PIMA NEUROLOGY Dr. Moeen Din | Polina Samoylova, NP | Ted Bollard, NP

Last Name: ______________________________ Birthdate: ______________

First Name: ______________________________ MI: _____ Gender: **M** **F** Age: _______

Mailing Address: ______________________________

City: ______________________________ State: ________ Zip Code: ______________

Cell Phone #: ______________________________ Home Phone #: ______________________________

E-Mail: ______________________________

Methods of Communication; Circle YES or NO on each item to agree or disagree:

Pima Neurology may call my cell phone: **YES** **NO**

Pima Neurology may leave voicemails on my cell: **YES** **NO**

Pima Neurology may send texts to my cell phone: **YES** **NO**

Pima Neurology may call my home phone: **YES** **NO**

Pima Neurology may leave messages at my home: **YES** **NO**

Pima Neurology may email me: **YES** **NO**

My preferred method of receiving appointment reminders is (circle): **TEXT** **CALL/CELL** **CALL/HOME** **E-MAIL**

Primary Insurance Name: ______________________________ **ID#:** ______________________________

Policy Holder Name: ______________________________ Birthdate: ______________ SSN: ______________

Secondary Insurance: ______________________________ ID#: ______________________________

Policy Holder Name: ______________________________ Birthdate: ______________ SSN: ______________

Primary Doctor: ______________________________ Practice Name: ______________________________

Phone: ______________________________ Fax: ______________________________

Address/Intersection: ______________________________

City: ______________________________ State: __________ Zip Code: ______________

Referring Doctor/Provider (if different than above): ______________________________

Emergency Contact Name: ______________________________

Phone: ______________________________ Relation: ______________________________

Name of authorized person or translator completing this form: ______________________________

Relation to patient: ______________________________ Reason for patient not completing form: ______________________________

Please read and sign: I agree that all the information provided above is correct. I authorize Pima Neurology to contact me using the information I provided above. I authorize the release of information to the emergency contact I listed above. I authorize the release of any of my medical, psychiatric, or other information necessary to process any insurance claim and to provide information to another healthcare provider when necessary to coordinate treatment. I authorize payment of benefits to Pima Neurology. I fully understand that if my insurance denies payment for any service, 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 of the collection cost.

Patient Signature: ______________________________ Date: ______________

OR Authorized Signature: ______________________________ Date: ______________

Pima Neurology | Medical History Form

Reason for visit and/or symptoms: ____

____

____

____

When reason/symptoms started: ___________________________________ Frequency/How often: ____________________________

Current Medical Conditions (check all that apply):

☐ Abnormal movements or tics
☐ Anemia
☐ Angina or chest pain
☐ Anxiety
☐ Arthritis
☐ Artificial Joint
☐ Back pain
☐ Cancer
☐ Cardiac Pacemaker
☐ Confusion
☐ Depression
☐ Diabetes
☐ Disorientation
☐ Dizziness
☐ Fatigue
☐ Headaches
☐ Heart attack/failure
☐ Heart disease
☐ Hepatitis
☐ High Blood Pressure
☐ HIV infection or AIDS
☐ Insomnia
☐ Irregular or rapid heartbeat
☐ Kidney disease
☐ Liver disease
☐ Lung/pulmonary disease
☐ Memory loss
☐ Migraines
☐ Mood disturbance
☐ Neck pain
☐ Numbness
☐ Pregnant or Breastfeeding
☐ Seizures
☐ Shoulder pain
☐ Skin tingling
☐ Stomach or duodenal ulcer
☐ Stroke
☐ Swelling
☐ Thyroid disease
☐ Tremor
☐ Unsteady on feet

Current medical conditions that aren't listed: ____

____

____

____

____

All past surgeries: ____

____

____

____

____

I consent to verbal information I provide to Pima Neurology and its staff being added to my medical health record. The information I have provided regarding my medical history is complete and accurate. I hereby assume responsibility for omission of details and reporting any changes in my medical history to Pima Neurology and its staff.

____ ______________

Patient or Authorized Person Signature Date Signed

Family medical history: ____

____

____

____

Current Medications; name, dose and how often taken:

____

____

____

____

____

____

Medication Allergies: ____

Other Allergies: ____

Preferred Pharmacy Name: ______________________ Phone: ______________

Location: ____

SOCIAL HISTORY (check for YES, check all that apply):

☐ Do you currently use tobacco products?

☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Snuff

☐ Chew ☐ E-Cigarettes

Current Intake: Packs/amount per day:

___________ for (# of years): __________

☐ Have you used tobacco in the past?

Past Intake: Packs/amount per day:

___________ for (# of years): __________

Quit Date: __________________________

☐ **Do you drink alcohol?**

☐ Beer ☐ Liquor ☐ Wine | # ______ drinks per:

☐ Day ☐ Week ☐ Month

☐ **Do you use marijuana?**

☐ Medical use ☐ Recreational use

Type: ☐ Smoke ☐ Edible ☐ Other: ________________

☐ **Do you use any other recreational drugs?**

Type: ____________________________________

☐ **Have you used needles to inject drugs?**

I consent to verbal information I provide to Pima Neurology and its staff being added to my medical health record. The information I have provided regarding my medical history is complete and accurate. I hereby assume responsibility for omission of details and reporting any changes in my medical history to Pima Neurology and its staff.

____ ______________

Patient or Authorized Person Signature Date Signed

Pima Neurology

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 and have been given a copy to keep, if requested.

Print Name:____

Signature:________________________________ Date:____________

PIMA NEUROLOGY Dr. Moeen Din | Polina Samoylova, NP | Ted Bollard, NP

400 W Magee Rd
Tucson, AZ 85704
Phone 520-638-5553
Fax 520-638-5543

Records to be released (check): ☐ TO ☐ FROM

Pima Neurology
ADDRESS: 400 W Magee Rd, Tucson, AZ 85704
PHONE: 520-638-5553
FAX: 520-638-5543

Records to be released (check): ☐ TO ☐ FROM

☐ Primary Care: ____

☐ Other: Doctor or Office Name: ____

Address/Intersection: ____

Phone: ______________________________ Fax: ____________________________

☐ All healthcare information ☐ Records (date range) from ____________ to ____________

I hereby authorize and request the release, Pima Neurology, to either release or receive my medical records, including office notes, x-rays, medications, operative reports, testing, whether negative or positive. Also any information regarding medical consultations and treatments I have received, including records of drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Name: ____

Date of Birth: ________________________ Previous Name(s): ___________________________________

Authorized Person Name: ____

Relation: ____________________________ Reason for Authorized Signer: ___________________________

Patient Signature: ____ Date: ___________________

OR Authorized Signature: ____ Date: ___________________

Pima Neurology | Financial & Office Policies

Insurance Policy: Pima Neurology will make a digital scan of your insurance card and ID to keep on file but will regularly ask you for any updated changes. Any deductible, coinsurance or non-covered services will be your responsibility. Monthly statements will be sent to collect those balances. Please inform our staff immediately of any insurance changes. If your visit with our providers is not covered for any reason by your insurance company, you are responsible for paying the entire visit.
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.
Payment Policy: Payment is expected at time of service. Your copay, coinsurance, and/or deductible is due at time of visit.
AZ Medicaid and AHCCCS Plans: Our office is not contracted with AZ Medicaid or AHCCCS and cannot accept cash pay or self-pay for patients currently covered by any of their plans.
Non-Covered Service Policy: Certain services performed by our office are NOT COVERED by insurance plans. Some of these services include testing, acupuncture, Durable Medical Equipment (DME), Urine Drug Screens (UDS) and certain injections. We suggest you contact your insurance carrier to verify your benefits and you understand any non-covered services will be your financial responsibility and payment will be required prior to your appointment. Medicare requires a signature on an Advanced Beneficiary Notice [ABN] for non-covered services.
Delinquent Accounts Policy: Delinquent accounts may be reported to our collection agency following normal collection procedures. If an account is reported to our collection agency a collection fee of 35% will be added to any outstanding balance. If a balance is over 61 days late, a 1.5% monthly interest fee will be added to the outstanding balance.
Medical Records: There is 7–10-day window and a processing fee of $50 for your medical records.
Forms Policy: Should you request our office to complete forms on your behalf for disability, work status, FMLA, etc., there will be a charge of $100 per form. Payment of this charge is expected prior to completion of all letters and/or forms.
Appointment Cancellations/No Shows/Reschedules: There is a $30 charge for all patients, tests and other in-office procedures who cancel, reschedule or no-show for an appointment without giving 48 hours notice, these appointments times could have been given to another patient who needs medical care. We understand unusual circumstances may arise, please contact our office as soon as possible. Repeatedly not showing may lead to termination of your care.
Late Arrivals: In order for our physicians to see their patients in a timely manner your help in arriving promptly for your appointment is required. If you are more than 30 minutes late, our office will reschedule your appointment to a new date and time. Tardiness effects your patient care as well as those patients that have a scheduled time after you. We understand your time is valuable and will do our best to respect it and see you in a timely manner. Please be aware that sometimes certain situations and emergencies can occur and cause your provider to run late.
Prescriptions: Contact our office a minimum of 10 days prior to your scheduled refill date for a renewal/refill appointment.
Returned Checks: Our office charges a $50 fee for all returned checks.
Referrals & Authorizations: If a referral is required by your insurance carrier you will be asked to obtain the referral prior to your appointment. If no referral exists on file or your referral has not been received, your appointment may be cancelled. Our office will obtain authorization for your procedure prior to scheduling your appointment. We suggest contacting your insurance carrier to verify your coverage, benefits and authorization requirements prior to having any procedures performed. Claims are paid based on medical necessity. Authorizations and referrals are not a guarantee of payment.
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 upwards of ten thousand US dollars 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.

Patient Name: ____ DOB: _______________

____ __________________

Patient or Authorized Person Signature Date Signed