DR. ROSARIO TRIFILETTI

PANDAS/PANS INSTITUTE

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ABOUT DR. TRIFILETTI

Having had the privilege of caring for over 5,000 patients with PANDAS/PANS not only from all over the United States, but also across the globe: Canada, England, Ireland, Italy, Austria, Finland, Mexico, Australia & Bangladesh, Dr. Rosario Trifiletti MD PhD, is the world's foremost authority of this condition. For more than two decades, Dr. Trifiletti ("Dr. T") has been deeply involved in PANDAS/PANS. In fact, from 2009-2019 he ran the only practice in the world dedicated exclusively to that condition.

Since he is a sole practitioner, Dr. Trifiletti has personally examined and treated every single patient. Specializing in highly complex cases, he has helped countless children who suffered for years while other professionals could not offer a proper diagnosis and simply gave up. Most importantly, because Dr. T is NOT affiliated with any hospital or hospital system, he is afforded total freedom to"think outside the box", which is critical to analyzing complex cases.

Dr. Trifiletti has superior clinical training, having been the chief of Child Neurology at two major institutions in the NYC metropolitan areas, and has extensive training in Pediatrics, Neurology, Neurogenetics, Metabolic Disease and Mitochondrial Disease, having published in all these areas. In additional to his medical degree from Johns Hopkins University School of Medicine (JHUSM), he has a Ph.D. in Pharmacology and Experimental Therapeutics from JHUSM, having been mentored by the Lasker-award winning (and Nobel-nominated) neuropharmacologist Dr. Solomon H. Snyder, and has published over 80 scientific papers.

WELCOME LETTER

Dear Patient,

Welcome to the PANDAS/PANS Institute family, and thank you for allowing us the opportunity to assist you. Please note, pediatric patients under 18 years of age may be accompanied by parents only - no siblings or caregivers please. *Adult patients 18 and over must be seen alone*.

Attached please find our patient forms which must be received in advance of your appointment, in order to be seen or treated by Dr. Trifiletti. We would appreciate if you would please review all of our practice policies, requested information, and *complete/return each page to our office via PDF file by Email to: info@pandaspansinstitute.com, no later than 72 hours in prior to your appointment*. If you are scheduled for a Monday appointment, all forms must be received by 12:00 PM on the preceding Thursday. Please print or write clearly, be answer every question, and include a copy of the front and back of your health insurance card.

We will be happy to submit a copy of the consultation notes and testing results to your primary care provider, but in order to do so, we will need you to please provide your physician's complete contact information, including a fax number.

If you would like to use an Health Savings card, please complete the credit card forms and note that your preferred method of payment is a HSA. We do however require all patients to please provide a credit card on file as a secondary method of payment.

All labs written by Dr. Trifiletti must be performed only at LabCorp or Quest. We do not accept or track labs from any other facility or physician's office, even if sent to LabCorp or Quest. We conveniently have LabCorp on site, however, please verify if the location participates with your insurance.

WELCOME LETTER CONTINUED

As discussed during consultation:

- New Patient Consultation: The fee for a new patient visit is $1,200, with a non-refundable, requited deposit of $400. The deposit will be applied toward your initial consultation, bringing the balance to $800 on consultation day.
- Initial Consultation: It is important that both parents and your child (minor) must attend the initial consultation. We allow up to 90 minutes for the initial consultation, with a required follow-up visit thereafter.
- Follow Up Consultations: We allow up to 60 minutes for follow up visits, including quarterly appointments. Each visit is $700.
- No Show Visit or Cancellation: We understand appointments sometimes must be rescheduled, but please note, not attending an appointment or cancelling less than 72 hours prior to the appointment, will result in a full visit fee. A Monday appointment must please be confirmed with staff no later than 12:00 PM on Thursday preceding the visit.
- Genetic Review: Please confirm the rate of a genetic review, which is an additional fee, not included in LabCorp charges.

We accept a maximum of 25 pages total:

- Lab testing
- MRI report if applicable
- EEG report if applicable
- Physician consultation notes

CLINICAL HISTORY QUESTIONNAIRE

PLEASE COMPLETE ALL PAGES AND RETURN VIA PDF FILE BY EMAIL TO: MARYZ@PANDASPANSINSTITUTE.COM, ALONG WITH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD. PLEASE NOTE PHOTOS OF DOCUMENTS ARE NOT ACCEPTED. PLEASE FORWARD A SCANNED PDF FILE.

ALL FORMS EXPIRE ON 12/31 OF THE CALENDAR YEAR, AND MUST BE RESUBMITTED THEREAFTER.

Please list ALL current medications, including over-the-counter, supplements and herbs. Please attach an additional page if needed:

_____

_____

_____

Has the patient EVER had or diagnosed with any of the following?

Anemia/Bleeding Tendency .....☐Y ☐N
ADD/ADHD .....☐Y ☐N
Autism.....☐Y ☐N
Behavioral Problems.....☐Y ☐N
Bowel/Stomach Problems.....☐Y ☐N
Cancer/Leukemia.....☐Y ☐N
COVID 19.....☐Y ☐N
Developmental Disorder.....☐Y ☐N
Diabetes.....☐Y ☐N
Eczema/Skin Disorder.....☐Y ☐N
Eye Disorder.....☐Y ☐N
Growth Disorder.....☐Y ☐N
Seizure or Epilepsy .....☐Y ☐N
Thyroid Disorder .....☐Y ☐N

Neurological:

Burning Sensation.....☐Y ☐N
Confusion.....☐Y ☐N
Dizziness.....☐Y ☐N
Disorientation.....☐Y ☐N
Decreased Strength.....☐Y ☐N
Fainting (Syncope).....☐Y ☐N
Headache .....☐Y ☐N
Memory Lapses/Loss.....☐Y ☐N
Numbness.....☐Y ☐N
Poor Coordination.....☐Y ☐N
Memory Lapses/Loss.....☐Y ☐N
Numbness.....☐Y ☐N
Seizures.....☐Y ☐N
Tingling.....☐Y ☐N
Tremor.....☐Y ☐N
Poor Coordination.....☐Y ☐N

Musculoskeletal

Back Pain.....☐Y ☐N
Joint Swelling.....☐Y ☐N
Limb Pain.....☐Y ☐N
Muscle Pain.....☐Y ☐N
Neck Pain.....☐Y ☐N
Muscle Weakness.....☐Y ☐N
Muscle Cramps.....☐Y ☐N
Other.....☐Y ☐N

Psychiatric:

Anxiety.....☐Y ☐N
Depression.....☐Y ☐N
Other .....☐Y ☐N

PANDAS/PANS INSTITUTE PRACTICE POLICY AGREEMENT

PLEASE REVIEW:

New Patient Policy: New Patients must be seen in person, no exceptions. *Both parents* and child must attend the initial consultation. The follow up consult is not included.
Initial Consultation Deposit Policy: A $400 non refundable non transferable deposit is required to secure your initial consultation. This will be applied towards your $800 balance on the day of your consultation
Adult Patients/18 and Over Policy: unless parental guardianship is on file, all care and treatment must be directed by the patient, including appointments, visits and all contact info. We are unable to discuss matters with a parent/guardian.
No show/Cancellation Policy: Full visit fee will be applied. Monday cancellation must be called in and confirmed with staff no later than Thursday the week prior by 12 PM. All cancellations are 72 hours in advance
Initial Patient Consultation: Appointment does not include your follow up testing review.
Follow up Appointment Policy: May be in person or virtually every four months. Yearly in office visit is $700.
Yearly Consultation Policy: Every patient must be seen in person once a year. This appointment is to take place on or before last in office consultation date. No exceptions please. The follow up testing review is not included in prior visit.
Patient Safety: Our staff is not responsible for the safety of your child. Minor children cannot be left unattended in our waiting area.
Lab Testing: We accept labs from Quest or LabCorp only. LabCorp is on site.
Testing Slip Policy: Slips are given at the time of the appointment, not prior, as they are based on the clinical need.
Genetic Testing Review Policy: We allow up to two hours via virtual appointment only, for genetic testing review and analysis for patient and parents only. Please confirm fee with staff. Fee does not include testing and review of extended members of the family. Dr Trifiletti's review fee is not included in the genetic testing fee. A $400 non refundable deposit is required to secure the visit. Due to liability, we are prohibited from releasing raw genetic raw data.
Medication Refill Policy: Please send parental update to rxrefill@pandaspansinstitute.com Please allow one week turnaround time. Dr Trifiletti does not provide automatic refills or 90 day fill of mediations. For refills, all patients must be up-to-date on visits.

PANDAS/PANS INSTITUTE PRACTICE POLICY CONTINUED

Forms and Letter Policy: Please allow one week turnaround time for school forms and letters from staff, and up to six weeks for .a physician letter. In depth letters will be charged a fee, please confirm.
Immunization Policy: Dr. Trifiletti does not write for exemptions for immunization, including COVID 19 or masks. Please follow state and local guidelines.
Diagnosis Policy: All patients being evaluated for PANDAS/PANS have a working diagnosis and will receive a formal diagnosis after completing six consecutive months of treatment with a positive response.
Treatment Policy: Dr. Trifiletti will only discuss and treat the scheduled patient. Dr Trifiletti will not discuss or treat extended members of the family. The appointment time is for one patient only, unless otherwise scheduled accordingly.
General Health Concerns: Please refer to your pediatrician.
Mental Health Medication: Please refer all requests and treatment to your psychiatrist.
Inactive Patients Policy: Patients who have not been seen in the past 16 months, are considered an inactive, requiring a new patient consultation in order to restart testing and treatment.
Credit Card Policy: The credit card on file will be charged prior to business hours on the day of your appointment. If you need to update or change the card, please notify us 72 hours in advance. We cannot reverse credit card charges due to high fees. Credit card/HSA form authorization expire 12/31 of the calendar year.
Refund Policy: All sales are final. No refunds or exceptions.
Physician Bill of Right: Dr. Trifiletti reserves the right to expel patients from the PANDAS/PANS Institute, if the patient or parents are verbally abusive and deemed threatening to the staff or physician, or refuse to abide by the office policy. Dr. Trifiletti can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights.

PANDAS/PANS INSTITUTE PRACTICE POLICY CONTINUED

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NJ License 25MA0S313700

I, _____ have reviewed the attached practice policies.

I agree to follow the practice policies as they are written. I also understand that this policy may be subject to change. I acknowledge that I have been provided with a copy of the practice policies for my personal records. By signing this document, I agree to abide by the policy set in place by Dr. Rosario Trifiletti and I understand that breach of any rule may result immediate discharge from the PANDAS/PANS Institute.

_____ _____

Print Patient's Name (18 and over) Signature of Patient (18 and over)

_____ _____

Print (Minor) Patient's Name Parental/Guardian Signature (Minor Patient)

HIPPA RELEASE FORM

PANDAS/PANS INSTITUTE
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NJ License 25MA0S313700

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

Please sign this form to acknowledge receipt of this office's Notice of Privacy Practice.

_____	_____
Print Patient's Name (18 and over)	Signature of Patient (18 and over)
_____	_____
Print (Minor) Patient's Name	Parental/Guardian Signature (Minor Patient)

PATIENT CONTACT INFORMATION

Date: _____ / _____ /_____

PATIENT INFORMATION

Name

Last: _____ First: _____

Address

Street: _____ City: _____

State: _____ Zip Code: _____

Primary Cell: _____ Other Tel: _____

Patient: M _____ F_____ Gender Identity: _____ Date of Birth: _____ / _____ /_____

MINORS ONLY

Mother's Name: _____ Date of Birth: _____ / _____ /_____

Father's Name: _____ Date of Birth: _____ / _____ /_____

Primary Email: _____ Other Email: _____

***DUE TO HIPPA REGULATIONS, PLEASE PROVIDE PERSONAL EMAIL ADDRESSES ONLY, WORK EMAILS CAN NOT BE UTILIZED**

PATIENT CONTACT INFORMATION

PRIMARY PHYSICIAN CONTACT
A copy of visit notes will be shared if fax is provided

Name: _____

Telephone: _____ Fax: _____

Address

Street: _____ City: _____

State: _____ Zip Code: _____

HEALTH INSURANCE
Please attach a copy of front & back of insurance card

Policy Holder's Name: _____ Policy Number: _____

Date of Birth: _____ / _____ /_____

Patience Preference: *Please check one*

Pills _____ Liquid_____ Lab Corp _____ Quest _____ Medication Allergies _____

Pharmacy Name: _____ Tel: _____

Address: _____ City: _____ State: _____ Zip:_____

HEALTH SAVINGS ACCOUNT AUTHORIZATION AGREEMENT

HEALTH SAVINGS ACCOUNT PREAUTHORIZATION/FINANCIAL AGREEMENT

I authorize Dr. Rosario Trifiletti or representative to keep my signature on file. I hereby provide consent and authorization to charge my HSA card for the following:

- Appointment Fee: In Office, Virtual or via Telephone

I understand that my credit card will be charged for balance due, a no-show fee or visit cancellation less than 72 hours prior to the appointment date, and that a Monday appointment must be cancelled no later than noon on the prior Thursday.

I understand that this authorization is valid for one calendar year, and all charges for medical services are final sales and non-refundable .

Name of Responsible Party/Guarantor: _____ Signature of Guarantor: _____

Patient Name: _____

Payment is due on the day of the appointment. I understand that payments are processed on the appointment date, prior to business hours, 7:00-8:00 AM. If changes need to be made, it is my responsibility to provide an updated credit card form 72 hours in advance. Due to the rising credit card fees, no charges will be reversed once processed.

We no longer accept personal checks.

If you would like to use a Health Savings Account, a credit card is required to be kept on file.

We do not guarantee or warrant that fees you have paid will be covered by your insurance. If you would like a receipt to submit to your carrier, it will be provided upon request. All medical care is fee for service and considered out of network.

HEALTH SAVINGS ACCOUNT AUTHORIZATION AGREEMENT CONTINUED

The amount charged to my account will depend on the service level provided. I understand it is my responsibility to confirm the exact amount being charged for any services.

I agree to all the above, and understand that all services are final and non-refundable. I agree not to dispute any charges with my credit card company. If I have any questions or concerns, I agree to contact Dr. Trifiletti or a representative regarding the matter.

The amount charged to my account will depend on the service level provided. I understand it is my responsibility to confirm the exact amount being charged for any services. I understand that credit card/HSA form authorization expire 12/31 of the calendar year.

I agree to all the above, and understand that all services are final and non-refundable. I agree not to dispute any charges with my credit card company. If I have any questions or concerns, I agree to contact Dr. Trifiletti or a representative regarding the matter.

Name of HSA card as it appears on your credit card . Please type or print clearly.

Name: _____ Card Type: _____

Card Number: _____ Expiration Date: _____ / _____ /_____ CVV:_____

Zip:_____ Signature: _____ Date: _____ / _____ /_____

CREDIT CARD AUTHORIZATION AGREEMENT (CONTINUED ON NEXT PAGE)

CREDIT CARD PREAUTHORIZATION/FINANCIAL AGREEMENT

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I understand that this authorization is valid until 12/31 of the year, and all charges for medical services are final sales and non-refundable .

Name of Responsible Party/Guarantor: _____

Signature of Guarantor: _____

Patient Name: _____

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CREDIT CARD AUTHORIZATION AGREEMENT CONTINUED

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We accept Visa, Master Card or HSA Cards only (American Express and Discover are not accepted).

Please type or print clearly.

Name of Cardholder as Appears on Card: _____

Card Type: _____ Card Number: _____

Expiration Date: _____ / _____ /_____ CVV:_____ Billing Zip Code:_____

Signature: _____ Date: _____ / _____ /_____