Progressive Neurology & Sleep Medicine Associates

PATIENT REGISTRATION FORM *(Print clearly & press firmly in black ink)*

Today's Date_____ Preferred Language _____

Patient Name_____
Last First MI Nickname

Date of Birth _____ SSN _____ Gender (circle) F M

Address _____
Street Apt/Ste City State Zip

E-Mail _____

Primary Phone ( )_____ May we leave a message? (circle) YES / NO

Secondary Phone ( )_____ May we leave a message? (circle) YES / NO

Work Phone ( )_____ OK to call work? (circle) YES / NO

Patient's Employer_____

Primary reason for today's visit_____

_____

Primary Care Physician_____ Referring Physician_____
Last First Last First

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

Secondary Insurance _____ Policy #/ID _____ Group # _____

Name of Policy Holder _____ SSN _____ Date of Birth _____ Gender (circle) F M

Relationship to Patient_____ Employer _____ Employer Phone ( )_____

If patient is a minor, name of Custodial Parent _____

Custodial Parent's Primary Phone ( )_____ Secondary Phone( )_____

Custodial Parent's SSN_____ Date of Birth_____

Emergency Contact or Close Friend/Relative:

Name _____ Relationship _____ Phone( )_____
Last First

Name of person we may speak with other than yourself regarding your medical care?_____

Primary Phone( )_____ Secondary Phone( )_____ Relationship_____

Progressive Neurology & Sleep Medicine Associates

MEDICAL HISTORY

Patient Name: _____

Date of Birth: _____ **Height:** _____ **Weight:** _____

Briefly Explain Your Symptoms:

_____
_____
_____
_____
_____

List Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies: _____

Smoke? _____ **Packs/Cigarettes per day**_____ **Alcohol?** _____ **Daily**___ **Occasional** ____

Medical Conditions: Circle all that apply

Headaches/Migraines	Stroke	Hypertension	Arthritis
Epilepsy/Seizures	Neuropathy	COPD	Cancer
Head Injury	Asthma	Renal Disease	Depression
Spinal Cord Injury	Diabetes	Thyroid Disease	Heart Disease
Spine Disease	Cholesterol	Anemia	Liver Disease

Others? Please List:

_____

Family History: Any family members that have or had neurological diseases/conditions?

_____
_____

Progressive Neurology & Sleep Medicine Associates
FINANCIAL POLICY

Patient Name_____
Last **First** **MI**

Date of Birth_____ **SSN**_____

We are committed to providing you with the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we need your assistance and understand of our financial policies. Please carefully review this information and sign/initial where indicated.

Current insurance cards must be presented to the office at each visit. Any changes to personal information must be given to the office immediately.

ASSIGNMENT: I request that payment of the authorized insurance, Medicare and Medicaid benefits be made payable to Progressive Neurology & Sleep Medicine associates on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the even that my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.

_____ ***(Initial) I have read and agree to the above statement***.

CO-PAY/INSURANCE/DEDUCTIBLE: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and I am ultimately responsible for assigned co-payments, coinsurance, and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.

_____ ***(Initial) I have read and agree to the above statement.***

RELEASE OF INFORMATION: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under and HMO, I authorize Progressive Neurology & Sleep Medicine Associates to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.

_____ ***(Initial) I have read and agree to the above statement.***

REQUESTS FOR INFORMATION: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately, in order to have the claim processed and paid.

_____ ***(Initial) I have read and agree to the above statement.***

SELF-PAY: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.

_____ ***(Initial) I have read and agree to the above statement.***

RETURNED CHECKS/NO SHOW POLICY: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification. I understand and agree to pay a $250.00 charge for appointments that I do not honor or cancel within 48 hours prior to the schedule appointment.

_____ ***(Initial) I have read and agree to the above statement.***

PRIVACY POLICY: I have been made aware of the privacy policy of Progressive Neurology & Sleep Medicine Associates and have reviewed (or reviewed or been given the option to receive and review) a copy of the Notice of Privacy Practices.

_____ ***(Initial) I have read and agree to the above statement.***

I have read and agree to the above information and I, the undersigned/patient, am ultimately responsible for the fees. By signing below, I consent to be contacted by regular may, by email, or by telephone/cell phone regarding any matter related to the above referenced account by the creditor, it's successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto-dialer technology and/or pre-recorded messages.

PRINT PATIENT'S FULL NAME: _____

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

Progressive Neurology & Sleep Medicine Associates
4234 Riverwalk Parkway Ste 280, Riverside CA 92505
1839 W. Redlands Blvd, Redlands CA 92373
Phone: 951-785-7190 Fax: 951-688-7246
www.progressiveneuroandsleep.com

TELEHEALTH CONSENT

- There are potential benefits and risks of telehealth or video conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services. Sessions are not recorded without the permission from the other person(s).
- We agree to use the video-conferencing platform selected for our virtual appointments. The clinical assistant will explain the process.
- You may need to use a webcam or smartphone during this appointment.
- It is important to be in a private space that is free of distractions, noise, or safety hazards, during the appointment.
- It is important to use a secure internet connection.
- It is important that we receive your documents in a timely manner on or before your appointment (e.g. new patient paperwork, ID, Ins card(s)).
- It is important to be on time. If you need to cancel or reschedule your tele-appointment, you must notify our staff in advance by phone or email.
- Please note, in some circumstances, the provider may determine that telehealth is no longer appropriate and other arrangements will need to be made.
- Should you wish an alternative platform, you agree to understand potential privacy risks as other methods, like facetime, do not guarantee the same levels of security as HIPAA compliant options.

If you accept the terms of this consent, please sign and date below.

Sign: _____ **Date:** _____

Progressive Neurology & Sleep Medicine Associates
4234 Riverwalk Parkway, Suite 280 Riverside, CA 92505
1839 West Redlands Boulevard, Redlands, CA 92373
(951) 785-7190

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

With the enactment of the Health Insurance Portability and Accountability Act (HIPAA), with a few exceptions permitted by law, your medical information is strictly confidential and may not be released or discussed with anyone, including your family members, without your permission. This may be prevented if you can provide a list of people to whom you will give permission to discuss your medical conditions to the extent your doctor feels appropriate or necessary.

I hereby authorize this office to release my medical information regarding my case to the following family members (if no family members are listed, they will NOT be given any information about your care, this includes the event of any hospitalization):

Patient Name: _____**D.O.B**._____

Family Member Name	Relationship	Ph#

I HEREBY DECLINE TO PROVIDE ALL FAMILY MEMBERS AT THIS TIME (Initial here) _____

I expressly refuse to disclose any of my medical conditions to the following people:

Name	Relationship

Patient/Guardian Signature:_____Date:_____

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Ph# (951) 785-7190 Fx# (951) 688-7246

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for the disclosure.

I hereby authorize this medical practice to use and disclose health information concerning:

Patient name: _____

D.O.B.: _____ *Patient address:* _____

as follows:

All medical records___ Dates: From_____To_____

Test Reports(Mri's/Ct's/EEGs etc.)_____ Discharge Summary _____Sleep study report_____

Most recent progress notes_____

This health information is requested FROM:

Name of Healthcare Provider/Hospital: _____
*Healthcare provider/Hospital Address:*_____
Healthcare Provider/Hospital Fax#: _____

This health information may be disclosed TO:

Name of Healthcare Provider/Hospital: _____
*Healthcare provider/Hospital Address:*_____
Healthcare Provider/Hospital Fax#: _____

Please release health information by: ____Fax ____ Mail ____Pick-Up

I understand that I may revoke this authorization at any time notifying this medical practice in writing.
My revocation will not affect actions taken by this medical practice prior to its receipt.
I understand that although federal law does not protect health information, which is disclosed to someone, other than another health care provider, health plan or health care clearinghouse.
Under California law, all recipients of health care information are prohibited from re-disclosing it, except as specifically required or permitted by law.
I understand that I have the right to receive a copy of this authorization.

Signed: _____ **Date:** _____

Print Name: _____

If not signed by the patient, please indicate relationship:
_____parent or guardian of minor patient (to the extent minor could not have consented to the care)
_____guardian or conservator of an incompetent patient
_____beneficiary or personal representative of deceased patient **
_____spouse or person financially responsible (where information solely for purpose of processing application for dependant healthcare coverage)