THE NEUROLOGY CENTER OF SOUTHERN CALIFORNIA

Account #_____

PATIENT REGISTRATION

Please answer all questions completely. **PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED**

Date_____ ☐**New** ☐**Update**

Name_____ Date of Birth _____ ☐ Male ☐ Female
Last First Middle

Home Address_____

City/State/Zip _____

Phone (_____) _____

Cell (_____) _____

Patient's Soc. Sec. # _____

Driver License No/State _____

Race __White/Caucasian __ Black or African American __ Asian __ American Indian __ Native Hawaiian or Other Pacific __ Decline to State

Ethnicity __ Hispanic or Latino __ Not Hispanic or Latino __ Decline to State

Primary Language Spoken _____

Employer_____ Employer's Address_____

Who is your Primary Care Physician? _____Referring Physician?_____

PATIENT'S E-MAIL ADDRESS _____

Financially Responsible Party (subscriber info)

If other than self _____Relationship _____

Address _____ Phone (____)_____
Number Street City

Patient's Primary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____**Subscriber's Group ID#** _____**DOB** _____/_____/_____

Patient's Secondary Insurance _____ **Subscriber's Social Security #**_____

Subscriber ID #_____ **Subscriber's Group ID#** _____ **DOB** _____/_____/_____

Subscriber to Secondary Insurance _____**Relationship to Patient**_____

Emergency contact_____ Relationship _____
Last Name First Middle

☐ **Please check box if authorized to release appointment/medical information.**

Address _____ Phone (_____)_____
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

_____ _____

Patient's Signature **Date**

31515 Rancho Pueblo Road, Suite 104, Temecula, CA 92592
6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011
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Welcome to The Neurology Center

STATEMENT OF FINANCIAL POLICY
This facility will bill your insurance and receive payment directly from them. Any services that your insurance will not cover are your responsibility. If for any reason you are not able to pay your co-payment at the time of service an additional $15.00 will be added to your statement.

If you have HMO insurance, it requires authorization for any treatment in our office. If this authorization has not been obtained before your visit, you will be required to sign a financial waiver. You will be expected to pay for all charges incurred, and if your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will bill your insurance as a courtesy, if you have provided us with complete information to do so.

If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard and American Express for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a $35 fee per form to be completed.
Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (760) 631-3020 to make payment arrangements.

New patients: A 24-hour advanced notice is required if you must cancel or change your appointment. If you miss your initial appointment without notifying our office, we will notify your referring provider and make an attempt to schedule another appointment. If a second appointment is missed with no notification, we will ask that you be referred to another provider.

For established patients who miss an appointment without giving a 24-hour advanced notice, there is a $75.00 charge for general office visits, and a $200.00 charge for all missed diagnostic testing or study appointments. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

LAB TEST, CAT SCANS, MRI'S, ETC:
When referred to an outside facility, please contact your insurance to ensure it is a contracted facility, in orders to keep your costs down. ***Ultimately, it is your responsibility to know your insurance plan benefits.***

*****Please note that our office does not call patients with normal test results. All normal test results will be reviewed during follow up office visit. If you wish to get your results prior to your next appointment please call our office at 760-631-3000 option 4. *****

Prescription Refills:

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Please call your pharmacy for prescription refills, at least 4 to 5 days before you run out of medication. Our doctors cannot authorize refills after office hours or on weekends, as they cannot access your medical records. Refills requested after hours will be reviewed for refill, on the next business day, and may take up to 48 hours to fill. Refills can take up to 4 days if we have to request authorization from your insurance as we have to wait for the approval before we can call pharmacy.

We provide medical records to other medical providers.

The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) **with your Primary Care Physician and/or the Provider or entity that referred you to The Neurology Center.**

HIPAA Notice of Privacy Practices – Acknowledgement of Receipt and Consent to Disclosure 14712

The Neurology Center of Southern California participates in an Organized Health Care Arrangement (OHCA) with the University of California, San Diego Health System (UCSD) for purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice is jointly used by and jointly describes the practices of all participants with the OHCA, including, without limitation any health care professional authorized to enter information into your medical record. UCSD also has its own Notice of Privacy Practices that can be access at http://health.ucsd.edu/hipaa/Pages/hipaa.aspx.
The OHCA will follow the terms of this joint notice. The OHCA may share medical information with each other for treatment, payment, or health care operations related to the OHCA as well as for research related purposes conducted at UCSD and at all related UC Medical Groups and UC Hospitals."

I have read and understand The Neurology Center's financial and claims filing policies.
I have read and understand all of the above and hereby give my consent for medical treatment.
I understand that I am responsible for my bill and consent to having my insurance payor billed.
I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

Patient's Signature_____

Responsible Parties Signature (if other than patient)

_____

Thank you for choosing The Neurology Center!

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Account #_____

PERMISSION TO FURNISH MY MEDICAL INFORMATION

Patient Name: _____

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available.

Approved Person(s)	Relationship to Patient
_____	_____
_____	_____
_____	_____

- ❑ I hereby authorize The Neurology Center to disclose medical information in the purpose to contact me with routine results and to remind me of my future appointments. You may email, send text messages and or leave this information on my answering machine.
- ❑ I hereby instruct The Neurology Center to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- ❑ Other special instructions regarding furnishing my medical information: _____

_____

_____

x_____ _____ _____

Patient Signature **Date** **Designated Power Of Attorney**

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) **about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.**

In addition, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Providers Name	Phone Number	City
_____	_____	_____
_____	_____	_____
_____	_____	_____

x_____ _____ _____

Patient Signature **Date** **Designated Power Of Attorney**

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Account #_____

Sleep Medicine Questionnaire

Name _____Date of Birth_____ Date_____

Referring Physician _____Primary Care Provider _____

HEIGHT_____ WEIGHT_____

NECK CIRCUMFERENCE _____ inches (*TNC STAFF TO MEASURE*). BMI _____

Insurance Type (Circle one): MCR PPO HMO

Do you snore? Yes / No / Don't know If yes, answer the following by circling:

Snoring is Soft Moderately loud Loud enough to be heard outside bedroom

Does snoring disrupt the bed-partner's sleep?	Yes	or	No	
Has anyone told you that you stop breathing during sleep?	Yes	or	No	
Any episodes of gasping or choking during sleep?	Yes	or	No	
Have you gained weight in the past year?	Yes	or	No	How many lbs? ___
Have you gained weight over the past 5 years?	Yes	or	No	How many lbs? ___

Please circle any symptoms that you experience during the day:

Fatigue Lack of energy Daytime tiredness Daytime sleepiness

Please circle any symptoms that you experience with your sleep:

Discomfort in legs	Kicking during sleep	Restless sleep
Frequent awakenings	Grinding/Clenching teeth	Frequent (>1) urination at night
Shortness of breath	Excessive perspiration	Racing heartbeat
Morning headaches	Frequent heartburn	Nasal congestion

Sleep Medicine Questionnaire (continued…)

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Please answer the following questions if you have previously had a sleep study or have been diagnosed with a sleep disorder. Otherwise, skip to the next section:

Have you ever had a sleep study either at home or in a sleep laboratory facility? Yes or No

If yes, When and Where? _____

Was sleep apnea diagnosed? Yes or No

If yes, please describe: _____

Are you on CPAP? Yes or No If yes, what is your pressure setting? _____

Are you currently having any of the following problems? Circle all that apply.

Constitution
Fever
Chills
Weight gain/loss

Eyes
Blurred/double vision
Floaters
Eye pain

Ears, Nose, Throat
Hearing loss
Ringing in the ears
Congestion
Imbalance
Difficulty swallowing

Cardiovascular
Chest pain
Irregular beats
Swelling in legs

Respiratory
Coughing
Wheezing
Short of breath

Skin
Rash
Hives
Pain
Itching

Endocrine
Excessive thirst
Sweating
Too hot/cold

Neurologic
Headache
Numbness/tingling
Dizziness
Seizures
Loss of consciousness
Sudden muscle weakness with strong emotion

Psychological
Mood problems
Depression
Anxiety
Increased life stressors
Crying spells
Thoughts of suicide

Gastrointestinal
Nausea, vomiting, heartburn, constipation,
Diarrhea, stomach pain, blood in stool

Genitourinary
Frequent urination
Incontinence
Painful urination
Bleeding with urination
Decreased sex drive or impotence
Menstrual problems

Musculoskeletal
Pain in muscles/joints
Swelling in joints
Weakness
Leg movements before/during sleep
Recent falls

Sleep Medicine Questionnaire (continued…)

Medical History – circle all that apply.

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Atrial fibrillation	Depression	Coronary artery disease
Insomnia	Heart failure	Stroke/TIA
High blood pressure (even if treated)		Type 2 diabetes

Any history of tonsillectomy? Yes or No

Any history of nasal surgery? Yes or No

Surgeries or other medical conditions:

_____ _____

_____ _____

_____ _____

Medications – Please list all of the medications you are currently taking.
(Include aspirin, birth control pills, hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.)

Medication	Dosage	How often taken?	How long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you have any allergies to medication? _____

Sleep Medicine Questionnaire (continued…)

Family History

Have any of your relatives had any of the following? If yes, indicate relationship (i.e. father, mother, sibling, children):

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Account #_____

Check if positive	Relationship
❒ Sleep apnea	_____
❒ Loud snoring	_____
❒ Restless leg syndrome	_____
❒ Heart disease	_____
❒ Stroke	_____
❒ High blood pressure	_____
❒ Insomnia	_____
❒ Mental illness	_____
❒ Diabetes	_____

Are there any other diseases that run in the family? _____

Sleep Schedule:

Bedtime on **weekdays or work days**: _____ Wake up time: _____

Bedtime on **weekends or days off**: _____ Time out of bed for the day: _____

Number of naps per week: _____ At what time? _____ How long are the naps?_____

Work shift: _____ Type of work: _____

Any trouble getting to sleep? Yes or No How many times per week? _____

Any trouble staying asleep? Yes or No How many times per week? _____

Do you use sleep aides (prescription or over-the-counter)? Yes or No

Names of the sleep aides and # of times used per week: _____

Caffeinated beverages? Yes or No How many per day?_____ How many total ounces? _____

Do you smoke cigarettes or use nicotine/tobacco products? Yes or No

Do you drink alcohol? Yes or No # of drinks per day? _____ # per week? _____

Circle: wine/beer/other liquor

Do you exercise? Yes or No Type of exercise: _____ Days per week: _____

Epworth Sleepiness Scale

How likely are you to doze off in the following situations? Answer with a number 0 – 3 as indicated below:

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0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation:	**Chance of Dozing:**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes at a stoplight or in traffic	_____

Total Score: _____

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