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? ❑ Self ❑ Spouse ❑ Parent ❑ 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? ❑ Self ❑ Spouse ❑ Parent ❑ 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 ☐ Married ☐ Divorced	Custodial Parent _____	
Custodial Parent Phone Number: ( ) -	Custodial Parent Date of Birth	
Custodial Parent's SS # :		

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

EMERGENCY CONTACTS

Name	Relationship	Phone
Name	Relationship	Phone

PATIENT DEMOGRAPHICS

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

RELIGION

❑ **Decline to answer**

Employer:

OCCUPATION

Current or Previous:

Is this work related? ❑ YES ❑ NO

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize my physician and Bass Medical Group- Neurology 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 Bass Medical Group. I authorize Bass Medical Group to release information to physicians referred by Bass Medical Group. I authorize payments of assigned medical benefits to be paid directly to my physician and Bass Medical Group. 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

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

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
❑ OK to leave detailed message*	❑ OK to leave detailed message*	❑ OK to leave detailed message*	Billing Statements & Correspondence will be mailed to your Home unless you provide alternate address:
❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ Leave message with call-back number only	❑ OK to contact you via Email **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)

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

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 Bass Medical Group 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 charges a $150.00 no show fee for a new, $75.00 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. 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 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 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.

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

REASON FOR VISIT

ALLERGIES

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

Describe Reaction(s):

CURRENT MEDICATION LIST

Medication	Dose	FREQUENCY	PRESCRIBING PHYSICIAN

CONSENT TO ACCESS MEDICATION HISTORY

In order to provide you with the best possible care, your prescriptions will be written electronically whenever possible. Electronic prescribing is now a common practice due to healthcare initiatives requiring the use of electronic medical records. With your permission, e-prescribing will provide us access your medication history electronically, enabling us to see critically important information on your current and past prescriptions, better assess potential medication issues, and improve safety and quality of care.

By signing below I give my consent to Bass Medical Group to access my medication history electronically and to the best of my knowledge, I verify that the above medical information is complete and correct. I understand that it is my responsibility to inform my physician if I ever have a change in my health.

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

PREFERRED LOCAL PHARMACY	PREFERRED MAIL ORDER/SPECIALTY PHARMACY
NAME:	NAME:
ADDRESS:	ADDRESS:
CITY:	CITY:
STATE:	STATE:
PHONE:	PHONE:
FAX:	FAX:

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

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	❑	❑	
Any other illnesses?	❑	❑	
Have you had any accidents/injuries within the last 24 months?	❑	❑	
Have you ever received the Shingles Vaccine?	❑	❑	
Do you have an Advanced Directive?	❑	❑	

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

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

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

TREATMENT HISTORY				
	YES	NO	Area of Body	Facility / City
Have you ever had radiation treatments?	❑	❑		
Have you ever had chemotherapy?	❑	❑		
GYNECOLOGICAL HISTORY (FEMALES)	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			

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

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	Year: Pack(s) A Day: Quit: ☐ 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____

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

REVIEW OF SYSTEMS

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

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