



# 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 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 mail, 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](http://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, Ste. 280 Riverside, CA 92505

1839 West Redlands Blvd. Redlands, CA 92373

Ph (951) 785-7190 Fax (951) 688-7246

## SLEEP HISTORY QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck Size: \_\_\_\_\_ (inches) Age: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_ Gender: Male Female

Spouse or Emergency Contact(s) \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician(s): \_\_\_\_\_

### MEDICAL HISTORY:

Do you now have or have you ever had?

High Blood Pressure (Hypertension)	Yes	No	Stroke/TIA	Yes	No
Atrial Fibrillation	Yes	No	Incontinence (Bowel/Bladder)	Yes	No
Congestive Heart Failure (CHF)	Yes	No	Excessive Daytime Sleepiness	Yes	No
Parkinson's Disease	Yes	No	Mood Disorders	Yes	No
Alzheimer's Disease	Yes	No	Anxiety	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No	Acid Reflux (GERD)	Yes	No
Insomnia	Yes	No	Diabetes	Yes	No

Are you currently on supplemental oxygen? Yes No

Other Medical History (please list any **major** illnesses or surgeries):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List All Current Medications:

Dosage/Times:

Reason for Medication:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical Allergies: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY:**

Marital Status:            Single                    Married                    Divorced                    Separated                    Widowed

What are your work hours? \_\_\_\_\_

Do you currently smoke?                    Yes            No

    If yes, how long have you smoked? \_\_\_\_\_

    If yes, how much on average do you smoke per day? \_\_\_\_\_

Have you quit smoking?                    Yes            No

    If yes, how long ago did you quit? \_\_\_\_\_

Do you drink caffeinated beverages?                    Yes            No

    If yes, how many (8 oz) cups do you drink per day? \_\_\_\_\_

Do you regularly drink alcohol?                    Yes            No

    If yes, how much on average do you drink per day? \_\_\_\_\_

**SLEEP TREATMENT:**

Are you or have you ever been on CPAP/BiPAP?    Yes            No

Are you or have you ever been on Bi-PAP?        Yes            No

Have you had your tonsils and adenoids removed?    Yes            No

    If so, when? \_\_\_\_\_

**SLEEP HISTORY:**

Describe the sleep problem(s) you are experiencing:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Which of the following describes the type of sleep problem(s) you are having?

    Snoring

    Daytime fatigue

    Difficulty falling asleep

    Difficulty staying asleep

    Restless legs

    Abnormal or unusual behaviors during sleep

**EPWORTH SLEEPINESS SCALE:**

Please **rate** your chance of dozing in the following situations:

    0 = would **never** doze

    1 = **slight** chance of dozing

    2 = **moderate** chance of dozing

    3 = **high** chance of dozing

**Situation:**

Sitting and reading

Watching TV

Sitting inactive in a public place (e.g., theater or meeting)

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 in traffic

**Chance of dozing:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(ESS TOTAL Score)**



**PROGRESSIVE NEUROLOGY & SLEEP MEDICINE ASSOCIATES**

**Modified F.O.S.Q.**

**Q1.** Do you have difficulty concentrating on the things you do because you are sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q2.** Do you generally have difficulty remembering things because you are sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q3.** Do you have difficulty operating a motor vehicle for short distances (less than 100 miles) because you become sleepy?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q4.** Do you have difficulty operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q5.** Do you have difficulty visiting your family or friends in their home because you become sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q6.** Has your relationship with family, friends or work colleagues been affected because you are sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q7.** Do you have difficulty watching a movie or video because you become sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q8.** Do you have difficulty being as active as you want to be in the evening because you are sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q9.** Do you have difficulty being as active as you want to be in the morning because you are sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

**Q10.** Has your mood been affected because you are sleepy or tired?

1. Yes, extreme      2. Yes, moderate      3. Yes, a little      4. No

Score	Patient Name: Last, First	D.O.B.	Today's Date:



# Progressive Neurology & Sleep Medicine Associates

## **NOTICE OF PRIVACY PRACTICES**

***THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

This notice describes how we (including other healthcare providers affiliated with us) may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practice. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practice by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **Your Rights Regarding Your Protected Health Information (PHI).**

- For Further Information/Complaint. If you desire further information about your rights or are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services without fear of retaliation from us or the Director.
- Right to Request Restrictions. You have the right to request a restriction on certain uses and disclosures of your PHI for our treatment, payment, and healthcare operations activities. You also have the right to request that we not release any part of your PHI to family members or others who may be involved in your care or with payment related to your care. Your request must be in writing to our Privacy Officer and must specify what parts of your PHI you do not want released and to whom you do not want it released. We will consider all requests carefully; however, we are not required to agree to requested restrictions. If you wish to request a restriction, please submit a written request to our Privacy Officer.
- Right to Receive Confidential Communications. You may request and we will accommodate any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.
- Right to Revoke Your Authorization. You may revoke your authorization, your marketing authorization, or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to our Privacy Officer
- Right to Access. You have the right to inspect and copy the PHI we maintain about you except for psychotherapy notes, information compiled in anticipation of a legal proceeding or other PHI to which your access is limited by federal law. Requests to inspect and copy records must be in writing directed to our Privacy Officer and provide specific information to assist us in fulfilling your request. We may charge a reasonable fee for copying and mailing copies.
- Right to Amendment. You have the right to request that we amend the PHI we maintain about you. Requests for amendment must be in writing directed to our Privacy Officer and provide a reason to support your requested amendment. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.
- Right to Receive an Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of your PHI made by us during any period of time, prior to the date of your request provided, such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003.
- Right to Receive Paper Copy of This Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

Requests to inspect and copy records must be in writing and provide specific information to assist us in fulfilling your request. We may charge a reasonable fee for copying and mailing copies. Please direct such requests to our Privacy Office at 4234 Riverwalk Parkway Suite 280, Riverside, CA 92505 or 1839 W. Redlands Blvd. Redlands, CA 92373.

### **Permitted and Required Disclosures of Protected Health Information:**

#### **Treatment, Payment, and Healthcare Operations.**

As one of your healthcare providers, we may use and disclose PHI about you for treatment, payment, and healthcare operations without your authorization. Some examples of these types of uses/disclosures are:

- Treatment. – We may use or disclose protected health information (PHI) about you to provide your prescribed products, equipment, or services. We may consult and coordinate with your physician. We may remind you of supply refills and scheduled visits/appointments. We may provide you information about treatment alternatives or other health benefits and services that may be of interest to you. We may also disclose your PHI to other healthcare providers (such as physicians and hospitals) involved in your treatment. We may provide these healthcare providers with copies of various reports that are relevant to your treatment.



## Progressive Neurology & Sleep Medicine Associates

- **Payment** – We may use or disclose your PHI to bill and collect payment for the products, equipment, or services we provide you. We may contact your insurer or other payer to obtain eligibility and coverage information. We may also disclose your PHI to health plans, or other healthcare providers involved in your care for their payment activities.

- **Healthcare Operations** – We may use or disclose your PHI for quality assessment activities, evaluation of our employees' performance, business planning and development, and management and general administrative purposes. We may disclose your PHI to health plans or other healthcare providers for their quality assessment, employee evaluation or healthcare compliance activities.

### ***Other Permitted and Required Uses and Disclosures.***

We may use or disclose your PHI for the following reasons without your consent:

- **Persons Involved in Care/Payment.** We may disclose relevant parts of your PHI to family members or other persons involved in your care and its payment. We may notify such persons or public or private entities involved in disaster relief efforts of your location, general condition, or death.

- **Business Associates.** There are some services provided in our organization through contacts with business associates such as our billing service. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we have asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Research.** We may disclose PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- **Funeral Directors.** We may disclose PHI to funeral directors consistent with applicable law to carry out their duties.

- **Organ procurement organizations.** We may disclose your PHI to organizations consistent with applicable law; we may disclose PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

- **Food and Drug Administration (FDA).** We may disclose to the FDA relevant PHI relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

- **Public Health Activities.** As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability. In certain circumstances, this may include disclosing parts of your health information to local utility companies or emergency services so that they may provide appropriate assistance in the event of an emergency or power outage.

- **Correctional Institutions.** If you are incarcerated or otherwise in the custody of law enforcement officials, we may disclose to the institution, or agents thereof, PHI necessary for your health and the health and safety of other individuals.

- **Abuse, Neglect or Domestic Violence.** We may disclose parts of your PHI to appropriate governmental agencies if we believe you may be a victim of abuse, neglect or domestic violence and such disclosure is authorized by applicable law or regulation.

- **Health Oversight Activities.** We may disclose parts of your PHI to a health oversight agency that oversees the healthcare system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

- **Law Enforcement.** We may disclose parts of your PHI for law enforcement purposes as required by law or in response to a valid subpoena.

- **De-Identified Information.** We may use or disclose parts of your PHI that do not personally identify you or reveal who you are.

- **Legal Proceedings.** We may disclose parts of your PHI in any judicial or administrative proceeding pursuant to court order or if we meet other legal requirements.

- **Specialized Government Functions.** Under certain circumstances, we may disclose parts of your PHI to units of the government with special functions, such as the U.S. Military or the U.S. Department of State under certain circumstances.

- **Governmental Agencies.** We may disclose parts of your PHI to governmental authorities entitled to receive such information, including the Secretary of Health and Human Services.

- **Required or Permitted by Law.** We may disclose parts of your PHI in other situations not mentioned above when required or permitted by law.

### **Uses and Disclosures Requiring Your Written Authorization**

- **Use or Disclosure with Your Authorization.** For any purpose other than the ones described above, we may only use or disclose your PHI when you grant us your written authorization. For instance, you will need to execute an authorization before we can send your PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved.



## Progressive Neurology & Sleep Medicine Associates

• **Marketing.** We must also obtain your written authorization prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter without obtaining a marketing authorization). In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers, or care settings without your marketing authorization.

• **Uses and Disclosures of Your Highly Confidential Information.** In addition, federal and state laws require special privacy protections for certain “highly confidential information”. We will comply with such special privacy protections which may cover the subset of your PHI that (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug prevention, treatment, and referral; (4) is about HIV/AIDS testing, diagnosis, or treatment; (5) is about sexually transmitted disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; (9) is about sexual assault; or abortion.

### **Our Responsibilities:**

This organization is required to:

- Maintain the privacy of your PHI
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.

We will not use or disclose your PHI without your authorization, except as described in this notice.