

Neurology and Sleep Medicine Associates

(480) 967-6888 (Phone)

(480) 967-6887 (Fax)

East Mesa Office

West Mesa Office

Augusta Ranch Professional Village

Odyssey Professional Park

2919 South Ellsworth Road, Suite 135

2045 S. Vineyard, Bldg N3, Ste 214

Mesa, Arizona 85212

Mesa, Arizona 85210

Date: _____

Patient Name: _____ Responsible Party Name: _____

Mailing Address: _____ City, State, Zip: _____

Permanent Address: _____ City, State, Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Email Address: _____ Pharmacy Number: _____

Sex: male female Birth Date (MM/DD/YYYY): _____ Age: _____

Marital Status: married single

Patient's Social Security #: _____ Responsible Party Social Security #: _____

Relation to Patient: self spouse child other _____

Referring Doctor's Name and Number: _____

Primary Care Doctor's Name and Number: _____

Employer Name and Number: _____

Billing information: I prefer you to bill my claim to:

1. The name of primary insurance: _____ ID# _____

2. The name of secondary insurance: _____ ID# _____

3. Do you have Medicare? yes no If yes, your Medicare #: _____

Is this visit related or from an accident? yes no

If injury or accident: auto accident job related injury, Date of Incident: _____

Claim number: _____ Third Party Information: _____

Is there an attorney involved in your case? yes no If yes, Your Attorney Name and Number: _____

Chief Complaints:

What is the chief problem that brings you to the Clinic?

How long have you had the problem? _____

What do you think might be causing it? _____

Current Medical Problems and Illnesses:

Disease		Year Diagnosed	Disease		Year Diagnosed
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Have you ever had? (Please check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> cancer (type? _____) | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> radiation therapy | <input type="checkbox"/> chemotherapy |
| <input type="checkbox"/> stroke (what year? _____) | <input type="checkbox"/> seizures | <input type="checkbox"/> depression | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> hypertension | <input type="checkbox"/> asthma | <input type="checkbox"/> COPD |
| <input type="checkbox"/> diabetes (for _____ years?) | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> kidney stone | <input type="checkbox"/> blood clot |
| <input type="checkbox"/> hepatitis (type? _____) | <input type="checkbox"/> stomach ulcer | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> polio |
| <input type="checkbox"/> sexually transmitted disease | <input type="checkbox"/> shingles | <input type="checkbox"/> headache | <input type="checkbox"/> sinus problem |
| <input type="checkbox"/> others: _____ | | | |

Previous Surgeries:

Surgical Disease		Year of Surgery	Surgical Disease		Year of Surgery
1.			4.		
2.			5.		
3.			6.		

Medications: List all medications that you have been taking recently, including all vitamins and non-prescribed medication. Please bring all medications for your visit.

Name	Dose (mg)	Times per day	Name	Dose (mg)	Times per day
1. _____			6. _____		
2. _____			7. _____		
3. _____			8. _____		
4. _____			9. _____		
5. _____			10. _____		

Allergies: Reaction to medication or other substances. List all medications and substances.

Name of Medication	Type of Reaction
1. _____	_____
2. _____	_____
3. _____	_____

Family History: List major medical problems in your family.

Disease	Who has it?	Disease	Who has it?
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

Social History:

Primary occupation: _____

Tobacco: yes no Have you ever smoked? yes no

Type and amount: _____ Years: _____ If stopped, when? _____

Alcohol: yes no Have you ever drank alcohol? yes no

Type and amount: _____ Years: _____ When was last drink? _____

Recreational drugs: yes no Have you ever used recreational drugs? yes no

Type and amount: _____ Years: _____ When was last use? _____

Exercise: yes no If Yes, what type? _____ How often? _____

Authorization to Pay: I hereby authorize payment directly to the business office of this physician/clinic for any treatment and/or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

Signature (Patient or Guardian, if patient is minor)

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Patient Payment Policy

Insurance: We participate in most insurance plans. We bill your insurance company as a courtesy to you. Although we may estimate what your insurance will pay, it is the insurance company that makes the final determination of your eligibility. Please be aware that the balance of the claim is your responsibility whether or not your insurance pays the claim. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contact with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Private Pay/No Insurance: Payment is due at the time of service. Payment will be accepted in the form of cash, debit, or credit.

Medicare: Because we accept assignment with Medicare, it is mandatory that we bill your claim directly to Medicare. If you have Medicare only, you are responsible for 20%. Per Medicare guidelines we are unable to waive or write these fees off. Payment is due at the time of service. If you wish to have your secondary insurance billed, please make sure you provide all pertinent information before your visit.

Referrals: If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival, we have a telephone available for you to call your primary care physician to obtain it. If you are unable to obtain the referral at that time, you will be rescheduled. If you choose to keep the scheduled appointment without a referral, you will be responsible for full charges to be paid that day and also sign a waiver.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Nonpayment: If your account is past due, you will receive a letter from us stating you have 30 days to pay your account in full. Please be aware that if your balance remains unpaid, we may refer your account to a collections agency. There will be a 35% charge assessed to any account sent to collections. If this occurs, you will not be seen in the office until your balance is paid in full and all charges for future visits will be collected up front.

Returned Checks: There is a fee of \$25.00 for any checks returned by the bank.

Missed Appointments: Our policy is 24 hours notice for an appointment change. Sleep study appointments require a 48-72 hour notice. If a 48-72 hour notice is not given, you will be assessed a \$200.00 fee. We understand that emergencies arise. If an emergency keeps you from keeping your appointment, please contact us as soon as possible to reschedule. Please help us to serve you better by keeping your scheduled appointments. If you miss 3 consecutive appointments we will discharge you from the practice for non-compliance.

Medical Record Copies: You will need to request copies of your records in writing. We are happy to email or fax your records to a secured fax free of charge. If you wish to have records printed, you will be charged a reasonable copy fee of \$1.00 per page. There is also a \$5.00 postage fee if the records are to be mailed.

Patient Name: _____

Date: _____

Signature: _____

Notice of Privacy Practice for Protected Health Information

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.

In compliance of the federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Neurology and Sleep Medicine Associates, has established privacy policies and procedures relating to the protected health information of our patients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPAA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in the Notice of Privacy Practices for Protected Health Information ("Notice"), or wish to register any complaints related to our privacy practices, you should contact:

Connie Wu
Neurology and Sleep Medicine Associates
2045 South Vineyard, Bldg. N3, Suite 144
Mesa, AZ 85210
(480) 967-6888

We will supply a written copy of this Notice to any person requesting it, whether or not a current patient. All patients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office.

We reserve the right to make changes to our Notice and have any new provisions become effective for all protected health information we maintain. If we make any material changes to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, This Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who requests a copy.

Your Rights as a Patient

With respect to your protected health information, you (or your personal representative, with legal authorization) have certain rights:

1. to obtain a paper copy of this Notice of Privacy Practices for Protected Health Information upon request
2. to revoke your consents or authorizations
3. to inspect and obtain a copy of the health information that is used to make individual health care decisions about you (so called "designated record sets")
4. to appeal decisions we make regarding denial of access to your records
5. to request amendments to your health records
6. to dispute decisions regarding denial of amendment to your records
7. to request restrictions on certain uses and disclosures
8. to request that confidential communications take place by alternative means to alternative locations
9. to obtain an accounting of disclosures
10. to lodge a complaint with us or with the Secretary of Health and Human Service if you believe there has been a HIPAA privacy violation, without fear of retaliation, coercion, or intimidation

Acknowledge of Receipt of this Notice of Privacy Practices

We will make a good faith effort to provide you with a paper copy of this Notice of Privacy Practices and obtain a written acknowledgement from you. If we are unable to obtain such acknowledgement, we will document the reason.

Patient's signature: _____ Date: _____

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Consent To Release Medical Information

I, _____, authorize George Wang, MD and/or his staff to release medical information pertaining to myself, such as lab results, medication information/changes, referrals to specialist, future appointment, responses to messages left for the doctor, and copies of medical records and/or medical information.

Name: _____ Relationship: _____

_____ May leave detailed information on voicemail

_____ Do not leave detailed information on voicemail

Patient's Signature: _____

Date: _____

Witness Signature: _____

Date: _____

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To our Patients:

It is our office policy to keep a copy of a credit/debit card number or your HSA (health savings account) card number on file.

This information will be held securely, and will be used to pay any remaining balance after insurance payments, (including deductibles), missed appointment fees and monthly payment agreements. This will benefit you, since you will no longer have to mail checks or call with payment. It will benefit us as well since we are a paperless office and will no longer have to generate and mail statements.

After we file a claim with your insurance company, you will receive an Explanation of Benefits from your insurance company, which will state the amount the patient is responsible for. If you have any questions regarding your EOB, please do not hesitate to call us. The amount owed, if any, will be charged to your card and you will not receive a statement from us. **Our billing department will attempt to contact you before anything is charged to your card; if we are unable to reach you and must leave a message, we will give you 24 hours to respond before charging your credit card.**

If we do not have a credit/debit card or HSA card number on file and it becomes necessary to send you a statement, you will be assessed an additional \$15.00 administrative fee.

Visa/MC/Discover

Card Number

Exp Date

Cardholder's Name (Print)

Patient Name (Print)

Signature

Date

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Patient Name: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

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

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

Situation	Chance of Dozing			
	Never	Slight	Mod.	High
Sitting and reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting inactive, in a public place (e.g. a theater or meeting)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
As a passenger in a car for an hour without break	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting and talking to someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Sitting quietly after lunch without alcohol	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
Total Score				

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AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Patient SSN: _____

Current Address: _____
Street City State Zip Code

Patient Phone: _____ Date of Birth: _____

Release Medical Information to:

Name: _____

Address: _____

Fax #: _____ Phone #: _____

	Consultation Note	MWT Reports	
	History and Physical	Lab Reports	
	EMG Reports	Radiology Reports	
	EEG Reports	Pathology Reports	
	EP Reports	All Medical Records	
	PSG Reports	Others:	
	MSLT Reports		

I hereby authorize Neurology and Sleep Medicine Associates and its employees to release any and all information contained in my patient records. I understand and acknowledge that this may include information and treatment for physical and mental illness, alcohol/drug abuse; HIV/AIDS test results or diagnosis.

Duplication and distribution of your medical records are a service. Neurology and Sleep Medicine Associates strive to ensure that timely completion of request for release of medical information. As a professional courtesy, no cost is assessed for information released directly to your health care provider. All other releases are subject to copy and distribution cost. If your request exceeds the amount of \$10.00 you will be contacted by a representative of Neurology and Sleep Medicine Associates to verify authorization of reimbursement prior to processing your request.

I understand the potentiality of charges for the service of release of medical information and accept financial responsibility.

Signature of Patient/Legal Guardian

Printed Name

Date Signed

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MISSED APPOINTMENT POLICY

Our policy is that a 24 hour notice must be given for an appointment change or cancellation. We understand that emergencies arise. If an emergency prevents you from keeping your appointment, please call out office as soon as possible to reschedule. AHCCCS patients: it is required for us to report all missed and late cancelled appointments. **Please be aware that if you miss three consecutive appointment, we will discharge you from the practice for non-compliance**

I have read and understand the appointment policy statement above.

Patient Name: _____

Date: _____

Chronic Migraine Screener

What are Chronic Migraines?

Chronic Migraine is a condition defined as 15 or more headache days a month with each headache lasting 4 hours or more per day. At least half of the headaches should be migraine.¹

How to use this screener

The following questions can help you and your physician understand your condition and help determine if you may have Chronic Migraine. Being thorough about your headaches/migraines will help your physician determine how much your headaches affect your daily life and help get you to a more accurate diagnosis and find treatment options that are right for you.²

Personal Information

Name: _____

Date of birth: _____

Important information before you get started

What are headache days?

It's important to understand the number of days your had headache (including migraines) rather than the number of attacks.²

- For example, you may have a headache that starts on Monday and doesn't go away until Wednesday; it may be 1 attack, but that's considered 3 headache days

Remember to provide your doctor with an accurate number of **ALL of the days your experience headache pain of any kind.**

Are migraine days the same as headache days?

Some of your headaches may be a type of headache known as a migraine. If you experience any combination of the following symptoms, your headache may be a migraine³.

- Constant, throbbing pain felt on 1 side of the head (but can be on both sides)
- Sensitivity to light and sound
- Nausea and/or vomiting
- Headaches that get worse with movement (you may want to lie down)

Whether your headache is a migraine or not it still counts as a headache day.

What if the headache gets better or goes away after I take medicine?

You should also count days that you treated/resolved your headache/migraine with either over-the-counter medication like Ibuprofen or prescription medication like Sumatriptan. These days are still considered as days with headache.

