

Patient Name: _____ Date of Birth: _____ Today's Date: _____
First Middle Initial Last

PATIENT INFORMATION		
Please Print Clearly & Fill Out Completely		
Last Name	First Name	Middle Initial
Date of Birth	Age	Social Security Number
Address		
City	State / Zip	Email
Home Phone () -	Cell Phone () -	Work Phone () -
Spouses's Name:		
PHYSICIAN INFORMATION		
Physician Who Referred You To Our Office		City
Primary Care Physician		City
PRIMARY INSURANCE COVERAGE		
Insurance Company Name		Insurance Care is in the Name of? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Complete the following information for the person whose name appears on the Insurance Card:		
Name	Date of Birth	Social Security Number
Group #		Plan Name
Policy ID #	Medical Group Name	Co-Pay \$
SECONDARY INSURANCE COVERAGE		
Insurance Company Name		Insurance Care is in the name of? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other
Complete the following information for the person whose name appears on the insurance card:		
Name	Date of Birth	Social Security Number
Group #		Plan Name
Policy ID #	Medical Group Name	Co-Pay \$
If Minor, are parents <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Custodial Parent
Custodial Parent Phone Number: () -		Custodial Parent Date of Birth
Custodial Parent's SS # :		

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EMERGENCY CONTACTS

Name	Relationship	Phone
Name	Relationship	Phone

PATIENT DEMOGRAPHICS

RACE / ETHNICITY	GENDER / STATUS	PREFERRED LANGUAGE
<input type="checkbox"/> Decline to Answer <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> White / Caucasian	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female MARITAL STATUS: <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Widow <input type="checkbox"/> Other	<input type="checkbox"/> Decline to Answer <input type="checkbox"/> Vietnamese <input type="checkbox"/> English <input type="checkbox"/> Chinese <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> French <input type="checkbox"/> Tagalog <input type="checkbox"/> Punjabi <input type="checkbox"/> Italian <input type="checkbox"/> Hindi <input type="checkbox"/> Other <input type="checkbox"/> Sign Language - Deaf

RELIGION	OCCUPATION
<input type="checkbox"/> Decline to answer	Current or Previous:
Employer:	Is this work related? <input type="checkbox"/> YES <input type="checkbox"/> NO

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Neurology Medical Group of Diablo Valley, Inc. (NMGDV) to submit insurance claims on my behalf. I authorize my insurance company or its carriers to disclose any information requested by my physicians regarding claims for medical services they provide me. I authorize John Muir Medical Center, Mt. Diablo Medical Center to release information requested by NMGDV. I authorize NMGDV to release information to physicians referred by NMGDV. I authorize payments of assigned medical benefits to be paid directly to my physician and NMGDV. I am responsible for deductibles, coinsurance, and non-covered items

*** SIGNATURE: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

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PATIENT INFORMATION AUTHORIZATION - HIPAA PRIVACY

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of Protected Health Information (PHI). Completion of this form tells us your preferences with regard to telephone messages and whom you give authorization for our office to speak with on your behalf. Further authorization may be needed under more specific circumstances.

CONTACT PREFERENCE (Check ONE): HOME CELL WORK MAIL

Below...Please check ALL that apply:

HOME PHONE	CELL PHONE	WORK PHONE	MAIL / EMAIL / FAX
<input type="checkbox"/> OK to leave detailed message*	<input type="checkbox"/> OK to leave detailed message*	<input type="checkbox"/> OK to leave detailed message*	Billing Statements & Correspondence will be mailed to your Home unless you provide alternate address:
<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> Leave message with call-back number only	<input type="checkbox"/> OK to contact you via Email
HOME # () -	CELL # () -	WORK # () -	HOME FAX # WORK FAX # () - () -

* Either with any individual, other than yourself, whom answers the phone or on an answering machine.

OTHER AUTHORIZED INDIVIDUALS

Other individuals I authorize to take messages or receive my Protected Health Information are:

NAME (List all that apply)	RELATIONSHIP TO YOU	CONTACT INFO
	Spouse / Significant Other	Phone: () -
		Phone: () -
		Phone: () -
		Phone: () -

I request the following restrictions to the use or disclosure of my health information:

My signature below authorizes Neurology Medical Group of Diablo Valley, Inc. (NMGDV) to use my Protected Health Information per my instructions above and acknowledges that I have received NMGDV'S Notice of Privacy Practices & I consent to the use and disclosure of my health information for treatment, payment or healthcare operations.

*** SIGNATURE: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient
NMGDV Witness Name / Signature	Date

INSURANCE BENEFITS REVIEW

In advance of your treatment counseling, one of our Care Coordinators will research and review your insurance benefits as they apply to the specific treatment regimen you are to receive. This will assist you in coordinating payments for our services.

We will explain:

- The cost of your specific treatment regimen
- Your specific insurance benefits (including co-pays, co-insurance, deductible & out-of-pocket maximum)
- Your personal financial responsibility
 Information on Patient Assistance resources (if you qualify)

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FINANCIAL POLICIES

We are required by law, and your health plan, to collect co-payments at the time of service. Co-payments are required each time you are seen by the physician or Physician Assistant. Additionally, some of the NMGDV physicians have a financial interest in California Imaging and Treatment Center, LLC.

With regards to appointments, we want to be able to provide every patient with all the attention they require. Therefore, if you are not on time for your appointment and are late, it may be necessary to reschedule for another day. Please provide us with a 24 hour notice if you will not be able to maintain your appointment or you will be charged a \$75.00 no show fee for a new, \$35.00 no show fee for any follow ups and a \$ 200.00 fee for any testing. Our office hours are Monday through Friday 9:00-4:45pm.

INSURANCE REIMBURSEMENT & BILLING POLICIES

BILLING STATEMENT: We are happy to bill your insurance as a courtesy to you. Each month you will receive a statement from us describing your current balance and any charges incurred during the statement month. You can submit this bill yourself, along with the appropriate forms, to your insurance carrier. Or, as many of our patients prefer, we will bill your primary and secondary insurance carrier for you. Neurology Medical Group of Diablo Valley Inc. / BASS Medical Group does not bill tertiary insurance coverage other than Medicare. For us to do so, you must sign the "Release of Information & Assignment of Benefits" statement on the first page of this packet or on the "Change of Insurance" form. We will bill your insurance a maximum of three (3) times, then the responsibility for handling issues with insurance reimbursement rests with you. You are ultimately responsible for payment of your bill.

When you receive our monthly statement, payment is expected within thirty (30) days. Payments are considered delinquent after sixty (60) days. If statements are not paid after this sixty-day (60) period, a late charge will be assessed on the unpaid balance at a rate of 1% per month, compounded monthly, unless alternative payment arrangements are made in writing. If NMGDV / BASS Medical Group are not contracted with your insurance carrier, you are considered a "self-pay" patient and payment is due in full at the time of service.

ATTORNEY FEES AND COLLECTION COSTS: If any legal action is necessary to enforce or interpret the terms of these billing policies, the prevailing party shall be entitled to reasonable attorneys' fees, costs and necessary disbursements in addition to any other relief to which that party may be entitled. You agree by your signature below to pay all collection costs, including attorneys' fees on all delinquent payments.

SUSPENSION OF CARE (EXCEPT EMERGENCY CARE): If no payment is received after ninety (90) days, we may be forced to suspend all but emergency care until a payment is received. Please discuss all billing issues directly with our billing department.

ADMINISTRATIVE FEES

Due to the high volume of requests we receive, we charge administrative fees for copying of all or part of a medical record, completion of disability forms, printouts of your billing statements, and other such administrative requests. The current fee schedule (which is subject to change) is:

Printing of Medical Records Fee:	\$18.00
Disability, Life Insurance, DMV	\$30.00
All Other Administrative Requests:	\$15.00
Returned Check Charge:	\$25.00

My signature below indicates that I have read, understood and agreed to the Financial Policies of Neurology Medical Group of Diablo Valley, Inc./ BASS Medical Group.

Signature: Patient or Legally Authorized Individual	Date
Print Name	If Signed on Behalf of Patient, Relationship to Patient

A copy of this page will be provided to you at your request.

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PAST MEDICAL HISTORY			
Do you have or have you had any of the following conditions?	YES	NO	Type / Year Diagnosed
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	
Bladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	
Brain Tumor	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Carpal Tunnel Syndrome: Right____Left____Both_____	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Vascular Accident (STROKE) (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	When?
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	
COPD	<input type="checkbox"/>	<input type="checkbox"/>	
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	
GERD / Reflux	<input type="checkbox"/>	<input type="checkbox"/>	
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Explain :
High Cholesterol (Hyperlipidemia)	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure(Hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Low Back Pain /Injury	<input type="checkbox"/>	<input type="checkbox"/>	Explain:
Lung Disease (Emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Prostate Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	
Any other illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any accidents/injuries within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever received the Shingles Vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have an Advanced Directive?	<input type="checkbox"/>	<input type="checkbox"/>	

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PAST SURGICAL HISTORY	
Type of Operation:	
Angioplasty	
Appendectomy	
Arthroscopy of knee	
Back Surgery: Mark location Please Neck ___ MidBack ___ LowBack ___	
Coronary or Heart bypass	
Carpal Tunnel Release: _____ Right ___ Left ___	
Cataract Extraction	
Cholecystectomy (Gall Bladder Removal)	
Gastric or Colonic Surgery	
Hernia Repair	
Hip replacement: Right ___ Left ___	
Knee replacement: Right ___ Left ___	
Lasik	
Spinal Fusion	
Thyroidectomy	
Tonsillectomy	
Transplant (Liver, Kidney, etc) please explain:	
MEN: Prostate Surgery	
MEN: Vasectomy	
WOMEN: Breast Surgery _____ Breast Reduction _____	
WOMEN: Bilateral tubal ligation	
WOMEN: Cesarean section (C-section)	
WOMEN: D and C	
WOMEN: Hysterectomy _____ Ovaries removed _____	
WOMEN: Mastectomy	
WOMEN: Myomectomy (removal of fibroids)	

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SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
<input type="checkbox"/>	ALCOHOL	Year: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Usually <input type="checkbox"/> Always
	Type:	Frequency:
	Type:	Frequency:
<input type="checkbox"/>	SMOKING STATUS	<input type="checkbox"/> Current/Every Day <input type="checkbox"/> Current/Some Days <input type="checkbox"/> Former Smoker <input type="checkbox"/> Never Smoker <input type="checkbox"/> Unknown
<input type="checkbox"/>	TOBACCO	Year: Pack(s) A Day: Quit: <input type="checkbox"/> NO <input type="checkbox"/> YES If YES, Date Quit:
<input type="checkbox"/>	STREET DRUGS/OTHER	Year: Type:

ADDITIONAL INFORMATION

	Do you live by yourself or with others?
	Do you live in a home/apartment or a senior center?
	Do you drive a car or other motorized vehicle?
	What kind of work do you do (or did in the past)?
	Are you full time ____ part time ____ disabled ____ unemployed ____ self employed ____
	So that we may better assist you, please list the highest level of education achieved. High School ____ Junior College ____ College/University ____ Graduate Work ____

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REVIEW OF SYSTEMS

Have you experienced any of these problems during the past month?

	YES	NO
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain /Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Skin rash or itching	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
FOR MEN:		
Decrease in size or force of urine	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with sex or impotence	<input type="checkbox"/>	<input type="checkbox"/>
FOR WOMEN:		
Lump, discharge or breast pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular menstrual bleeding	<input type="checkbox"/>	<input type="checkbox"/>