MEDICAL NEUROLOGY

PATIENT REGISTRATION FORM

Please do not leave any blanks. Mark out if necessary.

PATIENT IDENTIFICATION

Patient's last name: First: Middle:			❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		P.O. Box:		Daytime Phone No.: ( )	
City:	State:		Zip:	Cell Phone No.: ( )	
Occupation:	Employer:			Employer/Work phone no.: ( )	
Referred to by: Dr's Phone no.:				Primary Care Provider:	
Reason for visit: ❑ Consult ❑Testing only					

INSURANCE INFORMATION

PLEASE FILL OUT COMPLETELY EVEN THOUGH WE HAVE COPIES OF CARDS.

Primary insurance name:		Annual Deductible: $_____	Co-pay: $_____	
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Member ID:	Group no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other _____				

Secondary insurance name: (if applicable)		Beneficiary, Recipient or Sponsor's name:		
Annual Deductible: $_____	Subscriber's S.S. no.:	Birth date: / /	Member ID:	Group no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑Other _____				

IN CASE OF EMERGENCY

Name:		Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
Medical Power of Attorney?	❑ Yes	❑ No	*If yes, please provide a copy of your POA and/or medical directives.	

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in the MEDICAL NEUROLOGY Notice of Privacy Practices. I authorize my insurance benefits be paid directly to MEDICAL NEUROLOGY. I understand that I am financially responsible for any balance.

_____ _____

Patient/Guardian signature: Date

MEDICAL NEUROLOGY

FINANCIAL POLICY

PATIENT NAME (Please Print)**:** **DATE:**

The following is our financial policy. Please read and sign prior to treatment.

Insurance: As a convenience to our patients, we will bill most primary insurance carriers for you. If an insurance company has not paid within 60 days of billing, payment is due in full from you. All co pays, deductibles and patient responsibilities are due at the time services are rendered.

Insurance Eligibility: It is your responsibility to understand your insurance agreement, eligibility, effective date(s) and what benefits you are entitled to. You are responsible for verifying the physician's status with your insurance company (such as *in- plan, in-network, preferred, out of network,* etc.). Preventative health checks, labs and injections may or may not be covered under your health insurance policy. If you are unsure of your plan benefits, call your insurance prior seeing the physician because ultimately you are responsible for all fees for service.

Referrals and Authorization: If your insurance company requires a referral for any services rendered, it is your responsibility to obtain any referral forms, referral numbers and/or authorization numbers prior to your visit. Please note that some providers may offer to assist you in this process, but this does not relieve you of the financial responsibility should any subsequent claims be denied by your insurance for lack of prior authorization. If you did not obtain a referral or any other required authorization from your insurance company, you may be asked to reschedule your appointment, or you will be responsible to pay your visit in full.

Cash Pay: Unless prior arrangements are made, full payment is due at the time of service for cash patients. If you wish to see the physician where no benefits will be paid by your insurance, you may do so as a cash pay patient.

Missed Appointments: In fairness to other patients and the physician, we require at least 24 hours notice to cancel appointments. You will be charged $25.00 for missed appointments and dismissed from the clinic after two consecutive no-shows.

Types of Payment: The accepted methods of payment are cash, check or money order. Personal checks returned from the bank are subject to a $25.00 return check fee in addition to the fee for service.

Past Due Accounts: Upon receipt of an Explanation of Benefits (EOB) from your primary insurance, we will bill you for any remaining balance as indicated by your insurance. You are responsible for paying the amount on the bill in full within 30 days, unless you have contacted our office to make other payment arrangements. Accounts will be considered delinquent if left unpaid by the due date on the statement. All such delinquent accounts may be assigned to a collection agency unless prior arrangements have been made by you or your insurance company. In the event your account is assigned to a collections agency, you will be responsible for all reasonable collection and/or court costs up to 50% of the outstanding balance at the time the account is considered delinquent. I also understand that if my account becomes 30 days delinquent, that Medical Neurology may accrue interest at the rate of 18% per annum, beginning the first day of delinquency. If the collection agency cannot resolve an outstanding balance, the account may be turned over to an attorney for legal action.

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: MEDICAL NEUROLOGY. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ **Date:**_____

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ **Date:**_____

Patient Name: _____ DOB: _____

What is the reason for today's visit? _____

Have you been treated by another neurologist for this problem? ☐ Yes ☐ No If yes please give name and dates:

Are you on Disability? ☐ Yes ☐ No **Note: We only perform Disability consultations pre-arranged with the Bureau of Disability.**

Are you being seen for an injury?	☐ Yes ☐No	Are your main symptoms related to auto accident?	☐ Yes ☐No
Are your main symptoms work related?	☐ Yes ☐ No	Do you intend to file Worker's Comp Claim?	☐ Yes ☐No
Do you have an attorney involved in this case?	☐ Yes ☐ No	Do you plan to get an attorney?	☐ Yes ☐No

Medical History

1 _____
2 _____
3 _____
4 _____
5 _____

Surgical History

1 _____
2 _____
3 _____
4 _____
5 _____

Medications you take on a regular basis including over the counter medicines (i.e. aspirin or antacids):

	Name:	Milligrams:	Frequency:		Name:	Milligrams:	Frequency:
1				6			
2				7			
3				8			
4				9			
5							

Pharmacy Name: _____ **Pharmacy Phone #:** _____

Drug Allergies:

_____

_____

Social History:

Are you claustrophobic?	☐ Yes ☐ No	Prior history of substance abuse?	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No	If yes, How many packs/day? _____	How many years? ____
If no, have you smoked in the past?	☐ Yes ☐ No	If yes, when did you quit? _____	
Do you drink alcohol?	☐ Yes ☐ No	If yes, number of drink(s): _____	__per day __ per week
If you have prior history of substance abuse	(cocaine, etc…)	Please list_____	

FAMILY HEALTH HISTORY

Relative:		**If living: Age & Health**		**If deceased: Age at death & Cause**		**Has any blood relative ever had:**		**Who?**
Mother						Cancer	☐ Yes ☐ No	
Father						Diabetes	☐ Yes ☐ No	
Brother(s)	1					Heart Disease	☐ Yes ☐ No	
& Sister(s)	2					High Blood Pressure	☐ Yes ☐ No	
	3					Migraine Headaches	☐ Yes ☐ No	
	4							
Children	1					Brain Tumor	☐ Yes ☐ No	
	2					Aneurysm	☐ Yes ☐ No	
	3					Alzheimer's Disease	☐ Yes ☐ No	
	4					Parkinson's Disease	☐ Yes ☐ No	
	5					Seizures	☐ Yes ☐ No	
						Stroke	☐ Yes ☐ No	

Highest Level of Education Completed: __6th Grade __12th Grade __G.E.D. __ College __Post- Graduate

REVIEW OF SYSTEMS

Please circle and provide brief details for the symptoms listed below that apply to you now or within the last year.

NEUROLOGIC
Headache
Weakness
Stiffness
Numbness/tingling
Seizures or convulsions
Neck pain
Back pain
Pain in extremities
Difficulty walking
Falls
Tremors
Memory loss/confusion

CONSTITUTIONAL SYMPTOMS
Fever
Night sweats
Fatigue
Weight gain
Weight loss
Insomnia/trouble sleeping

CARDIOVASCULAR
Chest pain
Irregular heart beat
Shortness of breath
Palpitations
Swelling (feet, ankles, hands)

PSYCHOLOGICAL
Anxiety
Depression
Auditory or visual hallucinations
Fear/Phobia

GASTROINTESTINAL
Loss of appetite
Diarrhea
Constipation
Nausea
Vomiting

EAR/NOSE/THROAT
Hearing loss
Ringing in ears
Dizziness
Vertigo
Nose bleeds
Sinusitis
Lack of taste or smell

GENITOURINARY
Difficulty Urinating
Frequent urination
Blood in urine
painful urination

EYES
Blurred vision
Double vision
Pain behind eyes
Eye drooping

MEDICAL NEUROLOGY

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for purposes required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information (PHI)

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; OR your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has necessary information to diagnose or treat you.

Payment. Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a medical procedure may require that your relevant protected health information be disclosed to the health plan to establish medical necessity.

Healthcare Operations. We may use or disclose, as needed, your protected health information in order to conduct normal operations of the physician's practice. These activities include, but are not limited to:

- Quality control
- Licensing
- Employee reviews
- Training of medical students

For example, we may disclose your protected health information to medical students that see patients in our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you for test results or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required By Law, Public Health Issues, Communicable Disease, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law Enforcement; Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under Lay, we must make a disclosure to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in relation to the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your Protected Health Information.

You have the right to inspect and copy your Protected Health Information. Under federal law, however, you may not inspect or copy the following records – psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding.

You have the right to request a restriction of your Protected Health Information. This means you may ask us not to use or disclose any part of your Protected Health Information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restrictions, and whom they apply.

Your physician is not required to agree to a restriction that you may request. If physician believes your restriction is unreasonable and it is in your best interest to permit use and disclosure of your Protected Health Information, your Protected Health Information will not be restricted. If you wish, you then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically or by fax.

You may have the right to have your physician amend your Protected Health Information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your Protected Health Information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints – You may complain to the U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 if you believe your privacy rights have been violated by us; OR you may file a complaint with us by notifying our HIPAA Privacy Officer. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on January 22, 2008.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with our privacy officer.

ACKNOWLEDGEMENT

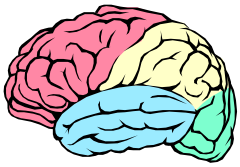
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name_____Signature_____Date_____

Dr. Bess Chang
Board Certified in Neurology

8530 W. Sunset Road, Suite 350
Las Vegas, NV 89113

MEDICAL NEUROLOGY



☎ **Phone:**
(702) 851-1065
🖷 **Fax:**
(702) 851-1066

RELEASE OF MEDICAL RECORDS

I hereby authorize: _____

To release my medical records to:

Medical Neurology
Dr. Bess L. Chang DO
8530 W. Sunset Road Suite 350
Las Vegas, NV 89113

Information contained in the medical records of:

Patient's Name: ___ _____

Date of Birth: ____/____/____ SS#: _____

I understand that I may revoke the authorization at any time except to the extent that action has been taken in reliance on it and that in any event this authorization automatically expires 90 days from the date of my signature or as otherwise specified by date, event or condition as follows.

_____ _____

Patient's Signature **Date**