Neurology Medical Center

M. Mike Kreidie, M.D.
Fellow of The American Academy of Neurology
Diplomat of the American Board
of Psychiatry and Neurology

26932 Oso Parkway
Suite 240
Mission Viejo, California 92692

(949) 348-8880
FAX (949) 348-8881
www.neuromedcenter.com

PATIENT REGISTRATION FORM

Please print all information

Patient Name ______________________ Date of Birth ______________________

Home Address ____

City ______________________ State ________ Zip ______________

Telephone ( ) ______________________

Cell Phone ( ) ______________________

Social Security # ______________________ Driver's License ______________________

Name of Spouse ______________________

Occupation ____

Employer's Name ____

Work Number ( ) ______________________

Work Address ____

City ______________________ State ________ Zip ______________

Primary Insurance ______________________ Relationship ______________________

Address ____

Policy I.D. # ______________________ Group # ______________________

Secondary Insurance ______________________ Relationship ______________________

Address ____

Policy I.D. # ______________________ Group # ______________________

If the Patient is a minor or student: State of Parents or Legal Guardian ______________________

Relationship ____

Neurology Medical Center

PATIENT REGISTRATION FORM **Please print all information**

If there are any questions regarding the bill, the person who is registering today will be responsible for payment. If the patient is a minor, the person registering the patient will be responsible.

RELEASE STATEMENT

1. I authorize NEUROLOGY MEDICAL CENTER and THEIR STAFF to perform diagnostic tests and provide treatment necessary for medical evaluation and health care to the above registered patient.

2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above registered patient.

3. I understand that ongoing primary medical care is the responsibility of the patient, and it is not the responsibility of NEUROLOGY MEDICAL CENTER.

4. NEUROLOGY MEDICAL CENTER will bill your insurance carrier. However, the balance owed will be the sole responsibility of the above registered patient.

Print Name ____

Signature ______________________________ Date ________________

Neurology Medical Center

MEDICAL HISTORY FORM

Last Name ______________________ First Name ______________________ MI __________

Date of Birth ______________________ Age ________ Male or Female (please circle one)

Height ________ Weight __________

CHIEF COMPLAINT: (What brings you here today?) ______________________________________

____

HISTORY:

Any serious illnesses? ____

Past Hospitalizations: ____

Are you currently under medical care? If so, reason ____________________________________

List all past surgeries ____

FAMILY HISTORY:

Father's Age ________ Health ______________________________ if deceased, age __________
Mother's Age ________ Health ______________________________ if deceased, age __________
Sister's Age ________ Health ______________________________ if deceased, age __________
Brother's Age ________ Health ______________________________ if deceased, age __________
Spouse's Age ________ Health ______________________________ if deceased, age __________

BLOOD RELATIVES:	YES	NO
CANCER	______	______
TUBERCULOSIS	______	______
DIABETES	______	______
HEART PROBLEMS	______	______
HIGH BLOOD PRESSURE	______	______
STROKE	______	______
CONVULSIONS	______	______
GOUT	______	______
ARTHRITIS	______	______

OTHER: ____

SOCIAL HISTORY:
Single __________ Married __________ Divorced __________ Widowed __________
Number of dependents at home __________
Alcoholic Beverages: Daily __________ Moderately __________ Rarely __________ Never __________
Tobacco Use: No __________ Yes __________ PPD __________
Drug or Substance Abuse: No __________ Yes __________ if yes, please list drug ______________
Employed: No __________ Yes __________ Occupation ______________________________

EDUCATION:
Grade School __________ years attended High School __________ years attended
College __________ years attended Post-graduate __________ years attended

SYSTEMIC REVIEW: DO YOU HAVE THE FOLLOWING?	YES	NO
Recent weight change	______	______
Have you been in good health	______	______
SKIN: Skin Disease ____________________	______	______
HEAD, EYES, EARS, NOSE, THROAT		
Eye disease or injury	______	______
Do you wear glasses/contacts?	______	______
Do you have headaches?	______	______
Glaucoma	______	______
Chronic sinus trouble	______	______
Impaired hearing	______	______
Dizziness/transient episodes/unconsciousness	______	______
Neck stiffness	______	______
Thyroid trouble	______	______
RESPIRATORY		
Chronic or frequent cough	______	______
Difficulty breathing	______	______
Asthma	______	______
CARDIOVASCULAR		
Chest pain/Angina pectoris	______	______
Shortness of breath with walking or lying down	______	______
Heart trouble or heart attacks	______	______
Swelling of hands, feet, or ankles	______	______
Heart murmur	______	______
GASTROINTESTINAL/UROLOGICAL		
Diarrhea	______	______
Constipation	______	______
Frequent urination	______	______
MUSCULOSKELETAL		
Weakness of muscles/joints	______	______
Difficulty walking	______	______
Pain in calves/buttocks/joints	______	______
Back pain	______	______
Pain in leg(s)/arm(s)	______	______
NEUROLOGICAL		
Convulsions/seizures	______	______
Difficulty speaking	______	______
Numbness or tingling in arms or legs	______	______
Weakness of arm or leg	______	______
PSYCHOLOGICAL		
Have you ever been under psychiatric care?	______	______
Depression or anxiety	______	______
Suicidal thoughts or attempts	______	______
HEMATOLOGICAL		
Anemia	______	______
Phlebitis (swelling of veins)	______	______
GYNECOLOGICAL		
Date of last PAP smear ________	______	______
Results of last PAP smear ________	______	______
Any pains with menstrual cycle	______	______
Date of last menstrual cycle ________	______	______
Hormone therapy	______	______

ALLERGIES/SENSITIVITIES: List any known allergies to medications ____________________

Food allergies ____

PATIENT PROFILE:

Place of Birth: ______________________________ Where were you raised? ______________________________

If foreign born, when did you move to the United States? ______________________________

Education: Grade Level Reached __________ High School __________ College __________

Certificates or Degrees: ______________________________

Military Service: YES __________ NO __________

Branch: ______________________________

Dates of Service: ______________________________

FOR WOMEN ONLY:

Number of pregnancies: __________ Number of live births: __________

Is there any possibility that you could be pregnant at this time? __________

ARE YOU EXPERIENCING ANY OF THE FOLLOWING COMPLAINTS: If so, please explain:

________ Difficulty in concentrating
________ Fatigue or lack of energy
________ Change in sex life
________ Fear
________ Trouble making decisions
________ Difficulty with work
________ Social withdrawal
________ Improbable beliefs
________ Sleep problems
________ Depression
________ Anger
________ Thoughts of suicide
________ Crying spells
________ Change in appetite
________ Anxiety or nervousness
________ Other ____________

ADDITIONAL COMMENTS:

____

____

______________________________ ______________________________

Patient Signature **Date**

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Dear Patient,

Neurology Medical Center agrees to bill your medical insurance. Therefore, unless other arrangements have been made, the remaining unpaid amount will continue to be your responsibility.

Signature ______________________________ Date ________________

Print Name ______________________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Neurology Medical Center
26932 Oso Parkway, #240
Mission Viejo, CA 92692
(949) 348-8880

I understand that, under the Health Insurance Portability & Accounting Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple heath care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I have received, read and understood the "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that Neurology Medical Center has the right to change its "Notices of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry our treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name: ____

Patient Representative: ______________________________________

Signature: ____

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices", but was unable to do so, as documented below.

Date	Initials	Reason
____________	____________	________________________________

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Our commitment to your privacy

- Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:
1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Neurology Medical Center. If you have questions, please contact the Office Manager at 949-348-8880.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Neurology Medical Center. If you have questions, contact the Office Manager at 949-348-8880. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at 949-348-8880.

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I hereby authorize:

Provider Name: ______________________ **Organization:** ______________________

Address: ______________________

Telephone #: ______________________ **Fax #:** ______________________

To disclose the following information from the health records of:

Patient Name (Last, First, Middle): ______________________

Previous Name (Last, First, Middle): ______________________

Address: ______________________

Telephone #: ______________________ **S.S. #:** ______________________

D.O.B.: ______________________

To be disclosed to:

Provider Name: ______________________ **Organization:** ______________________

Address: ______________________

Telephone #: ______________________ **Fax #:** ______________________

Information to be disclosed:

- o **All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.**
- o **All of my health information described above except for the following:** ______________________

  ____

  Only the following records or types of health information: (Insert dates of treatment, types of treatment and/or other designation): ______________________

For the purpose of: ______________________

I understand that I am entitled to a copy of this authorization upon my request.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization or as specifically required or permitted by law.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.
The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Expiration date or event: ______________________

Patient Signature: ______________________ **Date:** ______________________

(or)

Legal Representative & Relationship: ______________________ **Date:** ______________________

PLEASE
DO NOT
STAPLE
IN THIS
AREA

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ *(Medicare #)* MEDICAID ☐ *(Medicaid #)* CHAMPUS ☐ *(Sponsor's SSN)* CHAMPVA ☐ *(VA File #)* GROUP HEALTH PLAN ☐ *(SSN or ID)* FECA BLK LUNG ☐ *(SSN)* OTHER ☐ *(ID)*

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM | DD | YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM | DD | YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM | DD | YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM | DD | YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ___ . __
2. ___ . __
3. ___ . __
4. ___ . __

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#