



Offices:  
675 Ygnacio Valley Rd #A102 Walnut Creek, CA 94596  
111 Deerwood Road, Suite 305, San Ramon, CA, 94583  
925-938-5252 (phone)  
925-938-1343 (fax)  
www.eastbayneurology.com

Timothy Wei, MD, PhD  
Tanya Gupta, MD  
Harpreet Bal, NP

Chirag Patel, MD  
Erin Green-Krogmann, PhD  
Nisha Parmar, PA

Jason Massa, DO  
Maridez Jenkins, NP

## WELCOME TO OUR PRACTICE

Dear Friend,

Thank you for coming to us for your neurologic evaluation and care. For your convenience, we are enclosing forms to be filled out prior to your initial appointment. We have also enclosed a map for directions to our offices.

In order for our doctors to make an appropriate assessment, our office should have medical records pertinent to your visit. Please make sure that your referring physician or your primary care physician sends us a copy of your most recent consultation, clinical notes, labs and/or x-ray studies. You may bring any relevant records that you have as well.

To help us stay committed to serving our patients with respect, courtesy and responsiveness, we do expect you to keep your appointment on time. For new patients, we ask you to come 15 minutes prior to your appointment to allow time for initial appointment processing. If you are a new patient and have not filled this initial application packet, we ask you to come 30 minutes prior to your initial appointment. We ask you to call for cancellations at least 24 hours in advance if you cannot make it so that we can use the time to serve others who might need to be taken care of urgently. Per our policy, any missed appointment or cancellation under 24 hours of notice will be subject to a charge for reappointment.

Please make sure to fill out the enclosed information and bring it with you on the day of your scheduled appointment. This will help the physician to facilitate your care.

Your appointment is on:

\_\_\_\_\_ DAY \_\_\_\_\_ DATE \_\_\_\_\_ TIME

If you have any questions, please call of office at (925) 938-5252. If you are unable to keep your appointment, please call to cancel or reschedule preferably 2-3 days prior to your visit. Thank you for this courtesy. We look forward to meeting you.

Sincerely,

East Bay Neurology Physicians and Staff

**Please check what office your appointment is in!**

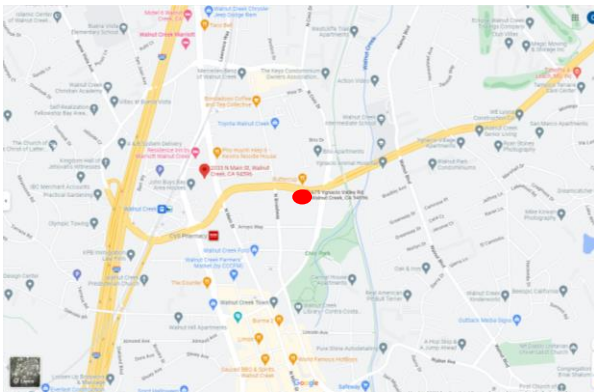
**DIRECTIONS TO:**

**WALNUT CREEK OFFICE: (675 Ygnacio Valley Road, Suite A102, Walnut Creek, CA, 94596)**

**From the North (Benicia, Vallejo, Martinez, Concord):** Take Highway 680 south to Walnut Creek, Take Exit 47 for N Main St toward Walnut Creek. Keep right at the fork, follow the sign for the North Main St. Turn right at N. Main St. Keep on driving till hitting Ygnacio Valley Road. Turn left at Ygnacio Valley Road and stay in the right-hand lane. You will pass N. Broadway. As soon as you pass the N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately after the And Oil gas station).

**From the South (Danville, Pleasanton, San Jose, Fremont):** Take Highway 680 North to Walnut Creek. Exit at Ygnacio Valley Road. Make a right onto Ygnacio Valley Road and stay in the right-hand lane. You will pass N. California Blvd, then N. Main St, then N. Broadway. As soon as you pass N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately after the And Oil gas station).

**From the West (Lafayette, Orinda, Berkeley, San Francisco):** Take Highway 24 East to Walnut Creek. Exit at Ygnacio Valley Road. Make a right onto Ygnacio Valley Road and stay in the right-hand lane. You will pass N. California Blvd, then N. Main St, then N. Broadway. As soon as you pass the N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately after the And Oil gas station).

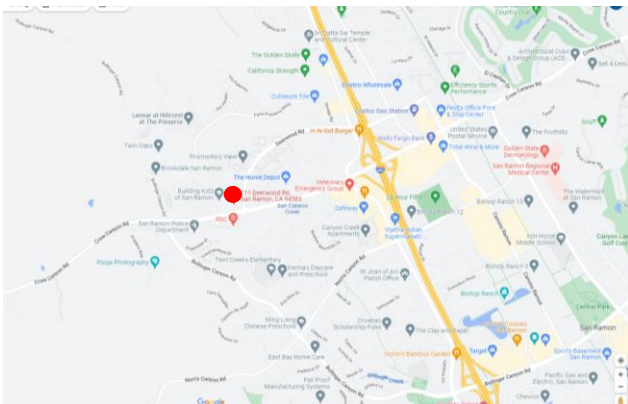


**SAN RAMON OFFICE: (111 Deerwood Road, Suite 305, San Ramon, CA, 94583)**

**From the North (Walnut Creek, Danville, Benicia, Vallejo, Martinez, Concord):** Take Highway 680 south to exit Crow Canyon Road and take a right. Continue down, passing Home Depot and Staples on the right. Take a right onto Deerwood Road, and then take the first left into the 111 Deerwood building complex and park anywhere. Take the elevators up to Suite 305.

**From the South (Dublin, Pleasanton, San Jose, Fremont):** Take Highway 680 North to exit Crow Canyon Road and take a left. Continue down, passing Home Depot and Staples on the right. Take a right onto Deerwood Road, and then take the first left into the 111 Deerwood building complex and park anywhere. Take the elevators up to Suite 305.

**From the Southwest (Hayward, Castro Valley, San Lorenzo):** Take Highway 580 East to Dublin, then change onto 680 North. Exit Crow Canyon Road and take a left. Continue down, passing Home Depot and Staples on the right. Take a right onto Deerwood Road, and then take the first left into the 111 Deerwood building complex and park anywhere. Take the elevators up to Suite 305.



**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

675 Ygnacio Valley Rd, A102 Walnut Creek, CA 94596  
111 Deerwood Rd, St 305, San Ramon, CA, 94583  
925-938-5252

We respect your right to privacy and understand that your medical information is personal to you. Your personal health information is confidential and this notice is intended **in summary** to help you understand how our practice uses and discloses your personal health information and what right you have with respect to your medical information. We abide by State and Federal HIPAA regulations.

**HOW WE MAY USE AND DISCLOSE YOUR INFORMATION**

**Medical Treatment:**

We may need to share information relating to your medical care, records, treatment with other physicians, nurses, health care professionals and the East Bay Neurology.

**Payment:**

We may need to disclose personal health information about you with your health plan and/or referring physician in order to obtain prior authorization for treatment, or to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

**Healthcare Operations:**

We may use and disclose your personal health information to business associates who need to provide a service for our medical practice; examples are our transcriptionist and medical biller.

**Appointment Reminders:**

Our practice may use and disclose medical information about you to provide you with reminders that you have an upcoming appointment. We may use third party services to help facilitate this. If you have any special requests about these reminders, please notify us.

**Please select all that apply, sign and date below.**

**PROTECTED HEALTH INFORMATION**

Laboratory, x-ray or scan results, medical records, medications, billing matters and/or any correspondence pertaining to:

Protected Health Information

I hereby authorize **East Bay Neurology, including physicians and staff**, to leave messages at the following:

- DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN THE CALL
- YES  NO-Home phone \_\_\_\_\_  YES  NO-Work phone \_\_\_\_\_
- YES  NO-Cell phone \_\_\_\_\_  YES  NO-Other phone \_\_\_\_\_

If you would like your Protected Health Information disclosed to other family members or friends, please indicate their name and relationship. Only the names listed will be given information.

\_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address or phone \_\_\_\_\_

\_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Address or phone \_\_\_\_\_

I hereby acknowledge that I have read and consent to this Notice of Privacy Practices. I further acknowledge that the entire Notice of Privacy Practices is in the waiting room for review, and you will be offered a **complete** copy of the Privacy Practices upon request.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## NOTICE OF FINANCIAL POLICIES FOR OUR VALUED PATIENTS

### **CASH PATIENTS**

Patients are financially responsible for services provided and are expected to pay at the time of service. Please inquire about our fee schedule prior to your visit to determine your cost. If you would like to bill your health plan still that is out of network, we can provide you a charges summary for you to submit to your insurance on request.

### **Insurance HMO / PPO PATIENTS**

Please refer to our website [www.eastbayneurology.com](http://www.eastbayneurology.com) for health plans we accept. Of note, our health plans can sometimes change without notice depending on health plan policy changes. Although we do our best to notify you of this beforehand, it is ultimately your responsibility to know whether we are considered "in-network" for your specific health plan at the time of any visit. It is also your responsibility to know exactly what procedures, visits, drugs and labs your plan covers. For some procedures, such as Botox injections for migraines, we obtain pre-authorization prior to the visit to ensure insurance coverage, but your specific individualized cost will be unknown to us until we actually do the procedure and the medical visit is processed by the health plan. You, however, can call your health plan beforehand to verify what your cost will be and we encourage you to do so. Please be aware, however, that any deductible, co-payment, or co-insurance charges you incur from these services, or any charges denied by your health plan, are ultimately your responsibility. As the costs of certain health services have increased, East Bay Neurology reserves the right to collect pre-payment if needed if there are anticipated large co-deductible/co-insurance payments.

Additionally, most HMO/PPO health plans will have a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. Co-payments will be collected at the time of service. Non-covered services must be paid at the time of service. If our staff has to bill for a co-payment, there will be an additional \$15.00 service charge.

Any time you receive a new insurance card, please notify us immediately to update your chart information, especially if you are on medications or treatments that require pre-authorization as we will likely need to re-process these under your new insurance. If we have to rebill because of incorrect insurance information, there will be a \$50.00 service charge. Please note for certain treatments, doing a retro-authorization if one is not on file may not be possible with a new insurance, and the entire cost will become your responsibility. Therefore, it is imperative to make sure we have your most up to date health plan information on file.

We accept you as a patient with the understanding you know your coverage and benefits. Again, any ultimate balances remaining (from co-payments, co-insurance, deductibles, or denied claims) after your claim has been processed from your health plan are ultimately your responsibility and due immediately upon receipt of statement. Failure to make timely payments on any outstanding balances may result in dismissal from the practice.

### **MEDICARE**

We are participating providers in Medicare, which means that we accept Medicare assignment as payment in full, once your deductible and co-payments have been made. We will bill Medicare for you, as well as your supplemental insurance. You must provide us with valid cards from Medicare and any other insurance if applicable. Without these documents we cannot bill your insurance and payment will be expected from you at the time of your visit. The patient is only responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier. The same financial responsibilities as described above apply.

### **CANCELLATIONS / NO SHOWS**

If you are scheduled to see the physician and are unable to keep your appointment, please contact our office as soon as possible so we may schedule your time for another patient. Failure to show up for your appointments creates gaps in our schedule and affects our ability to provide appropriate care to all of our patients. **"No Shows" and/or cancellations with less than 24 hours notice may result in a charge of \$100.00 if you are a new patient or scheduled for a procedure and \$75.00 if you are a return patient. This charge is NOT covered by your insurance company, and will be collected before you make your future appointment with us.** Repeated "No Shows" or cancelled appointments, without at least 24 hours notice, may result in dismissal from our practice.

### **COMPLETION OF FORMS / PHOTOCOPYING OF MEDICAL RECORDS**

Completion of various forms and/or letters (anything that requires a provider signature) will be charged a flat fee of \$30.00. If you are going to request your personal medical records you will also be charged a fee of \$30.00 and up depending on the thickness of your medical file.

A \$25.00 charge will be applied for all returned checks.

I hereby acknowledge that I have read and consent to this Notice of Financial Policies.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

## NEW PATIENT INFORMATION RECORD

PLEASE PRINT CLEARLY

### PATIENT INFORMATION

PATIENT'S NAME		GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER		DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
MARRITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPERATED		ETHNIC GROUP <input type="checkbox"/> EUROPEAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ARAB/MIDDLE EASTERN <input type="checkbox"/> JEWISH <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER		EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> LAID OFF <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED		PREFERRED LANGUAGE
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> TEMPORARY		CITY		STATE		ZIP CODE
HOME PHONE	BUSINESS PHONE NO.	CELL PHONE NO.	E-MAIL ADDRESS		DRIVER'S LIC NO.	
SIGNIFICANT OTHER'S NAME						
SPOUSE'S ADDRESS (IF DIFFERENT)		CITY		STATE		ZIP CODE
HOME PHONE	BUSINESS PHONE NO.	CELL PHONE NO.	E-MAIL ADDRESS		DRIVER'S LIC NO.	

### REFERRING INFORMATION

NAME OF REFERRING PHYSICIAN	CITY AND STATE	ZIP CODE	PHONE NO.
PRIMARY CARE PHYSICIAN	CITY AND STATE	ZIP CODE	PHONE NO.
FRIEND OR RELATIVE	CITY AND STATE	ZIP CODE	PHONE NO.

### BILLING INFORMATION If injury and/or treatment is the result of industrial accident or personal injury, please give name and policy number of responsible insurance company

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE, AND ZIP CODE		PHONE NO.
NAME OF INSURANCE COMPANY	MEMBER ID#	GROUP NUMBER	
NAME OF SUBSCRIBER	RELATIONSHIP TO PATIENT	D.O.B. OF SUBSCRIBER & SOCIAL SECURITY	
NAME OF SECONDARY OR OTHER INSURANCE COMPANY, ADDRESS			



Offices:  
675 Ygnacio Valley Rd #A102 Walnut  
Creek, CA 94596  
111 Deerwood Road, Suite 305, San  
Ramon, CA, 94583  
925-938-5252 (phone)  
925-938-1343 (fax)

**Please answer the following questions to help with your office visit:**

**GENERAL INFORMATION**

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Handedness: \_\_\_\_\_ Right handed \_\_\_\_\_ Left handed \_\_\_\_\_ Ambidextrous

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Other

Height \_\_\_\_\_ Weight \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**INFORMATION RELATED TO YOUR CURRENT PROBLEM OR CONDITION**

For what problem/condition are you seeing the doctor? (please explain in your own words)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Approximately how long has this been present \_\_\_\_\_

Has your problem or condition been:

Getting worse? \_\_\_\_\_  
Staying about the same? \_\_\_\_\_  
Getting better? \_\_\_\_\_

Please list any things that make your problem or condition better:

\_\_\_\_\_

Please list any things that make your problem or condition worse:

\_\_\_\_\_

Please list any other doctors you have seen about this problem:

\_\_\_\_\_

Please list any tests you have had done for this problem (and results, if known):

\_\_\_\_\_

Please list any medication you are **allergic** to or have an adverse reaction to:

\_\_\_\_\_

Please list all medications that you are **currently taking** (including non-prescription medications):

	Name	Dose	How often do you take it?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____

Which pharmacy you are using? Local: \_\_\_\_\_

Mail order: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Do you have (or have you had) any of the following medical conditions? (please circle all that apply)

- |                                 |                            |                          |
|---------------------------------|----------------------------|--------------------------|
| High blood pressure_____        | Arthritis_____             | Anxiety_____             |
| Diabetes_____                   | Thyroid disease_____       | Depression_____          |
| High cholesterol_____           | Anemia_____                | Bipolar disorder_____    |
| Heart disease/heart attack_____ | Epilepsy/seizures_____     | Schizophrenia_____       |
| Stroke/TIA_____                 | Migraine_____              | Parkinson’s disease_____ |
| Irregular heart beat_____       | Neuropathy_____            | Dementia_____            |
| GERD/Acid reflux_____           | Kidney stones/disease_____ | Cancer (type)_____       |
| Asthma/emphysema_____           | Multiple sclerosis_____    | Brain aneurysm_____      |

Others \_\_\_\_\_

Have you had any of the following surgeries?

- |                      |                        |                      |
|----------------------|------------------------|----------------------|
| Appendectomy _____   | Heart bypass_____      | Heart pacemaker_____ |
| Cataracts_____       | Valve replacement_____ | Hysterectomy_____    |
| Gallbladder_____     | Sinus surgery_____     | Hernia surgery_____  |
| Other surgeries_____ |                        |                      |

**FAMILY HISTORY** (please check any diseases that occur or have occurred in your blood relatives)

Diabetes _____	Multiple sclerosis _____	Parkinson's disease _____
Heart disease _____	Brain tumor _____	Headaches _____
Stroke _____	Brain aneurysm _____	Tremors _____
High blood pressure _____	Depression/other mental illness _____	Cancers _____
Epilepsy/seizure _____	Dementia _____	Others (please list) _____

**SOCIETY HISTORY**

Are you: \_\_\_\_\_ Single \_\_\_\_\_ Married

Are you: \_\_\_\_\_ Full time employed \_\_\_\_\_ Part time employed \_\_\_\_\_ Student \_\_\_\_\_ Laid off \_\_\_\_\_ Retired

Do you smoke tobacco cigarettes? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Quit How much \_\_\_\_\_

Do you drink alcoholic beverages? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Quit What type? (beer, wine, liquor) \_\_\_\_\_  
How much \_\_\_\_\_ How often \_\_\_\_\_

Do you drink or eat caffeine-containing food or beverages \_\_\_\_\_ Yes \_\_\_\_\_ No  
How much \_\_\_\_\_ How often \_\_\_\_\_

**DO YOU HAVE FOLLOWING SYMPTOMS? PLEASE CIRCLE**

<b>General</b>	fever, chills, weight loss, weight gain, fatigue
<b>Sleep</b>	insomnia, trouble falling asleep, trouble staying asleep, early morning awakening, involuntary leg movement while asleep, loud snoring, stopping breathing while asleep
<b>Eyes</b>	blurred vision, loss of vision, double vision, eye pain or redness, drooping eyelid
<b>Ears</b>	hearing loss, ringing in the ears, spinning sensation or lightheaded
<b>Nose/sinuses</b>	frequent runny nose, frequent sinus trouble, nosebleeds
<b>Mouth/throat</b>	hoarseness, difficulty swallowing, choking sore throat, bleeding gums, dry mouth, drooling
<b>Heart</b>	chest pain, palpitation
<b>Lungs</b>	cough, frequent productive cough, coughing up blood wheezing
<b>Gastrointestinal</b>	nausea, vomiting, diarrhea, constipation, stomachache/abdominal pain, blood in the stools
<b>Genitourinary</b>	difficulty urinating, frequent urination, burning on urination, loss of urine control
<b>Muscles/bones</b>	joint pain or swelling, neck stiffness or pain, back stiffness or pain, muscle aches/cramping
<b>Vascular</b>	poor circulation, leg swelling, varicose veins
<b>Endocrine</b>	Heat or cold intolerance, excessive sweating, thirst, hunger or frequent urination
<b>Blood</b>	easy bleeding or bruising
<b>Neurological</b>	headaches, fainting or passing out spells, seizures, lightheadedness, vertigo, localized weakness or numbness, poor balance, difficulty walking, falling, tremors, difficulty speaking, slurring of speech, poor coordination, trouble controlling arms or legs
<b>Psychiatric</b>	moodiness, excessive worrying or anxiety, excessive crying, tension, depression



**PLEASE COMPLETE ONLY IF YOU ARE SEEING EAST BAY NEUROLOGY FOR HEADACHES**

What medications did you take **in the PAST** for your headaches?

**Acute Medications (check all that apply)**

- |                                 |  |
|---------------------------------|--|
| _____ Sumatriptan (Imitrex)     | _____ Naratriptan (Amerge)                                   |
| _____ Rizatriptan (Maxalt)      | _____ Almotriptan (Axert)                                    |
| _____ Zolmitriptan (Zomig)      | _____ Frovatriptan (Frova)                                   |
| _____ Eletriptan (Relpax)       | _____ Dihydroergotamine (D.H.E.)                             |
| _____ Migranal NS               | _____ Treximet   |
| _____ Midrin/Epidrin            | _____ Fiorinal/Fioricet (Butalbital) with or without codeine |
| _____ Ultram(tramadol)/Ultracet | _____ Tylenol w/codeine                                      |
| _____ Darvocet                  | _____ Vicodin  |
| _____ Oxycodon                  | _____ MS Contin  |
| _____ Methadone                 | _____ Fentanyl/Duralgesic Patch                              |
| _____ Depakon (Depakote iv)     | _____ Toradol injection                                      |
| _____ Magnesium infusion        | _____ Thorazine  |
| _____ Indomethacine (Indocin)   | _____ Celebrex   |
| _____ Ubrelvy                   | _____ Nurtec   |

**Anti-Nausea Medications**

- |                               |              |                                    |
|-------------------------------|--------------|------------------------------------|
| _____ Metoclopramide (Reglan) | _____ Zofran | _____ Prochlorperazine (Compazine) |
| _____ Phenergan               |              |                                    |

**Prophylactic or Daily Medications**

- |                                  |                               |
|----------------------------------|-------------------------------|
| _____ Amitriptyline (Elavil)     | _____ Nortriptyline (Pamelor) |
| _____ Doxepine (sinequan)        | _____ SOMA (carisoprodol)     |
| _____ Flexeril (cyclobenzaprine) | _____ Inderal (propranolol)   |
| _____ Timolol                    | _____ Corgard (nadolol)       |
| _____ Topiramate (Topamax)       | _____ Neurontin(gabapentin)   |
| _____ Depakote (valproic acid)   | _____ Lamictal (lamotrigine)  |
| _____ Lyrica                     | _____ Remeron                 |
| _____ Zoloft (sertraline)        | _____ Celexa                  |
| _____ Lexapro                    | _____ Cymbalta                |
| _____ Paxil (paroxetine)         | _____ Wellbutrin (bupropion)  |
| _____ Clonidine                  | _____ Effexor                 |
| _____ Zyprexa                    | _____ Seroquel                |
| _____ Zanaflex (tizanidine)      | _____ Prednisone              |
| _____ Lithium                    | _____ Baclofen                |
| _____ Calan (verapamil)          | _____ Qulipta                 |

Other medications/treatment you had in the past: Botox Aimovig Ajovy Emgality

**Nutritional Supplement/Herbal Supplements/Minerals**

- |                            |                 |              |                |                 |
|----------------------------|-----------------|--------------|----------------|-----------------|
| _____ Vitamin B2           | _____ Magnesium | _____ Co-Q10 | _____ Feverfew | _____ Butterbur |
| _____ Others (please list) |                 |              |                |                 |

**Alternative Treatments**

- |                   |                   |                               |            |
|-------------------|-------------------|-------------------------------|------------|
| _____ Biofeedback | _____ Massage     | _____ Chiropractic Adjustment | _____ Yoga |
| _____ Acupuncture | _____ Acupressure |                               |            |