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 _____

Referred By _____

Neurology Medical Center

PATIENT REGISTRATION FORM **Please print all information**
Page 2

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.

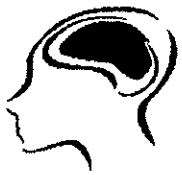
2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above registered patient.

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 _____

_____

_____

_____

_____

WHERE IS YOUR PAIN?

On the next page, please mark on the drawing the areas where you feel pain.

Put an "S" in the afflicted area if the pain is on the skin. Put an "I" in the afflicted area if the pain is inside the body. Put a "B" if both apply to the areas that you mark.

ADDITIONAL COMMENTS:

_____

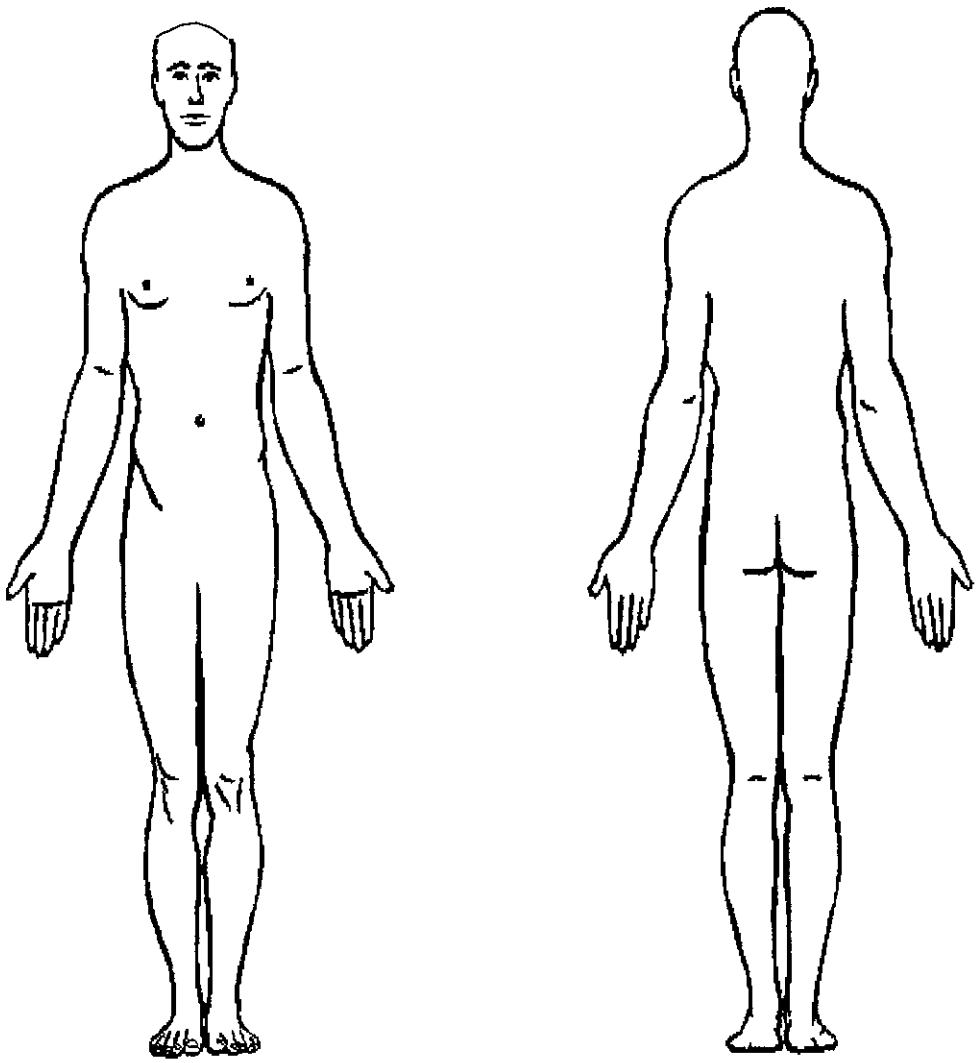
_____

_____ _____
Patient Signature Date

Mark an "S" in the afflicted area if the pain is on the SKIN

Mark an "I" in the afflicted area if the pain is INSIDE the body

Mark a "B" in the afflicted area if both apply in the areas that you mark



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Personal Injury Questionnaire

Name: _____ Phone #:_____
Address: _____
Age: _____ D.O.B.: _____ Sex: _____ S.S. #: _____
Employer's Name: _____
Employer's
Address:_____

Your Insurance Company: _____
Policy #: _____ Agent's Name: _____
Name on Insurance Policy (if other than self): _____
Responsible Party's Name: _____ Phone #: _____
Address: _____
Policy Holder's Name: _____ Policy #: _____

Attorney's Name: _____ Phone #: _____
Address: _____

Date of Injury: _____ Time of Day of Injury: _____
Were there any witnesses: _____ (Y or N)
If so, name them: _____

Description of Vehicular Accident

Were you the: _____:Driver _____:Front Seat Passenger _____:Back Seat Passenger
Number of people in your vehicle: _____ Everyone wearing seat belts?: _____ (Y or N)
What direction were you headed: _____:North _____:South _____:East _____:West
Name of the street: _____
Direction was the other vehicle headed? _____:North _____:South _____:East _____:West
Name of the street: _____
Were you struck from: _____:Front _____:Behind _____:Left Side _____:Right Side
Approximate speed of your car: _____ mph Approximate speed of the other car: _____ mph
Were you rendered unconscious: _____ (Y or N) If yes, for how long: _____
Were the police notified of your accident: _____ (Y or N)

In your own words, please describe the incident: _____
_____
_____
_____

Where were you taken immediately after the incident:

_____

_____

_____

_____

Have you been treated by another doctor since the incident: _____ (Y or N)

If yes, please provide:

Doctor's name(s) and address(es): _____

_____

_____

_____

Type of treatment(s) received: _____

_____

_____

_____

Did you have any physical complaints BEFORE the incident: _____ (Y or N)

If yes, please explain in detail: _____

_____

_____

Please describe how you felt:

DURING the incident: _____

IMMEDIATELY FOLLOWING the incident: _____

LATER THAT DAY: _____

THE NEXT DAY: _____

What are you PRESENT complaints and symptoms: _____

_____

_____

Since the injury, are your symptoms: _____:Improving _____:Getting Worse _____:Same

PLEASE CHECK ALL THE SYMPTOMS YOU HAVE NOTICED SINCE THE INJURY:

_____: Headache	_____: Irritability	_____: Numbness in Toes	_____: Face Flushed
_____: Neck Pain	_____: Chest Pain	_____: Shortness of Breath	_____: Buzzing in Ears
_____: Cold Hands	_____: Dizziness	_____: Neck Stiffness	_____: Loss of Balance
_____: Fatigue	_____: Back Pain	_____: Sleeping Problems	_____: Head Seems Heavy
_____: Depression	_____: Fainting	_____: Constipation	_____: Loss of Memory
_____: Pins & Needles in Arms		_____: Lights Bother Eyes	_____: Loss of Smell
_____: Cold Sweats	_____: Nervousness	_____: Upset Stomach	_____: Pins/Needles Legs
_____: Loss of Taste	_____: Fever	_____: Tension	_____: Numbness in Fingers
_____: Ears Ringing	_____: Diarrhea	_____: Cold Feet	

_____: Other, please explain: _____

Have you lost time from work as a result of this injury: _____ (Y or N)

If yes, please provide:

Last day worked: _____

Type of employment: _____

Present Salary: _____

Are you receiving compensation for time lost from work: _____ (Y or N)

If yes, please state type of compensation you are receiving: _____

_____

Did you notice any activity restrictions as a result of this injury: _____ (Y or N)

If yes please describe in detail: _____

_____

_____

Do you have any congenital (from birth) factors which relate to this problem: _____ (Y or N)

If yes, please describe: _____

_____

_____

_____

Do you have any previous illnesses which relate to this case: _____ (Y or N)

If yes, please describe: _____

_____

_____

_____

Have you ever been involved in an accident before: _____ (Y or N)

If yes, please describe (include date, type of accident, and injury sustained for each incident): _____

_____

_____

_____

_____

_____

_____

Please list any other pertinent information for review: _____

_____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

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ASSESSMENT OF ACTIVITIES OF DAILY LIVING (ADL)

Patient's Name: _____ Date: _____

Please CIRCLE the activity(ies) of daily living that is(are) affected by your medical condition(s).

1. Self-Care, Personal Hygiene:
   - Urinating
   - Defecating
   - Brushing teeth
   - Combing hair
   - Bathing
   - Dressing oneself
   - Eating

2. Communication:
   - Writing
   - Typing
   - Seeing
   - Hearing
   - Speaking

3. Physical activities:
   - Standing
   - Sitting
   - Reclining
   - Walking
   - Climbing stairs

4. Sensory function:
   - Hearing
   - Seeing
   - Tactile feeling
   - Tasting
   - Smelling

5. Non-specified hand activities:
   - Lifting
   - Grasping
   - Tactile discrimination

6. Travel:
   - Riding
   - Driving
   - Flying

7. Sexual function:
   - Orgasm
   - Ejaculation
   - Lubrication
   - Erection

8. Sleep:
   - Restful
   - Nocturnal sleep patterns

Notes:

_____

_____

_____

_____

RATINGS DETERMINING IMPAIRMENT ASSOCIATED WITH PAIN

Patient's Name: _____

Date of Birth: _____

Today's Date: _____

I. Pain (Self-Report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
No pain — Most severe pain imaginable

B. Rate how severe your pain is **at its worst** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
No pain — Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
No pain — Excruciating

D. Rate how severe your pain is **aggravated by activity** (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Activities does not aggravate pain — Excruciating following any activity

Sum score of Section I: **Add A through D = Total Pain Severity/4 =** _____

E. Rate how **frequently** you experience pain (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Rarely — All of the time

Add total pain severity score (items A through D/4) to score for item E = _____

TOTAL PAIN SEVERITY SCORE (RANGE FROM 0 TO 20) =

II. Activity Limitation or Interference:

A. How much does your pain interfere with your ability to **walk one block**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
No restrictions walking — Impossible to walk

B. How much does your pain prevent you from **lifting 10 lbs**? (a bag of groceries) (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not prevent from lifting 10 lbs — Impossible to lift 10 lbs

C. How much does your pain interfere with your ability to **sit for ½ hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not restrict ability To sit for ½ hour — Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to **stand for ½ hour**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Pain does not interfere with ability to stand — Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not prevent me from sleeping — Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**? (circle #):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere with social activities — Completely interferes with social activities

G. How much does your pain interfere with your ability to **travel 1 hour by car**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere with ability to travel 1 hour by car — Completely unable to travel 1 hour by car

H. In general, how much does your pain interfere with you **daily activities**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere with my daily activities — Completely interferes with my daily activities

I. How much do you limit your activities to prevent your pain from getting worse? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Do not limit activities — Completely limit activities

J. How much does your pain interfere with your **relationship with family/partner/spouse** (circle #):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely
interferes
With relationships with relationships

K. How much does your pain interfere with your ability to **do jobs at your home**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely unable
to
do jobs around
home

L. How much does your pain interfere with your ability to **shower/bathe without help**? (circle #):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Unable to shower/bathe
at all without help of others

M. How much does your pain interfere with your ability to **write or type**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Impossible to write
at all or type

N. How much does your pain interfere with your ability to **dress yourself**? (circle):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely impossible
at all to dress myself

O. How much does your pain interfere with your ability to **engage in sexual activities**? (circle #):

0 1 2 3 4 5 6 7 8 9 10
Does not interfere Impossible to engage
at all in sexual activities

P. How much does your pain interfere with your ability to **concentrate**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Never All the time

Sum Score of Section II:

Add A through P = Total score for activity limitation/16 = _____

Mean Activity limitation Score =

III. Individual's Report of Effect of Pain on Mood

A. Rate your overall mood over the last week (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Extremely high/good — Extremely low/bad

B. During the past week, how **anxious or worried** have you been because of your pain? (circle #):

0 1 2 3 4 5 6 7 8 9 10
Not anxious at all — Extremely anxious and worried

C. During the past week, how **depressed** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Not at all depressed — Extremely depressed

D. During the past week, how **irritable** have you been because of your pain? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Not at all irritable — Extremely irritable

E. In general, how anxious/worried are you about performing activities because they **might make your pain/symptoms worse**? (circle a number):

0 1 2 3 4 5 6 7 8 9 10
Not at all anxious/worried — Extremely anxious/worried

Sum Score of Section III:

Add A through E = Total pain impairment attributed to mood state/5 = _____

Mean Score =

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1. Total Pain Severity Score (range from 0 to 20) =
2. Mean Activity Limitation Score x 3 =
3. Mean Score Impairment Attributed to Mood =
4. Global Pain Behavior (0 +/- 10) =
5. Credibility (0 to 10) =

TOTAL =

0-6 = No significant Impairment
7-24 = Mild Impairment
25-42 = Moderate Impairment
43-60 = Moderately Severe Impairment
61-80 = Severe Impairment

Neurology Medical Center

OPPORTUNITES FOR ENJOYMENT SUMMARY

Patient's Name: _____ Date: _____

Complete the following questionnaire as it relates to the activities (work related or otherwise) you normally would be enjoying, but are currently not enjoying as a result of your injury(s). Include all activities which you:

- Can no longer do or perform, and/or
- Cannot do or perform as often as you did before your injury

Job Description: _____

Work	**Reason for the limitation**		
_____ Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
_____ Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
_____ Walking	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
_____ Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
Other: _____	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue

Studies/School	**Reason for the limitation**		
_____ Lifting	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
_____ Bending	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
_____ Sitting	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
_____ Walking	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
_____ Computer Duties	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
_____ Studying	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue

Domestic Duties	**Reason for the limitation**		
_____ Vacuuming	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
_____ Caring for kids	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue
_____ Cleaning	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
_____ Preparing Meals	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue

Household Duties	**Reason for the limitation**		
_____ Yard work	☐ Increased Pain	☐ Restricted Movement	☐ Fatigue
_____ Transportation	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue
_____ Shopping	☐ Increased Pain/Anxiety	☐ Restricted Movement	☐ Fatigue
_____ Taking out trash	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
Other: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness

Sports	**Reason for the limitation**		
Name Sport: _____	☐ Increased Pain	☐ Restricted Movement	☐ Weakness
Pre-accident level of participation:	☐ Socially	☐ Competitively	☐ Professionally

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MEDICAL LIEN

ATTORNEY Name: _____
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone:** _____ **Fax:** _____
PATIENT Last Name_____ **First Name:** _____
Date(s) of Accident(s): _____ _____ _____

PLEASE SIGN, DATE, AND IMMEDIATELY RETURN ONE COPY TO NEUROLOGY MEDICAL CENTER

RE: MEDICAL REPORTS, ITEMIZED BILLING AND MEDICAL LIEN

I hereby authorize the above named health care provider (here after referred to as the "N.M.C.") to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident and/or incident in which I was involved and have sought medical attention for.

I further authorize and direct you, my attorney, and/or and subsequent attorney, to pay directly to the N.M.C. such sums as may be due and owing him for medical services rendered to me by reason of the accident and/or incident and to withhold such sums from any settlement, judgments or verdict as may be necessary to adequately protect the N.M.C., and I hereby irrevocably give a lien and assignment on my case to the N.M.C. against any and all proceeds of any settlement, judgments or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the N.M.C. for all medical bills submitted by N.M.C. for service rendered to me and that this agreement is made solely for the N.M.C. additional protection and in consideration of N.M.C. awaiting payment. I further understand that such payment is not contingent on any settlement, judgments or verdict by which I may eventually recover. Facility may revoke this lien in the event attorney and/patient fails to provide facility with reasonable periodic status reports or patient's claim as requested by facility. In the event said lien is revoked, payment will be due for services rendered by facility immediately.

I agree that this lien is enforceable against any and all subsequent attorney representing me in regard to the accident and/or incident. I further agree that if I change my residence or my attorney that I will notify the N.M.C. within thirty (30) days of such changes including the new attorney's name, address and telephone number. If I do not notify the N.M.C. within the time prescribed, then all monies will be due and payable immediately. The prevailing party in any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney's fees and costs incurred in that action or proceeding or in efforts to negotiate the matter.

Dated: _____ **Patient's Signature:**_____

The undersigned being the attorney of record for the above patient hereby agrees to observe all terms of this lien and agrees to withhold such sums for any settlement, judgments or verdict as may be necessary to adequately protect the N.M.C. I agree that a finance charge at an interest rate of 5% per month will be imposed by the N.M.C. for every month that the above name client/patient's claim has been resolved and the N.M.C. remains unpaid.

Dated: _____ **Attorney's Signature:** _____

Attorney: Please sign and fax back to Neurology Medical Center at (949) 348-8881
Note: Narrative report and itemized billing will not be forwarded until properly signed lien has been returned to this office.

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MEDICAL LIEN

ATTORNEY Name: _____
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone:** _____ **Fax:** _____
PATIENT Last Name_____ **First Name:** _____
Date(s) of Accident(s): _____ _____ _____

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MEDICAL LIEN

ATTORNEY Name: _____
Address: _____ **City:** _____
State: _____ **Zip:** _____ **Phone:** _____ **Fax:** _____
PATIENT Last Name_____ **First Name:** _____
Date(s) of Accident(s): _____ _____ _____

PLEASE SIGN, DATE, AND IMMEDIATELY RETURN ONE COPY TO NEUROLOGY MEDICAL CENTER

RE: MEDICAL REPORTS, ITEMIZED BILLING AND MEDICAL LIEN

I hereby authorize the above named health care provider (here after referred to as the "N.M.C.") to furnish you, my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident and/or incident in which I was involved and have sought medical attention for.

I further authorize and direct you, my attorney, and/or and subsequent attorney, to pay directly to the N.M.C. such sums as may be due and owing him for medical services rendered to me by reason of the accident and/or incident and to withhold such sums from any settlement, judgments or verdict as may be necessary to adequately protect the N.M.C., and I hereby irrevocably give a lien and assignment on my case to the N.M.C. against any and all proceeds of any settlement, judgments or verdict which may be paid to you, my attorney, or myself as a result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to the N.M.C. for all medical bills submitted by N.M.C. for service rendered to me and that this agreement is made solely for the N.M.C. additional protection and in consideration of N.M.C. awaiting payment. I further understand that such payment is not contingent on any settlement, judgments or verdict by which I may eventually recover. Facility may revoke this lien in the event attorney and/patient fails to provide facility with reasonable periodic status reports or patient's claim as requested by facility. In the event said lien is revoked, payment will be due for services rendered by facility immediately.

I agree that this lien is enforceable against any and all subsequent attorney representing me in regard to the accident and/or incident. I further agree that if I change my residence or my attorney that I will notify the N.M.C. within thirty (30) days of such changes including the new attorney's name, address and telephone number. If I do not notify the N.M.C. within the time prescribed, then all monies will be due and payable immediately. The prevailing party in any action or proceeding to enforce any provision of this agreement will be awarded reasonable attorney's fees and costs incurred in that action or proceeding or in efforts to negotiate the matter.

Dated: _____ **Patient's Signature:**_____

The undersigned being the attorney of record for the above patient hereby agrees to observe all terms of this lien and agrees to withhold such sums for any settlement, judgments or verdict as may be necessary to adequately protect the N.M.C. I agree that a finance charge at an interest rate of 5% per month will be imposed by the N.M.C. for every month that the above name client/patient's claim has been resolved and the N.M.C. remains unpaid.

Dated: _____ **Attorney's Signature:** _____

Attorney: Please sign and fax back to Neurology Medical Center at (949) 348-8881
Note: Narrative report and itemized billing will not be forwarded until properly signed lien has been returned to this office.

Neurology Medical Center

26932 Oso Parkway, Suite #240; Mission Viejo, CA 92692
(949) 348-8880; Fax # (949) 348-8881

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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

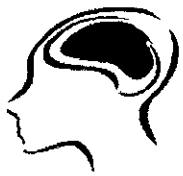
I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization or as specifically required or permitted by law.

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: _____



Neurology Medical Center

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

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.