# Southern California Neurology Consultants

625 S. Fair Oaks Ave., Suite 325
Pasadena, CA 91105
Phone: (626) 535-9344 • Fax: (626) 535-9387


## REGISTRATION FORM

### PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Miss ❑ Mrs. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|
| | | | | |

| Sex: ❑ M ❑ F | Birth date: / / | Age: | Social Security No.: / / | Home phone No.: ( ) | Cell phone No.: ( ) |
|---|---|---|---|---|---|
| | | | | | |

| Street address: | City: | State | ZIP Code: |
|---|---|---|---|
| | | | |

| Occupation: | Employer: | **Email:** |
|---|---|---|
| | | |

**Primary Care Physician:**

If patient is a minor, please provide parent/guardian names and specify relation to the patient:

| **Referred to clinic by (please check one box):** | | | ❑ Dr. Name | | |
|---|---|---|---|---|---|
| ❑ Family | ❑ Friend | ❑ Web Search | ❑ Insurance Plan | ❑ Hospital | ❑ Other |

### IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship: | Home phone No.: ( ) | Work phone No.: ( ) |
|---|---|---|---|
| | | | |

| Street address: | City: | State | ZIP Code: |
|---|---|---|---|
| | | | |

### INSURANCE INFORMATION

**(Please give your insurance card(s) to the receptionist)**

***If the patient is responsible for his/her bill, please skip the next section.***

| Person responsible for bill: | Birth date: / / | Address (if different): | Home phone No.: ( ) |
|---|---|---|---|
| | | | |

| Occupation: | Employer: | Employer address: | Employer phone No.: ( ) |
|---|---|---|---|
| | | | |

| Work related? | ❑ Yes | ❑ No | Auto Accident? | ❑ Yes | ❑ No | If yes, on what date did the injury occur? | / / |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

| **Name of Primary Insurance:** | | | | | |
|---|---|---|---|---|---|
| Subscriber's name: | Birth date: / / | Group No.: | Policy No.: | Co-payment: $ | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

| **Name of Secondary Insurance (if applicable):** | | | | | |
|---|---|---|---|---|---|
| Subscriber's name: | Birth date: / / | Group No.: | Policy No.: | Co-payment: $ | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

### PHARMACY

| Pharmacy name: | Pharmacy Address: | Phone No.: ( ) |
|---|---|---|
| | | |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Southern California Neurology Consultants** or insurance company to release any information required to process my claims.

***Patient/Guardian signature*** / / ***Date***

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www.pasadenaneurologist.com

# INITIAL VISIT PATIENT INTAKE FORM

**Name:**_____ **Date of Birth:** _____

**Patient Notification will be done by e-mail (please provide your e-mail address here):** _____

I authorize the use of the above e-mail: _____ _____

Patient Signature Date

**Race:** ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African-American ☐ More Than One Race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Refused to Report/Unreported

**Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refused to Report/Unreported

**Language:** ☐ English ☐ Spanish ☐ Other: _____

## REASON FOR COMING TO THE DOCTOR TODAY:

**Reason for Today's Visit:** _____

**Timing/Onset:** When did symptoms first occur? _____

**Duration:** Frequency of symptoms? _____

**Characterized as/Severity:** Describe the severity of the symptoms/pain. _____

**Associated Signs and Symptoms:** Are there any other symptoms associated with your problem? _____

**Modifying Factors:** What makes the condition better and/or worse? _____

## PROBLEM LIST/PAST MEDICAL HISTORY:

Have you been diagnosed with any of the following (currently or in the past)?

| | | | | |
|---|---|---|---|---|
| ☐ Anxiety | ☐ Cancer | ☐ Heart Disease | ☐ History of Carotid Dis. | ☐ Seizure Disorder |
| ☐ Arthritis | ☐ Depression | ☐ High Blood Pressure | ☐ Migraines | ☐ Stroke |
| ☐ Back Pain | ☐ Diabetes | ☐ High Cholesterol | ☐ Neck Pain | ☐ Thyroid Disease |

☐ Other: _____

## MEDICATION HISTORY:

☐ I am not currently taking any medications

List any medications, vitamins, minerals, and herbals that you are currently taking:

| Name of Medication | Dosage | Name of Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ALLERGY HISTORY:**

☐ **None** ☐ **NKDA (No Known Drug Allergies)**

Other: _____

**FAMILY HISTORY:**

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition and indicate if the family member passed away due to that condition.

| | **Mother** | **Father** | **Sister** | **Brother** | **Mother's Parents** | **Father's Parents** |
|---|---|---|---|---|---|---|
| Alzheimer's Disease | | | | | | |
| Aneurysm | | | | | | |
| Autoimmune Disorders | | | | | | |
| Bleeding Disorder | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Heart Disease | | | | | | |
| High Blood Pressure | | | | | | |
| Multiple Sclerosis | | | | | | |
| Parkinson's Disease | | | | | | |
| Stroke | | | | | | |
| Seizure Disorder | | | | | | |
| Tremors | | | | | | |

Other: _____

**PAST SURGICAL HISTORY:**

List significant surgeries or injuries (Write "None" if you have no past surgeries or injuries):

☐ Cardiac Pacemaker ☐ Coronary Artery Bypass Graft ☐ Craniotomy ☐ Spinal Fusion

☐ Carotid Surgery/Stent ☐ Craniotomy ☐ Discectomy

*Surgeries/Injuries* *Date(s) or Age/Surgeon*

_____

_____

_____

**SOCIAL HISTORY:**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please describe your Current Tobacco Use?

☐ Current every day smoker ☐ Current some day smoker ☐ Former Smoker ☐ Never Smoker

Do you drink alcoholic beverages? ☐ Never ☐ Occasionally ☐ Frequently

Do you drink caffeinated beverages? ☐ Yes ☐ No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you ever used any illicit drugs? ☐ Yes ☐ No

If yes, please indicate what type of drug and how often: _____

Please describe your current exercise routine: ☐ Inactive ☐ Light ☐ Moderate ☐ Heavy

## REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

**General:**
- ❑ Fatigue
- ❑ Fever
- ❑ Weight Gain
- ❑ Weight Loss

**Skin:**
- ❑ Excessive Sweating
- ❑ Rash

**HEENT:**
- ❑ Sleep Apnea
- ❑ Facial numbness/tingling

**Neck:**
- ❑ Neck Pain
- ❑ Neck Stiffness
- ❑ Neck Swelling

**Respiratory:**
- ❑ Difficulty Breathing
- ❑ Snoring
- ❑ Wheezing

**Cardiovascular:**
- ❑ Chest Pain
- ❑ Fainting/Blacking Out
- ❑ High Blood Pressure
- ❑ Irregular Heart Beat
- ❑ Swelling of Extremities

**Gastrointestinal:**
- ❑ Change in Bowel Habits
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty Swallowing
- ❑ Nausea
- ❑ Vomiting

**Genitourinary:**
- ❑ Frequency
- ❑ Incontinence
- ❑ Painful Urination
- ❑ Urgency

**Musculoskeletal:**
- ❑ Back Pain
- ❑ Decreased Range of Motion
- ❑ Joint Pain
- ❑ Muscle Pain
- ❑ Muscle Weakness

**Psychiatric:**
- ❑ Apathy
- ❑ Anxiety
- ❑ Change in Sleep Pattern
- ❑ Depression
- ❑ Hallucinations
- ❑ Nervousness
- ❑ Panic Attacks
- ❑ Trouble Falling Asleep

**Endocrine/Glands:**
- ❑ Appetite Changes
- ❑ Cold Intolerance
- ❑ Sexual Dysfunction
- ❑ Thyroid Problem

**Hematology:**
- ❑ Abnormal Bleeding
- ❑ Blood Clots
- ❑ Easy Bruising
- ❑ Painful Lymph Nodes

**Neurological:**
- ❑ Auras
- ❑ Balance Problems
- ❑ Decreased Memory
- ❑ Difficulty Speaking
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Frequent Falls
- ❑ Headaches
- ❑ Incoordination
- ❑ Numbness/Tingling
- ❑ Paralysis
- ❑ Seizures
- ❑ Stroke
- ❑ Tremor
- ❑ Trouble Walking
- ❑ Vertigo
- ❑ Visual Changes
- ❑ Weakness

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this practice of any changes in my medical status.**

**Signature:**

*Southern California Neurology Consultants*

## Informed Consent to Perform a Neurological Evaluation

Welcome to Southern California Neurology Consultants. This form will provide information about our services and about your rights and responsibilities as a client. Please be sure to discuss any questions with your clinician. Your signature at the bottom indicates that you understand the information and freely consent to participate in this assessment.

### INFORMED CONSENT

I understand that the information obtained in this evaluation is confidential and will not be released to any person or organization without my written permission. (*This release is available in our office or may be completed with any individual whom you wish to give such access, and then provided to us*.) The only exceptions to this policy are rare situations in which you are required by law to release information with or without my permission. These are: 1) if there is evidence of physical abuse to the elderly; 2) if you judge that I am in danger of harming myself or another individual; and 3) if my records are subpoenaed by the court. In the rare event of any of these situations, you would attempt to discuss your intentions with me before an action is taken, and you would limit disclosure of confidential information to the minimum necessary to ensure safety.

### CONFIDENTIALITY AGREEMENT

**Privacy Policy**

*Confidentiality is the legal right to privacy for all patients who receive neurological services. Such as, all personal information presented to this office will not be discussed with persons or agents outside of this office except as authorized by a written release or as required by law.* ***However, there are exceptions to confidentiality.*** *Please be advised, all information discussed in this office will remain confidential except under the following conditions set forth in this agreement:*

- You consent in writing for Southern California Neurology Consultants to release and disclose information.
- A breach of confidentiality is required or permitted by law. Examples include instances in which Southern California Neurology Consultants has a reasonable suspicion of elder/dependent adult abuse, dangerousness toward self or others, and other matters subject to law.
- Southern California Neurology Consultants in their discretion decide to obtain consultation on your case with a colleague or legal counsel, in which case no identifying information will be revealed.
- You fail to make regular payments on your outstanding bill, which can result in your billing being turned over to a collection agency or submitted to small claims court.
- Upon notification of a social service agency case, wherein all information shared with Southern California Consultants will be conveyed to the assigned social worker and/or other SSA representative and agents.
- If you are a party in litigation, including divorce litigation, and you tender your mental condition as an issue, your privilege may be waived. In custody case you may be required to waive your privilege to facilitate an evaluation by a court ordered evaluator. SCNC may be required to produce your records and/or testify at deposition or trial if we are served with subpoenas or court orders. We cannot give you legal advice as to what action may or may not waive your privilege.
- Please be aware that under California's Family Code, a parent without custody may still be entitled to information about his or her child's treatment.

_____Initial

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## RELEASE OF RECORDS

Written records are released *only* after a consent form is signed by the client or Legal Guardian.

## APPOINTMENT POLICIES

Initial evaluations, assessments and full sessions are generally about 30 to 45 minutes in duration. Subsequent follow-up session ranges from 15-30 minutes in duration. Medication refill sessions are about 15-30 minutes in duration. However, based on a case-to-case basis, these sessions may require more time than expected. All registration paperwork and submission of co-pay must be rendered before the beginning of the session. Please arrive 20-30 minutes before your scheduled appointment for ease of operations. Please respect time guidelines so that the next patient waiting is not affected.

## 24-HOUR CANCELLATION POLICY

**Cancellation & late arrival phone number: 626-535-9344**
*Please store this number where it will be convenient for you if you need it.*

***LATE ARRIVALS:***

If you arrive late, it is the providers discretion to see you on that day or request to reschedule for a future date. Calling in to notify of late arrival does not guarantee your appointment will be kept.

***ABOUT THE 24-HOUR CANCELLATION POLICY:***

**You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.**

**Reason for this policy:** Notifying of your intention to cancel or reschedule 24 hours in advance gives an opportunity to schedule someone else for that time slot. This is important because others may be on a waiting list or may also be looking for an opportunity to reschedule for a different time. As much advance notice as possible is really appreciated.

**If you cancel your appointment with less than 24-hour notice, you will be charged for the appointment.
**If you simply do not show up for a scheduled appointment, you will be charged for the missed appointment.

Because it is illegal to bill your insurance company for a missed appointment, you will end up paying the full fee for the missed session out-of-pocket (resulting in a much higher payment than you may have paid for a kept appointment).

This cancellation policy is standard in the medical field and will be strictly enforced. On occasion, there will be understandable reasons for missing appointments, but exceptions to this policy will be rare. If you have three (3) no shows within a calendar year, we may discontinue treatment services to the patient. Cancellation fees will be charged to your credit card on file.

_____Initial

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## FINANCIAL TERMS

Please note, you are responsible for obtaining prior authorization for treatment from your insurance company. In addition, you are responsible for all co-pays and insurance services when rendered. Furthermore, I understand I am responsible for charges not covered by my insurance. I further agree if at any time during my treatment, I become aware that I am ineligible for insurance coverage, I will notify SCNC immediately, I understand I will be financially responsible for 100% of the billed charges. Lastly, I agree to notify SCNC of changes to my personal and/or insurance information, and we keep a current credit card on file.

**Medicare Only Patients, by signing below I agree to pay 20% of the Initial Visit, all follow-up visits, and any deductible amount.**

## PAYMENT TERMS AND UNCOVERED SERVICES

I understand I will be charged the regular cash rate of $20- $400 for services required outside of the treatment sessions. These services include consultations with other professionals. I will be charged a fee for forms such as DMV, EDD, disability, and/or any letter that is required for medical leave.

Please be advised, should it become necessary for SCNC to employ an attorney to enforce any of these conditions hereof, I understand I will pay any/and all expenses so incurred included reasonable attorney fees.

**Types of Payment.** Services are payable in advance of each appointment. Please make checks payable to Southern California Neurology Consultants. Also, for your convenience, you may pay by cash or credit card. Please note, receipts will only be given by request at the beginning of your appointment.

**Prompt Payment**. Balances not paid within 30 days are considered "PAST DUE". Balances not paid within 60 days may be sent to our collections agency or pursued through small claims court. IF you are not able to make a full payment, you agree to make regular payments on a six-month payment plan with no less than $75.00 until the balance is paid in full.

**Insurance Claims.** Please note, you are required to pay for all services rendered not covered by your insurance carrier.

**Prescription Refill Policies.** You are responsible to notify the office at the time of your appointment if you are running out of medication so that we can avoid medication shortages. If you have mail-in service, you are responsible to mail the forms and prescriptions after we fill them out to avoid any confusion. Medication refills are not emergencies and must be taken care of during your appointment, under unforeseen circumstances if you run out of medicines, please contact the office during regular business hours. A medication refill outside of these parameters will be considered a concierge service and is not covered by your insurance plan. This will be billed on a prorated basis at the fee for service rate of $400.00. Please be advised that controlled substance prescriptions cannot be mailed out and must be picked up personally. We will be happy to refill your medications if you have a scheduled follow-up appointment. Medications cannot be auto refilled after your first no show and/or more than six months since last appointment.

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**RETURN CHECK FEE.** Returned check fee is $30.00. If for any reason a check is returned without having been paid, the patient will pay an additional thirty dollars ($30.00) as an administrative non-sufficient fund's payment.

**RIGHT TO END TREATMENT.** You have the right to end treatment at any time with no obligation except to pay for completed services.

## FINANCIAL POLICIES

Professional services and rates: Our professional services and rates are as follows:

| Professional Services | Times | Rates MD/DO | Rates for Nurse Practitioner | Rates for Neuropsychology |
|---|---|---|---|---|
| Initial Visit | MD, NP 30-45min<br>PhD. 360min | $400 | $300 | $4500 |
| Follow Up | MD, NP 15-30min<br>PhD. 60min | $200 | $150 | $250 |
| Missed Appointments | No Call/No Show | $150 | $100 | $200 |

| Missed Procedures | No Call/No Show | EEG $200 | EMG $200 | Botox $200 |
|---|---|---|---|---|

Forms, letters, and other non-specific

| Forms, Report Writing (Disability, EDD, Jury Duty, letters, etc.) | Varies by document | $20 minimum<br>$10 per page | $20 minimum<br>$10 per page | $20 minimum<br>$10 per page |
|---|---|---|---|---|

_____Initial

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## MEDICAL EVALUATION CONSENT

By my signature below, I acknowledge that I consent to a neurological evaluation by Southern California Neurology Consultants, that I have been informed of the policies regarding evaluations at the clinic and have read the 5 pages consent form as well the policies regarding late/cancellation and missed appointments; and I agree to all of the payment arrangements outlined in this form. I fully understand my rights and obligations as a client at SCNC and I freely agree to this assessment.

| _____ | _____ | _____ |
|---|---|---|
| Signature | Date | (Please print name) |
| _____ | _____ | _____ |
| Signature/Relationship | Date | (Please print name) |

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## CREDIT CARD AUTHORIZATION (OPTIONAL)

I,_____, authorize Southern California Neurology Consultants, to charge my credit card for additional services provided to patient,_____, for services not paid by insurance carrier and which are considered concierge services as noted under payment terms and uncovered services. Charges to this credit card may include but are not limited to office visit, phones sessions, paperwork, and late cancellation and no-shows. I understand my credit card will be charged for these services and I have reviewed Southern California Neurology Consultants 24-hour cancellation policy.

Card Type: _____Visa _____MasterCard _____Discover _____AMEX

Card Number: _____

Security Number on Card: _____

Expiration Date: _____

Signature:_____Date: _____

If this authorization was given a verbal authorization, please include date, time, and contact number.

Date: _____ Time: _____ Phone:_____

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## AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

**Patient Information Name:** _____ **Date of Birth:** _____

**Address:**_____**Day Phone:** _____

**City:**_____ **State:** _____ **Zip:**_____

Clinical/Hospital/Health Care Provider:
**Name:**_____

**Address:**_____ **Phone:** _____

**City:** _____**State:** _____ **Zip:** _____

Additional Parties to Disclose Information: **(If more than two people please provide name and Relation on separate attachment).**

Name: _____ Relation:_____

Name: _____ Relation: _____

□ **I do not wish to disclose information to the above name parties**
Information to be released:

□ All Information on File □All Progress notes □ Electrocardiogram (EKG) □ Dietician/Biofeedback
□ Electromyography (EMG) □Sleep Study Records □ Neuro Diagnostic Reports □ Radiology/X-ray report
□ Other

Purpose of disclosure: (Check all that are applicable)

□ Medical Necessity □ Insurance Company claim □Legal matter □Personal □Work/Workers Comp. claim
□Other

Special authorization: Please circle what is applicable:
Alcohol Drugs Mental Health Neuro Diagnostic Testing Sexually transmitted diseases
HIV AIDS

**Note:** If this release pertains to alcohol, drug or mental health information, please note that this information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless additional further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The fede3ral rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

By signing below, I understand that I may revoke this consent at any time except to the extent that action has already been taken. I understand that a reasonable le fee will be charged for the following services, duplication of records postage, and copies. The fee disclosure for this service is postdated at the front desk. An Estimate of those charges will be provided upon request prior to duplication. Upon request the requestor may be provided with a copy of this authorization.

Patient Signature:_____Date:_____ Last Four of Social Security Number: _____

Print Name: _____

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