Neurology and Sleep Medicine Associates

(480) 967-6888 (phone); (480) 967-6887 (FAX)

Mesa Office
Augusta Ranch Professional Village
2919 South Ellsworth Road, Suite 135
Mesa, Arizona 85212

Tempe Office
Tempe St. Lukes Medical Office
1492 South Mill Avenue, Suite 214
Tempe, Arizona 85281

Patient Registration Form (Confidential)

Date: ____________________

Patient Name: ________________________ Responsible Party Name: ________________________

Mailing Address: ________________________________ City, State, Zip: ____________________

Permanent Address: ______________________________ City, State, Zip: ____________________

Home Phone: ______________ Business Phone: ______________ Cell Phone: ______________

Email Address: ______________________________ Pharmacy Number: ____________________

Sex: ☐ male ☐ female Birth Date (MM/DD/YYYY): __________________ Age: ________

Marital status: ☐ married ☐ single

Patient's Social Security #: ______________ Responsible Party Social Security #: ______________

Relation to Patient: ☐ self ☐ spouse ☐ child ☐ other ____________________

Referring Doctor's Name and Number: ____

Primary Care Doctor's Name and Number: ____

Employer Name and Number: ____

Billing information: I prefer you to bill my claims to:

1. The name of primary insurance: ____________________________ ID # ____________
2. The name of secondary insurance: ____________________________ ID# ____________
3. Do you have Medicare? ☐ yes ☐ no If yes, your Medicare # ________________

Is this visit injury related or from an accident? ☐ yes ☐ no
If injury or accident: ☐ auto accident ☐ job related injury, Date of Incident ________________

Claim Number: ______________________ Third Party Information: ________________________

____

Is there an attorney involved in your case? ☐ yes ☐ no If yes, Your Attorney Name and Number:

____

Chief Complaints:

What is the chief problem that brings you to the Clinic?

____

____

How long have you had the problem?______________________________

What do you think might be causing it?______________________________

Current Medical Problem and Illness:

Disease	Year Diagnosed			Disease	Year Diagnosed
1.				6.	
2.				7.	
3.				8.	
4.				9.	
5.				10.	

Have you ever had? (Please check all that apply)

__ cancer (type?______________) __ AIDS or HIV __ radiation therapy __ chemotherapy

__ stroke (what year?__________) __ seizures __ depression __ anxiety

__ congestive heart failure __ hypertension __ asthma __ COPD

__ diabetes (for __________years?) __ thyroid dz __ kidney stone __ blood clot

__ hepatitis (type?_____________) __ stomach ulcer __ rheumatic fever __ polio

__ sexually transmitted dz __ shingles __ headache __ sinus problem

others: ______________________________________

Previous Surgeries:

Surgical Disease	Year of Surgery			Surgical Disease	Year of Surgery
1.				4.	
2.				5.	
3.				6.	

Medications: List all medications that you have been taking recently, including all vitamins and non-prescribed medications. Please bring all medications for your visit.

Name	Dose (mg)	Times per day	Name	Dose(mg)	Times per day
1.__________			6.__________		
2.__________			7.__________		
3.__________			8.__________		
4.__________			9.__________		
5.__________			10__________		

Allergies: Reaction to medications or other substances. List all medications and substances.

Name of Medication	Type of Reaction
1.__________	__________
2.__________	__________
3.__________	__________

Family History: List **major** medical problems in your family.

Disease	Who has it?			Disease	Who has it?
1.				4.	
2.				5.	
3.				6.	

Social History:

Primary occupation:____________________

Tobacco: ☐ yes ☐ no Have you ever smoked? ☐ yes ☐ no
Type and amount:__________ Years:________ If stopped, when?______

Alcohol: ☐ yes ☐ no Have you ever drank alcohol? ☐ yes ☐ no
Type and amount:__________ Years:______ When was last drink?________

Recreational drugs: ☐ yes ☐ no Have you ever used recreational drugs? ☐ yes ☐ no
Type and amount:__________ Years:______ When was last use?________

Exercise: ☐ yes ☐ no If Yes, what type?__________ How often?________

Authorization to Pay: I hereby authorize payment directly to the business office of this physician/clinic for any treatment and / or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

__________________________ Signature (Patient or Guardian, if patient is minor)

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Patient Payment Policy

Insurance: We participate in most insurance plans. We bill your insurance company as a courtesy to you. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility. Please be aware that the balance of the claim is your responsibility whether or not your insurance pays the claim. **All co-payments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Private Pay/ No Insurance: Payment is due at the time of service. Payment will be accepted in the form of cash, debit or credit.

Medicare: Because we accept assignment with Medicare, it is mandatory that we bill your claim directly to Medicare. If you have Medicare only, you are responsible for 20% which is due at the time of service. Federal law requires us to bill you for deductibles and/or co-insurance 20%. Per Medicare guidelines we are unable to waive or write these fees off. Payment is due at the time of service. If you wish to have your secondary insurance billed, please make sure you provide all pertinent information before your visit.

Referrals: If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and also sign a waiver.

Worker's Compensation: We require written approval/ authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Nonpayment: If your account is past due, you will receive a letter from us stating you have 30 days to pay your account in full. Please be aware that if your balance remains unpaid, we may refer your account to a collections agency. There will be a 35% charge assessed to any account sent to collections. If this occurs, you will not be seen in the office until your balance is paid in full and all charges for future visits will be collected up front.

Returned Checks: There is a fee of $25.00 for any checks returned by the bank.

Missed Appointments: Our policy is 24 hours notice for an appointment change. Sleep study appointments require a 48-72 hour notice. If a 48-72 hour notice is not given, you will be assessed a $200 fee. We understand that emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as possible to reschedule. Please help us to serve you better by keeping your scheduled appointments. **If you miss 3 consecutive appointments, we will discharge you from the practice for non-compliance.**

Medical Record Copies: You will need to request copies of your records in writing. We are happy to email or fax your records to a secured fax free of charge. If you wish to have your records printed, you will be charged a reasonable copying fee of $1 per page. There is also a $5 postage fee if the records are to be mailed.

Patient Name: ______________________________ **Date:** ______________________________

Signature: ______________________________

Notice of Privacy Practice for Protected Health Information

This notice describes how medical information about you may be used and disclose and how you can get access to this information. Please review it carefully.

In compliance of the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), **Neurology and Sleep Medicine Associates**, has established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPAA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

Connie Wu
Neurology and Sleep Medicine Associates
1492 S. Mill Ave, Ste 214
Tempe, AZ 85281
(480) 967-6888

We will supply a written copy of this Notice to any person requesting it, whether or not a current patient. All patients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office.

We reserve the right to make changes to our Notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, this Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who requests a copy.

Your Rights as a Patient

With respect to your protected health information, you (or your personal representative, with legal authorization) have certain rights:

1. to obtain a paper copy of this Notice of Privacy Practices for Protected Health Information upon request;
2. to revoke your consents or authorizations;
3. to inspect and obtain a copy of the health information that is used to make individual health care decision about you (so called "designated record sets");
4. to appeal decisions we make regarding denial of access to your records;
5. to request amendments to your health records;
6. to dispute decisions regarding denial of amendment to your records;
7. to request restrictions on certain uses arid disclosures;
8. to request that confidential communications take place by alternative means to alternative locations;
9. to obtain an accounting of disclosures;
10. to lodge a complaint with us or with the Secretary of Health and Human Service if you believe there has been a HIPAA privacy violation, without fear of retaliation, coercion, or intimidation.

Acknowledge of Receipt of this Notice of Privacy Practices

We will make a good faith effort to provide you with a paper copy of this Notice of Privacy Practices and obtain a written acknowledgement from you. If we are unable to obtain such acknowledgement, we will document the reason.

Patient's signature ____________________ Date ________________

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Consent To Release Medical Information

I, ______________________________, authorize George Wang, MD and/or his staff to release medical information pertaining to myself, such as lab results, medication information/changes, referrals to specialists, future appointments, responses to messages left for the doctor, and copies of medical records and/or medical information.

Name: ___________________________ **Relationship:** ______________________

_____ **May leave detailed information on voicemail**

_____ **Do not leave detailed information on voicemail**

Patients Signature: ______________________________ **Date:** _______________

Witness Signature: ______________________________ **Date:** _______________

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To our Patients:

As of 03/25/09, our practice has implemented a new policy that will require a copy of a credit/debit card number or your HSA (health savings account) card number on file.

This information will be held securely, and will be used to pay any remaining balance after insurance payments, (including deductibles), missed appointment fees and monthly payment agreements. This will benefit you, since you will no longer have to mail checks or call with payment. It will benefit us as well since we are a paperless office and will no longer have to generate and mail statements.

After we file a claim with your insurance company, you will receive an Explanation of Benefits from your insurance company, which will state the amount the patient is responsible for. If you have any questions regarding your EOB, please do not hesitate to call us. The amount owed, if any, will be charged to your card and you will not receive a statement from us. **Our billing department will attempt to contact you before anything is charged to your card; if we are unable to reach you and must leave a message, we will give you 24 hours to respond before charging your credit card.**

If we do not have a credit/debit card or HSA card number on file and it becomes necessary to send you a statement, you will be assessed an additional $15.00 administrative fee.

____________________ ____________________ ________

Visa/MC/Discover Card Number Exp date

____________________ ____________________

Cardholders Name (print) Patient Name (print)

______________________________ ______________

Signature Date

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Patient Name: ____________________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.
Use the following scale to choose the most appropriate number for each situation:

0 = would **never** dose
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

Situation	**Chance of Dozing** Never	Slight	Mod.	High
Sitting and reading	☐ 0	☐ 1	☐ 2	☐ 3
Watching TV	☐ 0	☐ 1	☐ 2	☐ 3
Sitting inactive, in a public place (e.g. a theater or meeting)	☐ 0	☐ 1	☐ 2	☐ 3
As a passenger in a car for an hour without break	☐ 0	☐ 1	☐ 2	☐ 3
Lying down to rest in the afternoon when circumstances permit	☐ 0	☐ 1	☐ 2	☐ 3
Sitting and talking to someone	☐ 0	☐ 1	☐ 2	☐ 3
Sitting quietly after a lunch without alcohol	☐ 0	☐ 1	☐ 2	☐ 3
In a car, while stopped for a few minutes in traffic	☐ 0	☐ 1	☐ 2	☐ 3
Total Score				

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AUTHORIZATION FOR THE RELEASE OF MEDIAL INFORMATION

Patient Name: ______________________ Patient SSN ______________________

Current Address ____
Street City State Zip Code

Patient Phone#: ______________________ Date of Birth: ______________________

Release Medical Information to:

Name: ____

Address: ____

FAX#: ______________________ Phone#: ______________________

	Consultation Note		MWT Reports
	History and Physical		Lab Reports
	EMG Reports		Radiology Reports
	EEG Reports		Pathology Reports
	EP Reports		All Medical Records
	PSG Reports		Others:
	MSLT Reports		

I hereby authorize Neurology and Sleep Medicine Associates and its employees to release any and all information contained in my patient records. I understand and acknowledge that this may include information and treatment for physical and mental illness, alcohol / drug abuse HIV / AIDS test results or diagnosis

Duplication and distribution of your medical records are service. Neurology and Sleep Medicine Associates strives to ensure the timely completion of request for release of medical information. As a professional courtesy, no cost is assessed for information released directly to your health care provider. All other release are subject to copy and distribution cost. If your request exceeds the amount of $10.00, you will be contacted by a representative of Neurology and Sleep Medicine Associates to verify authorization of reimbursement prior to processing your request.

I understand the potentiality of charges for the service of release of medical information, and accept financial responsibility.

______________________ / ______________________ / ____/____/____

Signature of Patient/Legal Guardian Printed Name Date Signed

Last Name:__________________ First:____________ M.I:____ Date of Birth:________________

PATIENT TO COMPLETE:

Thinking Ability Changes

1) I have noticed a recent decline in my memory. Yes ☐ No ☐

2) Others (my friends or family) tell me that I am forgetting things they tell me. Yes ☐ No ☐

3) My ability to concentrate seems to have declined recently. Yes ☐ No ☐

4) I have suffered recent losses that might hurt some of my thinking abilities. Yes ☐ No ☐

5) I get confused or easily distracted more than I used to. Yes ☐ No ☐

PROVIDER AND OFFICE STAFF USE ONLY

Healthcare Provider Notes re: Patient Questionnaire and completion by close family member/friend/caregiver:

Staff Instructions:

Order CANS MCI? Yes: ○ No: ○ Follow-up Plan:________________

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Missed Appointment Policy

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I have read and understand the appointment policy stated above.

Patient Name: ____________________________ **Date:** ________________