



General Neurology Registration Form

Patient's Name _____
(Last) (First) (Middle)

Date of Birth _____ Sex _____ Age _____ Height _____ Weight _____
(Month, Day, Year)

Race: ☐ White or Caucasian ☐ Asian ☐ Black or African American
☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ Other ☐ Unknown ☐ Patient Refused

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Patient Refused

Religion: _____ () Declined to state Preferred Language: _____

E-mail Address: _____ (used for Patient Portal access)

Mailing Address: _____
(Street Address) (Apt or Unit #)

(City) (State) (Zip)

Phone (Include Area Codes) Which is primary? (Check One) ☐ Home ☐ Cell ☐ Work

Home # _____ Cell # _____ Work # _____

Employer _____ Social Security # _____

Work Address _____
(Street Address) (City) (State) (Zip)

Primary Care Physician: _____ Reason for your visit: _____

Source of Referral: (Check One) ☐ Self-Referral ☐ Patient Referral ☐ Physician Referral

If referred by a physician, provide physician name: _____

Marital Status: () Single () Married () Separated () Divorced () Widowed

Emergency Contact _____ Contact phone # _____

Relationship to Emergency Contact _____

Who is the primary person on your insurance? () Self () Other (i.e. spouse, parent, employer)

If other, name here _____ Relationship _____

Date of birth of primary person on your insurance _____ (i.e., if spouse is primary on insurance, date of birth of spouse)

MEDICAL HISTORY: (Please check which apply to your past medical history)

☐ High Blood Pressure ☐ Diabetes ☐ Seizures ☐ Stroke ☐ Migraine ☐ Heart Disease

☐ Cancer (Type of Cancer) _____

☐ Other Medical or Neurologic Problems _____

SURGICAL HISTORY (Please check which apply to your past medical history)

☐ Tonsillectomy ☐ Appendectomy ☐ Gyn Surgery ☐ Hernia

☐ Gallbladder ☐ Heart Surgery ☐ Cataract

☐ Other Surgeries _____

FAMILY HISTORY: (List those people in your family with the following illnesses):

High Blood Pressure _____ Heart Disease _____

Diabetes _____ Cancer _____

Stroke _____ Migraine _____

Seizures _____ Parkinson's _____

Alzheimer's _____ Other Neurologic Problems _____

SOCIAL HISTORY:

Smoking? ☐ No ☐ Yes

(If Yes, please list how many packs per day and for how many years you have smoked):

_____ packs per day, for _____ year(s). Date Quit Smoking: _____

Use of smokeless tobacco (ex. snuff, chew)? ☐ No ☐ Yes Date Quit: _____

Alcohol? ☐ No ☐ Yes

(If Yes, please indicate the number of drinks per day, per week or per month and number of years, and type(s) of alcohol used): _____ drink(s) per day/week/month for _____ year(s).

Type(s) of Drinks: ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Hospitalized for Alcohol Use

Recreational Drugs? ☐ No ☐ Yes

(If Yes, please indicate type of drugs used and how frequently): _____

Occupation: _____ hours per day _____ days per week

Levels of Stress: ☐ High ☐ Medium ☐ Low

Highest Level of Education Achieved _____

History of Military Service? ☐ Yes ☐ No If yes, describe: _____

CURRENT MEDICATIONS & DOSAGE:

Please list all of your current medications and dosing:

Preferred Pharmacy Name: _____

Pharmacy Location: _____

ALLERGIES:

Please list any allergies to medications, dyes, latex, etc.:

REVIEW OF SYSTEMS (check all that apply):

General:

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain
- ☐ Headaches

Allergies:

- ☐ Seasonal allergies
- ☐ Trouble breathing
- ☐ Skin Rash
- ☐ Reaction to foods

Cardiovascular:

- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath on exertion
- ☐ Swelling of feet or ankles

Endocrine:

- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Glandular or hormone problem

Ears, Nose, and Throat:

- ☐ Nasal congestion
- ☐ Nose bleeding
- ☐ Sore throat
- ☐ Ear ache

Gastrointestinal:

- ☐ Nausea
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Constipation

Genitourinary:

- ☐ Kidney stones
- ☐ Urinary retention
- ☐ Urinary urgency
- ☐ Increased urinary frequency

Musculoskeletal:

- ☐ Weakness
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle spasms/cramps

Neurological:

- ☐ Numbness
- ☐ Light-headedness
- ☐ Dizziness
- ☐ Seizure
- ☐ Weakness
- ☐ Memory difficulties
- ☐ Tremor

Psychiatric:

- ☐ Depression
- ☐ Anxiety
- ☐ Hallucinations
- ☐ Insomnia

Respiratory:

- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing
- ☐ Coughing up blood

Skin:

- ☐ Rash
- ☐ Change in hair or nails
- ☐ Itching
- ☐ Dry skin

Sleep:

- ☐ Snoring
- ☐ Excessive daytime sleepiness
- ☐ Insomnia
- ☐ Other

Blood/Lymphatic:

- ☐ Abnormal bleeding
- ☐ Swollen glands
- ☐ Excessive bruising

**Consent for Treatment
(Signature Required)**

Signature:

Date:



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HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1 of 2

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 2 of 2

- We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. Please designate who our offices CAN disclose your health information to by checking the boxes below:

☐ OK to Spouse: _____

☐ OK to ALL family members: Please list names of family members:

☐ OK to Other: _____

☐ OK to leave health information on answering machine or voice mail

☐ DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).

☐ DO NOT RELEASE TO _____

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Jenny Aivazian, at (925) 932-6330. This notice goes into effect as of July 28, 2011.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

You understand that you have the right to revoke this authorization, in writing, at any time. You understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signed: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient please provide:

Name: _____ Relationship to patient: _____



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FINANCIAL POLICIES

This policy is intended to educate and clarify the responsibilities of the patient, your insurance, and our office in processing your claims and payments. Please take the time to read and understand the policies below:

All charges, receipts, claims etc will be under the name **BAY AREA SURGICAL SPECIALISTS**. Your credit card statement will identify the location as **MORGAN HILL**, our main office branch.

- Payment of co-pay, co-insurance or outstanding balances is required at the time of service. Please bring your payments to each appointment to avoid the need to reschedule. We accept cash, check, MasterCard, Visa, Discover, and American Express.
- A credit card authorization agreement is required to be completed by every patient and is attached to this financial policy. *We cannot see you if you do not have a valid credit card agreement on file with our office.*
- Patients with medical insurance must present proof of insurance at every visit. We will verify your insurance plan and personal information at every visit. If your insurance changes, please notify us before your next visit. *If for any reason, the insurance card(s) you provide us is found later to be outdated or invalid or does not cover your office visits or procedures (such as due to pre-existing condition clauses), you understand that you are responsible for paying for the services in full.*
- We follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services may be determined to be non-covered or not considered "reasonable or necessary" based on the benefits of your specific insurance plan. Each insurance company has their own policies and they are subject to change at any time. The billing codes we use are covered by most, if not all, insurance plans, but from time to time, a limited number of specific plans have their own restrictions. *You agree to be financially responsible for the cost of services that are not paid by your plan.*
- Patients without medical insurance will be considered "Self-Pay" and are expected to pay for services received at the time of service. As a courtesy, we provide discounts to "Self-Pay" patients that are generally in line with insurance contracted rates.
- If we are an "Out of Network" provider with your health plan, you will likely be required to pay a higher copay/coinsurance/deductible and a higher cost for services, which will be collected at the time of service.
- Patient statements are sent out monthly and are due within 15 days of the statement date. If the patient responsibility portion of your account is over 45 days past due, you will receive a **Pre-Collections Letter** stating that you have 10 days to pay your account in full to halt collection activity. Any account that is referred to a **collection agency** will be required to be paid in full, as well as all reasonable collection agency/attorney fees, plus filing and processing costs before being seen for an appointment. As part of, but not limited to, the reasonable collection agency fees, *there will be an added 50% above the outstanding balance charged to your account.*

INSURANCE:

- *Your insurance benefit is a contract between you and your insurance company.* We cannot keep track of the ever-evolving complexity of the multitude of insurance plans held by our patients; it simply is not a possible task. We will submit claims for the services that have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request in a timely manner.
- If you provide our office with secondary insurance information, we will forward your claim to the secondary carrier.
- If your insurance company (primary and/or secondary) denies any services or does not cover any service as part of their medical policy, *you agree to be financially responsible for the services provided.*
- We usually submit claims to your insurance within one business day of your visit. *If your insurance plan(s) does not finalize the processing of our claims within 60 days from the time of service, you will receive a bill and you agree to pay for the cost of services at that time.* If and when your insurance plan finally does process the claim, we agree to promptly refund all money due back to you as determined by your insurance company.

FEES:

- If you are unable to keep your appointment, you must call our office at least 24 hours before your appointment to cancel or reschedule. You must also arrive to your scheduled appointment on time. *If you fail to promptly arrive to your scheduled appointment (no more than 15 minutes late) or call to reschedule with less than 24 hours notice, you will be considered a "No Show". For Monday appointments, this means by the prior Friday at noon.*

You will be charged the following "No Show" fees: \$75 for a new patient visit; \$75 for any diagnostic test or procedure (such as EEG, EMG/NCS, botox or other injections); and \$50 for a follow-up patient visit. These fees apply to each appointment missed. You agree to pay the "No Show" fee prior to rescheduling or attending an already existing appointment. If there is a third No Show, the office reserves the right to discharge you from the clinic. We really dislike having to do this, but we really need some notice to allow other patients to schedule. We turn away other people needing care in order to hold a place for a patient.

- *A \$35.00 charge will be added to your account for any check returned by your bank for any reason.*
- *There will be a minimum charge of \$25.00 for the completion of medical forms, such as disability, legal, or school, and/or letters written on your behalf. Each form or letter requires a separate fee.* Payment is due no later than the time you pick up the forms. Please allow 10-14 days for completion of the forms.
- A copy of your medical records can be provided upon receipt of a written authorization of release signed by the patient or guardian. *There will be a minimum charge of \$25 to cover the costs of fulfilling each request for copies of medical records.*

Acknowledgement of Financial Policies and Guarantee of Payment:

We ask that you sign the bottom of the Financial Policy to acknowledge that you have read the policy and agree to the terms.

Signature

Date

rev. 03/28/2017



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**Financial Policy
Credit Card Authorization Agreement**

Our office requires all patients to maintain a Credit Card Authorization Agreement on file for billing. The policy helps you seamlessly pay your account balance on time and allows us to focus our time and energy on your medical care.

We take the security of your credit card information very seriously:

- Your credit card information is encrypted and stored securely by TransFirst (a leading national provider of credit card services).
- No credit card numbers are stored in your medical records or at our practice.
- Only the last four digits of your credit card number are visible to our staff.

Your copay and an estimate of your coinsurance and deductibles are due at time of service. Our office has the ability to get real-time verification and eligibility for most major insurance providers, which includes deductibles, copays, coinsurances, and out-of-pocket maximums. Your credit card will be used after your insurance company finalizes the processing of your claim. If a balance remains due at that time, our office will charge your credit card for the amount due based on your finalized insurance claim. Whenever we make a charge to your credit card, we will mail to you a copy of the paid invoice and your credit card receipt for your records. The Credit Card Authorization Agreement may also be used for non-covered services, such as requests for medical records, form completion, returned check fees, and anything else identified in the Financial Policies agreement you signed. Your credit card will never be charged for anything not consented to in the documents you have signed with our office.

The vast majority of our patients choose to leave their credit card on file. If you opt out of leaving your credit card on file, you will be required to pay 100% of your estimated coinsurance and deductibles at time of service. Also, before being seen again in our office, your account balance must be paid in its entirety. All prior balances will be due before new services are provided. At this time, we have held off on charging an Administration Fee for the billing costs we incur as a result of patients choosing to not leave a credit card on file. By choosing this option, you agree to an Administrative Fee not to exceed \$5.00 per mailed statement, if and when such a policy is implemented.

Today's Date: _____

Please check #1 or #2 below

#1 _____ I, the undersigned, authorize Bay Area Surgical Specialists to use the specified credit card provided on the next page as payments for the charges due to this office.

OR

#2 _____ I the undersigned choose to opt out of completing the Credit Card Authorization and agree to the terms described in the *italicized* paragraph above.

Printed Patient Name: _____ Patient Signature: _____

If Patient is NOT the guarantor: Guarantor Name: _____ Signature: _____

The authorization is in effect until a written request to revoke is received.



Type of card: ___ VISA ___ MasterCard ___ American Express ___ Discover

Print Card Holder's NAME: _____

Card Holder's ADDRESS: _____

CITY, STATE, ZIP CODE: _____

Company Name (if applicable): _____

Credit Card Number: _____

Credit Card Expiration Date: _____

Credit card Security Code: (3 digits or 4 digits for AmEx): _____

Remember, we take the security of your credit card information very seriously:

- Your credit card information is encrypted and stored securely by TransFirst (a leading national provider of credit card services).
- No credit card numbers are stored in your medical records or at our practice.
- Only the last four digits of your credit card number are visible to our staff.
- This page will be destroyed using a commercial cross cut shredding solution. It does not stay in our office.