Account# _____

PATIENT REGISTRATION

Please answer all questions completely. **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date_____ ☐**New** ☐**Update**

Name_____ Date of Birth _____ ☐ Male ☐ Female
Last First Middle

Home Address_____

City/State/Zip _____

Phone (_____) _____

Cell (_____) _____

Patient's Soc. Sec. # _____

Driver License No/State _____

Race __White/Caucasian __ Black or African American __ Asian __ American Indian __ Native Hawaiian or Other Pacific __ Decline to State

Ethnicity __ Hispanic or Latino __ Not Hispanic or Latino __ Decline to State

Primary Language Spoken _____

Employer _____ Bus. Phone (_____) _____

Employer Address _____

Who is your Primary Care Physician? _____ Referring Physician? _____

PATIENT'S E-MAIL ADDRESS _____

Financially Responsible Party (subscriber info)

If other than self _____ Relationship _____

Address _____ Phone (_____) _____
Number Street City

Patient's Primary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ **Group ID#** _____ **Subscriber's DOB** ____/_____/_____

Patient's Secondary Insurance (if any) _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ **Group ID#** _____ **Subscriber's DOB** ____/_____/_____

Subscriber to Secondary Insurance _____ **Relationship to Patient**_____

Spouse or **Nearest Relative**_____ Relationship _____
Last Name First Middle

Address _____ Phone (_____) _____
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

Patient's Signature **Date**

STATEMENT OF FINANCIAL POLICY

The Neurology Center is a provider for many insurance plans and we will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. Your co-payment is due at the time of service. If for any reason you are not able to pay your co-payment at the time of service an additional $15.00 will be added to your statement. Also, any services that your insurance will not cover are your responsibility.

If you have HMO insurance, it requires authorization for any of your treatment here in the office or if the Doctor refers you elsewhere. If this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred, and will be required to sign a financial waiver. If your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us until after the insurance has paid its portion providing the insurance company pays within 30 days.

If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard and American Express for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a $35 fee per form to be completed.

Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 631-3020 to make payment arrangements.

A 24 hour advanced notice is required if you must cancel or change your appointment.
If you are new to our practice and miss your initial appointment without notifying our office, all future appointments must be guaranteed with a credit card. A second missed appointment without notice will result in a missed appointment charge of $50.00 for general medical visits, or a $75.00 charge for a missed diagnostic study appointment.

For established patients who miss an appointment without giving a 24 hour advanced notice, there is a $50.00 charge for general office visits, and a $75.00 charge for all missed diagnostic testing or study appointments. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

Thank you for choosing The Neurology Center!

I have read and understand The Neurology Center's financial and claims filing policies.

Print Patient's Name_____

Patient's Signature_____**Date**_____

Responsible Parties Signature (if other than patient) _____**Date**_____

Prescription Refill and Diagnostic Testing Policy

PATIENT NAME: _____

Thank you for consulting The Neurology Center. We have developed the following policies to help make your follow-up care go smoothly.

PRESCRIPTION REFILLS:

IF YOU FILL YOUR PRESCRIPTION THROUGH A LOCAL PHARMACY, you should telephone your pharmacy **several** days before you are ready for a refill. Do not call our office as this will delay your refill. Your pharmacist will call us for authorization if necessary. ***Phoning your pharmacy directly, several days early, is the fastest way to get your prescription medication refilled.***

If you:

A) Fill a prescription through a mail-in-service, or
B) Fill a prescription at Camp Pendleton, or Balboa Naval Hospital
C) Need a written prescription for refills for any other reason

Please call our office several weeks before you need your refill. Most mail-in-services have a limit on the amount of medication you can receive at any time. We will make every effort to get the necessary amounts for you. Ultimately, it is your prescription benefit that will determine how your prescription is filled.

LAB TEST, CAT SCANS, MRI'S, ETC:

Depending upon your insurance, you may have several choices as to where you may go for the outside tests your doctor recommends. If you have insurance and want to keep your costs as low as possible, we recommend that you call your insurance company to be sure you are using an approved provider of these services and they have received proper authorization. ***Ultimately, it is your responsibility to know your insurance plan benefits.***

Please sign and date that you have read and understood these policies.

X_____ Date: _____

PERMISSION TO FURNISH MY MEDICAL INFORMATION

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available. Unless otherwise indicated, you will leave a message on my answering machine or voice mail with any routine results, instructions or appointment reminders when I am not immediately available.

Approved Person(s)	Relationship to Me
_____	_____
_____	_____
_____	_____

- ❑ I hereby instruct The Neurology Center to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- ❑ Other special instructions regarding furnishing my medical information: _____

_____

_____

_____

_____

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc) **about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.**

In addition, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Name and Contact Information	**Send copies**	**OK to discuss**
_____	☐	☐
_____	☐	☐
_____	☐	☐

X _____ _____ _____

Signature **Date** **Print Name**

HIPAA Notice of Privacy Practices – Acknowledgement of Receipt and Consent to Disclosure

I hereby acknowledge that I received a copy of the Notice of Privacy Practices pertaining to the doctors who participate in the Connect the Docs Network. I further acknowledge that a current version with any revisions that may be made will be posted at www.ctdmso.com and in the reception area.

I acknowledge that my health information may be used and disclosed to Connect the Docs Medical Management, Inc. ("CTDMM"), a management services entity, to the extent CTDMM needs the information to schedule appointments with any other health care providers, coordinate my care, remind me of appointments, or to provide other services that pertain to my treatment, payment for services and the health care operations of Physician members of Connect the Docs, A Multi-Specialty Network, Inc.

Signed:

_____

Date:

_____

Print Name:

_____

Telephone:

_____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor patient

_____ Guardian or conservator of an incompetent patient

Name and Address of Patient_____

_____

FOR OFFICE USE ONLY:

Acknowledgement Tracking Information

Date received: ____/____/____ Processed by:

_____

Office follow-up: ____/____/____ Date of follow-up: ____/____/____

Patient refused to sign the Acknowledgement:

Efforts to obtain signature:

_____

_____

Reason for refusal:

_____

_____

NEW PATIENT HISTORY

Name _____ **Birthdate** _____ **Date** _____

Age: _____ I am: □ Right Handed □ Left Handed □ Ambidextrous

Referring Physician: _____

What is your primary language spoken? _____

How do you prefer to receive information about your diagnosis? ___Verbal ___Written ___Pictures

Chief Complaint
Please list the main problems which bring you to the doctor

1. _____

2. _____

3. _____

4. _____

Please describe the problems:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Review of Systems
Check boxes if you are having any of these symptoms; write in details:

Constitutional
- □ Chills
- □ Fatigue
- □ Changes in Weight

Eyes
- □ Double vision
- □ Eye Pain
- □ Blurred vision

Ears, Nose and throat
- □ Hearing loss
- □ Ringing
- □ Dizziness
- □ Sore throat

Cardiovascular
- □ Ankle swelling
- □ Night sweats
- □ Chest Pain or Pressure
- □ Skipped beats
- □ Blackouts

Respiratory
- □ Cough
- □ Shortness of breath
- □ Hyperventilation

Gastrointestinal
- □ Abdominal Pain
- □ Appetite loss
- □ Blood in stool
- □ Constipation
- □ Diarrhea
- □ Nausea
- □ Vomiting

Hematologic/Lymphatic
- □ Easy bruising or bleeding
- □ Anemia

Musculoskeletal
- □ Joint stiffness
- □ Joint swelling
- □ Joint Limitation
- □ Joint pain
- □ Neck pain
- □ Back pain

Genitourinary
- □ Blood in urine
- □ Burning with urination
- □ Hesitancy
- □ Night time frequency
- □ Difficulty with urination

Skin/Breast
- □ Rashes
- □ Nipple discharge

Endocrine
- □ Intolerant of heat or cold
- □ Excessive urination
- □ Excessive hunger
- □ Increased thirst

Allergic/Immunologic
- □ Allergies to medication, Iodine, shellfish,

Neurological
- □ Difficulty with speech
- □ Impaired memory
- □ Confusion
- □ Headaches
- □ Seizures
- □ Blackouts
- □ Fainting
- □ Trouble swallowing
- □ Arm pain
- □ Leg pain
- □ Weakness or paralysis
- □ Tremors
- □ Incoordination
- □ Uncontrolled movements
- □ Stroke
- □ Imbalance
- □ Numbness
- □ Tingling

Psychiatric
- □ Mood swings
- □ Depression
- □ Anxiety
- □ Memory
- □ Hallucinations

Current height _____ Current weight _____

Patient Name: _____

Past Medical History

Check if you have had any of these problems. Give details.

- □ Angina
- □ Asthma
- □ Blindness, part or full
- □ Cancer
- □ Depression
- □ Diabetes
- □ Dizziness
- □ Double vision
- □ Fainting
- □ Head trauma
- □ Headache
- □ Hearing problem
- □ Heart attack
- □ Heart failure
- □ Hepatitis
- □ Herniated disc
- □ High blood pressure
- □ High cholesterol
- □ Irregular heart beats
- □ Nervous breakdown
- □ Numbness
- □ Polio
- □ Psychiatric conditions
- □ Sciatica
- □ Seizures (epilepsy)
- □ Speech problems
- □ Stroke
- □ Swallowing problems
- □ Ulcers
- □ Venereal infections
- □ Vertigo
- □ Walking problems

Have you had any of these tests? Give details.

- □ Angiogram of the brain
- □ CAT scan
- □ EEG (brain wave test)
- □ EMG (nerve-muscle test)
- □ Spinal tap
- □ Skull X-ray
- □ Spine X-ray
- □ Magnetic Resonance (MRI)

Medications – Please list all of the medications you are currently taking. Include aspirin, birth control pills hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?	For how long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Surgical Procedures – List chronologically

Operations	Hospital & City	Date
1.		
2.		
3.		
4.		
5.		

Other Hospitalizations Or Other Medical Problems

1.	
2.	
3.	
4.	

Patient Name: _____

Allergies:
Please list any allergies to medications _____

Are you allergic to X-ray dye? _____

Are you allergic to shellfish? _____

Social History
Your place of birth: _____

Martial Status: □ Married □ Single □ Divorced □ Widowed

Education Completed: (YEARS) □ 9 □10 □11 □12 □13 □14 □15 □16 □ 16+

Occupation: _____

Do you exercise regularly? □ Yes □ No, if so what do you do? _____
_____

Habits
Check any of the following that you have used and state amount:
□ Caffeine How much per day? _____
□ Alcohol How much per day? _____
□ Tobacco How much per day? _____

Family History
Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):
Check if positive **Relationship**

□ Alcoholism _____
□ Cancer _____
□ Diabetes _____
□ Heart Disease _____
□ Mental Illness _____
□ Migraine _____
□ Seizures _____
□ Stroke _____
□ Tuberculosis _____

Are there any other diseases that run in the family?
_____
_____

Did you need any assistance filling out this form? ____Y ____N If yes please explain.
_____

_____

Signature _____ Date _____

THE NEUROLOGY CENTER

Sleep Survey

Name: _____

DOB: _____ Age: _____

Weight: _____ Height: _____

Gender ☐ Female ☐ Male

Do you snore?	☐ **Yes**	☐ **No**
Do you feel tired, fatigued or sleepy during the day?	☐ **Yes**	☐ **No**
Has anyone observed you stop breathing while you sleep?	☐ **Yes**	☐ **No**
Do you nap during the day?	☐ **Yes**	☐ **No**

Do you have any of the following?

Heart Disease	□ Yes	□ No
History of Stroke	□ Yes	□ No
High Blood Pressure	□ Yes	□ No
Depression	□ Yes	□ No
Morning Headaches	□ Yes	□ No
Trouble with Memory Or Concentration	□ Yes	□ No

Sleep Orders

For Office Use Only

□ Sleep Consult

□ PSG

□ CPAP Titration Study

_____ _____

Physician Signature **Date**