PLEASE MAKE SURE TO SEND A COPY OF YOUR DRIVER LICENSE/ID AND THE FRONT AND BACK OF ALL OF YOUR INSURANCE CARDS.

THANK YOU!

Neurology and Electrodiagnostic Center

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Chun Chow NP, Courtney Pietsch NP, Joy Gao NP

8851 Center Dr Ste 603 - La Mesa, CA 91942

Ph: 619-667-4545 Fx: 619-667-4550

Office hours: Monday-Friday 9am to 5pm

Phone hours: Monday-Friday 9am to 12pm - 2pm-5pm

PATIENTS NAME: **DATE OF BIRTH:**

_____

GENDER: (PLEASE CIRCLE) MALE FEMALE **OR IDENTIFY AS** _____

ADDRESS: _____

_____

PHONE NUMBER(S):

CELL: _____ **HOME:** _____ **WORK:** _____

EMAIL ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

PRIMARY CARE PHYSICIAN: _____

PH: _____ **FX:** _____

REFERRING PHYSICIAN: _____

PH: _____ **FX:** _____

PREFERED PHARMACY: _____ **LOCATION:** _____

EMERGENCY CONTACT: _____ **RELATION TO PATIENT:** _____

PH: (MUST BE DIFFERENT FROM PATIENT) _____

PREFERED LANGUAGE: _____ **ETHNICITY/RACE:** _____

- **NEW PATIENTS ARE REQUIRED TO SIGN IN 15 MINUTES BEFORE SCHEDULED TIME – ALL WHO FAIL TO COMPLY WILL BE RESCHEDULED.**
- **OUR OFFICE IS WHEELCHAIR ACCESSIBLE ONLY - NO GURNEYS**
- **Please be aware: WE DO NOT VALIDATE PARKING.**
- **Photo ID and insurance cards are required for office visits**
- **Paperwork can be mailed back before the appointment or faxed to 619-667-4550**

NAME: _____ DOB: _____

ON GOING MEDICAL PROBLEMS

DO YOU CURRENTLY HAVE ANY MEDICAL PROBLEMS? **_____NO _____YES**, IF SO PLEASE LIST

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

SURGICAL HISTORY OR MAJOR HEALTH EVENTS

HAVE YOU EVER HAD SURGERY OR HAD A MAJOR HEALTH EVENT? **_____NO _____YES**, IF SO PLEASE LIST

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

FAMILY MEDICAL HISTORY

Do any medical conditions run in your family? **_____NO _____YES,** IF SO PLEASE LIST

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

SOCIAL HISTORY

(PLEASE CIRCLE IF NECESSARY)

MARITAL STATUS: MARRIED DIVORCED SEPERATED SINGLE WIDOW

NUMBER OF CHILDREN: _____ CURRENT LIVING ARRANGEMENTS: _____

SMOKING STATUS: NEVER FORMER CURRENT **HOW LONG/HOW MANY A DAY: _____**

ALCOHOL STATUS: NEVER FORMER CURRENT **HOW LONG/HOW MANY A DAY: _____**

CAFFEINE STATUS: NEVER FORMER CURRENT **HOW LONG/HOW MANY A DAY: _____**

DRUG USE STATUS: NEVER FORMER CURRENT **HOW LONG/HOW MANY A DAY: _____**

NAME: _____ DOB: _____

MEDICATION

Do you currently take any medications? **_____NO _____YES,** IF SO PLEASE LIST OR ATTACH ONE

NAME	**MG**	**CIRCLE**	**HOW MANY TIMES A DAY**
1. _____	_____ mg	capsule or tablet	_____
2. _____	_____ mg	capsule or tablet	_____
3. _____	_____ mg	capsule or tablet	_____
4. _____	_____ mg	capsule or tablet	_____
5. _____	_____ mg	capsule or tablet	_____
6. _____	_____ mg	capsule or tablet	_____
7. _____	_____ mg	capsule or tablet	_____
8. _____	_____ mg	capsule or tablet	_____
9. _____	_____ mg	capsule or tablet	_____
10. _____	_____ mg	capsule or tablet	_____
11. _____	_____ mg	capsule or tablet	_____
12. _____	_____ mg	capsule or tablet	_____
13. _____	_____ mg	capsule or tablet	_____
14. _____	_____ mg	capsule or tablet	_____
15. _____	_____ mg	capsule or tablet	_____

FOOD ALLERGY ___NO ___YES, IF SO PLEASE LIST

1.
2.
3.
4.

ENVIRONMENTAL ALLERGY ___NO ___YES, IF SO PLEASE LIST

1.
2.
3.
4.

DRUG ALLERGY ___NO ___YES, IF SO PLEASE LIST

1.
2.
3.
5.
6.
7.

NAME: _____ DOB: _____

POLICY ACKNOWLEDGMENTS AND RELEASES

Please read each of the following statements carefully and initial as your authorization and understanding agreement to each statement.

_____**ASSIGNMENT AND RELEASE:** I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer prospective employer and/or insurance carrier.

_____**FINANCIAL OBLIGATION:** I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am responsible for any and all charges not covered by my insurance carrier. I understand that payment will be requested at time of service.

_____**CONSENT FOR TREATMENT & TELEMEDICINE APPOINTMENTS:** I hereby authorize the physician, nurse, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable as well as perform consultations and evaluations via Video with Audio (telemedicine).

_____**MEDICATION HISTORY AUTHORITY:** I authorize Neurology and Electrodiagnostic Center to obtain my medication history.

_____**MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. The practice is closed on weekends and refill requests will not be accepted.

_____**PAYMENTS:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, all major credit cards. There is a $35 charge for all returned checks.

_____**CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as they are available. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

_____ **FORMS:** Should you require our office to complete any applicable forms, there may be a fee of $25 or more due at time of completion.

_____**APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals after the appointment time is considered no show and it will require appointment rescheduling.

NAME: _____ DOB: _____

NO SHOW POLICY

Patients who fail to present for a scheduled appointment will be considered a “no show.” Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a “no show.”

A patient determined to be a “no show” will be charged $25.00 for each episode.

Patients who have missed 2 appointments in a 12 month period will be considered a “chronic no show” and may be discharged from the practice. By signing, you understand and agree to this statement.

Signature: _____ Date: _____

This consent was signed by: _____ (PRINT NAME PLEASE)

HIPAA

By signing this form, I understand that:

· Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

· The practice reserves the right to change the privacy policy as allowed by law.

· The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.

· The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

· The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? _____**YES** _____ **NO**

May we leave a message on your answering machine at home or on your cell phone? _____**YES** _____**NO**

May we discuss your medical condition with any member of your family? _____**YES** _____**NO** If YES, please name the members allowed:_____

ADVANCED DIRECTIVE: Do you have an advance directive? (living will/power of attorney?)

____**YES** ____**NO** If yes, please provide a copy for our records.

Signature: _____ Date: _____

This consent was signed by: _____ (PRINT NAME PLEASE)

Witness: _____ Date: _____