California Neurology Institute

First Name	Middle Initial	Last Name	Date of Birth MMDDYYY

Address	City:	State:	Zip:

Home Phone (Primary) ( )	Cell Phone (Secondary) ( )	We may leave a message on ☐ Home ☐ Cell	Gender ☐ Male ☐ Female

Social Security #	Marital Status	Employer Name	Work Phone ( )

Race	Ethnicity	Primary Language
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Hispanic ☐ Other:	☐ Hispanic or Latin ☐ Not Hispanic or Latin	☐ English ☐ Spanish ☐ Other:

Permission to enroll you on our patient portal?	Email Address
☐ Yes. By checking YES, you are giving us permission to contact you via email, portal message and/or text message. ☐ No, If no please tell us why?	☐ I do not have an email address

RESPONSIBLE PARTY INFORMATION

☐ **Check here if same as Patient information**

First Name	Middle Initial	Last Name	Date of Birth MMDDYYY

Address	City:	State:	Zip:

Home Phone ( )	Cell Phone ( )	Relationship to Patient	Gender ☐ Male ☐ Female

Social Security #	Employer Name	Work Phone ( )

INSURANCE INFORMATION

(Please provide copies of ALL cards)

Primary Insurance Carrier	Subscriber ID	Group Number

Subscriber Name	Subscriber Date of Birth	Relationship to Patient

Secondary Insurance Carrier	Subscriber ID	Group Number

Subscriber Name	Subscriber Date of Birth	Relationship to Patient

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Pharmacy Information	
Local Pharmacy Name	**Phone #**
Address	
Mail In Order Pharmacy	**Phone #**
Address	

Prescription History Consent

I hereby authorize ***California Neurology Institute*** to access and use my electronic prescription history, by doing so I understand I am allowing full electronic history of prescriptions that have been prescribed to me by any and all of my healthcare providers including but not limited to hospitals, urgent care, dentists, and any other practitioner. I am also allowing access to my records regarding prescriptions filled in my name by local, mail order, and specialty pharmacies. I understand this authorization shall not expire unless I submit a written request.

Patient or Legal Representative Signature	**Date**

Other Providers ACTIVELY involved in your care. Please list PCP below.

Are you currently in a SKILLED NURSING FACILITY? ☐NO ☐YES, Facility Name: _____

Physician Name	*Phone #*	*Specialty*	*Month/Year of Last Visit*

Emergency Contact Information

Please provide us with two (2) Emergency Contacts

Contact Name	*Phone #*	*Relationship*	*HIPPA*

I authorize ***California Neurology Institute*** to provide information to my contacts listed above in the event there is an emergency. If I would like my complete or a portion of my medical records released, I will do so by completing an ***Authorization for Use or Disclosure of Protected Health Information***. *This form is available at the front desk, or I can choose the HIPAA option next to the emergency contacts as an alternative.*

Patient or Legal Representative Signature	**Patients Name**	
Patient Date of Birth	**Relationship to Patient**	**Date Signed**

Medications

Name	Dosage	Frequency	Start Date	Response	Prescribing Physicians	Discontinued Date

History

List any past Surgeries

Surgery	Year of Surgery

Allergies

List your allergies including any medications that caused an allergic reaction

List All Allergies	Allergic Reaction

History / Review of Systems

Neurology	Yes	No
Migraines		
Burning Pain in Feet		
Dizziness		
Confusion		
Burning Pain in Hands		
Visual Changes		
Loss of Consciousness		
Peripheral Neuropathy		
Stroke		
Loss of Smell		
Fainting		
Loss of Sensation in Specific Body Area		
Trouble with Balance		
Restless Leg Symptoms		
Restless Sleep		

Psychology	Yes	No
Depression		
Suicidal Ideation		
Mental of Physical Abuse		
Confusion		
Mania		
Hyperactivity		
Irritibilaty		
Psychiatric Hospitalization		
High Stress Level		
Sleep Disturbances		
Eating Disorder		
Anxiety		
Hallucinations		
Mood Swings		
Attention Deficit		
Nightmares		
Other Psychiatric Diagnosis		
Are you receiving counseling?		

California Neurology Institute

Financial Policy Agreement

Patient Initials_____

The providers at ***California Neurology Institute*** are committed to providing you with superior healthcare, as part of that commitment it is important for us to establish our financial policy and your responsibilities.

IDENTIFICATION

- In order to prevent identity theft, you will be required to provide us with a government issued picture ID.
- A copy of all valid insurance cards are required. In the event a card is not available, you must be able to provide us with information so that we may verify insurance coverage and eligibility.

INSURANCE

- If we are unable to verify eligibility and benefits, you will be required to pay for services in full at the time of service.
- While we are contracted with many health plans, we may not be contracted with all health plans. It is your responsibility to provide us with your most current insurance information. Any changes in your insurance coverage must be reported to us immediately. If this information is not provided to us before or at the time of service, or within your insurance's timely filing limits you will be financially responsible for any services provided.
- As a courtesy our business office will submit claims to your health plan for services rendered by our office. Our business office will also assist you to the best of their ability to help get your claims paid.
- In the event your claim is delayed or denied payment due to a lack of information from the subscriber, patient, employer, or any entity or person outside of our office will be your financial responsibility.
- Some medical services may be considered by your insurance to be non-covered, out-of-network, or not medically necessary services. Our office will do its due diligence to obtain authorization and verify benefits for services being provided, however it is your responsibility to know your medical coverage and will be your financial responsibility.
- Any Co-pays, coinsurances, deductibles and balances are due prior to the rendering of services. In the event we do not collect such amounts at the time of service, it does not waive our right to collect and your financial responsibility for these services. We will do our best to estimate your portions due at the time of service, however your final balance is determined after your claim is processed by your insurance. Our business office will send you a patient statement of any balances not collected at the time of service.

PAYMENTS

- We accept the following methods of payment; CASH, CHECK, CREDIT OR DEBIT CARD.
- We understand at times there may be hardships, we encourage you to contact our office for other arrangements if are unable to make any of your expected payments.
- Any patient payments received are applied to the oldest balances first (does not apply to insurance payments).
- If a credit occurs from an advanced payment or after the insurance has finalized the claim we reserve the right to re-apply that credit to any other services with an outstanding balance.

BALANCES

- In accordance with state law, federal law, and any payer contract agreements, we will not waive, fail to collect, or discount any co-pays, co-insurances, deductible, or any other patient financial responsibility.

Statements will be sent by our business office for any balances due, payment is due upon receipt, but no later than 30 days from the date of the statement.

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BALANCES cont'd

- Any past due balances beyond 90 days are subject to late fees, and/or interest fees.
- Our business office will attempt to notify you of your debt by utilizing one or more of the following methods: statements, letters, phone calls, or messages through your patient portal (if you are enrolled).
- Any unpaid balances may be referred to our outside collection agency, and may be subject to additional interest fees, and/or negative credit rating reporting with various credit bureaus.
- If the event you are unable to pay your bill in full, we encourage you to call our office to make reasonable payment arrangements.
- You may also request for financial hardship consideration regarding your balance. However, you may be required to submit personal financial information (i.e. check stubs, bank statements, etc.) in order for us to determine whether or not you qualify.

RETURN CHECKS

- A check returned for any reason is subject to a return check fee of $35 per check.
- The returned check fee must be paid by cash, money order, and credit or debit card.
- We may refuse to accept any future check payments.
- We reserve the right to utilize all available legal remedies under California Law, including reporting your returned check to our local District Attorney's office.

MISSED APPOINTMENTS AND LATE ARRIVALS

- We require a cancellation notice of at least 24 hours.
- If you arrive to your appointment more than 5 minutes late your appointment may need to be rescheduled and you may be subject to or missed appointment fee.
- If 24 hour notice is not given you may be charged a missed appointment fee of at least $50 for provider visits and at least $150 for testing appointments. This fee may be waived at our discretion.
- We understand at times circumstances may not allow for you to cancel within 24 hours, however we ask that you call as soon as possible so that we have the opportunity to offer the appointment to another patient.

FORMS

- Any forms requiring medical review and/or a provider's signature is subject to an administrative fee of $25 per form.
- This fee is due prior to release of any completed forms.

REQUEST FOR MEDICAL RECORDS

- The security of your records if very important to us, therefore we require a WRITTEN request for any release of medical records.
- Release of records is subject to an administrative fee of $25 per request plus $0.25 per page if paper copies, or $5 if provided digitally (i.e. USB, CD, etc.).
- Records will NOT be released until the required fees are paid.

Patient Initials: _____

California Neurology Institute

BY SIGNING THIS AGREEMENT:

- **I acknowledge I have read and will comply with *California Neurology Institute's* Financial Policy as described above. I may request a copy at any time.**
- **I hereby assign all of my applicable health insurance benefits and all rights and obligation that I and my dependents have under my health plan to *California Neurology Institute* and it's representatives and I appoint them as my authorized representative with the power to:**
    - File medical claims with my health plan
    - Be paid directly by my health plan for services rendered to me or my dependents
    - File appeals and grievances with my health plan
    - Discuss or provide any of my personal health information or that of my dependents with any third party including my health plan
- **I certify that I have provided accurate insurance information as of the date below and that I am responsible for keeping it updated.**
- **I am fully aware that by having health insurance it does not release me of my responsibility to ensure *California Neurology Institute* is paid in full.**
- **I hereby authorize *California Neurology Institute* and its representatives to:**
    - Release information necessary to my health plan or its administrator regarding my illness and treatments
    - Process insurance claims generated in the course of examination or treatment; and
    - Allow a photocopy of my signature to be used to process insurance claims.
- **I understand in order to terminate this agreement I must submit a formal written request to revoke my authorization.**
- **I understand *California Neurology Institute* may update or amend its policies without prior notice.**

Patient name:	**Patient Date of Birth**

Patient or Legal Guardian Signature	**Date Signed**

California Neurology Institute

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

California Neurology Institute's Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Patient or Patients Representative Date

_____ _____

Print Patients Name Relationship to Patient

OPEN PAYMENTS ACT ACKNOWLEDGMENT

The Open Payments database is a federal tool used to search payments made by the drug and device companies to physicians and teaching hospitals. For informational purposes only, a link to federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is Provided here https://openpaymentsdata.cms.gov. The Federal Physician Payments Sunshine Acts requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices and biologics to physicians and teaching hospitals be made available to the public.

I acknowledge I have received a copy of this notice of disclosure.

_____ _____

Patient or Legal Representative Signature Date

California Neurology Institute

NOTICE OF PRIVACY PRACTICES

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

We understand the importance of privacy and are committed to maintaining the confidentiality of your health information. We make a record of the health care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality health care, to obtain payment for services provided to you, as permitted by your health plan, and to fulfill our professional and legal obligations to properly operate this medical practice. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals after a breach of unsecured protected health information. This notice describes how we may use and disclose your health information. It also describes your rights and our legal obligations with respect to your health information. If you have any questions about this Notice, please contact our Privacy Officer.

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a record, on a computer, and in an electronic health record/personal health record, considered your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment - We use medical information about you to provide your health care. We disclose health information to our employees and others who are involved in providing the care you need. For example, we may share your health information with other doctors or health care providers who will provide services that we do not offer. Or we may share this information with a pharmacist who needs it to fill a prescription, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who may be able to help you when you are sick or injured, or after your death.

Payment – We use and disclose health information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it pays us. We may also disclose information to other health care providers to help them obtain payment for the services they have provided to you.

Health Care Operations - We may use and disclose health information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get authorization from your health plan for services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs, and for business planning and management. We may also share your health information with our "business associates," such as our billing service, who perform administrative services for us. We have a written contract with each of these business associates that contains terms that require them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health processing centers, or health plans that have a relationship with you. They may request this information to assist them with their quality assessment and improvement activities, their patient safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, competency review, qualifications and performance of health care professionals, their training programs, their accreditation, certification, or licensing activities, or their health care fraud and abuse detection and enforcement efforts. We may also share health information about you with other health care providers, health processing centers, and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities that jointly provide health care services. A list of the OHCAs in which we participate is available in the Privacy Officer.

Appointment Reminders - We may use and disclose medical information to contact you and remind you about appointments. If you are not at home, we may leave this information on your answering machine or in a message with the person answering the phone.

Signature Sheet - We may use and disclose medical information about you by having you sign upon arrival at our office. We can also call your name when we are ready to serve you.

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Family Notification and Communication- We may disclose your health information to notify or assist in notifying a family member, or to coordinate these notification efforts in the event of an emergency or disaster. We may also disclose information to someone who is involved in your care or who helps pay for your care. If you are available and able to agree or object, we will give you an opportunity to do so before making these disclosures. We may disclose this information in a disaster, even if you object, if we believe it is necessary to respond to emergency circumstances. Except as described in this Notice of Privacy Practices, this medical practice will, in accordance with its legal obligations, not use or disclose health information that identifies you without your written authorization. If you authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Right to Request Confidential Communications - You have the right to request that you receive your health information in a specific manner or at a particular location. For example, you can ask us to send the information to a particular email account or to your work address. We will comply with all reasonable written requests that specify how or where you wish to receive these communications.

Right to Inspect and Copy - You have the right to inspect and request a copy of your health information, with limited exceptions. To access your health information, you must submit a written request detailing what information you want to access. Information can be requested in paper or electronic format if it is easily producible. We will provide you with an alternative format that you find acceptable. We will also send a copy to any other person you designate in writing. We charge a reasonable fee that covers our costs for labor, supplies, mailing, and, if requested and agreed upon in advance, the cost of preparing an explanation or summary. We may deny your request in limited circumstances.

Right to an Accounting of Disclosures- You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to disclose disclosures provided to you or with your written authorization.

Right to a Paper or Electronic Copy of This Notice – You have the right to receive notice of our legal duties and privacy practices with respect to your health information, including the right to a paper copy of this Notice of Privacy Practices, even if you have previously requested receipt of it by email.

Changes to this Notice of Privacy Practices:

We reserve the right to change this Notice of Privacy Practices at any time. The changes will apply to all protected health information we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area and will also post the current notice on our website. A copy will be available at each appointment.

Complaints

If you have any questions or need further clarification, I encourage you to contact the practice's Privacy Officer. 661-371-2771

If you are not satisfied with the way this office handles a complaint, you can file a formal complaint to:

Department of Health and Human Services
Office for Civil Rights
Hubert Humphrey Bldg.
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201
OC.RMail@hhs.gov

The complaint form can be found on www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf.

You will not be penalized in any way for filing a complaint.