Neurology and Sleep Medicine Associates

(480) 967-6888 Phone **(480)967-6887 Fax**

East Mesa Office	Gilbert Office	West Mesa Office
2919 S. Ellsworth rd. Bldg. 8, Ste. 135	4001 E Baseline Rd Suite 205	2045 S. Vineyard, Bldg. 3 Ste.144
Mesa, Arizona 85212	Gilbert, Arizona 85234	Mesa, Arizona 85210

Date: _____

Sex: ☐ Male ☐ Female Birth Date (MM/DD/YYYY) _____ Marital Status: ☐Married ☐ Single

Patient Name: _____ Responsible Party Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child Other _____

Primary/Preferred spoken language _____

Patient Social Security # _____ Responsible Party Social Security #: _____

Mailing Address: _____ City, State, Zip: _____

Permanent Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone #:_____

Email Address: _____

Emergency Contact Name and #: _____

Pharmacy Name: _____ City: _____ Major cross streets _____

Primary Care Doctor's Name and Number: _____

Referring Doctor's Name and Number: _____

Billing Information: I prefer you bill my claim to:

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Do you have Medicare? ☐ Yes ☐ No If yes, what is your Medicare #: _____

Is this visit related or from an accident? ☐ Yes ☐ No

If injury or accident: ☐ Auto Accident or ☐ Job related injury -Date of accident _____

Is there an attorney involved: ☐ Yes ☐ No

If yes, list attorney Name and Number: _____

Claim number: _____ Third Party Information: _____

Chief Complaints:

Why are we seeing you today? List symptoms you are currently having.

_____

_____

How long have you been experiencing this issue? Specify length (i.e. Years, months, week's days be specific. _____

☐ I am currently not taking medications (If you are taking medications please fill out below.)

Current Medications: List all medications that you are currently taking (including vitamins and non-prescribed medications) with name, dose (mg), and how many times per day it is taken.

_____ _____

_____ _____

_____ _____

Allergies to medications: ☐ No Known Drug Allergies or please list the name of the medication or substance and the reaction to the medication or substance.

_____ _____

_____ _____

_____ _____

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 ☐ Polio

☐ Diabetes (Years_____) ☐ thyroid disease ☐ Kidney stone ☐ blood clot

☐ Hepatitis (Type? _____) ☐ stomach ulcer ☐ rheumatic Fever ☐ shingles

☐ Sexually transmitted disease ☐ headache ☐ sinus problem ☐OSA

☐Others:

_____

Are you currently pregnant or breast feeding? Yes ☐ ☐ No

List current Medical Problems and Illnesses: ☐ None or please list the name of the disease and the year it was diagnosed.

_____ _____

_____ _____

Previous Surgeries: ☐ **None or list all surgeries and the year they were done**

_____ _____
_____ _____
_____ _____

Have you recently been hospitalized? ☐ Yes ☐ No If Yes, please list Hospital name & date of discharge.

_____ _____
_____ _____

Family History: ☐ **None ☐ adopted or list all major medical problems in your family. Please include name of medical issue and which family member it involves (i.e. Father, Mother, sister, brother, grandparent, aunt, uncle etc.)**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Social History:

Primary occupation:

_____

Have you ever smoked? ☐ Yes ☐ No used Tobacco: ☐ Yes ☐ No

Type and amount daily _____ Years: _____ if stopped, when? _____

Alcohol: ☐ Yes ☐ No

Type and amount daily _____ Years: _____ your last drink? _____

Have you ever used recreational drugs: ☐ Yes ☐ No

Type and amount daily _____ Years _____ 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 he 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.**

Arriving late to an appointment: We understand arriving late to an appointment sometimes cannot be helped, however if you are going to be 10 min late please call our office to let us know so we may inform the provider. The provider will make a decision based upon their schedule if we may see you late or not

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: _____Signature: _____ Date: _____

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:

Neurology and Sleep Medicine Associates

2919 S. Ellsworth rd Bldg. 8 Suite 135

Mesa, AZ 85212

(480) 967-6888 Phone Fax (480) 967-6887

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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East Mesa Office

Augusta Ranch Professional Village

2919 South Ellsworth Road, Suite 135

Mesa, Arizona 85212

West Mesa Office

Odyssey Professional Park

2045 S. Vineyard Bldg. 3 Suite 144

Mesa, Arizona 85210

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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AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Patient Name_____SSN_____

CurrentAddress_____
City State Zip Code

Patient Phone#_____ Date of Birth_____

OBTAIN records from:

FacilityName_____

Physician Name_____

Address_____

Phone: _____ Fax: _____Email_____

	Consultation Note (s)	
	History and Physical	
	MRI, MRA, EEG, EKG, ECG	
	Radiology Reports	
	Lab Reports/Pathology Reports	
	MWT Reports	
	Ultrasound	
	CAROTID DOPPLER	
	Other	
	All Medical Records	

I hereby authorize Neurology and Sleep Medicine Associates and its employees to obtain 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 diagnoses.

This consent is subject to revocation at any time except to the extent the action has been taken thereon. This authorization and consent will expire in one year from the date of authorization.

I hereby acknowledge and agree, as informed consent, Neurology and Sleep Medicine Associates to obtain my medical records.

_____/_____/_____

Signature of Patient/ Legal Guardian PRINTED NAME Date signed

Relationship if not patient