ANGELS NEUROLOGICAL CENTERS, P.C.

Patient Registration Form Today's Date: ______________________

Name: ____
First Middle Last

Date of Birth: ____________________ Social Security Number: ____________________

Address: ____________________ City: ______________ State: _____ Zip: _____

Home Phone: ( ) ______________ Other Phone: ( ) ______________ ( ) Cell

Email : ______________________________ Work Phone: ( ) ______________

Marital Status: please check: () Single () Married () Widowed () Legal Separated () Other

Spouse's Name:____________________ Spouse's Date of Birth: ______________

Spouse's Contact Number: ( ) ______________ Spouse's Employer: ______________

Emergency Contact: ______________________________ Phone: ( ) ______________

Primary Care Physician's (PCP) Name: ______________________________

Phone: ( ) ______________________ Fax: ( ) ______________________

Address: ____________________ City: ______________ State: _____ Zip: _____

Insurance Information: Is PATIENT under 18 years of age? () No () Yes – If yes we need subscribers information

Primary Coverage:

Insurance Plan: ______________________

ID #: ______________________

Group #: ______________________

Subscriber's Name: ______________________

Subscriber's D/o/B: ______________________

Subscriber's Social Security #: ______________________

Secondary Coverage:

Insurance Plan: ______________________

ID #: ______________________

Group #: ______________________

Subscriber's Name: ______________________

Subscriber's D/o/B: ______________________

Subscriber's S.S. #: ______________________

If this is a result of an accident, please specify: ( ) Auto ( ) Workers Comp ( ) Other:__________

Date of Incident: ____________________ Claim Number: ____________________

Please note, all patients should REMOVE call block form their phones when paging a provider. If not, the provider may not be able to return your call from certain private & hospital extensions.

I understand that my insurance plan may require prior authorization or a referral for the services I may receive. It is my responsibility, as a patient, to get the proper authorizations to cover these services.

______________________________ ______________
Patient's (or Guardian's) Signature Date

Revised Sept 2008

YOUR NAME: ______________________ / ______________________
Last First

What **medical conditions** do you have? ______________________

What **medications** are you on and what doses? ______________________

Are you allergic to any medication? What?

Are there any diseases that run in your **family**?

Do you **smoke**? How much?

Do you **drink**? How much?

Do you **work**? What do you do?

Are you married? Do you have any children?

Have you ever been exposed to any **toxins** in the past (worked in a factory or served in any wars)?

Have you had any major **trauma** to your back or head?

Do you have any problems with urination or the genitals?

Do you have any problems with your bowel movements (constipation, diarrhea etc)?

Do you have any symptoms related to your breathing?

Do you have any chest pain or palpitation?

Do you have any psychiatric symptoms or do you feel depressed?

M.D. Eneyni, Mazen

** (Place Patient Sticker Here)

____

Please read, understand and, if necessary, discuss all of the items listed below with your doctor:

All of the symptoms you now experience (and/or have experienced in the past) must be reported on the patient questionnaire form. ALL symptoms must be accurate and complete.

The natural history of your diagnosis and all available treatments, including treatments that may not be covered under your insurance carrier, are to be explained to you by your doctor(s) and provider(s) prior to the end of your office visit. Please be sure you understand all information given at the time of your visit.

Make sure all of your questions are answered.

You need to be aware that the recommendation(s) made during this visit are dependent on the information supplied by you (the patient) and records made available during this visit. You are responsible to make available ALL records, films and tests to Angels Healthcare Centers for a definitive recommendation. Our recommendation may change once more information is available. You may not have a final answer regarding your illness and/or course of treatment until all information has been received and reviewed by Angels Healthcare Centers providers.

Angels Healthcare Centers are not responsible if the patient (and/or family members/responsible parties authorized by the patient to give us information) report inaccurate or incomplete information during any visit or correspondence with Angels Healthcare providers.

Be aware that all information given by telephone or any other mode of communication, direct or indirect, will affect the recommendation(s) given to you by our providers. You are to provide accurate and complete information at all times.

You are to report your symptoms and cooperate with your doctors and providers completely. Inaccurate or incomplete cooperation will affect the recommendation given to you. When you are asked to report any symptoms you have, you MUST report ALL symptoms accurately and completely.

You must report to us at ALL times any recommendations or evaluations, done by any other medical professional(s) at any time in the past, immediately. The results may affect our recommendation.

It is always recommended to pursue a second opinion by another specialist in the field if you do not feel that you received the information and help you were hoping for. If we issue a recommendation to seek a second opinion, it is the patients' responsibility to carry through this recommendation, or else it may affect the treatment you receive from us and your outcome.

I understand all of these items. I have good command of English and I have received all the help I need in reference to comprehending these items. I plan to comply with all these items at all times. There is no expiration of this understanding.

____ / /

Signature of patient Name Date

____ / /

Witness to signature Name Date

Angels Neurological Centers, P.C.

It is our office policy to inform you of our patient payment procedure. Please review the section below that is applicable to you.

Patient without insurance (Private Pay)

Please make payment for your care at each patient visit

Patient with insurance

You are responsible for deductibles, copays , noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay copayments as services ar e rendered. If your insurance requires referrals, it is your responsibility to obtain them. The remaining balance should be taken care of withinone (1) month of notice from insurance company. If you or your insurance company makes payment exceeding your balance, reimbursement will be remitted.

Worker's Compensation Patient

As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment. Please provide us with the correct billing information. Failure to do so will result in you being billed.

Personal Injury (Accident)

If you are a personal injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all the information needed for billing including any health insurance information. If you have health insurance, you will need to adhere to the requirements of your health insurance, this includes obtaining all necessary referrals and authorizations. If you have health insurance, you will need to adhere to the requirements of your health insurance, thisincludes obtaining all necessary referrals and authorizations. If you have no health insurance, a doctor's lien must be signed by you and your attorney.

Medicare

Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

Assignment

I request that payment of authorized Medicare benefits be made to Angels Neurological Centers, P.C. for any service furnished me by that provider. Medicare Number ______________________

The signature below authorizes payment of mandated Medigap benefits to Angels Neurological Centers, P.C.

I assign the benefits from my insurance carrier(s) to this cl inic for the medical/surgical benefits for which I am entitled.

Release of Information

I authorize Angels Neurological Centers, P.C. to release to my insurance carrier(s) and/or CMS (formerly HCFA) and its agents and/or my Medigap insurer any information needed to determine benefits or benefits payable for related services. I also author ize Angels Neurological Centers, P.C. to release any information to other physicians involved in my care.

I have read and agree to the Financial Policy, Assignment, and Re lease of Information paragraphs stated above that apply to me.

X ____

Patient or responsible party signature — Date

____

Person Signing on Behalf of Patient — (print name) — Reason Patient can't sign

____

Relationship to Patient — Address — Phone

Rev 1/15/02

Angels Neurological Centers, P.C.

Patient Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This notice is provided in two sections. This page briefly summarizes how we handle your medical information, and the enclosed document provides further details of our privacy policies and procedures.

How we may use and disclose our medical information. We use medical information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care you receive. For example, your medical information may be shared with other providers to whom you are referred. Information may be shared by paper, mail, fax or other methods. We may use or disclose your medical information without your authorization for several reasons. But beyond those situations, we will ask for your written authorization before using or disclosing your medical information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses or disclosures.

Your rights. In most cases, you have the right to look at or get a copy of your medical information that we use to make decisions about you. If you request copies, we may charge you a fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your medical information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.

Our legal duty. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek acknowledgement of this notice. We may change our privacy policies any time. Before we make significant changes in our policies, we will change our notice and post a new notice in the same locations as the original notice. You can also request a copy of our notice at any time. For more information about our privacy policies, please contact the person listed below.

Privacy Complaints. If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact the person listed below. Your may also send a written complaint to the U.S. Department of Health and Human Services.

If you have questions or complaints, pleas contact the Director of Health Information Management at 781-871-3773.

Acknowledgement of receipt of Patient Notice of Privacy Practices. Please print and sign your name below to acknowledge that you have received this Patient Notice of Privacy Practices.

____

Printed Name

____

Signature of Patient or Legal Representative **Date**

____

If signed by legal representative, relationship to patient

Effective Date: April 14, 2003

************PATIENT NOTICE****************

If you must cancel or reschedule your appointment, we require at least 24 hours notice from the time of your appointment. Otherwise a $75.00 fee will be charged

Also, to insure availability of appointments to our valued patients, anyone who has two or more no shows, may receive a discharge letter from our practice.

No show will be noted if:

- Did not show up to your appointment or
- Cancelled with less than 24 hours notice

I agree that I understand this and I will be held responsible for payment and that this fee is not covered by my insurance company.

____

Patient Name

______________________________ ______________

Signature of patient/ guardian Date

Epworth Sleepiness Scale

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of **10 or more is considered sleepy**. A score of **18 or more is considered very sleepy.** If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would **never** doze or sleep
1= **slight** chance of dozing or sleeping
2 = **moderate** chance of dozing or sleeping
3 = **high** chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	________
Watching T.V.	________
Sitting inactive in a public place	________
Being a passenger in a motor vehicle for an hour or more	________
Lying down in the afternoon	________
Sitting and talking to someone	________
Sitting quietly after lunch (no alcohol)	________
Stopped for a few minutes in traffic while driving	________
Total Score	________

______________________________	____________	_____________
(Patient's Name)	(D.O.B)	(Today's Date)

Additional Demographics:

Name: DOB:

Choose from options below.

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Italian
- ☐ German
- ☐ Vietnamese
- ☐ Mandarin
- ☐ Portuguese
- ☐ Haitian Creole
- ☐ Cape Verdean Creole
- ☐ Non-Verbal
- ☐ American Sign Language

Race:

- ☐ Hispanic
- ☐ Asian
- ☐ Caucasian
- ☐ African American
- ☐ Black or African American
- ☐ Native American
- ☐ American Indian or Alaska Native
- ☐ Other
- ☐ Undetermined
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ Multiracial
- ☐ Pacific Islander

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino
- ☐ Other or Undetermined