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: _____

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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: _____

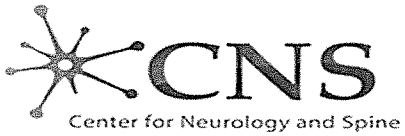
Address: _____ Fax: _____

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

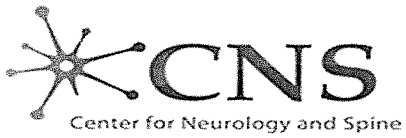
School Name: _____

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:**_____

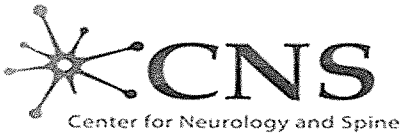
I understand I am financially responsible for any co-payments, deductibles, coinsurance and all other charges which are considered to not be a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments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

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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

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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.		

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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

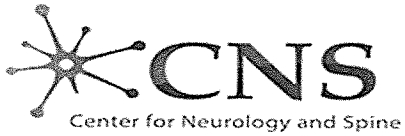
If yes, what? _____

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:	_____	☐	_____
Mother:	_____	☐	_____
Brother(s):	_____	☐	_____
Sister(s):	_____	☐	_____
Son(s):	_____	☐	_____
Daughter(s):	_____	☐	_____