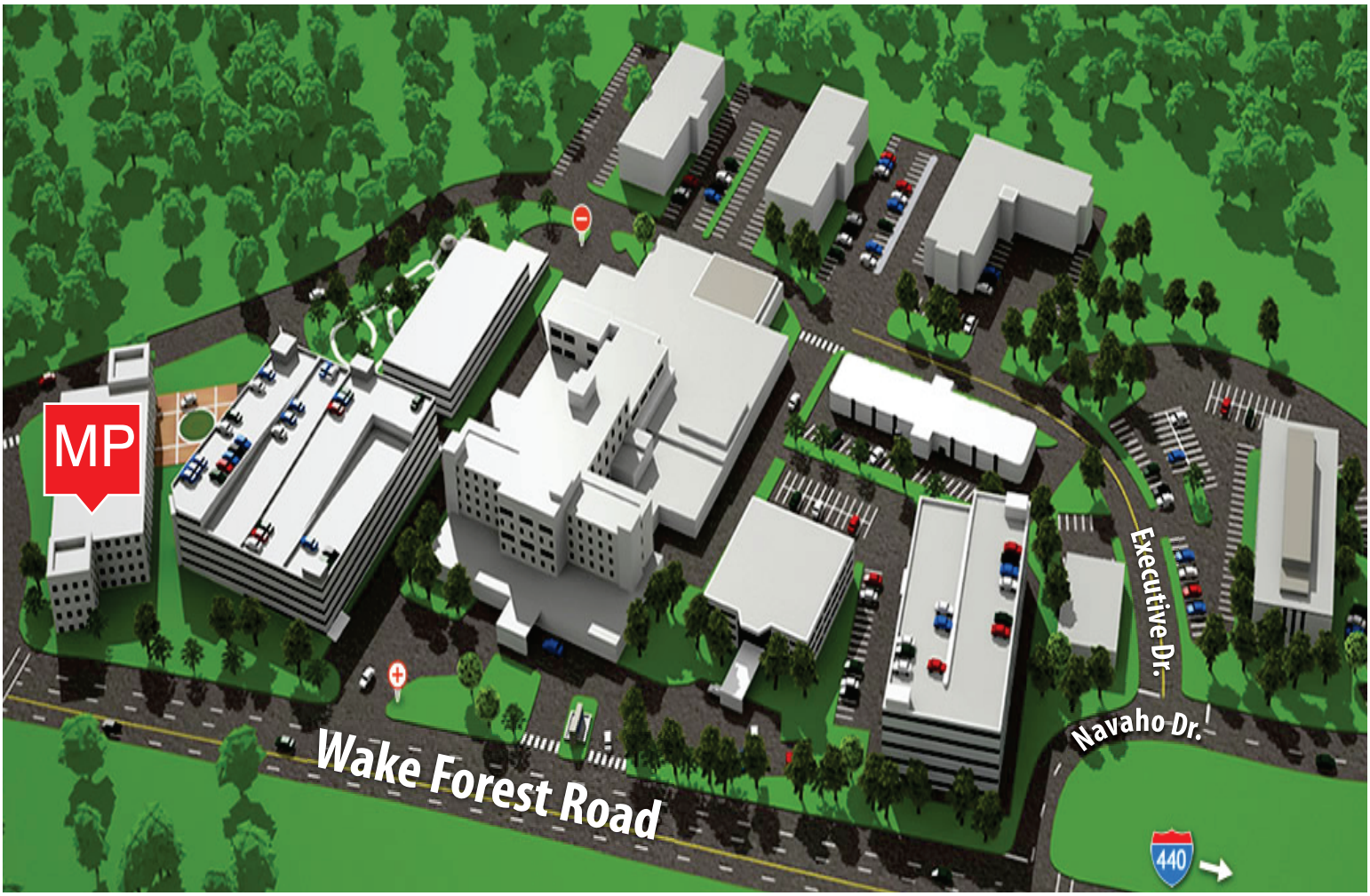
DukeHealth

Duke Neurology of Raleigh
3480 Wake Forest Road, Suite 310
Raleigh, NC 27609

Duke Neurology of Raleigh

Duke Medicine Plaza - 3rd Floor, Suite 310
3480 Wake Forest Road, Raleigh, NC 27609

(919) 862-5620



Your appointment is at Duke Neurology of Raleigh which is in the **Duke Medicine Plaza Building** at 3480 Wake Forest Rd. It is NOT in the Duke Health Raleigh Hospital. Please park in the parking garage and exit on the groundfloor.

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DIRECTIONS:

From 440:

- Take the Wake Forest Road exit (Exit 10)
- The Duke Medical Plaza is located about a ¼ mile north of 440, on the right, just past the Hospital and before the CVS.
- Turn right on St. Albans Street and right again on Executive Street.
- Park in the parking garage on your right.

From 540:

- Take the Falls of Neuse Road exit (Exit 14).
- Go about 5 miles south and the Duke Professional Building will be on your left, just past the CVS.
- Turn left on St. Albans Street and right onto Executive Street.
- Park in the parking garage on your right.

What if I'm late?

- Please arrive up to 30 minutes prior to your appointment time to allow for parking and access to the building.
- If you arrive more than 20 minutes after your scheduled time, you may be asked to reschedule.

What if I need to cancel or reschedule?

- Please call (919) 862-5620 or sign in to Duke My Chart as soon as you realize that you won't be able to make it to your appointment.

Helpful tips for getting the most out of your visit:

- Arrive 30 minutes early to allow for parking and access to the building.
- Please bring your completed medical history paperwork to your appointment.
- Please bring all past imaging records to your appointment.
- Please bring your picture ID, insurance card(s), and your copay to every visit. Failure to provide copay at check-in may result in your appointment being rescheduled.
- In order to have expedient access to test results, please sign up for Duke My Chart.
- All prescription refill issues will be addressed during office visits. No refills will be filled after hours or on weekends. Please fax prescription requests to (919) 862-5622.

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Alternate Communication Form

GUIDE FOR ALTERNATIVE MEANS OF COMMUNICATION

Patient Name:_____

Medical Record Number:_____ Date of Birth: _____

Specific Clinic for Patient:_____

The Health Insurance Portability and Accountability Act (HIPAA) require the Private Diagnostic Clinic (PDC) to have reasonable safeguards to protect our patients' health information. In addition, HIPAA requires the PDC to reasonably limit incidental uses or disclosures of our patients protected health information (medical records) and agree to reasonable requests by our patients to communicate with them by alternative means or at alternative locations.

While we strive to provide out patients directly with prompt results of clinical and lab tests, the PDC's providers are often asked to disclose the results to spouses, children, significant others, and other medical offices. In addition, some of the PDC's patients prefer to receive messages left on home answering machines or work voicemails. Absent an agreement by a specific PDC clinic or clinical site to the contrary (which shall cover only that particular clinic or clinical site), the PDC reserves the right to use its professional judgment to determine what reasonable actions and safeguards it should take when communicating with its patients and individuals involved in our patient's care. However, to help guide the PDC's judgement, please complete the relevant portions below to help your PDC providers understand what alternative means of communication and disclosures to individuals involved in your care you would prefer so that the PDC providers may use this information to determine reasonable ways to inform you of your test results and other pertinent clinical information.

SPOUSE (NAME/NUMBER): _____

SIGNIFICANT (NAME/NUMBER): _____

CHILD(REN) (NAME/NUMBER): _____

_____

WORK VOICEMAIL (NAME/NUMBER): _____

DR. OFFICE (NAME/NUMBER): _____

OTHER (NAME/NUMBER): _____

This form shall be used as a guide by the PDC providers and it is not to be an agreement by the PDC to accept any restrictions or protections of the patient's protected health information requested by the patient of the patient's personal representative. In addition, this form is not a conclusive determination by the PDC that your requests for communications by alternative locations are reasonable. Further, this form shall be used only by the particular clinic or clinical site listed herein.

Signature:_____ Date:_____

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Place Patient Label Here

No-Show and Short Notice Cancellation Policy

No-shows and cancellations within 24 hours of your appointment are major inconveniences for our office and other patients receiving care at Duke Neurology of Raleigh. We would like to be able to see all of our patients in the timely manner that they deserve. As such, Duke Neurology of Raleigh strictly adheres to the following policies:

- The first No-Show or short-notice-cancellation within a 12-month period will result in a friendly reminder of the clinic's policies.
- The second No-Show or short-notice-cancellation within a 12-month period will result in a $25.00 fee and a review of the clinic's policies.
- The third No-Show or short-notice-cancellation within a 12-month period will result in being discharged from our practice.

Late Policy

Our clinic strives to see our patients at their scheduled time for all appointments. We ask that all patients arrive at least 30 minutes prior to their appointment time; this measure is our attempt to ensure that patients receiving care at our clinic will be seen in a timely manner. If you are more than 20 minutes late for your appointment, you may be asked to reschedule your appointment for a later date.

Patient Signature:_____ Date: _____

REVIEW OF SYSTEMS:

(**Check All that Apply** OR **Check All Negative** Under Each Section)

Place Patient Label Here

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Constitutional ☐ All Negative

❑	Weight Gain	❑	Chills
❑	Weight Change	❑	Night Sweats
❑	Fever	❑	Fatigue

HEENT ☐ All Negative

❑	Difficulty Swallowing	❑	Light Sensitivity
❑	Ringing in Ears	❑	Visual Disturbances
❑	Hoarseness	❑	Hearing Loss

Respiratory ☐ All Negative

❑	Shortness of Breath
❑	Cough
❑	Wheezing
❑	Apnea
❑	Choking

Genitourinary ☐ All Negative

❑	Frequency
❑	Urgency
❑	Blood in Urine

Cardiovascular ☐ All Negative

❑	Chest Pain
❑	Feel Heart Beating Hard
❑	Fainting Spells
❑	Leg Swelling
❑	DVT/Phlebitis
❑	Open wounds that don't heal

Gastrointestinal ☐ All Negative

❑	Nausea
❑	Dark Stool or Blood Stool
❑	Heartburn
❑	Diarrhea
❑	Constipation
❑	Vomiting

Musculoskeletal ☐ All Negative

❑	Arthralgias
❑	Gout
❑	Osteoporosis
❑	Back Pain
❑	Muscle Aches
❑	Gait Problem

Skin ☐ All Negative

❑	Rashes
❑	Wound
❑	Color Change

Psychiatric ☐ All Negative

❑	Agitation
❑	Behavior problem
❑	Confusion
❑	Hallucinations
❑	
❑	

Endocrine ☐ All Negative

❑	Cold Intolerance	❑	Increased Thirst
❑	Heat Intolerance	❑	

Hematologic ☐ All Negative

❑	Easy Bruising
❑	Easy Bleeding

Neurological ☐ All Negative

❑	Loss of coordination	❑	Seizure(s)
❑	Tremors	❑	Dizziness
❑	Feeling faint	❑	Weakness
❑	Speech Diffficulty	❑	Numbness
❑	Headaches	❑	

Everything I have answered above is true and correct to the best of my knowledge.

Signature:_____Date:_____/_____/_____

Reviewed by MD:_____Date:_____/_____/_____