**PATIENT REGISTRATION** (please print) Neurology Associates of Mesilla Valley, PC

PATIENT'S LAST NAME | FIRST NAME | MI | SOCIAL SECURITY #

MAILING ADDRESS | CITY | STATE | ZIP

DATE OF BIRTH | AGE | SEX: **M** **F** | TRANS: MALE TO FEMALE | FEMLE TO MALE | NAME PREFERRED

HOME PHONE | WORK PHONE | CELL PHONE

REFERRING DOCTOR | OFFICE PHONE #

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

**INCASE OF EMERGENCY NOTIFY:** _____

NAME | PHONE #

**INSURANCE INFORMATION**- WE CANNOT FILE YOUR INSURANCE WITHOUT COMPLETE INFORMATION AND A COPY OF YOUR INSURANCE CARDS. PLEASE BRING YOUR INSURANCE CARD WITH YOU TO THE FRONT DESK WHEN YOU HAVE COMPLETED THIS FORM.

**PRIMARY INSURANCE COVERAGE**

INSURANCE COMPANY ☐ ☐

SUBSCRIBER'S NAME | SUBSCRIBER'S DOB | SEX: **M** **F**

SUBSCRIBER'S SOCIAL SECURITY # | RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S ID # | GROUP #

**SECONDARY INSURANCE COVERAGE**

INSURANCE COMPANY ☐ ☐

SUBSCRIBER'S NAME | SUBSCRIBER'S DOB | SEX: **M** **F**

SUBSCRIBER'S SOCIAL SECURITY # | RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S ID # | GROUP #

**THIRD INSURANCE COVERAGE**

INSURANCE COMPANY ☐ ☐

SUBSCRIBER'S NAME | SUBSCRIBER'S DOB | SEX: **M** **F**

SUBSCRIBER'S SOCIAL SECURITY # | RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S ID # | GROUP #

**IS THIS RELATED TO:** ☐ **WORKMENS COMP** ☐ **MOTOR VEHICLE ACCIDENT** ☐ **OTHER**

**ASSIGNMENT AND RELEASE:** I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NEUROLOGY ASSOCIATES OF MESILLA VALLEY AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. ALSO ALL PATIENTS WHO FAIL TO INFORM NAOMV THAT WORKMENS COMP OR MOTOR VEHICLE ACCIDENTS ARE ASSOCIATED WITH THEIR VISIT, OR CONDITION, OR SHOULD BE APPLICABLE WILL BE HELD RESPONSIBLE FOR THEIR BILLS IN FULL. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I HEREBY GRANT MY AUTHORIZATION AND CONSENT TO TREATMENT.

**I HAVE READ THE ABOVE ACKNOWLEDGMENT AND AGREEMENT, AND FULLY UNDERSTAND.**

**SIGNATURE** **DATE**

# NEUROLOGY ASSOCIATES OF MESILLA VALLEY, PC.

3855 Foothills Road, Las Cruces NM 88011

Tel: (575) 532-8561 Fax: (575) 532-8567

**Javed Iqbal, M.D.**

*Board Certified in Neurology*
*Board Certified in Electro-Diagnostic Medicine*
*Certified in Neuro-Imaging*


## RELEASE OF MEDICAL INFORMATION

Please list all persons you give permission to obtain any information regarding your health records at Neurology Associates of Mesilla Valley, PC.

I hereby authorize:

Print Name Relationship

Print Name Relationship

Print Name Relationship

To obtain information on my behalf concerning my medical condition. I understand that only the people listed on this form are allowed access or to discuss any issues, concerns, treatment plans, etc. with the doctor or staff of Neurology Associates of Mesilla Valley, PC. I understand this release includes all information in my medical records.

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

Date of Birth

Signature of Patient or Personal Representative Date

***Please note if patient is unable to sign, a copy of 'Power of Attorney' must be on file giving permission of the guarantor to sign; otherwise this form is not valid.**

**EMAIL ADDRESS: _____**

# REVIEW OF SYSTEM

(Circle all symptoms that apply)

GENERAL: (fever, wt. loss)_____

ENT: (hearing loss, dizziness, vertigo, dysarthria, dysphagia)_____

RESPIRATORY: (cough, SOB, wheezing, hemoptosis)_____

GU: (polyuria, hematuria, incontinence, stones)_____

SKIN: (prutitis, moles)_____

ENDO: (goiter, impotence)_____

ALLERGY/IMMUN: (hives, eczema) _____

EYES: (VISION, DIPLOPIA, PAIN)_____

CV: (chest pain, SOB)_____

GI: (nausea, vomiting)_____

MS: (myalgias, weakness, artralgias)_____

PSYCH: (memory loss, depression, mood, sleep)_____

LYMPH/HEMO: (adenopathy, bruising)_____

NEURO: (HA, seizures, pain, numbness)

(cramps, ataxia, handwriting problems)_____

**PLEASE LIST <u>ALL</u> MEDICINES YOU ARE TAKING: (including supplements and over counter medications)**
***LISTA DE MEDICAMENTOS (incluyendo suplementos y medicamentos de venta libre durante)**

1:_____ DOSE/DOSIS:_____

2:_____ DOSE/DOSIS:_____

3:_____ DOSE/DOSIS:_____

4:_____ DOSE/DOSIS:_____

5:_____ DOSE/DOSIS:_____

6:_____ DOSE/DOSIS:_____

7:_____ DOSE/DOSIS:_____

8:_____ DOSE/DOSIS:_____

9:_____ DOSE/DOSIS:_____

10:_____DOSE/DOSIS:_____

11:_____DOSE/DOSIS:_____

**DOB/Fecha de nacimiento:** _____/_____/_____

**PATIENT'S NAME/NOMBRE DE PACIENTE**:_____ **DATE/FECHA:** _____

**PHYSICIAN'S SIGNATURE/FIRMA DEL MEDICO**:_____ **DATE/FECHA:** _____

Revised 05/2016

**Print name/Imprimir**: _____ **Date/Fecha: _____**

NEUROLOGY ASSOCIATES OF MESILLA VALLEY, P.C.

JAVED IQBAL, M.D. Veronica Malone, CNP

MEDICAL INFORMATION/INFORMACION MEDICA

**Reason for your visit and symptoms/Razón por su visita y síntomas**:

_____

_____

_____

**Duration of symptoms/ Duración de los síntomas**: _____

_____

_____

**List all past surgeries/ Lista de cirugías**: _____

_____

_____

**List all allergies to medication/ Lista de alergias a medicamentos**: _____

_____

_____

## Medical History/ Historia Medica

(Please circle)(Por favor marque)

High blood pressure/ Alta presión: yes/si no

Diabetes: yes/si no

Sleep Apnea/Apnea del sueño: yes/si no

Kidney disease/enfermedad del riñón: yes/si no

Stop breathing while sleeping/Para de respirar mientras duerme: yes/si no

other/otro: _____

Do you smoke/Fuma? yes/si no how much/cuánto? _____

Alcohol intake/Toma alcohol? yes/si no how much/cuánto? _____

Occupation/Ocupación? _____

## Family History/Historia Familiar

Heart disorder/problemas cardiac: yes/si no

High blood pressure/Altra presion: yes/si no

Diabetes: yes/si no

Seizures/convulsiones: yes/si no

Headaches/Dolores de cabeza: yes/si no

other/otro: _____

ALL PATIENT'S WHO FAIL TO INFORM **NAOMV** THAT WORKMEN COMP / MOTOR VECHICLE ACCIDENTS ARE ASSOCIATED WITH THEIR VISIT, OR CONDITION, OR SHOULD BE APPLICABLE WILL BE HELD RESPONSIBLE FOR THEIR BILL IN FULL.

**Is this Workmans Comp related?/ Es relacionado con Workmens comp?** yes/si no

**Is this Motor Vehicle Accident related?/ Es relacionado con un accidente automovilístico**? yes/si no

**Patient signature/Firma**: _____ revised 9/2017

# CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by Neurology Associates of Mesilla Valley, P.C., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Neurology Associates of Mesilla Valley, P.C. I understand that diagnosis or treatment of me by Dr. Iqbal may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this practice. Neurology Associates of Mesilla Valley, P.C., is not required to agree to the restrictions that I may request. However, if Neurology Associates of Mesilla Valley, P.C., agrees to that request, the restriction is binding on Neurology Associates of Mesilla Valley, P.C., and Dr. Iqbal.

I have the right to revoke this consent, in writing, at any time, except to the extent that Neurology Associates of Mesilla Valley, P.C., has acted in reliance to this consent.

My "protected health information" means health information, including my demographic information , collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Neurology Associates of Mesilla Valley, P.C.'s Notice of Privacy Practices prior to signing this document. The Neurology Associates of Mesilla Valley, P.C.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or the performances of health care operations of the Neurology Associates of Mesilla Valley, P.C. The Notice of Privacy Practices for Neurology Associates of Mesilla Valley, P.C., is also provided in the front office. This Notice of Privacy Practices also describes my rights and the Neurology Associates of Mesilla Valley, P.C.'s duties with respect to my protected health information.

Neurology Associates of Mesilla Valley, P.C. reserved the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

If you have any question regarding your privacy rights, please refer to the full version of this notice or contact our privacy officer at (575) 532-8561. You may also address questions of concerns to the privacy officer by writing to: **Privacy Officer, 3855 Foothills, Las Cruces NM 88011.**

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

# NEUROLOGY ASSOCIATES OF MESILLA VALLEY, PC.

3855 Foothills Road, Las Cruces NM 88011

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**Javed Iqbal, M.D.**

*Board Certified in Neurology*
*Board Certified in Electro-Diagnostic Medicine*

*Certified in Neuro-Imaging*


## PROVIDER POLICY:

Neurology Associates of Mesilla Valley has two (2) providers. Dr. Javed Iqbal is a Board-Certified Neurologist, Board Certified in Electro-Diagnostic Medicine, and Certified in Neuro-Imaging. Veronica Malone CNP is a Board-Certified Nurse Practitioner. She has been working extensively with Dr. Iqbal in Neurology, and have extensive Intensive Care Unit experience. Dr. Iqbal reviews all patient charts, and Veronica Malone CNP consults with Dr. Iqbal about all the patients.

Although we can try to schedule you with the provider you prefer, they do occasionally cover for each other. All patients may have to see the other provider upon occasion. Please speak with the front desk if you have any concerns.

## APPOINTMENT CANCELLATION POLICY

In order to ensure effective scheduling and patient flow, NAOMV requires 24-hour cancellation for all scheduled appointments. It is important to us that you keep your appointment. As a courtesy, we will call to remind you of your appointment. However, a $35.00 charge will be billed directly to you if you fail to show up or cancel a scheduled appointment with less than 24-hour notice unless an unavoidable emergency occurs. The determination of an "emergency" shall be at the sole discretion of NAOMV.

_____ _____

Name of Patient Date

_____ _____

Signature of Patient Date

_____ _____

Staff Signature Date