SOUTHLAND NEUROLOGIC ASSOCIATES

NIRAV PATEL, MD ALAN COHEN, MD
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Patient Registration

(Please Print Clearly)

Date: ____________________

Patient: ____
(Last Name) (First Name) (MI)

Address:____

City: ________________________ **State:** ____________ **Zip:** ____________

Home Phone: ______________________ **Cell Phone:** ______________________

SSN#: ____________________ **Female:** ___ **Male:** ___ **Marital Status: S M D W**

Driver's License #: ____________________ **Date of birth:**____________________

Employer: __________________________ **Occupation:** ______________________

Work Phone #: ______________________ **May we call you at work? Y __ N __**

Emergency Contact: ___________________ **Phone #:** ________________________

Relationship to Patient: ____

Referring Physician: ___________________ **Phone #:** ________________________

Name of Pharmacy: ___________________ **Phone #:** ________________________

Primary Insurance: ______________________________ **ID#:** __________________

Address: ____________________________ **City, State, Zip:** __________________

Subscriber: ________________ **Date of Birth:** _____________
(Self or Spouse)

If HMO or IPA, what contract? ____

Secondary Insurance: ______________________________ **ID#:** __________________

Address: ____________________________ **City, State, Zip:** __________________

Subscriber: ________________ **Date of Birth:** _____________
(Self or Spouse)

If HMO or IPA, what contract? ____

Patient's Signature: ______________________________________**Date:** ____________

By signing this, I certify that the above information is correct to the best of my knowledge. I will not hold Southland Neurologic Associates or any members of the staff responsible for any errors or omissions that I may have made in the completion of this form. I clearly understand that I am personally responsible for payment for all services provided to me. I also understand that if I terminate my care and treatment, fees for professional services rendered to me will be immediately due and payable.

MEDICAL HISTORY

NAME________________________________ DATE: ___________________

AGE: ______________ ☐ RIGHT HANDED LEFT HANDED ☐

BRIEFLY DESCRIBE THE REASON YOU ARE BEING SEEN TODAY.

____

____

WHEN DID IT BEGIN? __________ YOU SEEN ANOTHER DOCTOR FOR THIS PROBLEM? ______

WHO? ________________________________

WERE TEST PERFORMED? ____

WHAT WERE THE RESULTS? ____

DO YOU HAVE ANY OF THE FOLLOWING?

Double vision? __

Speech abnormality? __

Walking difficulty? __

Face? __ left or right side?

Arm? ___ left or right?

Leg? __ left or right?

In coordination? __

Hearing loss? __

Buzzing in ear or ringing? __

Numbness or tingling? ___

Swallowing difficulty? ___

Dizziness? ___

Vertigo? ___

Weakness? ___

Lightheadedness? ___

Blackouts? ___

Seizures or convulsions? ___

Tremors? ___

SYSTEM REVIEW:

Diabetes __ High blood pressure __ Heart disease/attack __

Stroke __ Chest Pain __ Meningitis __

Recent infection __ Nervuousness __ Personality change __

Memory loss __ Depression __ Liver Disease __

Kidney disease __ Cancer/ Tumor __ Mental illness __

Anemia __ Ulcer __ Asthma/Hay fever __

HABITS

Tobacco __ Alcohol __ Drugs __

MEDICATION ALLERGIES	OPERATIONS	LIST OF MEDICATIONS

FAMILY HISTORY

FAMILY MEMBERS	AGE	HEALTH	AGE OF DEATH	CAUSE OF DEATH
FATHER				
MOTHER				
BROTHER				
SISTER				
SON				
DAUGHTER				

REVIEW OF SYSTEMS

Thank you for coming to our office today. We need to update your information on a regular basis. We are asking you to report any of the following problems, whether it is a new or new problem. Fill in the circles on any problems you have so we can scan in your answers. <u>Please fill in marks completely (don't draw lines)</u>. If you have none of the problems, leave the circles blank. This is page 1 of 3 pages.

GENERAL

None of these problems O None

fever	O Yes	fatigue	O Yes
loss of appetite	O Yes	weight loss	O Yes
weight gain	O Yes	weakness	O Yes
chills	O Yes	sweats	O Yes

OPHTHALMOLOGY

None of these problems	O None	blood in eye	O Yes
vision loss	O Yes	itchy eyes	O Yes
change in vision	O Yes	dry eyes	O Yes
double vision	O Yes	red eyes	O Yes

EARS, NOSE, THROAT

None of these problems O None

nosebleeds	O Yes	swollen lymph nodes	O Yes
decreased hearing	O Yes	dizziness	O Yes
ringing in ears	O Yes	lump on throat	O Yes
pain in ears	O Yes	sores in mouth	O Yes
pain in sinuses	O Yes	pain in mouth or teeth	O Yes

CARDIOVASCULAR

None of these problems O None

chest pain	O Yes	shortness of breath	O Yes
palpitations	O Yes	leg swelling	O Yes

RESPIRATORY

None of these problems O None

chest congestion	O Yes	cough	O Yes
pain with deep breath	O Yes	cough up blood	O Yes
wheezing	O Yes	coughing up phlegm	O Yes
tobacco use	O Yes		

GASTROENTEROLOGY

None of these problems O None

nausea	O Yes	Difficulties swallowing	O Yes
pain on swallowing	O Yes	bloating	O Yes
burp up food	O Yes	stomach pain	O Yes
heartburn	O Yes	abdominal pain	O Yes
vomiting	O Yes	change in bowel habits	O Yes
vomiting blood	O Yes	pain in rectal area	O Yes
blood in stool	O Yes		

Name:________________________ Date of birth_____________

MALE REPRODUCTIVE

None of these problems	O None	diminished sexual drive	O Yes
painful urination	O Yes	penile discharge	O Yes
pain or lump on testicle	O Yes	difficulty with erection	O Yes
undescended testicle	O Yes	pain with sex	O Yes
urgency/frequency	O Yes	unable to get erection	O Yes

FEMALE REPRODUCTIVE

None of these problems O None

breast pain	O Yes	infertility	O Yes
breast lump	O Yes	pelvic pain	O Yes
nipple discharge	O Yes	pain with sex	O Yes
no periods	O Yes	pain urinating	O Yes
periods irregular	O Yes	frequent yeast infections	O Yes
periods heavy	O Yes	vaginal discharge or yeast	O Yes
periods painful	O Yes	hot flashes	O Yes

MUSCULOSKELETAL

None of these problems	O None	leg cramps	O Yes
joint stiffness	O Yes	neck pain	O Yes
joint pain	O Yes	sciatica	O Yes
joint swelling	O Yes	carpal tunnel	O Yes
fracture	O Yes	back pain	O Yes
osteoporosis treatment	O Yes	muscle pain	O Yes

DERMATOLOGY

None of these problems	O None	dry or sensitive skin	O Yes
acne	O Yes	hives	O Yes
rash	O Yes	eczema	O Yes
change in mole	O Yes	itching	O Yes

NEUROLOGY

None of these problems O None

headache	O Yes	paralysis	O Yes
seizures	O Yes	sleep problems	O Yes
insomnia	O Yes	tremor	O Yes
memory loss	O Yes	burning pain in feet or hands	O Yes
difficult walking	O Yes	confusion	O Yes

MENTAL HEALTH

None of these problems O None

depression	O Yes	seeing things or hearing voices	O Yes
suicidal thoughts	O Yes	anxiety	O Yes
eating disorder	O Yes	mood swings	O Yes
loss of interest in activities	O Yes	feeling helpless	O Yes

ENDOCRINOLOGY

None of these problems	O None		
frequent urination	O Yes	hair changes	O Yes
cold intolerance	O Yes	dark skin	O Yes
heat intolerance	O Yes	hunger	O Yes
excessive sweating	O Yes	enlarged thyroid	O Yes
excessive thirst	O Yes		

HEMATOLOGY/LYMPH

None of these problems	O None		
swollen glands	O Yes	anemia	O Yes
easy bruising	O Yes	easy bleeding	O Yes

ALLERGY

None of these problems	O None
runny nose	O Yes
scratchy throat	O Yes
ear fullness	O Yes
sinus congestion	O Yes
ear symptoms	O Yes
facial pressure	O Yes
nasal congestion	O Yes
post-nasal drip	O Yes
sneezing	O Yes

UROLOGY

None of these problems	O None
blood in urine	O Yes
urinary incontinence	O Yes
kidney stones	O Yes
obstructive symptoms	O Yes
previous urinary infections	O Yes

Southland Neurologic Associates, Inc.

Nirav Patel, M.D.   Alan Cohen, M.D.   Omid Omidvar, M.D.
Nima Ramezan, M.D.   MICHAEL THOMPSON, M.D.

OFFICE POLICY

Welcome to our office and thank you for selecting Southland Neurologic for your Neurology needs. The following information is to help you become acquainted with our office and our policies. Please read the following information carefully. If you have any questions or concerns, please feel free to ask the receptionist.

- Regular office hours are from 8:00 AM to 4:00 PM Monday through Friday. Closed for lunch 12:00 PM to 2:00 PM.
- Please arrive on time for each appointment. Should you be more then 15 minutes late you will be rescheduled for another date and time.
- Two missed appointments not cancelled will result in being referred back to your primary physician.
- Notify this office of any cancellations 24 hours in advance. Failure to keep the time reserved for your appointment will result in a fine. This fine is due and payable before another appointment is scheduled.
- Insurance CO-PAY AND INSURANCE DEDUCTIBLES ARE DUE AND PAYABLE AT EACH VISIT. Credit card, personal checks and/or cash are accepted. No exceptions to this policy will be made.
- HEALTH PLANS: Because our doctors are specialists, you have been referred by your primary care physician. You are responsible for making sure that we have an authorization to see you. We are responsible for getting the authorization for follow-up care. You should familiarize yourself with your co-pay amount which can usually be found on you health plan card. If it is not listed, call your plan and write it on your card for reference. Your co-pay is due before seeing the physician.
- Please notify the receptionist of any changes with your insurance coverage or any address changes when you arrive for your appointment.
- Minor children cannot be left in the waiting area without adult supervision (15 yrs. or older) accompanying them. As a courtesy to our other patients we ask that you keep the children quiet and mannerly.
- All non-English speaking patients must have an adult interpreter (15 yrs. or older) accompanying them on each visit. The appointment will be rescheduled if an interpreter is not present.
- Prescription refill requests must be faxed to our office. This needs to be done at least one week before your prescription runs out.

Please complete the forms attached being as detailed as possible and answer all questions as completely as possible. List all medications you are currently taking. Feel free to use another sheet of paper if needed. You may use the reverse side of this form if needed.
Thank you for reviewing these important policies and we look forward to having you as part of our patient family.
I have read, understand and agree to comply with above policies.

Signature: ____
Patient or Responsible Party

Date: ____
Revised 12/04/09

Late Cancellation and Failed Appointment Statement

Patients who have appointments have a "reserved" time for them to be given their medical service and care. This neurology practice schedules appointments up to 8 weeks in advance. We make every effort to give our patients appointments which fit their schedules as well as the office schedule. Our policy is to call scheduled patients two days prior to confirm their appointments and cancellations are accepted up to 24 hours prior to the scheduled appointment.

We have a wait list for patients who request to be seen earlier than their scheduled appointments. Notification of a cancelled appointment within 24 hours allows us time to notify a patient on the wait list and place them in the cancelled appointment timeframe. If a patient does not come in at the appointed day and time, and does not notify the office of the cancellation, then it is too late to call another patient to have them seen at that time. This has a negative impact on the practice for the patients, the staff, and the physician. Unfilled appointments impact the overall scheduling of patients and extends the next available appointment date.

It is customary for businesses that deal with individual reserved appointments to charge a fee for persons who do not show for their appointed time or fail to cancel the appointment within the designated timeframe. Although it is our hope that our patients will honor their appointments, if a patient fails to keep their designated appointment time or fails to notify the office of a cancellation within 24 hours, a fee will be charged. The fee will be based upon the amount of time the appointment occupied. New patient consultations and treatment appointments will be charged up to a maximum of $100.00. Follow up appointments will be charged up to a maximum of $50.00. Payments must be received prior to the rescheduling of the missed or failed appointment.

We realize that no one wants to pay for time when there was no service provided and insurances do not cover these fees because it was the patient's responsibility to keep the appointment and abide by the cancellation policy. Therefore, your understanding and cooperation is truly appreciated.

Thank you,

Business Management Department
Southland Neurology Associates of Orange County

☐ I have read and agree to comply with the above cancellation and failed appointments statement.

____ __________________
Signature of Patient/Responsible Party Date

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MICHAEL THOMPSON, M.D.

Financial Policy

Welcome to our office and thank you for choosing Southland Neurologic Associates for your Neurology needs. The following information is to help you become acquainted with our office and our policies. We are committed to your treatment being successful and we will work very hard to make sure your paperwork is processed both accurately and promptly.

All co-pay and deductible payments are due at the time of your appointment. For payment, we accept cash, major credit cards (MC, Visa, American Express) and personal checks. Please be assured that your personal information will be held in the strictest confidence.

For patients utilizing their insurance coverage for services rendered:

- A current insurance card must be provided at the time of the first visit. If an insurance card is not provided and/or verification of insurance cannot be obtained, the patient will be responsible to pay for services rendered at the time of the visit.
- Your insurance policy is a contract between you and your insurance company. IT IS YOUR RESPONSIBILITY TO:
    1. Verify eligibility and benefits.
    2. Verify contracted laboratory facilities, radiology facilities and hospitals.
- Any balance not paid by the insurance company will be due in full at the time of the next visit, or upon receipt of our statement.

PPO/POS, Non-contracted or Indemnity Insurance Plans:
We will bill your insurance as a courtesy. Please understand that insurance reimbursement can be a long and difficult process. To the end, our billing specialists as a convenience and a service to you will absorb all costs incurred for billing. Our billing specialists have undergone extensive training to reimburse us within the legally allowable 45 days, the outstanding balance will become your financial responsibility. If this becomes necessary, your may make arrangements for payment as indicated by you initialed preference.

Medicare:
As a participating provider, we may bill your Medicare carrier; however, if you do not have a secondary insurer, you will be responsible for the 20% co-pay.

Secondary insurers:
Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy; however, you will be financially responsible for any balances after payment has been received from your insurers.

Thank you for reviewing our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree with this policy.

X____ Date:_________________________
Signature of Patient or Responsible Party
Revised 04/01/09

SOUTHLAND NEUROLOGIC ASSOCIATES, INC.

DIPLOMATES AMERICAN BOARD OF NEUROLOGY

OMID OMIDVAR, M.D. **ALAN COHEN, M.D.**
NIRAV PATEL, M.D **NIMA RAMEZAN-ARAB, M.D.**
MICHAEL THOMPSON, M.D.
Phone: 562 430-4513 Fax: 562 430-7718

NEW HIPAA PRIVACY REGULATION

Federal law, the Health Insurance Portability and Accountability Act of 1996, authorized the Department of Health and Human Services to adopt new rules to protect patient privacy.

Notification is, therefore, given that Southland Neurologic Associates, a Medical Corporation, will not reveal any personal information about you or about a family member (i.e., name, address, Social Security number, as well as other health information) without your permission. Your information will never be sold, or listed for the purpose of advertisement solicitation or fund raising.

It is, however, understood that within the realm of doing business and for general patient care purposes, your personal information will be necessary and used in the following context:

*Patient registration.
*Procure medical records from former physicians.
*Converse with a colleague for opinions and\or care.
*Insurance: verifications, billing, paper and wire, (includes fax transmissions), insurance company follow-up or interaction with billing services relating to patient care.
*Pursue collections of unpaid bills.
*Hospital workers, nurses, aids and medical records department.
*Emergency officials, Paramedics, Fire personnel, emergency room physicians, nurses or technicians. Personal religious designated.
*Our office staff.
*Pharmacists, drug program personnel/workers.
*Completion of disability forms.
*Computer and electronically stored information, (i.e., related business vendor and service personnel).

I authorize the release of this necessary information.

________________________________ _________________
Patient or Parent Signature Date

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

NAME: ______________________________________ DATE OF BIRTH:___________
LAST FIRST MIDDLE

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this authorization to the recipient that I have identified below.

Name of Provider: Southland Neurologic and Associates
Address of Provider: 3791 Katella Ave #106
Los Alamitos, CA 90720
Fax Number: 562-430-7718
Phone#: 562-430-4513
Recipient (REFERRING DOCTOR)

Name of Referring Doctor: ___________________________

Address of Referring Doctor: ________________________

Fax Number: ___________________________________

INFORMATION TO BE DISCLOSED: This authorization permits the above named health care provider to disclose the following medial records:

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.
- All of my health information described above except for following: ____
- Only the following records or types of health information: (insert dates of treatment, types of treatment or other designation.)____

TERM: This Authorization will remain in effect for (1) year from the date this authorization is signed.

REDISCLOSURE: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

REFUSAL TO SIGN/RIGHT TO REVOKE: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider

REVOCATION: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on the Authorization before it received my written note of revocation.

QUESTIONS: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have rights to receive a copy of this authorization from my health care provider.

PHOTOCOPY: A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid as the original.

______________________________ ________________ ______________________

Signature Date Signature of Witness

Name: ____

(PLEASE PRINT)

IF INDIVIDUAL IS UNABLE TO SIGN THIS AUTHORIZATION, PLEASE COMPLETE THE INFORMATION BELOW:

____

____

Signature of Personal Representative Legal Relationship Date Witness Signature

Name: ____

(PLEASE PRINT)