



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

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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? _____

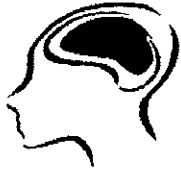
ARE YOU EXPERIENCING ANY OF THE FOLLOWING COMPLAINTS: If so, please explain:

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

Neurology Medical Center

26932 Oso Parkway, Suite #240; Mission Viejo, CA 92692

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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:

- 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.
- 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

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM																													
PICA					PICA																								
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					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 <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY STATE																			
ZIP CODE TELEPHONE (include Area Code)					Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					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) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO					b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																			
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																			
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 _____																			
14. DATE OF CURRENT: <input type="checkbox"/> ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY					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? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)										23. PRIOR AUTHORIZATION NUMBER																			
1. _____ 3. _____																													
2. _____ 4. _____																													
24. A DATE(S) OF SERVICE From To		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 EPSTD Family Plan		I EMG		J COB		K RESERVED FOR LOCAL USE								
MM DD YY MM DD YY																													
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) <input type="checkbox"/> YES <input type="checkbox"/> 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.)										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 #									
SIGNED _____ DATE _____										PIN# _____ GRP# _____																			