

Orange County Neurology, Inc. REGISTRATION FORM

(Please Print)						
Today's date:			Primary Care Physician:			
PATIENT INFORMATION						
Patient's last name:		First:	M:	Email:		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date:	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security no.:	Home phone no.:		
P.O. box:		City:		State:	ZIP Code:	
Occupation:		Employer:		Employer phone no.:		
Referring Physician:			Tel. no.	Fax no.		
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist.)						
Please indicate primary insurance: <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Aetna <input type="checkbox"/> Cigna <input type="checkbox"/> Greatwest <input type="checkbox"/> Tricare <input type="checkbox"/> PacifiCare <input type="checkbox"/> United Healthcare <input type="checkbox"/> Other -						
Please indicate insurance plan: <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> HMO – Bristol Park Medical Group <input type="checkbox"/> HMO – Mission Hospital Affiliated Physicians						
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:	Member ID no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other -						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Member ID no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other -						
IN CASE OF EMERGENCY						
Name of local friend or relative (not living at same address):			Relationship to patient:	Home phone no.:	Work 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 Orange County Neurology, Inc. to release any information required to process my claims.						
<i>Patient/Guardian signature</i>				<i>Date</i>		

Orange County Neurology, Inc.

26800 Crown Valley Parkway
Suite 455
Mission Viejo, California 92691

(949) 365-9128

Original Date:

Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

Please explain the chief complaint for which you are consulting the doctor

Describe symptoms associated with the chief complaint

List any medical problems that other doctors have diagnosed

Are any symptoms/injuries due to a motor vehicle accident?

Yes No

Other Medical Problems

Year	Reason	Treating Physician

Other hospitalizations

Year	Reason	Hospital

Please turn to next page

List your prescribed drugs

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

REVIEW OF SYSTEMS

Please indicate if you currently have any of the following symptoms. Disregard the bold heading in quotes on the left. They are for administrative purposes only.

- | | | | |
|------------------------------------|--|---|--|
| 1. "Constitutional" | <input type="checkbox"/> Fever | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fatigue |
| 2. "Eyes problem" | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Double vision | <input type="checkbox"/> Loss of vision |
| | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Eye redness | <input type="checkbox"/> Eye dryness |
| 3. "Ear/nose/throat" | <input type="checkbox"/> Trouble hearing | <input type="checkbox"/> Ringing in ear | <input type="checkbox"/> Dizziness |
| | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Ear discharge |
| | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Slurred speech |
| 4. "Cardiovascular" | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Fast heart beat |
| 5. "Respiratory" | <input type="checkbox"/> Trouble breathing | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Coughing blood |
| 6. "Gastrointestinal" | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Heart burn | <input type="checkbox"/> Abdominal pain |
| | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Regurgitation |
| | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bloody stool |
| 7. "Genitourinary" | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine |
| 8. "Musculoskeletal" | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle cramp | <input type="checkbox"/> Muscle twitches |
| | <input type="checkbox"/> Loss of muscle | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Back pain |
| | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Joint stiffness | <input type="checkbox"/> Joint swelling |
| 9. "Skin & breast" | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Discoloration |
| | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Nail changes | <input type="checkbox"/> Sweating changes |
| 10. "Neurologic" | <input type="checkbox"/> Headache | <input type="checkbox"/> Face pain | <input type="checkbox"/> Face numbness |
| | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tremors | <input type="checkbox"/> Clumsiness |
| | <input type="checkbox"/> Blackout | <input type="checkbox"/> Memory trouble | <input type="checkbox"/> Trouble concentrating |
| 11. "Psychiatric" | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Feeling depressed | <input type="checkbox"/> Trouble sleeping |
| | <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Inappropriate crying | |
| 12. "Hematologic/lymphatic" | <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Lumps or swellings |
| 13. "Allergic/immunologic" | <input type="checkbox"/> Skin rash | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Dry eyes or mouth |
| 14. "Endocrine" | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Excessive urination | |

Please turn to next page

OTHER SYMPTOMS

Check if you have, or have had, any symptoms in the following areas to a significant degree.

Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Blood in Stool or Urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain or Swelling of the Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Visual Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	How many drinks per week?					
Tobacco	Do you use tobacco?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit			
Pregnancy	Are you pregnant?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Siblings	<input type="checkbox"/> M		Grandmother		
	<input type="checkbox"/> F		<i>Maternal</i>		
	<input type="checkbox"/> M		Grandfather		
	<input type="checkbox"/> F		<i>Maternal</i>		

Orange County Neurology, Inc.

Ali Elahi, M.D.

Diplomate, American Board of Psychiatry and Neurology
Electrodiagnostic and Neuromuscular Medicine

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PATIENT FINANCIAL LIABILITY AGREEMENT DISCLOSURE STATEMENT

Orange county Neurology, Inc. (OCN) is dedicated to providing the very highest level of medical care and services to our patients. The doctor and staff will make every effort to ensure that you receive quality medical care. However, please be aware that when you use a Health Insurance plan or designated medical group for reimbursement of medical services, that third party makes the final determination with respect to approval and reimbursement of all of the medical care rendered to you.

As a courtesy service to our patients, Orange County Neurology, Inc (OCN) will bill your health insurance company for services that you receive in our office if we are contracted with them. With respect to billing your insurance or third party payer, please adhere to the following policies:

- A current valid insurance card. (We must obtain copy to provide proof of insurance)
- Valid picture identification (we must obtain copy for HIPAA & Red Flag Law “identity theft” policies)
- OCN will file both primary and secondary insurance claims for medical services rendered. Claims for a third insurance contract will not be filed. Any balance not paid by primary and secondary insurance will be patient’s responsibility.
- All co-pays are due when checking into the office. Co-pays will not be billed. If you are not ready to pay your co-pays at time of checking in for your appointment, you will be re-scheduled.
- If you have any balance on deductible and/or co-insurance amounts that must be met, you will be billed once your insurance has processed the claim.
- Failure to collect co-payments, co-insurance and deductibles from patients by our office is considered fraudulent as per insurance contract.
- OCN does not assume responsibility for verification of insurance benefits or explanation of patient’s coverage, co-payments, co-insurance, deductibles or pre-existing conditions. Verification of insurance coverage is not a guarantee of payment for all medical services recommended or performed by OCN. The patient’s insurance coverage is a contract between the patient and their insurance carrier. It is the patient’s responsibility to understand their insurance coverage, all policy limitations and preferred providers under their policy. The patient is responsible for all denied or non-payment of charges from your insurance company or medical group. Eligibility and benefits are determined by the insurance company or medical group.
- Any disputes regarding the approval of payment by the insurance company or medical group are between the patient and their insurance company or medical group. Your insurance may deny payment if your insurance company or medical group (not your doctor or OCN) determines that:
 - The care provided is not medically necessary.
 - The care provided is a non-covered benefit.
 - The patient is ineligible to receive benefits under the plan.
 - The policy is terminated.
 - Services were provided by a non-participating or out of network provider.

- A referral and/or preauthorization are necessary.
 - Pre-existing conditions applies.
 - Additional information from the patient is necessary.
 - Incorrect billing and demographic information was obtained from patient.
- If your insurance plan requires a “Referral Authorization” from your primary care physician (PCP) for any service provided by OCN, you will need to contact your PCP for the referral. Receiving a referral is the patient’s responsibility and NOT the responsibility of the office of OCN. Any treatment that was provided by OCN to any patient without first having the required referral will be deemed as your consent for treatments that was not covered by insurance and will be payable upon receipt of a statement from our office.
 - If you have insurance coverage with a plan with which OCN does not have a contract, the charges for your care and treatment are due at the time of service. We do not bill insurance carriers with whom we do not have an agreement and/or contract. A superbill for all charges can be provided and you may, at your discretion, bill your health insurance carrier or medical group for reimbursement.
 - OCN is a participating provider for Medicare. This means that we must accept Medicare’s allowed charges for the service rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20% plus any out-of-pocket deductibles. We will adjust the difference between what we charge and what Medicare approves. If you have secondary or supplemental insurance (that we are contracted with) we will submit the claim for the remaining balance after Medicare has paid.
 - Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance company.
 - The parent(s) or legal guardian(s) must accompany all minors. Minors are all patients who are younger than age 18. No minors will be seen or treated unaccompanied. The parent(s) or legal guardian(s) is responsible for any payment and will receive the billing statements. Responsibility for payments for services rendered to the child/children of divorced or separated parents’ rests with the parent who seeks treatment. Any court-ordered judgment must be between the individuals involved, and does not include our facility.
 - OCN does not accept liens, personal injury cases, auto accident insurance, third party payments, and worker’s compensation cases. We require payment in full at time of service. It is the patient’s responsibility to submit their claims to any and all entities listed above.
 - Any changes to your insurance coverage, name, address or contact phone number need to be communicated to OCN front office staff at time of check-in to assure correct billing and contact information is maintained in our records for your appointment. Any denials or non-payments from insurance carrier based on incorrect and/or invalid information provided to OCN is patient’s responsibility.

SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, liens, personal injury cases, auto accident insurance, worker’s compensation cases. Full payment is due at time of service.

A courtesy discount of 20% will be given for the office visit portion of the total charge. We accept cash, Visa, MasterCard, American Express, and discover.

No personal checks accepted for self-pay accounts.

HMO PATIENTS

At this time, OCN is affiliated with MHAP (Mission Hospital Affiliated Physicians) and Bristol Park Medical Group ONLY. Your Primary Care Physician (PCP) will need to initiate your authorization for any new patient referrals through your IPA. New patients cannot be scheduled until hard copy of authorization is submitted to our office. We will contact all new referrals once a referral authorization is received from your IPA or PCP. Following your initial visit, OCN will request authorization for any follow-up visits and treatments requested by OCN physician(s). No follow-up visits or other treatments or tests will be scheduled until we receive authorization through your IPA. We will contact you regarding follow-up visits and treatments and tests, once we receive the authorization from your IPA. Please allow ten-to-fourteen (10-14) days following your visit for an approval. Per your IPA stipulation, we must submit supportive documentation along with our request to your IPA for review prior to approving any visits, treatments, or tests.

REQUEST FOR MEDICAL RECORDS

Copies of your records must be requested in writing. Copying fee applies and must be paid prior to mailing or faxing records. In accordance to HIPPA regulations, we request that you complete an Authorization to Release Confidential Information form before copies are mailed or faxed.

- \$15 for 1-50 pages
- \$30 for 50-200 pages
- \$50 for over 200 pages

REQUEST FOR COMPLETIONS OF FORMS & LETTERS

All forms and letters that require doctor's documentation such as from the DMV, EDD Disability, FMLA (Family Medical Leave Act) papers, work excuses, school excuses, jury duty excuses, paperwork required from your employer, letters to attorney...etc. require a fee at time of form submission. The forms will be completed within 3 business days. The forms can be faxed or submitted to you for pick-up at our office with prior arrangement with the office staff.

These services are not billable to your insurance and are your personal responsibility. Each form may have a different fee set according to the type and complexity of information required. As per HIPAA regulation and for the protection of your health privacy, you must authorize release of your medical information before the form is completed.

RETURNED CHECKS

If payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account closed (AC), or Refer to Maker (RTM), the patient or the patient's responsible party will be responsible for the original check amount in addition to a \$25 service charge. Once notice is received of the returned check, OCN will notify you in writing via a letter to the Responsible Party of the returned check.

If a response is not made within 15 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency.

CANCELLATION POLICY

Our staff and physician try their best to keep on schedule and provide prompt service. Please help us keep services prompt. As a courtesy to your physician, staff and other patients, please give 24-hour notice to cancel or reschedule your appointment. In the event that you fail to cancel a scheduled appointment and/or are a no-show, i.e. do not show for scheduled appointment without 24-hour notice, you will be billed \$25. This fee will be due upon receipt of a statement from our office.

Exceptions may be made for emergency situations such as hospitalization. Patients who repeatedly miss scheduled appointments may be discharged from the practice.

BALANCE AND STATEMENT

A statement of charges will be sent to the patient or responsible party showing the patient’s due balance each month. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. Balances older than sixty days may be subject to a \$15 late fee per month. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise arranged by our office. Please be aware that delinquent balances will be referred to a collections agency. The patient or responsible party will be financially responsible for any interest, attorney fees, legal fees, collection fees and any other fees that are required in the collection of the delinquent balances. Once your account is referred to a collections agency, you will be discharged from this practice. Notification that you have 30 days to find another medical service provider will be sent by standard and/or certified mail. During that 30-day period, our physician will only be able to treat you on an emergency basis.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to abide by these terms.

In addition, you also authorize OCN to furnish your information concerning your medical treatment, tests, and evaluations to your insurance carriers or medical group.

I hereby assign all payments for services rendered. A photocopy of the agreement is to be considered valid. In the event a signed claim is not obtained, this document may be used in its place.

Patient Name (please print)_____

Patient Signature_____ Date_____

Responsible Party Name_____

Responsible Party Relationship to the patient_____

Responsible Party Signature_____ Date_____

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PATIENT PREFERENCE FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

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.

_____ Home Telephone: _____

Check one for home telephone preferences:

- It is ok to leave message on answering machine with detailed information
- Leave message with call-back number only

_____ Work Telephone: _____

Check one for work telephone preferences:

- It is ok to leave message with detailed information
- Leave message with call-back number only

_____ Cell Phone: _____

Check one for cell phone preferences:

- It is ok to leave message with detailed information
- Leave message with call-back number only

_____ Email address (must be a password protected email address): _____

Check one for Email Preferences:

- It is ok to email messages with detailed information including test results.
- Do not email any messages or results

_____ Written Communication:

Check all that may apply:

- It is ok to send mail to my home address
- It is ok to send mail to my work/office address
- It is okay to Fax this number: _____

Communication with person(s) other than the patient:

I grant permission to OCN to relay or leave message with detailed information regarding my personal health information with the person(s) listed below:

Full Name _____ Relationship to Patient _____

Phone Number _____

Full Name _____ Relationship to Patient _____

Phone Number _____

Patient Signature: _____

Date: _____

Print Name: _____

