SOUTH VALLEY NEUROLOGY BASS MEDICAL GROUP

General Neurology Registration Form

Patient's Name_____
(Last) (First) (Middle)

Date of Birth_____ Sex____ Age_____ Height_____ Weight_____
(Month, Day, Year)

Race: ___ White or Caucasian ___ Asian ___ Black or African American
___ American Indian or Alaska Native ___ Native Hawaiian or Other Pacific Islander
___ Other ___ Unknown ___ Patient Refused

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Unknown ___ Patient Refused

Religion: _____ ( ) Declined to state Preferred Language: _____

E-mail Address: _____ (used for Patient Portal access)

Mailing Address: _____ _____
(Street Address) (Apt or Unit #)

_____
(City) (State) (Zip)

Phone (Include Area Codes) Which is primary? (Check One) ___ Home ___ Cell ___ Work

Home # _____ Cell #_____ Work # _____

Employer_____ Social Security # _____

Work Address _____
(Street Address) (City) (State) (Zip)

Primary Care Physician: _____ Reason for your visit: _____

Source of Referral: (Check One) ___ Self-Referral ___ Patient Referral ___ Physician Referral

If referred by a physician, provide physician name: _____

Marital Status: ( ) Single ( )Married ( ) Separated ( ) Divorced ( ) Widowed

Emergency Contact _____ Contact phone #_____

Relationship to Emergency Contact _____

Who is the primary person on your insurance? ( ) Self ( ) Other (i.e. spouse, parent, employer)

If other, name here _____ Relationship _____

Date of birth of primary person on your insurance _____ (i.e., if spouse is primary on insurance, date of birth of spouse)

MEDICAL HISTORY: (Please check which apply to your past medical history)

__ High Blood Pressure __ Diabetes __ Seizures __ Stroke __ Migraine __ Heart Disease

__ Cancer (Type of Cancer) _____

__ Other Medical or Neurologic Problems _____

SURGICAL HISTORY (Please check which apply to your past medical history)

__ Tonsillectomy __ Appendectomy __ Gyn Surgery __ Hernia

__ Gallbladder __ Heart Surgery __ Cataract

__ Other Surgeries_____

FAMILY HISTORY: (List those people in your family with the following illnesses):

High Blood Pressure _____ Heart Disease _____

Diabetes _____ Cancer _____

Stroke_____ Migraine _____

Seizures_____ Parkinson's _____

Alzheimer's _____ Other Neurologic Problems _____

SOCIAL HISTORY:

Smoking? __ No __ Yes
(If Yes, please list how many packs per day and for how many years you have smoked):
_____packs per day, for ____ year(s). Date Quit Smoking: _____

Use of smokeless tobacco (ex. snuff, chew)? __ No __ Yes Date Quit: _____

Alcohol? __ No __ Yes
(If Yes, please indicate the number of drinks per day, per week or per month and number of years, and type(s) of alcohol used): _____drink(s) per day/week/month for ____ year(s).
Type(s) of Drinks: __ Beer __ Wine __ Mixed Drinks __ Hospitalized for Alcohol Use

Recreational Drugs? _No _ Yes
(If Yes, please indicate type of drugs used and how frequently): _____

Occupation: _____ _____ hours per day _____ days per week

Levels of Stress: _ High _ Medium _ Low

Highest Level of Education Achieved_____

History of Military Service? ____ Yes _____ No If yes, describe: _____

CURRENT MEDICATIONS & DOSAGE:
Please list all of your current medications and dosing:

_____
_____
_____
_____

Preferred Pharmacy Name: _____

Pharmacy Location: _____

ALLERGIES:
Please list any allergies to medications, dyes, latex, etc.:

_____

REVIEW OF SYSTEMS (check all that apply):

General:
___ Fever
___ Chills
___ Fatigue
___ Weight loss
___ Weight gain
___ Headaches

Allergies:
___ Seasonal allergies
___ Trouble breathing
___ Skin Rash
___ Reaction to foods

Cardiovascular:
___ Chest pain
___ Palpitations
___ Shortness of breath on exertion
___ Swelling of feet or ankles

Endocrine:
___ Excessive thirst
___ Heat intolerance
___ Cold intolerance
___ Glandular or hormone problem

Ears, Nose, and Throat:
___ Nasal congestion
___ Nose bleeding
___ Sore throat
___ Ear ache

Gastrointestinal:
___ Nausea
___ Diarrhea
___ Vomiting
___ Constipation

Genitourinary:
___ Kidney stones
___ Urinary retention
___ Urinary urgency
___ Increased urinary frequency

Musculoskeletal:
___ Weakness
___ Back pain
___ Joint pain
___ Muscle spasms/cramps

Neurological:
___ Numbness
___ Light-headedness
___ Dizziness
___ Seizure
___ Weakness
___ Memory difficulties
___ Tremor

Psychiatric:
___ Depression
___ Anxiety
___ Hallucinations
___ Insomnia

Respiratory:
___ Shortness of breath
___ Cough
___ Wheezing
___ Coughing up blood

Skin:
___ Rash
___ Change in hair or nails
___ Itching
___ Dry skin

Sleep:
___ Snoring
___ Excessive daytime sleepiness
___ Insomnia
___ Other

Blood/Lymphatic:
___ Abnormal bleeding
___ Swollen glands
___ Excessive bruising

Consent for Treatment
(Signature Required)

Signature:

Date:

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HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 1 of 3

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996) this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent *via* fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.

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HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 2 of 3

- You have the right to request an alternate means or location to receive communications regarding your health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., *via* telephone text or email).

- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  * Conditions and limitations may apply; obtain additional information from our Privacy Officer.

- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent *via* Text, *via* email, or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.

- **MINORS:** We take patient privacy laws very seriously. The State of California limits what type of health information we can share with the parents or legal guardians of minor teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for minors in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: ____ AND DATE OF BIRTH: _____

- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Health Information is voluntary.

  ☐ **OK to Spouse: Please list name, alternative address, phone number, & email address of Spouse, as applicable:** _____

  ☐ **OK to Family Members: Please list name(s), alternative address, phone numbers, & email addresses of Family Member(s), as applicable:** _____
  _____

  ☐ **OK to Other (E.g., Attorney, Accountant, Financial Advisor, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone numbers, and email addresses of authorized person(s) or entities:**
  _____
  _____

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HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM – Page 3 of 3

☒ **OK to leave health information on answering machine, voicemail, telephone text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ _____**Phone:** _____

Email address: _____

IF PATIENT IS A MINOR, PLEASE STATE AGE: ____ **AND DATE OF BIRTH:** _____

☐ **DO NOT RELEASE TO:**_____
[Please list names, as applicable].

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (925) 627-3424.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT
This acknowledges that you have received and read a copy of our Privacy Practices Notice and Consent to the disclosure of your health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature:_____ Date:_____

Patient's Name:_____ Date of Birth:_____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name:_____

Capacity and/or Relationship to patient: _____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.

SOUTH VALLEY NEUROLOGY

A Division of

BASS MEDICAL GROUP

FINANCIAL POLICIES

This policy is intended to educate and clarify the responsibilities of the patient, your insurance, and our office in processing your claims and payments. Please take the time to read and understand the policies below:

All charges, receipts, claims etc will be under the name **BAY AREA SURGICAL SPECIALISTS.** Your credit card statement will identify the location as **MORGAN HILL**, our main office branch.

- Payment of co-pay, co-insurance or outstanding balances is required at the time of service. Please bring your payments to each appointment to avoid the need to reschedule. We accept cash, check, MasterCard, Visa, Discover, and American Express.
- A credit card authorization agreement is required to be completed by every patient and is attached to this financial policy. ***We cannot see you if you do not have a valid credit card agreement on file with our office.***
- Patients with medical insurance must present proof of insurance at every visit. We will verify your insurance plan and personal information at every visit. If your insurance changes, please notify us before your next visit. ***If for any reason, the insurance card(s) you provide us is found later to be outdated or invalid or does not cover your office visits or procedures (such as due to pre-existing condition clauses), you understand that you are responsible for paying for the services in full.***
- We follow appropriate medical guidelines for standard of care based on your medical condition. Please be aware that some of the services may be determined to be non-covered or not considered "reasonable or necessary" based on the benefits of your specific insurance plan. Each insurance company has their own policies and they are subject to change at any time. The billing codes we use are covered by most, if not all, insurance plans, but from time to time, a limited number of specific plans have their own restrictions. ***You agree to be financially responsible for the cost of services that are not paid by your plan.***
- Patients without medical insurance will be considered "Self-Pay" and are expected to pay for services received at the time of service. As a courtesy, we provide discounts to "Self-Pay" patients that are generally in line with insurance contracted rates.
- If we are an "Out of Network" provider with your health plan, you will likely be required to pay a higher copay/coinsurance/deductible and a higher cost for services, which will be collected at the time of service.
- Patient statements are sent out monthly and are due within 15 days of the statement date. If the patient responsibility portion of your account is over 45 days past due, you will receive a ***Pre-Collections Letter*** stating that you have 10 days to pay your account in full to halt collection activity. Any account that is referred to a ***collection agency*** will be required to be paid in full, as well as all reasonable collection agency/attorney fees, plus filing and processing costs before being seen for an appointment. As part of, but not limited to, the reasonable collection agency fees, ***there will be an added 50% above the outstanding balance charged to your account.***

INSURANCE:

• ***Your insurance benefit is a contract between you and your insurance company.*** We cannot keep track of the ever-evolving complexity of the multitude of insurance plans held by our patients; it simply is not a possible task. We will submit claims for the services that have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request in a timely manner.

• If you provide our office with secondary insurance information, we will forward your claim to the secondary carrier.

• If your insurance company (primary and/or secondary) denies any services or does not cover any service as part of their medical policy, ***you agree to be financially responsible for the services provided.***

• We usually submit claims to your insurance within one business day of your visit. ***If your insurance plan(s) does not finalize the processing of our claims within 60 days from the time of service, you will receive a bill and you agree to pay for the cost of services at that time.*** If and when your insurance plan finally does process the claim, we agree to promptly refund all money due back to you as determined by your insurance company.

FEES:

• If you are unable to keep your appointment, you must call our office at least 24 hours before your appointment to cancel or reschedule. You must also arrive to your scheduled appointment on time. ***If you fail to promptly arrive to your scheduled appointment (no more than 15 minutes late) or call to reschedule with less than 24 hours notice, you will be considered a "No Show". For Monday appointments, this means by the prior Friday at noon.***

You will be charged the following "No Show" fees: $100 for a new patient visit; $100 for any diagnostic test or procedure (such as EEG, EMG/NCS, botox or other injections); and $50 for a follow-up patient visit. These fees apply to each appointment missed. You agree to pay the "No Show" fee prior to rescheduling or attending an already existing appointment. If there is a third No Show, the office reserves the right to discharge you from the clinic. We really dislike having to do this, but we really need notice to allow other patients to schedule. We turn away people needing care in order to hold a place for a patient. We also have to pay our technicians and staff whether a patient is seen or not.

• ***A $35.00 charge will be added to your account for any check returned by your bank for any reason.***

• ***There will be a minimum charge of $25.00 for the completion of medical forms, such as disability, legal, or school, and/or letters written on your behalf. Each form or letter requires a separate fee.*** Payment is due no later than the time you pick up the forms. Please allow 10-14 days for completion of the forms.

• A copy of your medical records can be provided upon receipt of a written authorization of release signed by the patient or guardian. ***There will be a minimum charge of $25 to cover the costs of fulfilling each request for copies of medical records.***

<u>Acknowledgement of Financial Policies and Guarantee of Payment:</u>

We ask that you sign the bottom of the Financial Policy to acknowledge that you have read the policy and agree to the terms.

_____ _____

Signature Date

SOUTH VALLEY NEUROLOGY BASS MEDICAL GROUP

Financial Policy: Credit Card Authorization Agreement

Our office requires all patients to maintain a Credit Card Authorization Agreement on file for billing.

Understanding your options. Please initial Option #1 or Option #2

_____ **Option # 1 (most popular): Leave credit card on file. You consent to BASS Medical Group to use the specified credit card provided on the next page as payments for the charges due to this office.**

Benefits: Streamlined check in and payment process. We collect less money up front. You keep your money for longer. You automatically receive paid statements and receipts in the mail. You receive an unlimited $10 discount on the completion of forms, letters, and records requests.

- Office Visits: If you have only a copay, we collect copay with card on file at check in. If your co-insurance applies to a visit, we will collect $0 at check in and will charge your card the amount due after your claim processes. If your deductible applies to a visit, we will collect $200 at check in for a new patient visit and $0 for a follow-up visit. We will charge your card for the remaining amount due after your claim processes.

- Diagnostic Tests and Treatment Injections: If your co-insurance applies, we will collect $0 at check in and will charge your card the amount due after your claim processes. If your deductible applies, we will collect the deductible amount at check in and if there is a remaining balance (e.g., a coinsurance), we will charge your credit card for the remaining amount due after your claim processes. * Given the high costs for ambulatory prolonged EEG studies and Botox injections, there may be a higher payment due at check in.

_____ **Option # 2: Do not leave a credit card on file.**

You will be required to pay 100% of your estimated copays, deductibles, and coinsurances at check in. Check in takes longer due to required calculations and manual payment collection. We will base our estimates on the data we collect from your insurance and our contracted rates with your insurance. Though we do our best to be accurate, our estimate may result in an underpayment or overpayment. For example, if you meet more of your deductible by the time our claim processes, you may have a credit on your account. Alternatively, your deductible or coinsurance may be higher than the information obtained, resulting in an additional balance due.

- All Services (Office Visits, Diagnostic Tests, Treatment Injections): We will collect 100% of your estimated cost at check in. This applies to copays, deductibles, and coinsurances. You pay all estimated costs up front.

Please note the Credit Card Authorization Agreement may also be used for non-covered services, such as requests for medical records, form completion, and anything else identified in the Financial Policies agreement you signed. Your credit card will never be charged for anything not consented to in the documents you have signed with our office. Also, regardless of the option you choose, your account balance must be paid in its entirety prior to being seen again in our office.

Printed Patient Name: _____ Date: _____

If Patient is NOT the guarantor: Guarantor Name: _____ Signature: _____

The authorization is in effect until a written request to revoke is received.

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If you have chosen Option #1: Leave credit card on file, please complete the following.

If you are leaving a FSA/HSA card, we ask that you leave a secondary card on file, which will be charged only if the primary FSA/HSA card does not have sufficient funds to cover the charges.

Primary Card

Patent Name: _____

Card Billing Address: _____

City, State, Zip Code: _____

Card Number: _____

Card Expiration Date: _____

Secondary Card

Patent Name: _____

Card Billing Address: _____

City, State, Zip Code: _____

Card Number: _____

Card Expiration Date: _____

Remember, we take the security of your credit card information very seriously:

- Your credit card information is encrypted and stored securely by TransFirst (a leading national provider of credit card services).
- No credit card numbers are stored in your medical records or at our practice.
- Only the last four digits of your credit card number are visible to our staff.
- This page will be destroyed using a commercial cross cut shredding solution. It does not stay in our office.

We ask that you send us photos of your driver's license (front side) and insurance card(s) (front and back sides). Are you able to upload these documents now? If yes, please select the attachment icons below.

Yes (attach now)

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Open Payments Database Notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

My signature below confirms that I have read and understand that notice above.

_____ _____

Patient Name (Print) Patient Representative Name

_____ _____

Patient or Patient Representative Signature Date

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