PATIENT INFORMATION

Patient's Name_____
(Last) (First) (Middle)

Date of Birth_____ Sex_____ Age_____ Height_____ Weight____
(Month, Day, Year)

Race:

___ Caucasian ___Asian ___Pacific Islander

___African American ___Native American ___Other:_____

___ Two or more: _____

Ethnicity: ___Hispanic ___Latino

Preferred Language:_____

Home Address (no P.O. Boxes, please):_____
(Street, Apt #)

_____
(City) (State) (Zip)

Phone (Include Area Code) Home # _____

Work # _____ Cell #_____

Employer_____Soc. Sec # _____

Work Address _____
(Street) (City) (State) (Zip)

My Primary Care Physician is: _____

Source of Referral: ____ Self-Referral ____ Patient Referral ____ Physician Referral

Reason for your visit: _____

Marital Status: ( ) Single ( )Married ( ) Separated ( ) Divorced ( ) Widowed

Emergency Contact _____ Contact phone #_____

Who is the primary person on your insurance? ( ) Self ( ) Other (i.e. spouse/parent/employer)

If other, name here _____ Relationship _____

Date of birth of primary person on your insurance _____

Consent for Treatment (Please sign here)

Signature:_____**Date**_____

MEDICAL HISTORY: (Please check which apply to your past medical history)

_ High Blood Pressure _ Diabetes _ Seizures

_ Stroke _ Migraine _ Heart Disease

_ Cancer (Type of Cancer) _____

_ Other Medical or Neurologic Problems _____

SURGICAL HISTORY (Please check which apply to your past medical history)

_ Tonsillectomy _ Appendectomy _ Gyn Surgery _ Hernia

_ Gallbladder _ Heart Surgery _ Cataract

_ Other Surgeries_____

FAMILY HISTORY: (List those people in your family with the following illnesses):

High Blood Pressure _____ Heart Disease _____

Diabetes _____ Cancer _____

Stroke_____ Migraine _____

Seizures_____ Parkinson's _____

Alzheimer's _____ Other Neurologic Problems _____

SOCIAL HISTORY:

Smoking? _ No _ Yes
(If Yes, please list how many packs per day and for how many years you have smoked): _____packs per day, for ____ year(s).
Date Quit Smoking: _____

Alcohol? _ No _ Yes
(If Yes, please indicate the number of drinks per day, per week or per month and number of years, and type(s) of alcohol used): _____drink(s) per day/week/month for ____ year(s).
Type(s) of Drinks: _ Beer _ Wine _ Mixed Drinks _ Hospitalized for Alcohol Use

Recreational Drugs? _No _ Yes
(If Yes, please indicate type of drugs used and how frequently): _____
Occupation: _____ ____ hours per day _____ days per week

Levels of Stress: __ High __ Medium __ Low

Highest Level of Education Achieved_____

History of Military Service? ____ Yes _____ No If yes, describe: _____

CURRENT MEDICATIONS & DOSAGE:
Please list all of your current medications and dosing:

_____
_____
_____
_____

ALLERGIES:
Please list any allergies to medications, dyes, latex, etc.:

_____

REVIEW OF SYSTEMS (check all that apply):

General:
__ Fever
__ Chills
__ Fatigue
__ Weight loss
__ Weight gain
__ Headaches

Allergies:
__ Seasonal allergies
__ Trouble breathing
__ Skin Rash
__ Reaction to foods

Cardiovascular:
__ Chest pain
__ Palpitations
__ Shortness of breath on exertion
__ Swelling of feet or ankles

Endocrine:
__ Excessive thirst
__ Heat intolerance
__ Cold intolerance
__ Glandular or hormone problem

Ears, Nose, and Throat:
__ Nasal congestion
__ Nose bleeding
__ Sore throat
__ Ear ache

Gastrointestinal:
__ Nausea
__ Diarrhea
__ Vomiting
__ Constipation

Genitourinary:
__ Kidney stones
__ Urinary retention
__ Urinary urgency
__ Increased urinary frequency

Musculoskeletal:
__ Weakness
__ Back pain
__ Joint pain
__ Muscle spasms/cramps

Neurological:
__ Numbness
__ Light-headedness
__ Dizziness
__ Seizure
__ Weakness
__ Memory difficulties
__ Tremor

Psychiatric:
__ Depression
__ Anxiety
__ Hallucinations
__ Insomnia

Respiratory:
__ Shortness of breath
__ Cough
__ Wheezing
__ Coughing up blood

Skin:
__ Rash
__ Change in hair or nails
__ Itching
__ Dry skin

Sleep:
__ Snoring
__ Excessive daytime sleepiness
__ Insomnia
__ Other

Blood/Lymphatic:
__ Abnormal bleeding
__ Swollen glands
__ Excessive bruising

SOUTH VALLEY NEUROLOGY, P.C.
FINANCIAL POLICY

This policy is intended to educate and clarify the responsibilities of the patient, your insurance, and our office in processing your claims and payments. Over the past several years, we have seen patient copays/coinsurance/deductibles increase substantially. We are sure you have also noticed that your bills from physician offices have gotten larger as well. Please note that even though your out-of-pocket costs may have increased over the years, our charges have not increased. In fact, our charges have decreased significantly during the past few years. Please take the time to read and understand the policies below:

- Payment of co-pay, co-insurance or outstanding balances is required at the time of service. Please bring your payments to each appointment to avoid the need to reschedule. We accept cash, check, MasterCard, Visa, Discover, and American Express.
- A credit card authorization agreement is required to be completed by every patient and is attached to this financial policy. ***We cannot see you if you do not have a valid credit card agreement on file with our office.***
- Patients with medical insurance must present proof of insurance at every visit. We will verify your insurance plan and personal information at every visit. If your insurance changes, please notify us before your next visit. ***If for any reason, the insurance card(s) you provide us is found later to be outdated or invalid or does not cover your office visits or procedures (such as due to pre-existing condition clauses), you understand that you are responsible for paying for the services in full.***
- We follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services may be determined to be non-covered or not considered "reasonable or necessary" based on the benefits of your specific insurance plan. Each insurance company has their own policies and they are subject to change at any time. The billing codes we use are covered by most, if not all, insurance plans, but from time to time, a limited number of specific plans have their own restrictions. ***You agree to be financially responsible for the cost of services that are not paid by your plan even if they are determined to not be "reasonable or necessary" by your plan.***
- Patients without medical insurance will be considered "Self-Pay" and are expected to pay for services received at the time of service. As a courtesy, we provide discounts to "Self-Pay" patients that are generally in line with insurance contracted rates.
- If we are an "Out of Network" provider with your health plan, you will likely be required to pay a higher copay/coinsurance/deductible and a higher cost for services, which will be collected at the time of service.
- Patient statements are sent out monthly and are due within 15 days of the statement date. If the patient responsibility portion of your account is over 45 days past due, you will receive a Pre-Collections Letter stating that you have 10 days to pay your account in full to halt collection activity. Any account that is referred to a collection agency will be required to be paid in full, as well as all reasonable collection agency/attorney fees, plus filing and processing costs before being seen for an appointment.

INSURANCE:

- ***Your insurance benefit is a contract between you and your insurance company.*** We cannot keep track of the ever-evolving complexity of the multitude of insurance plans held by our patients; it simply is not a possible task. We will submit claims for the services that have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request in a timely manner.
- If you provide our office with secondary insurance information, we will forward your claim to the secondary carrier.
- If your insurance company (primary and/or secondary) denies any services or does not cover any service as part of their medical policy, ***you agree to be financially responsible for the services provided.***

• We usually submit claims to your insurance within one business day of your visit. ***If your insurance plan(s) does not finalize the processing of our claims within 60 days from the time of service, you will receive a bill and you agree to pay for the cost of services at that time.*** If and when your insurance plan finally does process the claim, we agree to promptly refund all money due back to you as determined by your insurance company.

FEES:

• If you are unable to keep your appointment, you must call our office at least 24 hours before your appointment to cancel or reschedule. You must also arrive to your scheduled appointment on time. ***If you fail to promptly arrive to your scheduled appointment (no more than 15 minutes late) or call to reschedule with less than 24 hours notice, you will be considered a "No Show". For Monday appointments, this means by the prior Friday at noon.***

You will be charged the following "No Show" fees: $75 for a new patient visit; $75 for any diagnostic test or procedure (such as EEG, EMG/NCS, botox or other injections); and $50 for a follow-up patient visit. These fees apply to each appointment missed. You agree to pay the "No Show" fee prior to rescheduling or attending an already existing appointment. If there is a third No Show, the office reserves the right to discharge you from the clinic. We really dislike having to do this, but we really need some notice to allow other patients to schedule. We turn away other people needing care in order to hold a place for a patient.

• ***A $35.00 charge will be added to your account for any check returned by your bank for any reason.***

• ***There will be a minimum charge of $25.00 for the completion of medical forms, such as disability, legal, or school, and/or letters written on your behalf. Each form or letter requires a separate fee.*** Payment is due no later than the time you pick up the forms. Please allow 10-14 days for completion of the forms.

• A copy of your medical records can be provided upon receipt of a written authorization of release signed by the patient or guardian. ***There will be a minimum charge of $25 and a maximum charge of $100 to cover the costs of fulfilling each request for copies of medical records.***

Acknowledgement of Financial Policies and Guarantee of Payment:

We ask that you sign the bottom of the Financial Policy to acknowledge that you have read the policy and agree to the terms.

_____ _____

Signature Date

Consent Form:

Patient Authorization Form/
HIPAA Privacy Acknowledgment:

I hereby acknowledge the receipt of South Valley Neurology's Notice of Privacy Practices.

Initials: _____

Date:_____

I do hereby authorize South Valley Neurology P.C., to apply for benefits on my behalf for covered services rendered.

I do hereby authorize and direct my personal injury protection insurance carrier/automobile insurance to make check(s) payable to South Valley Neurology any monies due them for medical services provided to me as a result of a personal injury.

I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier permit a copy of this authorization to be used in place of the original.

MANAGED CARE and HMOs:

I certify that the information I have reported with regard to my insurance coverage is correct. I understand that my insurance plan requires that I submit a referral for specialty care services, and I am responsible for obtaining that referral. I am aware that if I fail to submit my referral, I will be responsible for full payment.

_____(Initial)

It is further understood that the signing of this form in no way relieves me of my personal primary obligation to pay for services rendered and does not prohibit customary billing by South Valley Neurology.

_____ _____

DA T E SIGNATURE

_____

PRINTED NAME OF SUBSCRIBER

Consent to Discuss or Release Information

Date: _____

I, _____, give Dr. Kouyoumdjian and her office permission to discuss and/or disclose my medical history and information with the following people (e.g. family members) :

1) _____

2) _____

3) _____

_____ (PRINT NAME)

_____ (SIGNATURE)

South Valley Neurology, P.C.
18181 Butterfield Blvd., Ste. 140, Morgan Hill, CA 95037

Office Financial Policy Effective March 3, 2013
Credit Card Authorization Agreement

For your convenience in paying the balance on your account, we ask all patients to complete a Credit Card Authorization Form. Your copay and a conservative estimate of your coinsurance and deductibles are due at time of service. Our office has the ability to get real-time verification and eligibility for most major insurance providers, which includes deductibles, copays, coinsurances, and out-of-pocket maximums. The Credit Card Authorization form will be used after your insurance company finalizes the processing of your claim. If a balance remains due at that time, our office will charge your credit card for the amount due based on your finalized insurance claim. Whenever we make a charge to your credit card, we will mail to you a copy of the paid invoice and your credit card receipt for your records. The Credit Card Authorization Form may also be used for non-covered services, such as requests for medical records, form completion, returned check fees, etc.

If you opt out of completing the Credit Card Authorization Form, you will be required to pay 100% of your estimated coinsurance and deductibles at time of service. Also, before being seen again in our office, your account balance must be paid in its entirety. All prior balances will be due before new services are provided.

Date Today: _____ **Please check #1 or #2 below.**

#1 _____ I the undersigned, authorize South Valley Neurology, P.C. to use the specified credit card as payments for the charges described in the first paragraph above.

___ VISA ___ MasterCard ___ American Express ___ Discover

Print Card Holder's NAME: _____

Card Holder's ADDRESS: _____

CITY, STATE, ZIP CODE: _____

Company Name (if applicable):_____

Credit Card Number: _____

Credit Card Expiration Date: _____

Credit card Security Code: (3 digits or 4 digits for AmEx): _____

Card Holder's Signature: _____

The authorization is in effect until a written request to revoke is received.

#2 _____ I the undersigned choose to opt out of completing the Credit Card Authorization and agree to the terms described in the second paragraph above.

Printed Patient Name:_____

Patient Signature: _____