Degree (MD, JD)

Occupation: _____ Retired? ☐ Yes ☐ No

Year _____

MILITARY SERVICE

> **Did you serve in the military?** ☐ Yes ☐ No

If yes:

Which branch? _____

Did you serve in active duty? ☐ Yes ☐ No

Did your spouse serve in the military? ☐ Yes ☐ No

ADVANCED DIRECTIVES

> **Check all forms you have completed. Please BRING COPIES of your completed documents:**

☐ Healthcare Power of Attorney Name: _____ Relationship: _____

☐ Financial Power of Attorney Name: _____ Relationship: _____

☐ Living Will

☐ DNR

☐ MOST form

PLEASE CONTINUE TO NEXT PAGE →

SAFETY

> Scams:

Has the patient been the victim of a financial scam? ☐ Yes ☐ No

Does the patient handle money, credit cards, pay bills? ☐ Yes ☐ No

Does the patient answer calls from unknown numbers? ☐ Yes ☐ No

Does the patient open (and respond to) mail? ☐ Yes ☐ No

Are you concerned about the patient's ability to manage this type of correspondence? ☐ Yes ☐ No

> Falls:

Is the patient worried about falling? ☐ Yes ☐ No

Has the patient fallen? ☐ Yes ☐ No

If so, how many times in the past 6 months? _____ **Did any injuries occur?** ☐ Yes ☐ No

Do you have concerns about the patient falling? ☐ Yes ☐ No

> Flight:

Does the patient make statements such as:

"I have to go home" when they are inside their home, or
"I need to go to work" when they are no longer employed? ☐ Yes ☐ No

Has the patient wandered or gotten lost? ☐ Yes ☐ No

Can he/she use a cell phone to contact you? ☐ Yes ☐ No

Does he/she always carry ID or wear an ID bracelet? ☐ Yes ☐ No

Are you concerned about the patient getting lost? ☐ Yes ☐ No

> Fire:

Does the patient use a stove or oven? ☐ Yes ☐ No

Has the patient ever left the stove or oven on unintentionally? ☐ Yes ☐ No

Does the patient smoke? ☐ Yes ☐ No

Is there a working fire extinguisher in the home? ☐ Yes ☐ No

> Medications:

Who manages the patients' medication refills, contacts the pharmacy? _____

Who organizes and dispenses medications daily? _____

How many doses have been missed or errors made within the past 2 weeks? _____

Do you have concerns about the current routine of managing medications? ☐ Yes ☐ No

PLEASE CONTINUE TO NEXT PAGE →

SAFETY (CONTINUED)

> Firearms:

Are there firearms in the home? ☐ Yes ☐ No

If yes, are they stored and locked securely? ☐ Yes ☐ No

> Driving:

Does the patient currently drive? ☐ Yes ☐ No

If yes:

Have there been any close calls, accidents, scrapes, tickets within the past year? ☐ Yes ☐ No

Do you have concerns about their driving? ☐ Yes ☐ No

HEALTH HABITS

> Sleep:

On average, how many hours of sleep does the patient get each night? _____

Does the patient have difficulty falling or staying sleep? ☐ Yes ☐ No

Does the patient snore loudly or stop breathing during sleep? ☐ Yes ☐ No

Does the patient act out dreams or exhibit violent behavior at night? ☐ Yes ☐ No

> Vision:

Do you have concerns about the patient's vision? ☐ Yes ☐ No

Does the patient wear glasses? ☐ Yes ☐ No

When was the patient's last eye exam? _____

> Hearing:

Do you have concerns about the patient's hearing? ☐ Yes ☐ No

When was the patient's last hearing exam? _____

Does the patient wear hearing aids? ☐ Yes ☐ No

Care Team Contact List

MEMORY & MOVEMENT CHARLOTTE

PATIENT NAME

DATE OF BIRTH

PATIENT SIGNATURE

MMC PHYSICIAN

PERSON COMPLETING FORM (print name)

RELATIONSHIP TO PATIENT

SIGNATURE OF PERSON COMPLETING FORM

DATE

PRIMARY CONTACT

Health Care POA ☐
Financial POA ☐

NAME

RELATIONSHIP TO PATIENT / OR "SELF" IF PATIENT

MAILING ADDRESS

EMAIL

PHONE ☐MOBILE ☐HOME

PATIENT ONLINE PORTAL PERMISSIONS:
- ☐ MEDICAL AND BILLING
- ☐ BILLING ONLY
- ☐ NO PORTAL

☐ ALLOW ACCESS TO PATIENT'S MEDICAL RECORDS UPON REQUEST.

STAFF USE ONLY.
☐REVIEWED _____ ☐ATH_____
☐BLO _____

CONTACT 2

Health Care POA ☐
Financial POA ☐

NAME

RELATIONSHIP TO PATIENT

MAILING ADDRESS

EMAIL

PHONE ☐MOBILE ☐HOME

PATIENT ONLINE PORTAL PERMISSIONS:
- ☐ MEDICAL AND BILLING
- ☐ BILLING ONLY
- ☐ NO PORTAL

☐ ALLOW ACCESS TO PATIENT'S MEDICAL RECORDS UPON REQUEST.

STAFF USE ONLY.
☐REVIEWED _____ ☐ATH_____
☐BLO _____

CONTACT 3

Health Care POA ☐
Financial POA ☐

NAME

RELATIONSHIP TO PATIENT

MAILING ADDRESS

EMAIL

PHONE ☐MOBILE ☐HOME

PATIENT ONLINE PORTAL PERMISSIONS:
- ☐ MEDICAL AND BILLING
- ☐ BILLING ONLY
- ☐ NO PORTAL

☐ ALLOW ACCESS TO PATIENT'S MEDICAL RECORDS UPON REQUEST.

STAFF USE ONLY.
☐REVIEWED _____ ☐ATH_____
☐BLO _____

Patient or Responsible person signature

Date

MEMORY & MOVEMENT
CHARLOTTE

RELEASE OF MEDICAL RECORDS AUTHORIZATION

Patient Name _____ Date of Birth _____

Address _____ Telephone Number _____

City, State, Zip Code _____

I may revoke this authorization by notifying Memory & Movement Charlotte in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Signature of Patient or Authorized Individual _____ Date _____ Relationship to Patient _____

for staff use only:

I request the office of Dr._____of

Practice Name _____ Practice Address _____

Phone _____ Fax _____

To release **most recent office visit notes, labs, EKG and head imaging results to**:

Memory & Movement Charlotte
411 Billingsley Road, Suite 103
Charlotte, NC 28211

Phone: 704-577-3186
Fax: 704-626-2701

MEMORY & MOVEMENT
CHARLOTTE

No Show & Cancellation Agreement

Memory & Movement Charlotte's goal is to provide excellent care in a timely manner. Providing the best care requires attending all appointments, but in the event an appointment must be changed, it is important to do so as early as possible so we may schedule other patients in open slots.

- Whenever possible, I shall provide at least 72 hours' notice if I need to change or cancel an appointment. I understand that not doing so may impact patients on the waiting list who are unable to use my time slot.
- I understand that multiple reminders by phone and email serve as opportunities for patients or caregivers to confirm, cancel or reschedule an upcoming appointment.
- I understand that missing or rescheduling an appointment without notifying our office at least 48 hours prior to the appointment time will result in a $50 fee.
- I understand that rescheduling an appointment may result in a delay in scheduling my next appointment.
- I understand that repeated no shows may result in dismissal from the practice.

Emergencies occur, such as hospitalization of patient or caregiver, car accident or other unavoidable situations, yet I will make every effort to keep my appointment slot. Missed appointments are reviewed on an individual basis.

I understand and agree to the above No Show & Cancellation Agreement.

Patient name (printed): _____ Patient DOB: _____

Responsible person name, if not patient (printed): _____

Relationship to patient: _____

_____ _____

Patient or Responsible person signature **Date**

Effective June 2023

MEMORY & MOVEMENT
CHARLOTTE

Financial Agreement

Memory & Movement Charlotte is a nonprofit charitable organization.

We accept Medicare and many private insurance options. It is the responsibility of the patient and family to confirm whether we are in-network or out-of-network with your insurance. If we are out of network, out-of-pocket costs may be higher. Memory & Movement Charlotte will file Medicare and/or other insurance for medically necessary care. The patient is responsible for any insurance deductible amount that has not been met and/or any co-payment or co-insurance that results from the clinical portion of the visit.

An annual membership fee of $750 will be charged for each patient. This fee is not covered by insurance. This fee covers services for the supportive care and education provided to families and caregivers for a one-year period and will be charged annually on the anniversary of the patient's first visit to Memory & Movement Charlotte.

A $250 deposit is due when the initial patient appointment is scheduled. The remaining $500 is due at check-in at the second visit.

If the annual membership fee is a financial burden, please contact Dede Heath at dheath@mmclt.org to discuss payment options and scholarship opportunities.

I understand and agree to the above Financial Agreement.

Patient name (printed): _____ Date of birth: _____

Person responsible for paying annual fee (printed): _____

Relationship to patient (if self, indicate): _____

Responsible person signature: _____ **Date:** _____

CANCELLATION AND REFUND OF ANNUAL FEE POLICY

In order to be eligible for full reimbursement of $250 Annual Fee deposit, cancellation of new patient appointment must occur at least two weeks prior to the appointment date.

Effective Oct 2022

MEMORY & MOVEMENT
CHARLOTTE

ASSIGNMENT OF BENEFITS
and
RELEASE OF INFORMATION FOR INSURANCE BILLING

Patient Name _____ Date of Birth _____

FINANCIAL RESPONSIBILITY

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. The necessary forms will be completed to file for insurance carrier payments.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Memory & Movement Charlotte for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Memory & Movement Charlotte to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Memory & Movement Charlotte on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient's Signature/Signature of Authorized Individual _____ Date _____

Relationship to Patient _____