PIMA NEUROLOGY

www.pimaneurology.com

PATIENT REGISTRATION

PATIENT:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Secondary Number: _____

Date of Birth: _____ Gender: M F E-mail: _____

Preferred method of communication: (please list below)

Written: _____ Phone: _____ Fax: _____

INSURANCE:

Primary Insurance: _____

Policy Holder: _____ Date of Birth: _____ SSN: _____

Secondary Insurance: _____

Policy Holder: _____ Date of Birth: _____ SSN: _____

Primary Care Physician: _____

Name: _____ Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Phone Number: _____ Relationship: _____

Who May we share information with:

Name: _____ Phone Number: _____

NOTICE:

Our office provides the service of "reminder calls." To protect your privacy, please indicate how would you prefer this to be done.

1. You prefer that staff does not confirm your appointment
2. By phone on primary number (leave message?) ___ Yes ___ No
3. By phone on secondary number (leave message?) ___ Yes ___ No

PLEASE READ AND SIGN:

I agree that all the information provided above is correct. I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and to provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of benefits to Pima Neurology. I fully understand that if my insurance denies payment for any service defined as "not covered," I will be responsible for that amount due. In the event this account must be placed with Surety Acceptance Corporation for collection, I agree to pay all the collection cost.

SIGNATURE:	DATE:

PIMA NEUROLOGY MEDICAL HISTORY FORM

Reason for visit:

_____

_____

_____

Pharmacy: _____ Phone Number: _____

Medications, dose of med and how often taken:

_____

_____

_____

Allergies:

_____

_____

_____

Please list all current medical conditions:

_____

_____

Please list all past surgeries:

_____

_____

Please list family medical history:

_____

_____

Records to be released from:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

I hereby authorize the release, Pima Neurology (Dr. Din) , to either release or receive my medical records, including office notes, x-rays, operative reports, and any information regarding medical consultations and treatments I have received.

Pima Neurology (Dr. Din)

400 W. Magee Rd.

Tucson, AZ 85704

Phone (520) 638-5553

Fax (520) 638 – 5543

NAME OF PATIENT:	DATE OF BIRTH:
PATIENT SIGNATURE:	DATE:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse person health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health care operations include the business aspects of funding our practice, such as conducting quality assessment and improvement activates, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment and health care operations.

I hereby acknowledge that I have been presented with a copy of Pima Neurology's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

PRINT PATIENT'S NAME:	
PATIENT SIGNATURE:	DATE:

PIMA NEUROLGY FINANCIAL POLICY

Your Visits: We are pleased you have chosen us to provide your health care. Each time you come to see your doctor, we will ask to see you proof of identification and proof of insurance so that we can properly bill your insurance company/companies and charge you the correct amount.

Payment: Any amount you owe is due when you arrive to see your doctor, prior to the visit. (If you do not have health insurance or one that our office accepts, you will need to pay the full cost of your visit the day of the appointment.) Cash, personal checks and credit cards other than American Express are acceptable forms of payment. In the event your bank returns your check to our office as un-payable, there will be a $35 return check fee charged to you. Un-payable bounced checks are prosecuted under criminal law. A collection agency will be used to collect on delinquent accounts, and an added fee for that service, of 30% of your balance, will be applied to your total due. This is to defer costs that we will incur to collect on your debt.

Insurance: If your visit with our doctor is not covered for any reason by your insurance company, you are responsible for paying the entire visit based on our office charges.

No Insurance: If you do not have insurance or our office is not contracted with your insurance company, you will be responsible to pay the full cost of your visit at the time of your appointment.

Appointment Cancellations: We want to make sure our patients have access to their doctors when they need them, so we pay close attention to how we schedule appointments. If you arrive 30 minutes or more late to your appointment, you WILL BE rescheduled. If you arrive under 30 minutes late, we may need to reschedule your appointment but will make all the effort we can to have you see the doctor. Please give our office at least 24 hours advance notice when you need to change or cancel your appointment, otherwise a $30 cancellation fee may be charged, to keep our doctor on time. Repeatedly not showing may lead to termination of your care.

No Shows: If you no show for an appointment you may be charged a $30 no show fee. If you no show for a test you WILL be charged a $30 fee will be charged. If you no show for a HIVAMAT therapy you WILL BE charged a $30 fee and may forfeit future treatment appointments.

If you have any questions regarding our financial policies, please let us know.

I have read and fully understand the financial policies of Pima Neurology and have been given the opportunity to ask any questions I may have. I understand my responsibility for payment to Pima Neurology. In the event additional information is needed to ensure insurance coverage, I will provide it in an accurate and timely manner.

PRINT PATIENT NAME:	DATE OF BIRTH:
PATIENT SIGNATURE:	DATE: