PATIENT FOCUSED
NEUROLOGY

"Patient Care is our FOCUS."

2650 Jones Way #30, Simi Valley, CA 93065 | Phone (805) 579-9999 | Fax (805) 579-9900 | www.PFneurology.com

PATIENT INFORMATION

PATIENT (LAST) _____ (FIRST) _____ (MI) _____ DOB _____

ADDRESS *(PLEASE NO P.O. BOX)* _____ ☐ MALE ☐ FEMALE

CITY, STATE, ZIP_____ EMAIL _____

HOME PHONE _____ CELL _____ WORK _____ S.S. #_____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED

EMPLOYER NAME _____ OCCUPATION _____

ADDRESS _____ PHONE _____

CITY, STATE, ZIP_____

REFERRING PHYSICIAN_____ PHONE _____

OR REFERED BY: ☐ FAMILY/FRIEND ☐ INTERNET ☐ CLOSE TO HOME/WORK ☐ YELLOW PAGES ☐ OTHER

EMERGENCY CONTACT#1 _____ RELATION _____ PHONE _____

EMERGENCY CONTACT#2 _____ RELATION _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE NAME _____

SUBSCRIBER NAME _____

SUBSCRIBER ID# _____

DOB_____ S.S. #_____

GENDER: MALE FEMALE

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

ADDRESS (NO P.O. BOX) _____

CITY, STATE, ZIP_____

HOME PHONE _____ CELL _____

WORK _____ S.S. #_____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY, STATE, ZIP_____

OCCUPATION _____

SECONDARY INSURANCE

INSURANCE NAME _____

SUBSCRIBER NAME _____

SUBSCRIBER ID# _____

DOB_____ S.S. #_____

GENDER: MALE FEMALE

RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD

ADDRESS (NO P.O. BOX) _____

CITY, STATE, ZIP_____

HOME PHONE _____ CELL _____

WORK _____ S.S. #_____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

CITY, STATE, ZIP_____

OCCUPATION _____

*I certify that the above information is correct and true to the best of my knowledge. I consent to treatment and I authorize **Henry Tang, D.O. Inc.** to release to any insurance company or government agency any and all information necessary to process this claim. I authorize my insurance benefits be paid directly to the physicians or party who accepts assignment of this claim. I understand that charges not covered by my insurance carrier are my responsibility. I permit a copy of this authorization to be used in place of the original.*

Patient/ Guardian signature _____ *Date* _____

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Health History Questionnaire

Patient Name: (Last) _____ (First) _____ DOB: _____ Today's Date: _____

Please list your doctors (starting with the doctor who referred you here, if any)

Doctor:	**Specialty:**
_____	_____
_____	_____
_____	_____

CHIEF COMPLAINT
What is the reason for your visit today?

PERSONAL HEALTH HISTORY
List Any Medical Problems/Current Illnesses

Surgeries: Operations:	Age or Year	**Other Hospitalizations:** Year	Reason

List Your Prescription and Over-the-Counter Medication

Name the Medication	*How much?*	*When?*	*Name the Medication*	*How much?*	*When?*
1.			**6.**		
2.			**7.**		
3.			**8.**		
4.			**9.**		
5.			**10.**		

Are you allergic to any medication? No Yes (If yes, please list medication and the kind of reaction)

Name the Medication	*Allergic Reaction*	*Name the Medication*	*Allergic Reaction*
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

SOCIAL HISTORY

Highest level of education: ☐ Some HS ☐ HS diploma ☐ GED ☐ Some College ☐ AA degree ☐ BA/BS degree ☐ Graduate Degree ☐ Other _____

Caffeine ☐ Yes ☐ No
Alcohol ☐ Yes ☐ No (If yes, what kind? How many drinks/week _____
Drugs ☐ Yes ☐ No (Do you currently use recreational or street drugs? (Cocaine, methamphetamine, marijuana, etc.?
Tobacco ☐ Yes ☐ No No (If yes, Cigarettes-Pks/day _____ # of Years _____
Are you currently driving? ☐ Yes ☐ No

FAMILY HISTORY

Family Members	*Age*	*Medical problems*	*Deceased? If so, from what cause?*
Father			
Mother			
Brothers/Sisters			

REVIEW OF SYSTEMS

Do you currently have any of the following? Please mark all that apply.

GENERAL

☐ Fever
☐ Weight changes
☐ Night sweats

EYES, EARS, NOSE & THROAT

☐ Visual changes
☐ Trouble hearing
☐ Ear ringing
☐ Nose bleeds
☐ Hoarseness
☐ Sinus problems
☐ Dry mouth

CARDIOVASCULAR

☐ High blood pressure
☐ Heart disease
☐ Heart murmur
☐ Palpitations
☐ High cholesterol

PULMONARY

☐ Shortness of breath
☐ Asthma
☐ Tuberculosis

GASTROINTESTINAL

☐ Trouble swallowing
☐ Indigestion/heartburn
☐ Ulcers
☐ Constipation
☐ Diarrhea

GENITOURINARY

☐ Nursing
☐ Hysterectomy
☐ Sexual dysfunction
☐ Bladder problems
☐ Kidney disease

DERMATOLOGIC

☐ Skin problem
☐ Malignant melanoma
☐ Other skin cancer form

HEMATOLOGIC

☐ Easy bruising
☐ Anemia
☐ B12 deficiency
☐ Cancer

RHEUMATOLOGIC

☐ Muscle pain/swelling
☐ Joint pain/swelling
☐ Back or neck pain

ENDOCRINE

☐ Thyroid problems
☐ Diabetes

PSYCHOLOGIC

☐ Stress
☐ Depression
☐ Anxiety
☐ Eating problem
☐ Suicidal

NEUROLOGIC

☐ Headaches
☐ Seizures/convulsion
☐ Numbness sensation
☐ Weakness
☐ Tremors
☐ Concussion/whiplash
☐ Trouble sleeping
☐ Trouble walking
☐ Speech difficulty
☐ Dizziness
☐ Motion sickness
☐ Double vision
☐ History of stroke
☐ Confusion
☐ Memory problems

NOTES (Office Use Only)

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PATIENT PREFERENCE FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

Patient's Last Name _____ **First** _____ **DOB:** _____

The HIPAA privacy law gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means.

Please read and mark those forms of communications listed below that you personally approve for disclosure and discussion of protected health information. Please put a checkmark on all the contact boxes with your preferences.

Communication with person(s) other than the patient:

Is there a power of attorney? ☐ **Yes** ☐ **No** (If yes, please provide us a copy)

May we discuss your condition with anybody else? ☐ **Yes** ☐ **No** *(If yes, please list the names and relationship to you.)*

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

Name: _____ Relationship: _____ Phone _____

PATIENT CONTACT INFORMATION

Home Phone Number: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Cell Phone Number: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Work Phone Number: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

Please list any other phone numbers we can call: _____
May we leave a message about your appointment? ☐ Yes ☐ No
May we leave a message about your condition? ☐ Yes ☐ No

If you would like your medical information to be faxed or emailed to you when requested in the future, please provide us your fax number and/or a valid email address. If no fax number and/or email address provided, then you'll have to sign a separate release form in the future in order for us to send your medical information to you via fax and email.

Unless otherwise revoked, or an alternative expiration date is provided here, _____ **(indicate date here) this authorization is valid for ONE YEAR from the date listed below. Initials:** _____

Written Communication:
May we send mail to my home address? _____ ☐ Yes ☐ No
May we mail to my work/office address? _____ ☐ Yes ☐ No
May we send mail to my email address? _____ ☐ Yes ☐ No

May we send a fax to this number? _____ ☐ Yes ☐ No

I grant permission to ***Patient Focused Neurology*** *to relay, leave message, fax and/or email me with detailed information regarding my personal health information with the person(s) and contact number(s) and information listed above.*

Patient Name _____ **Signature** X_____ **Date** _____

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PATIENT PHARMACY INFORMATION

Pharmacy Name _____ Phone _____

Pharmacy Address _____

Pharmacy two major cross streets (if applies) _____

Mail Order Pharmacy _____ Phone _____

Pharmacy Address _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY POLICIES

I certify that I have received a copy of Notice of HIPAA Privacy Policies and I have been provided an opportunity to review it. The Notice of HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Patient Focused Neurology's** health care operations. The Notice of HIPAA Privacy Policies also describes my rights and **Patient Focused Neurology's** duties with respect to my protected health information. The Notice of HIPAA Privacy Policies is available in the reception area. **Patient Focused Neurology** reserves the right to change the privacy policies that are described in the Notice of HIPAA Privacy Policies. I may obtain a revised Notice of HIPAA Privacy Policies by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or through e-mail.

Name _____ Signature X_____ Date _____

In the event this request is made by the individual's personal representative:

Representative Name _____ Representative Signature _____ Date _____

PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

Statement to Permit Payment of Health Insurances Benefit to supplier, physician, or patient

Beneficiary Signature Regulations in effect April 1, 1982, allow physicians to obtain from the patient a signature authorization for the physician to submit assigned or unassigned claims to the insurance company on the patient's behalf. The signature will be retained in our file for any future claims for the patient.

The patient must sign a brief statement substantially as follows:

"I, _____ *(patient name)* request that payment of authorized medical insurance benefits be made on my behalf to **Patient Focused Neurology** for any services by the physician(s). I authorize my medical information to be released to my insurance company and its agents needed to determine these benefits or the benefits payable for related services"

Patient Name _____ Signature X_____ Date _____

PATIENT FINANCIAL POLICY STATEMENT

Thank you for choosing **Patient Focused Neurology (PFN)** as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our **Patient Financial Policy Statement** is important to our professional relationship. It is intended to describe our expectations regarding payments for the services we provide. Due to the current situation with the healthcare industry, we rely on payments from both health insurance companies and our patients in order to cover our expenses. ***It is your responsibility to notify our office of any patient information changes (i.e. address, phone numbers, name, insurance information, etc).*** Please read this policy carefully and feel free to ask question for any item(s) that you do not fully understand.

MEDICATION REFILLS: Please contact your pharmacy directly for refill requests. We recommend that you contact your pharmacy approximately one week prior to running out of medications. **Prescription refills may take 3-5 business days to process.** Routine refill requests might not be honored if the patient has not been evaluated by their physician within the past 3-6 months. However, urgent refill requests may be honored with the understanding that the patient must be evaluated by their physician before another refill is authorized.

CO-PAYS: For in office copayments, we no longer accept **personal checks**. We accept the following forms of payments: Cash, Credit and Debit card ***(Visa/Mastercard only.)*** $10 minimum for Credit & Debit transactions. There will be a transaction fee of $.50 for charges under $10.00. All co-payments, co-insurances, deductibles and past due balances are due at the time of check-in, prior to your visit, unless previous arrangements have been made with our billing department. ***A $15 processing fee will be charged in addition to your copayment if not paid at time of service or by the end of the next business day.***

OUTSTANDING BALANCE POLICY: It is our policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections cost including attorney fees and court costs. If you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. **All outstanding balance needs to be paid in full prior to receiving new medical services unless previous arrangement has been made with our billing department.**

RETURNED CHECKS: The Bank Fee for a returned check is $25.00 payable by cash, credit card or money order. This will be applied to your account in addition to the insufficient funds amount. Please make immediate financial arrangements prior to your appointment, if there is a possibility of insufficient funds.

Although we estimate what your insurance company may pay as well as estimate your patient liability, it is the insurance company that makes the final determination of your eligibility and benefits. Any other balances deemed the patient responsibility by your insurance company will be billed to you. ***Payment is due in full within 15 days upon receipt of the statement.*** ***A $20 billing charge will be added to each outstanding statement.***

INSURANCE CLAIMS: Insurance is a contract between you and your insurance company. We are NOT a party of this contract. We will bill your insurance company as a courtesy to you. We are contracted with most insurance plans but not all and we are required per our agreement with insurance carriers to collect all patient's cost share, deductibles, co-pays and co-insurances. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. Should your insurance fails to pay for any reason, you are responsible for the balance. We make every attempt to know the specifications of your policy and keep us update with your current policy and contact information. ***It is ultimately your responsibility to understand your insurance policy***. **Patient Focused Neurology** expects you to be interactive and responsible for communicating with your insurance carrier on any open claims. We will transfer liability of the claim to you if your insurance does not pay properly within 60 days.

DENIED CLAIMS: Our office will not be involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefit issues, eligibility issues, pre-existing conditions or any other matter, which causes the claim to be denied. Should your claim be denied for any of these reasons or any other reasons not listed here, the claim payment will become your responsibility.

MEDICARE: We participate in the Medicare program. Medicare only covers 80% of the allowable charges. Patient is responsible for the 20% difference. If you have Medigap, (*Medicare supplemental coverage*) we will add it to your file and you will be billed for any remaining balance after supplemental insurance payment received. If you don't have Medigap benefits then you are responsible for the 20% not covered by Medicare and we will bill you directly.
You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fee and notifies you of your financial responsibility for certain medical services.

COORDINATION OF BENEFITS (COB): COB is a provision used to establish the order in which health insurance plans pay claims when more than one plan exists. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance. It is imperative to keep both your insurance company and your physician updated on any COB changes. Failure to report any changes to us or to your insurance carrier may result in patient responsibility for the entire bill.

SELF-PAY ACCOUNTS: Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which our office does not participate, or patients without an insurance card on file with us. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Payment in full is required at each appointment prior to services rendered for self-pay patients. However, we do offer a cash discount for self-pay and cash patients.

MINORS: The parent(s) or guardian(s) present in the office and signing this financial policy and/or the release to treat is the guarantor, therefore responsible for full payments and billing statements.

REFUND POLICY: If the overpayment amount is over $200, our office will automatically issue a refund check to the guarantor automatically after all the remaining balances are resolved. It is the guarantor's responsibility to initiate a written request for a refund on an overpayment under $200. Refunds are only released to the guarantor on the account or the issuant of the payment in excess. Before an overpayment check can be issued, all open claims must be closed. Please allow at least 30 days for processing and the issuance of a refund check.

FORMS: There is a $20.00 documentation fee for all forms or letters. The fee is intended to cover the administrative costs required to complete these forms because the administrative services are not covered by health insurance plans.

MEDICAL RECORDS: We are dedicated to keeping your medical records confidential and therefore require written authorization for release of medical records. Request for medical records will be processed between 5-10 business days and will be subjected to a processing fee. If your insurance company required medical reports or records to document your treatment or progress, *or* to secure payment of benefits, your signature below authorizes this office to release the medical information necessary to process your claim.

LATE RESCHEDULE/CANCELLATION AND MISSED APPOINTMENT POLICY

Our practice has found it necessary to implement and enforce a Missed Appointment/Cancellation Policy due to the ongoing issue of patients canceling without giving adequate notice for our staff to fill the appointment. Missed appointments result in a loss of valuable time that could be spent with patients in need of medical care and they are very costly to our office. This is a standard policy in most other practices. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family and we do take these exceptions into considerations.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with less than 48 hour advance notice *(business hours/ weekend dates do not count.)* Our office will call and confirm your scheduled appointment one business day in advance, if you decide to cancel your appointment during this time, you will be charged $25/regular visits and for visits including a procedure, you will be charged $50/visit, because it's too late for us to fill your time slot. Keep in mind that this will not be covered by your insurance company.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner which is at least 48 business hours notice in advance. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". A "no show" fee needs to be paid during check-in at your next office visit before any medical service can be provided.

Late Appointment Arrival: As a courtesy to others, we reserve the right to reschedule your appointment if you are 15 minutes late arriving to your appointment. We will try to accommodate your appointment if our schedule allows. However, if it can't be done, we may ask for you to reschedule your appointment.

I, hereby agree that I fully acknowledge and understand my patient responsibilities and the written Financial Policy Statement of this office. By signing below, I agree to comply and accept all terms and conditions stated above.

I also understand that my signature authorizes employees and physicians of ***Patient Focused Neurology*** *to provide treatment to me. My signature shall be valid as the Release, Assignment and responsibility for my insurance company including MEDIGAP for the purpose of billing.*

Patient Name _____ Signature X_____ Date _____

In the event this request is made by the individual's personal representative:

Representative Name _____ Representative Signature _____ Date _____