BASS Medical Group-Neurology

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Diplomates of the American Board of Psychiatry and Neurology (Neurology)
General Neurology • Electroencephalography • Electromyography • Clinical Research

Thank you for choosing Bass Medical Group-Neurology for your neurological care.

To enable us to provide you with the best possible care, **Please read the following carefully.** It is important for you to follow these instructions to get the most from your upcoming appointment.

***Please check in 20 minutes before your scheduled appointment time for registration.**

***What do I need to bring to my appointment?**

- The enclosed forms and questionnaire need to be filled out completely.
- Please bring current insurance card (s).
- Your referral if you have an HMO or a plan that requires one.
- Medical records and other information related to your current condition, such as referring physician office notes, MRI's, CT Scans and Lab Work.

***What if I need to change my appointment?**

If you are unable to keep your appointment, Please notify our office at least 48 hours prior to the appointment for rescheduling. If you no-show for an appointment or cancel less than 24 hours before an appointment you will be charged **$150.00** for new appointments, **$75.00** for follow up appointments and **$200.00** for testing.

Please Note: For all new patient, EMG, EEG, and Botox appointments our office requires a verbal confirmation at least 24 hours prior to your appointment. We will call you to remind you of this appointment, however if we leave a message you must call back to confirm that you will attend this appointment. If we do not receive a verbal confirmation ***we can cancel your appointment.***

We look forward to seeing you soon.

BASS Medical Group Neurology

400 Taylor Boulevard, Suite 301, Pleasant Hill, California 94523

PATIENT DEMOGRAPHICS

Patients Legal Name: (Last, First, Initial)	Preferred Name:	
Date of Birth:	Age:	
Address:		
City & State:	Zip Code:	Email:
Home Phone: ( ) -	Cell Phone: ( ) -	Work Phone: ( ) -
Spouses's Name:	Cell Phone: ( ) -	Work Phone: ( ) -

PHYSICIAN INFORMATION

Physician Who Referred You To Our Office:	City:
Primary Care Physician:	City:

If Patient Is a Minor Parent Information:	If Patient Is a Minor Parent Information:
Parent: Name/Relation:	Phone #:
Parent: Name/Relation:	Phone #:

If Minor, are parents
☐ Married ☐ Divorced

Custodial Parent: _____ Custodial Parent's SS#:_____ Custodial Parent's DOB:_____

PRIMARY INSURANCE COVERAGE

Insurance Company Name:	Insurance Care is in the Name of? ❑ Self ❑ Spouse ❑ Parent/Child ❑ Other	
Subscriber Name:	Date of Birth:	Subscriber SSN:
Group #:	Plan Name:	
Policy ID #:		

SECONDARY INSURANCE COVERAGE

Insurance Company Name:	Insurance Care is in the name of? ❑ Self ❑ Spouse ❑ Parent/Child ❑ Other	
Subscriber Name:	Date of Birth:	Subscriber SSN:
Group #:	Plan Name:	
Policy ID #:		

EMERGENCY CONTACT

Name of friend or relative:	Relationship to patient:	Cell/Work Phone:

GENERAL INFROMATION

RACE / ETHNICITY

- ❑ Decline to Answer
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Hispanic or Latino
- ❑ Native Hawaiian / Pacific Islander
- ❑ White / Caucasian

GENDER / STATUS

GENDER: ❑ Male ❑ Female

MARITAL STATUS:

- ❑ Decline to Answer
- ❑ Single
- ❑ Divorced
- ❑ Married
- ❑ Domestic Partner
- ❑ Widow
- ❑ Other

PREFERRED LANGUAGE

- ❑ Decline to Answer
- ❑ English
- ❑ Spanish
- ❑ French
- ❑ Punjabi
- ❑ Hindi
- ❑ Sign Language - Deaf
- ❑ Vietnamese
- ❑ Chinese
- ❑ Russian
- ❑ Tagalog
- ❑ Italian
- ❑ Other

RELIGION

❑ **Decline to answer**

OCCUPATION

Current or Previous:

REASON FOR VISIT

ALLERGIES

☐ No Known Allergies ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Other (List All):

Describe Reaction(s):

CURRENT MEDICATION LIST

Medication	Dose	FREQUENCY	PRESCRIBING PHYSICIAN

PREFERRED LOCAL PHARMACY

NAME:

ADDRESS:

CITY:

STATE:

PHONE:

PREFERRED MAIL ORDER/SPECIALTY PHARMACY

NAME:

ADDRESS:

CITY:

STATE:

PHONE:

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

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: Cesearan section (C-section)
WOMEN: D and C
WOMEN: Hysterectomy _____ Ovaries removed____
WOMEN: Mastectomy
WOMEN: Myomectomy (removal of fibroids)

TREATMENT HISTORY				
	YES	**NO**	**Area of Body**	**Facility / City**
Have you ever had radiation treatments?	❑	❑		
Have you ever had chemotherapy?	❑	❑		
GYNECOLOGICAL HISTORY	**YES**	**NO**		
Is there any chance you could be pregnant?	❑	❑		
Have you ever taken birth control pills?	❑	❑		
Have you ever taken hormone replacement therapy?	❑	❑	If yes, when:	

IMMEDIATE FAMILY HISTORY

RELATION	AGE(S)	Health Problems	IF DECEASED, CAUSE/AGE OF DEATH
Mother			
Father			
Siblings			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
❑ Adopted			
❑ Family History Unknown			

SOCIAL HISTORY

(✓)	SUBSTANCE:	APPROXIMATE YEAR STARTED / FREQUENCY:
❑	ALCOHOL	Year: ☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always
	Type:	Frequency:
	Type:	Frequency:
❑	SMOKING STATUS	❑ Current/Every Day ❑ Current/Some Days ❑ Former Smoker ❑ Never Smoker ❑ Unknown
❑	TOBACCO (chew)	Year: Pack(s) A Day: Quit: ☐ NO ☐ YES *If YES*, Date Quit:
❑	SMOKELESS TOBACCO	☐ NO ☐ YES *If YES*, Date Quit:
❑	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____

BASS NEUROLOGY PATIENT HIPAA CONSENT FORM

_____ _____ _____

Patient's Name (Please Print) **Date of Birth** **Date**

I wished to be called at **Home**: _____ **Cell**_____ regarding my care and follow up.
The best telephone number(s) to reach me are:

_____Home _____Cell _____

PERMISSION TO GIVE HEALTH RELATED INFORMATION TO SPOUSE/SIBLING/CHILD/FRIEND/ETC:

I hereby authorize Bass Neurology providers and its medical staff to disclose my protected health/billing information to:

Name: _____ Relationship: _____ Contact #:_____

Name: _____ Relationship: _____ Contact #:_____

Name: _____ Relationship: _____ Contact #:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE:

I acknowledge that I have been provided an opportunity to review the NOTICE OF PRIVACY PRACTICES for Bass Neurology.

PERMISSION TO LEAVE VERBAL DIAGNOSTIC STUDY RESULTS:

I give permission to have Bass Neurology leave MRI or diagnostic results on my voicemail at the phone numbers I have listed in the event that I cannot be reached.

I hereby grant permission, acknowledge, and agree to the statements noted above:

Patient/Patient's Agent Signature: X_____ Date: _____

PERMISSION TO TREAT A MINOR: (If Applicable)

I give permission to have my son/daughter receive the necessary medical treatment as prescribed by the medical providers of Bass Neurology.

_____ _____ **PARENT/GUARDIAN SIGNATURE**

DATE

BASS MEDICAL GROUP NEUROLOGY DIVISION

Bass Medical Group Neurology has adopted the following financial policies to simplify the billing process and help secure reimbursement for medical services provided to you.

Co-payments are due at the time of service: I understand that if my insurance policy requires that I make a co-payment for office visits, I will be expected to pay that co-payment at the time of my appointment. I understand that this is a term of my health care contract. The co-payment and any billing fees are due upon receipt of statement from this practice.

When verification of insurance coverage is not available: I understand that if Bass-Neurology cannot confirm that I am covered by an accepted insurance plan, I will be expected to pay for my charges in full at the time of my visit. Once Bass-Neurology can confirm insurance coverage, Bass-Neurology will bill my insurance company. I understand if an insurance payment is received, Bass-Neurology will promptly refund any money due to me.

Auto Accidents and other injuries: I understand that Bass-Neurology does not bill third parties; nor do they accept liens. I understand I will be expected to pay my charges in full at the time of service.

When the insurance company denies a claim: I understand if my insurance company denies a claim, I will be billed for all services provided, in accordance with the contract of my insurance company. This may include, but is not limited to, denials due to eligibility, out of network services, when the insurance carrier has requested information from me and that information is not provided in a timely manner and instances where maximum benefits have been reached. I understand Bass-Neurology is not able to determine my specific coverage and benefits, plan limitations, or plan provisions. For this information, I should contact my insurance carrier.

Medical Records: I understand there is a charge of $18.00-$30.00 for reproduction of my medical record, depending on the size of the record. This charge includes the transfer of records to an attorney and other medical facilities.

Medical Forms: I understand there is a $30.00 charge for the completion of forms. This fee is due in advance.

Payment Options: For your convenience, we accept Visa, MasterCard, Discover and American Express. I understand that Bass-Neurology may also take the verbal request by me over the phone to make credit card payment of my account. I give the authorization for Bass-Neurology to bill my card for the amount specified and acknowledge that verbal requests can only be made by the responsible party since no credit card information is kept on file.

Missed Appointments and Cancellations: If you cancel of reschedule you appointment, please notify us no less than one business day in advance. Please be courteous and remember that the appointment time reserved for you can be used by another patient.

I understand that cancellations with less than one business day notice and no shows will be billed $75.00 for follow up, $150.00 for new patient appointments and $200.00 for procedures/testing.

Returned or "Bounced" Checks: We pass along our banks' service charge to you for any checks that are returned for non-payment for any reason.

BASS MEDICAL GROUP NEUROLOGY DIVISION

Delinquent Accounts: I understand charges are due in full at the time of service, or upon receipt of a statement from this practice. I assume receipt of all statements sent to me at the most recent address I have given. I accept all charges as accurate unless I contact Bass-Neurology promptly upon receipt of a statement to dispute them.

I understand that I will be billed for any amounts due to be (co-payments/co-insurance amounts/deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payments. I further understand that if I have not made payment prior to the third statement being mailed, the third statement will be marked as "Final Notice" and may result in my account being sent to an outside collection service if I still do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with those collection efforts. I understand it is my responsibility to keep my account and contact information current.

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I hereby authorize Bass-Neurology to apply for benefits and receive payments directly on my behalf for covered services for the purpose of satisfying charges billed.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I have read and understand the Financial Policies of Bass-Neurology. I also understand that no guarantee has been made to me about my insurance coverage. I do not hold Bass-Neurology or any of the providers of staff responsible for my insurance coverage, or for decisions made by my insurance company.

I, the patient or the patient's representative, understand that all medical doctors at Bass-Neurology are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800)-633-2322 or via the internet at their website: www.mbc.ca.gov.

_____

Patient Name (Please print)

_____ _____

Parent/Guardian Name, if applicable (Please Print) **Relationship to Patient**

X_____ _____

Patient or Guardian Signature **Date**