MEDICAL HISTORY FORM

Reason for visit: ____

____

____

____

Preferred Pharmacy: ______________________________________ Phone Number: ____________________

Medication names, dose and frequency: ____

____

____

____

Allergies: ____

____

Please list all current medical conditions: ____

____

____

____

Please list all past surgeries: ____

____

____

____

Family medical history: ____

____

____

Records to be released from:

Name: ____

Address: ____

Phone Number: ______________________________________

Fax Number: ____

Name: ____

Address: ____

Phone Number: ______________________________________

Fax Number: ____

I hereby authorize 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 SIGNED: _________________

NAME OF AUTHORIZED PERSON: ____

RELATION TO PATIENT: ____ DATE SIGNED:_________________

AUTHORIZED PERSON SIGNATURE: ____

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:	DATE:
PATIENT OR AUTHORIZED PERSON SIGNATURE:	

PIMA NEUROLOGY OFFICE AND FINANCIAL POLICIES

Your Visits: We are pleased you have chosen us to provide your health care. Each time you come to see a provider, 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 your appointment, 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 for any reason, there will be a $35 returned check fee charged to you. 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 providers 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 providers 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 a provider. 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 schedule 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. If you no-show for a Hivamat Therapy, you WILL be charged a $30 fee and may forfeit future treatment appointments.

Medical Records: Should you request a copy of your medical records, allow our office 7-10 business days for completion. There is a processing fee of $30 for your medical records. This will be paid at the time of pick up.

Forms Policy: Should you request our office to complete forms on your behalf for medical reasons, there will be a minimum charge of $50.00 per form. Payment of this charge is expected prior to completion of all letters and/or forms.

Libel Policy: Client/patient agrees not to attack/criticize Pima Neurology or any of its employees, associates or affiliates publicly (on public forums, blogs, social networks, etc.) at any time during or subsequent to this agreement. In case of breach of this clause, client/patient agrees to pay $10,000 to Pima Neurology as damages.

Medical Consent: By seeking services from Pima Neurology, you authorize Dr. Din and practice staff to perform services for the patient named below. You also agree that all disputes concerning the Medical Consent and the treatment shall be resolved by arbitration, which shall be final and binding, held in Pima County, Arizona according to A.R.S. Title 12, Chapter 9, Article 1, as may be amended from time to time. It is agreed that any issue of medical malpractice shall be decided by neutral arbitration rather than by jury or court trial.

Termination of Treatment: You play an important role in your own health care. Just as a patient can choose to discontinue care at any time, Pima Neurology reserves the right to terminate a doctor-patient relationship if a patient is continually unable to comply with reasonable treatment plans and/or office and financial policies.

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

I have read and fully understand the office and 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.

PATIENT NAME:	DATE OF BIRTH:
PATIENT SIGNATURE:	DATE:
AUTHORIZED PERSON NAME:	RELATION:
AUTHORIZED PERSON SIGNATURE:	DATE: