East Bay Neurology
Center for Headache & Neurologic Care

Offices:
675 Ygnacio Valley Rd, Suite A102, Walnut Creek, CA, 94596
111 Deerwood Road, Suite 305, San Ramon, CA, 94583

Phone: 925-938-5252 Fax: 925-938-1343
www.eastbayneurology.com

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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, along with a map with directions to our office.

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.

As we are committed to serve our patients with respect, courtesy and responsiveness, we do expect that you keep your appointment to respect the time the physicians put aside specifically for you. 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 $100 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 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 at least 48 hours prior to your visit. Thank you for this courtesy. We look forward to meeting you.

Sincerely,

East Bay Neurology Physicians and Staff

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

675 Ygnacio Valley Rd, A102 Walnut Creek, CA, 94596
111 Deerwood Road, Suite 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.

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.

PROCTECTED 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:_____

IMPORTANT FINANCIAL INFORMATION 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. As a courtesy, we can on request bill your out of network insurance; however, you will need to provide complete billing information at the time of your visit.

Insurance HMO / PPO PATIENTS
Please refer to our website www.eastbayneurology.com for health plans we accept. Of note, our health plans can sometimes change without notice depending on health plan policy changes, and although we will 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.

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 that you receive a new insurance card, it is imperative to 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.

We accept you as a patient with the understanding that 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 your responsibility and due immediately upon receipt of statement.

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 other insurance. 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. If you cancel appointments with less than 24 hours notice, you will be subject to a charged $100.00 fee for reappointment. 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 $25.00. If you are going to request your personal medical records you will also be charged a fee of $25.00 and up depending on the thickness of your medical file.

If you are experiencing financial hardship, please speak with our office manager regarding a possible payment plan.
We accept MasterCard and Visa. We **DO NOT** accept American Express or Discover.

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 ☐ MALE ☐ FEMALE ☐ OTHER	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
MARRITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVERCED ☐ SEPERATED	ETHNIC GROUP ☐ EUROPEAN ☐ HISPANIC ☐ ASIAN/PACIFIC ISLANDER ☐ AFRICAN AMERICAN ☐ ARAB/MIDDLE EASTERN ☐ JEWISH ☐ NATIVE AMERICAN ☐ OTHER	EMPLOYMENT STATUS ☐ FULL TIME ☐ PART TIME ☐ UNEMPLOYED ☐ LAID OFF ☐ DISABLED ☐ RETIRED		PREFERRED LANGUAGE

STREET ADDRESS ☐ PERMANENT ☐ 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 SUBCRIBER	RELATIONSHIP TO PATIENT	D.O.B. OF SUBSCRIBER & SOCIAL SECURITY	
NAME OF SECONDARY OR OTHER INSURANCE COMPANY, ADDRESS			

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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 you have the adverse reaction:

_____

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 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

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

(To be completed ONLY by patients 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)
_____Rizatriptan (Maxalt)
_____Zolmitriptan (Zomig)
_____Eletriptan (Relpax)
_____Migranal NS
_____Midrin/Epidrin
_____Ultram(tramadol)/Ultracet
_____Darvocet
_____Oxycodon
_____Methadone
_____Depakon (Depakote iv)
_____Magnesium infusion
_____Indomethacine (Indocin)
_____Naratriptan (Amerge)
_____Almotriptan (Axert)
_____Frovatriptan (Frova)
_____Dihydroergotamine (D.H.E.)
_____Treximet
_____Fiorinal /Fioricet (Butalbital) with or without codeine
_____Tylenol w/codeine
_____Vicodin
_____MS Contin
_____Fentanyl/Duralgesic Patch
_____Toradol injection
_____Thorazine
_____Celebrex

Anti-Nausea Medications

_____Metaclopramide (Reglan) _____Zofran _____Prochlorperazine (Compazine)
_____Phenergan

Prophylactic or Daily Medications

_____Amitriptyline (Elavil)
_____Doxepine (sinequan)
_____Flexeril (cyclobenzaprine)
_____Timolol
_____Topiramate (Topamax)
_____Depakote (valproic acid)
_____Lyrica
_____Zoloft (sertraline)
_____Lexapro
_____Paxil (paroxetine)
_____Clonidine
_____Zyprexa
_____Zanaflex (tizanidine)
_____Lithium
_____ Calan (verapamil)
_____Nortriptyline (Pamelor)
_____SOMA (carisoprodol)
_____Inderal (propranolol)
_____Corgard (nadolol)
_____Neurontin(gabapentin)
_____Lamictal (lamotrigine)
_____Remeron
_____Celexa
_____Cymbalta
_____Wellbutrin (bupropion)
_____Effexor
_____Seroquel
_____Prednisone
_____Baclofen

Other medications you took in the past:

Nutritional Supplement/Herbal Supplements/Minerals

_____Vitamin B2 _____Magnesium _____Co-Q10 _____Feverfew _____Butterbur
_____Others (please list)

Alternative Treatments

_____Biofeedback _____Massage _____Chiropractic Adjustment _____Yoga
_____Acupuncture _____Acupressure