



PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

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

Name: _____ Birthdate: _____

Signature: _____

Date: _____



COMMUNICATION AUTHORIZATION

Patient Name: _____ DOB: _____

At what number (s) may we contact you? 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: _____

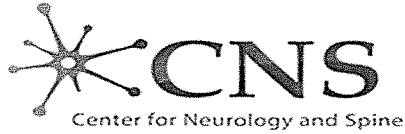
Address: _____ Fax: _____

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: _____ Birthdate: _____ Sex: Male Female Unknown

Marital Status: _____ Social Security Number: _____

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

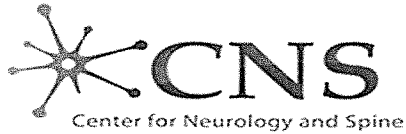
School Name: _____

Emergency Contact

Name: _____ Relation: _____

Address: _____

Phone: _____



Payment Policy

Address correspondence to:

3805 E Bell Road, #2400

Phoenix, Az 85032

Phone: 602-482-2116 Fax: 602-482-9563

Patient Name: _____ DOB: _____ Date: _____

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

Center for Neurology and Spine

Initial: _____

I understand I am financially responsible for any co-payments, deductibles, coinsurance and all other charges which are considered to not be 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.

Please inform staff immediately of any insurance changes.

Payments:

Initial: _____

Payment is expected at time of service for Co-pays, co-insurance, and/or deductibles. CNS accepts cash, Checks, Visa, Master Card, and American Express as forms of payment. If your check is returned for insufficient funds, a \$35 dollar returned check fee will be applied to your outstanding balance.



Delinquent Accounts:

Initial: _____

Delinquent accounts will be reported to a collection agency following CNS normal collection procedure of four (4) patient statements being mailed to you. If an account is reported to a collection agency then a fee of 30% will be added to your outstanding balance. Please inform the billing department if your payment will be late arriving or you need to set up a payment plan.

Forms:

Initial _____

Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a fee of \$50. Payment of this charge is expected at time of completion.

Appointment NO-SHOW:

Initial: _____

There is a charge for not canceling/rescheduling you appointment within 24 hours. Regular office visit \$50, Procedure EEG, AEEG, , EMG, Botox, Neuro Psychometric testing \$100. These appointment times could have been given to another patient who needs medical care. We understand unusual circumstances might arise. Please contact our office as soon as possible.

Signed: _____

Date: _____

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 processing of any insurance claims.

Signed: _____

Date: _____



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 list name (s): _____

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

If yes, by whom? _____



PLEASE CHECK ALL SYMPTOMS THAT YOU HAVE

1. **Hematology/Lymphatic:** Easy Bleeding Easy Bruising Recurrent Infections

2. **Constitutional:** Fatigue Fever Weight Gain Weight Loss Chills

3. **Eyes:** Vision Loss Blurred Vision Eye Pain Double Vision

4. **ENT:** Jaw Pain Jaw Popping/Clicking Hearing Loss Ear Pain
 Ringing in ears Snoring

5. **Respiratory** Cough Wheezing

6. **Cardiovascular:** Lightheadedness Passing Out Chest Pain/Pressure
 Irregular Heartbeat Palpitations

7. **Gastrointestinal:** Abdominal Pain Constipation Diarrhea Nausea
 Vomiting

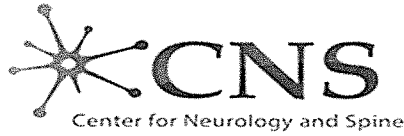
8. **Genitourinary:** Kidney Stones Urinary Retention/Urgency Urinary Incontinence

9. **Musculoskeletal:** Neck Pain Mid or Lower Back Pain Sore Muscles Cramps

10. **Skin:** Hair Loss New Rashes Skin Ulcerations Hives

11. **Neurologic:** Balance Difficulty Coordination Dizziness Headache
 Memory Loss Seizures Tingling/Numbness Tremor

12. **Psychiatric:** Panic Attacks Depression Visual or Auditory Hallucinations
 Anxiety



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

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

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

- | | |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

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

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

MEDICATIONS: (Including supplements and herbs)

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



PERSONAL AND SOCIAL HISTORY:

Are you presently working? Yes No Occupation: _____

IF DISABLED:

Date 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? (years) _____ How many per day? _____

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

Do you drink alcohol? Yes No Weekly amount? _____

Do you drink caffeinated beverages? Yes No Weekly amount? _____

Have you used recreational drugs within the past year? Yes No

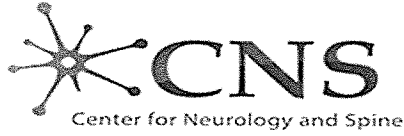
If yes, what? _____

Family history: Please check all diseases any of your immediate family members have (siblings, parents, children)

Stroke TIA Seizures/Epilepsy Headache/Migraine Multiple Sclerosis

Heart Disease Diabetes Hypertension High Cholesterol Cancer

Other Neurological disease (please explain):



PLEASE FILL OUT FAMILY MEMBER HEALTH INFORMATION BELOW:

	Age	Living	Medical issues (if deceased, please state cause)
Father:	_____	<input type="checkbox"/>	_____
Mother:	_____	<input type="checkbox"/>	_____
Brother(s):	_____	<input type="checkbox"/>	_____
Sister(s):	_____	<input type="checkbox"/>	_____
Son(s):	_____	<input type="checkbox"/>	_____
Daughter(s):	_____	<input type="checkbox"/>	_____