NEUROLOGY CENTER OF NORTH ORANGE COUNTY

A Medical Corporation
NEUROLOGY ● NEURODIAGNOSTICS

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Certified in the Subspecialty of Clinical Neurophysiology

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Diplomate, American Board of Neurology
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Certified in the Subspecialty of Neurocritical Care

Manpreet K. Multani, M.D.
Diplomate, American Board of Neurology

OFFICE POLICY

Dear Patient,

Welcome to our practice! It is our goal to give you the highest level of medical care possible.

Please complete the enclosed forms and bring them with you to your scheduled visit, along with your insurance card. A map to our office is also attached.

As a courtesy to you, we will bill your insurance carrier/carriers, so it is important that you bring all the information you have, including your insurance identification card. If your insurance requires you to pay a co-payment or a deductible, you will be responsible to pay that at the time of service. As long as your account has a balance, you will receive a monthly statement. This balance is not yours to pay unless your insurance has already paid its portion of your charges or if the claim has been denied. If you have any billing questions or comments, please do not hesitate to call our billing office at 800-727-5662.

We participate in many insurance plans, including Medicare and select PPO and HMO panels. Please discuss your insurance / financial situation with our office as some plans may require prior authorization or are considered out-of-network, resulting in increased patient financial responsibility.

Our billing is separate from those of the hospital, radiology, or any lab. Should you receive a bill/statement from those mentioned, you will need to contact them.

Our office will call to confirm your appointment the day before. If you are unable to keep your appointment and the office is not notified at least 24 hours prior to the appointment time, there will be a $45.00 missed appointment fee. If after office hours, please leave a message in our voicemail.

For certain types of forms that we are requested to complete (for example, insurance disability forms or DMV forms), there will be a charge based on time needed to complete the form. For lengthy telephone calls to the doctor (over 10 minutes) there may be a charge.

Please note: If you are scheduled for nerve testing, please do not apply any lotions, creams, or oils the night prior to or the day of testing. Thank you in advance for your compliance.

Thank you for choosing us for your neurological care. We are looking forward to seeing you.

Sincerely,

Neurology Center of North Orange County

381 E. Imperial Highway, Fullerton, CA 92835 phone (714) 879-7200 fax (714) 879-1055
www.NeurologyOC.com

NEUROLOGY CENTER OF NORTH ORANGE COUNTY

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OUR OFFICE NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

- In our office, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice, and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. An example is a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal health care operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. This request with the specific amendment or a statement in your file must be notarized. We may or may not make the changes you request, but we will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, Washington DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Christi, at (714) 879-7200.

This notice goes into effect as of April 14, 2003. You have a right to receive a copy of this notice.

Date: _____

Signed: _____ Print Name: _____

If signing as a parent or guardian, please note the name of the patient: _____

NEUROLOGY CENTER OF NORTH ORANGE COUNTY

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ELIGIBILITY GUARANTEE FORM

I, _____, hereby certify that I am an eligible member of the health plan whose insurance card I have provided to the Neurology Center. I understand that if the above is not true or if I am not eligible under the terms of my Medical and Hospital Subscriber Agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered within thirty days of receiving a bill from the above noted medical group/physician.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION:

I authorize any holder of medical information about me to release said medical information requested by insurance companies with whom I have coverage, or any public agency and its agents to determine benefits for services provided or benefits for related services.

ASSIGNMENT OF BENEFITS:

I hereby authorize payment of benefits be made directly to NEUROLOGY CENTER OF NORTH ORANGE COUNTY for services provided to me by NEUROLOGY CENTER OF NORTH ORANGE COUNTY, and that I am financially responsible for charges not covered by this assignment. I authorize refund of overpaid insurance benefits where my coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection.

NOTICE TO CONSUMERS:

Medical doctors are licensed and regulated by the
Medical Board of California
(800) 633-2322
www.mbc.ca.gov

_____ _____

Signature of Member Date

NEUROLOGY CENTER OF NORTH ORANGE COUNTY

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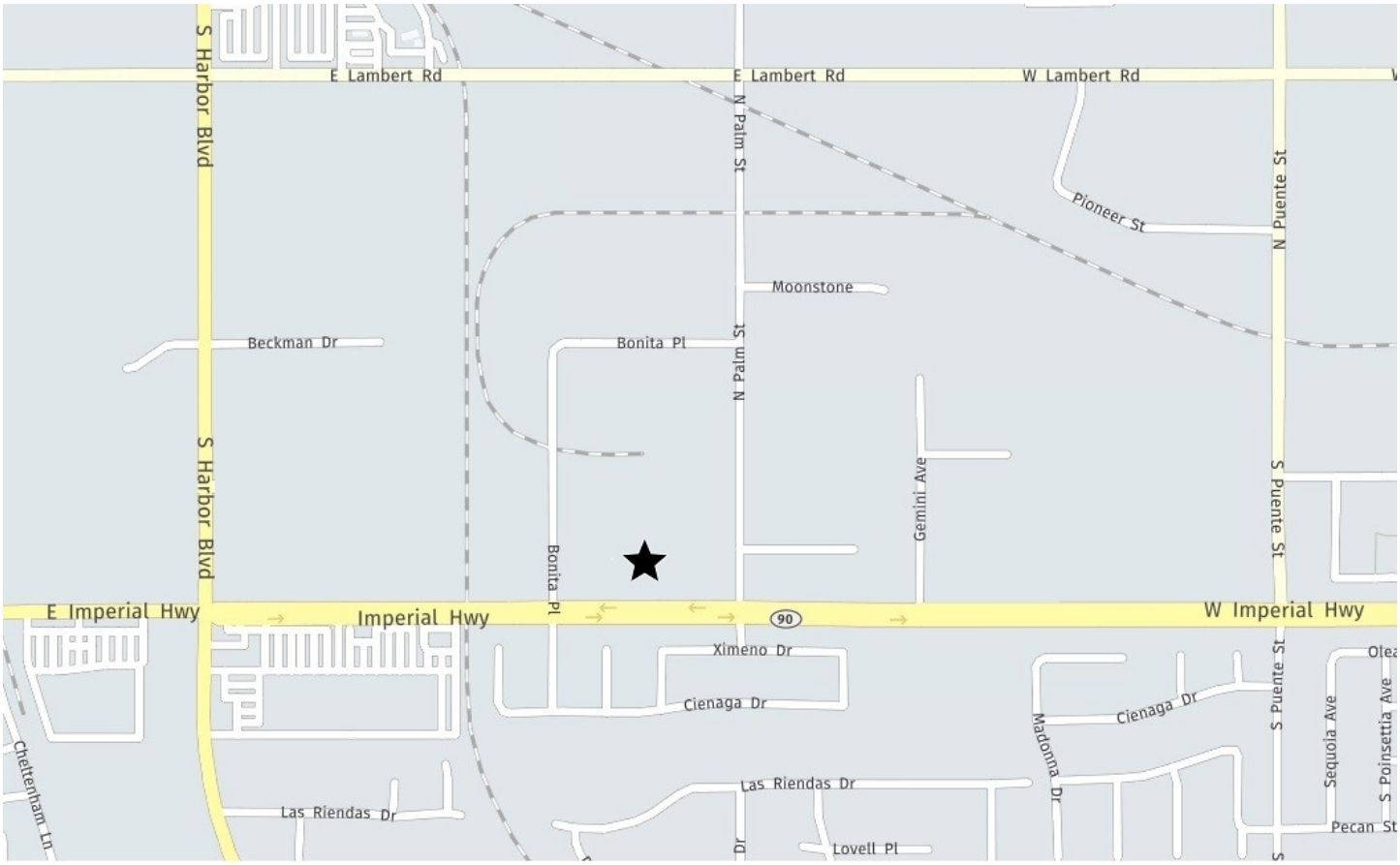
381 E. Imperial Highway, Fullerton, CA 92835
Phone: (714) 879-7200 Fax: (714) 879-1055



We are located at 381 E Imperial Highway, on the second block east of Harbor Blvd, on the north side of the street in the shopping center between Bonita Pl and Palm Street.

Neurology Center of North Orange County

Neurology · Neurodiagnostics

Patient Information

Patient Name _____ Date of Birth ___/___/_____ Sex ____
Last First Middle
Social Security # _____Marital Status _____ Race _____ Ethnicity_____
Home Address _____ Unit/Apt # _____
City _____ State _____ Zip Code _____
Daytime phone _____ Alt Phone _____
Email Address _____ (email will only be used for our records)
Primary Care Physician _____ Phone # _____
Referring Physician _____ Phone # _____

Responsible Party

Responsible Party Name _____ Social Security # _____
Last First
Relationship to Patient _____ Date of Birth ___/___/____
Home Address _____ Unit/Apt # _____
City _____ State _____ Zip Code _____
Daytime phone _____ Alt Phone _____

Emergency Contact

Contact Name _____ Relationship to Patient _____
Last First
Home Address _____ Unit/Apt # _____
City _____ State _____ Zip Code _____
Daytime phone _____ Alt Phone _____

Insurance Information

Insurance Company Name _____ Phone # _____
Billing Address _____
Street # and Name City State Zip code
Subscriber # _____ Group # _____
Subscriber Name _____ Subscriber Date of Birth ___/___/____
Relationship to Patient _____ Daytime Phone _____

Secondary Insurance Information

Insurance Company Name _____ Phone # _____
Billing Address _____
Street # and Name City State Zip code
Subscriber # _____ Group # _____
Subscriber Name _____ Subscriber Date of Birth ___/___/____
Relationship to Patient _____ Daytime Phone _____

By signing my name at the bottom of this document I declare that I have answered all the above questions to the best of my knowledge.

_____ _____
Signature Date

NEUROLOGY CENTER OF NORTH ORANGE COUNTY

A Medical Corporation

Date: ___/____/____

Name: _____ Birthday ____/____/____ Age:_____
First Name Middle Initial Last Name

Symptoms: _____

Location:_____ Duration:_____

Severity:_____ Context:_____

Associated symptoms:_____ Modifying factors:_____

PAST MEDICAL HISTORY:

			Other Medical Problems or surgeries	Date
Diabetes_____	☐No	☐ Yes	_____	
Hypertension_____	☐ No	☐ Yes	_____	
Cancer_____	☐ No	☐ Yes	_____	
Stroke_____	☐ No	☐ Yes	_____	
Heart trouble_____	☐ No	☐ Yes	_____	
Arthritis/Gout_____	☐ No	☐ Yes	_____	
Seizures_____	☐ No	☐ Yes	_____	
Bleeding tendency_____	☐ No	☐ Yes	_____	

MEDICATIONS:

Medicine	Dose	Times per day	Reason taken

ALLERGIES: _____

Do you smoke? ☐ Yes _____ Packs per day
☐ No ☐ Prior smoker but quit _____ years ago

Do you drink alcohol? ☐ Yes _____ Drinks per ☐ day ☐ week ☐ month Type of alcohol _____
☐ No ☐ Prior drinker but quit _____ years ago

Marital status? ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Education? ☐ High school ☐ Some college ☐ College graduate

Occupation _____

FAMILY HISTORY:

	Age	Medical Conditions	Cause of death if deceased
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
Children	_____	_____	_____

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SYSTEM REVIEW:

CONSTITUTIONAL:
Good general health lately…… No Yes
Recent weight change…… No Yes
Fever…… No Yes
Fatigue…… No Yes
Headache…… No Yes

EYES:
Eye disease or injury…… No Yes
Wear glasses/contact lenses…… No Yes
Blurred or double vision…… No Yes
Glaucoma…… No Yes

EARS/NOSE/MOUTH/THROAT:
Hearing loss or ringing…… No Yes
Earaches or drainage…… No Yes
Chronic sinus problems or rhinitis…… No Yes
Nosebleeds…… No Yes
Mouth sores…… No Yes
Bleeding gums…… No Yes
Bad breath or bad taste…… No Yes
Sore throat or voice change…… No Yes
Swollen glands in neck…… No Yes

CARDIOVASCULAR:
Heart trouble…… No Yes
Chest pain or angina pectoris…… No Yes
Palpitations…… No Yes
Shortness of breath with walking or lying flat…… No Yes
Swelling of feet, ankles or hands…… No Yes

RESPIRATORY:
Chronic or frequent coughs…… No Yes
Spitting up blood…… No Yes
Shortness of breath…… No Yes
Asthma or wheezing…… No Yes

GASTROINTESTINAL:
Loss of appetite…… No Yes
Change in bowel movements…… No Yes
Nausea or vomiting…… No Yes
Frequent diarrhea…… No Yes
Painful bowel movements or constipation…… No Yes
Rectal bleeding or blood in stool…… No Yes
Abdominal pain or heartburn…… No Yes
Peptic ulcer (stomach or duodenal)…… No Yes

GENITOURINARY:
Frequent urination…… No Yes
Burning or painful urination…… No Yes
Blood in urine…… No Yes
Change in force or strain when urinating…… No Yes
Incontinence or dribbling…… No Yes
Kidney stones…… No Yes
Sexual difficulty…… No Yes
Male - testicular pain…… No Yes
Female - pain with periods…… No Yes
Female - irregular periods…… No Yes
Female - vaginal discharge…… No Yes
Female - # of pregnancies ____ # of miscarriages ____
Female - date of last pap smear _____

MUSCULOSKELETAL:
Joint pain…… No Yes
Joint stiffness or swelling…… No Yes
Weakness of muscles or joints…… No Yes
Muscle pain or cramps…… No Yes
Back pain…… No Yes
Cold extremities…… No Yes
Difficulty in walking…… No Yes

INTEGUMENTARY (skin, breast):
Rash or itching…… No Yes
Change in skin color…… No Yes
Change in hair or nails…… No Yes
Varicose veins…… No Yes
Breast pain…… No Yes
Breast lump…… No Yes
Breast discharge…… No Yes

NEUROLOGICAL:
Frequent or recurring headaches…… No Yes
Lightheaded or dizzy…… No Yes
Convulsions or seizures…… No Yes
Numbness or tingling sensations…… No Yes
Tremors…… No Yes
Paralysis…… No Yes
Stroke…… No Yes
Head injury…… No Yes

PSYCHIATRIC:
Memory loss or confusion…… No Yes
Nervousness…… No Yes
Depression…… No Yes
Insomnia…… No Yes

ENDOCRINE:
Glandular or hormone problem…… No Yes
Thyroid disease…… No Yes
Diabetes…… No Yes
Excessive thirst or urination…… No Yes
Heat or cold intolerance…… No Yes
Skin becoming dryer…… No Yes
Change in hat or glove size…… No Yes

HEMATOLOGIC/LYMPHATIC:
Slow to heal after cuts…… No Yes
Bleeding or bruising tendency…… No Yes
Anemia…… No Yes
Phlebitis…… No Yes
Past transfusion…… No Yes
Enlarged glands…… No Yes

ALLERGIC/IMMUNOLOGIC:
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics…… No Yes
Morphine, Demerol, or other narcotics…… No Yes
Novocaine or other anesthetics…… No Yes
Aspirin or other pain remedies…… No Yes
Tetanus antitoxin or other serums…… No Yes
Iodine, merthiolate or other antiseptic…… No Yes
Other drugs/medications _____
Known food allergies _____

Pharmacy Information

Patient Name: _____

Name of Local Pharmacy: _____

Telephone number (local pharmacy): _____

City (local pharmacy): _____

Major Cross Streets (local pharmacy):

_____

_____

Name of Mail Order Pharmacy:

_____

Contact phone number:

_____

HIPAA Authorization to Share Health Information

Date: _____

TO: NEUROLOGY CENTER OF NORTH ORANGE COUNTY
381 IMPERIAL HIGHWAY
FULLERTON, CA. 92835

I hereby authorize the NEUROLOGY CENTER OF NORTH ORANGE COUNTY to contact or disclose my personal and medical information, without any limitation to the following people:

	Name	Relationship	Contact information
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Patient's Signature: _____

Print Patient's Name: _____ Date of Birth: _____

Relationship (if other than patient): _____

Witness: _____