PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Birth Date: _____

Signature: _____

Date: _____

CNS
Center for Neurology and Spine

COMMUNICATION AUTHORIZATION

Patient Name: _____ DOB: _____

What number(s) may we contact you at? May we leave a message?

_____ ☐ Yes ☐ No

_____ ☐ Yes ☐ No

Is there anyone other than yourself that you authorize CNS to speak with on behalf of your medical care? If so please list below:

_____ _____ _____
Name Phone Relationship

_____ _____ _____
Name Phone Relationship

Do you authorize CNS to communicate with your Pharmacy? ☐ Yes ☐ No

Local Pharmacy: _____ Phone: _____

Address: _____ Fax: _____

Mail Order Pharmacy: _____ Phone: _____

May we communicate with you via Email? ☐ Yes ☐ No

Email: _____

Patient Signature _____ Date: _____

CONFIDENTIAL BILLING INFORMATION

You were referred to us by: _____

Your primary care physician Is: _____

Patient Name: _____ _____ _____
Last First Middle

Address: _____ _____ _____ _____
Address City State ZIP

Phone: _____ Cell: _____

Age: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Marital Status: _____ Social Security #: _____

Employer: _____ Business Phone: _____

Employer Address: _____

Parent/Spouse's Name: _____ Parent/Spouse's SS#: _____

Parent/Spouse's Birth Date _____

Parent/Spouse's Employer: _____ Business Phone: _____

Student: ☐ Yes ☐ No ☐ Full Time ☐ Part Time

School Name: _____

Emergency Contact - other than a relative in the same home:

Name: _____

Address: _____

Phone: _____

Address correspondence to:
3815 East Bell Road, #2400
Phoenix, Arizona 85032
(602) 482-2116
FAX: 482-9563

Patient's Name: _____ Date: _____

I hereby authorize my insurance company to make direct payment to:

Center for Neurology and Spine

And I understand I am financially responsible for any co-payments, deductibles, coinsurance and all charges which are considered to be not a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received.

I understand that I am financially responsible for all charges if it is determined that the insurance information I have provided is no longer in effect.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Signed: _____

RELEASE OF INFORMATION:

I hereby authorize release of medical Information to my referring physician and/or to any other physicians who have been or may become Involved in my medical care. I also authorize release of Information that may be necessary in the processing of any Insurance claims.

Signature: _____ Date: _____

A photostatic copy of this authorization shall be considered as effective and valid as the original

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PATIENT HISTORY

Patient Name: _____ _____ _____ Age: _____
Last First Middle

Main complaint and symptoms (briefly describe what and where it hurts):

When did this problem first start? (please fill-in date): _____

Describe the frequency and duration of symptoms:

Please describe treatments tried and how effective they are:

Have you consulted other doctors for this problem? ☐ Yes ☐ No

If yes, please mentioned name: _____

Have you been treated by a physical or occupational therapist? ☐ Yes ☐ No

If yes, by whom? _____

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PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE

1. Constitutional:	☐ Weight Gain	☐ Weight Loss	☐ Fatigue	☐ Fever
	☐ Chills			
2. Eyes:	☐ Vision Loss	☐ Blurred Vision	☐ Double Vision	☐ Eye Pain
3. ENT:	☐ Ringing In Ears	☐ Hearing Loss	☐ Ear Pain	☐ Jaw Pain
	☐ Jaw Popping/Clicking			
4. Cardiovascular:	☐ Lightheadedness	☐ Passing Out	☐ Chest Pain/Pressure	
	☐ Palpitations			
5. Respiratory:	☐ Wheezing	☐ Coughing		
6. Gastrointestinal:	☐ Belly Pain	☐ Nausea	☐ Vomiting	
	☐ Constipation	☐ Diarrhea		
7. Genitourinary:	☐ Kidney Stones	☐ Urinary Retention Or Urgency		
	☐ Urinary Incontinence			
8. Musculoskeletal:	☐ Neck Pain	☐ Mid Or Lower-back Pain		
	☐ Sore Muscles	☐ Cramps		
9. Integument:	☐ Skin Ulcerations	☐ New Rashes	☐ Hair Loss	
10. Cardiovascular:	☐ Anxiety	☐ Panic Attacks	☐ Depression	
	☐ Visual or Auditory Hallucinations			
10. Hematology/ Lymphatic:	☐ Easy Bleeding	☐ Easy Bruising	☐ Recurrent Infections	

PAST MEDICAL HISTORY: (All illnesses diagnosed, controlled or not)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____

OPERATIONS: (Please list all, even minor ones such as tonsillectomy)

1. _____ 2. _____
3. _____ 4. _____

ALLERGIES: (For example: IV contrast dye, penicillin, latex, etc.)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

MEDICATIONS: (Including supplements and herbs)

	Dose	Times per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

(Continue on the back of page if necessary)

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Personal and Social History:

Are you presently working? ☐ Yes ☐ No Occupation: _____

If disabled:

Date of disability began: _____

Cause of disability: _____

Highest level of education: _____

How many steps to the entrance of your home? _____

How many floors in your home? _____

Have you ever smoked? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No How long: _____ How much: _____

If you quit, what year did you quit? _____ How long did you smoke?: _____

Do you drink alcohol? ☐ Yes ☐ No Weekly amount? _____

Caffeinated? ☐ Yes ☐ No

Do you drink soda? ☐ Yes ☐ No Weekly amount? _____

Caffeinated? ☐ Yes ☐ No

Have you used illegal drug? ☐ Yes ☐ No If yes, what? _____

Family History: Please circle all diseases anyone in your family has

☐ Stroke ☐ TIA ☐ Seizures/Epilepsy ☐ Headaches/Migraine ☐ Multiple Sclerosis

☐ Heart Disease ☐ Diabetes ☐ Hypertension ☐ High Cholesterol ☐ Cancer

Other neurological disease (please explain):

Do any diseases run in your family? _____

PLEASE FILL-OUT FAMILY MEMBER HEALTH INFORMATION BELOW:

	Age	Living	Medical issues (if deceased please state cause)
Father:	_____	☐	_____
Mother	_____	☐	_____
Brother(s)	_____	☐	_____
Sisters(s)	_____	☐	_____
Son(s)	_____	☐	_____
Daughter(s)	_____	☐	_____

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