24910 Las Brisas Rd., Suite 115
Murrieta, CA 92562
(951) 698-7366

Date: _________________

PATIENT REGISTRATION FORM

Demographics

Patient Name:_______________________________________ Birthdate:________________________
Last First M.I.
Address:____ Marital Status:____________________
:____ Gender:_________________________
Home Phone:_______________________________________ SSN:__________________________
Cell Phone:____ Driver's Lic. #:____________________
Email:____

Please be advised that the Doctor will not see anyone without the patient being present.

Insurance Information

Primary Insurance:____
Address:____
Policy #:____ Group #:________________________
Subscriber's Name:___________________________________ Relationship to Patient:_____________
Subscriber's Employer:________________________________ Subscriber's Date of Birth:___________

Secondary Insurance:____
Address:____
Policy #:____ Group #:________________________
Subscriber's Name:___________________________________ Relationship to Patient:_____________
Subscriber's Employer:________________________________ Subscriber's Date of Birth:___________

Emergency Contact

Name:____ Phone #: ________________________

Relationship to Patient:________________________________

Attestation

The information above is true to the best of my knowledge. I understand I am responsible for all charges or the remaining balance after payment from my health insurance. I hereby authorize Dr. Pamela L. Alvarez to release pertinent information to process insurance claims. I also authorize my insurance be paid directly to Valley Neurology.

____ Date:________________________
Signature of Patient or Guarantor

Print Patient or Guarantor's name____

MEDICAL QUESTIONNAIRE

PATIENT'S NAME:___________________________________ APPOINTMENT DATE:___/___/___
DATE OF BIRTH:____/___/_____
PRIMARY CARE PHYSICIAN:____
REFERRING PHYSICIAN:____
HISTORY OF PRESENT ILLNESS:____
What is your primary neurologic concern?

When did this problem commence? Briefly outline development over time.

Have you seen a neurologist for this problem? If so, please list name, address and telephone number of doctor.

Have you undertaken any imaging studies (CT/MRI) or diagnostic tests (EEG/EMG)?
If so, please bring results with you to the appointment.

REVIEW OF SYSTEM:
Do you currently have any problems with:

	Yes	No	Explain
General Health			
Fever	☐	☐	
Fatigue	☐	☐	
Weakness	☐	☐	
Weight gain/loss	☐	☐	
Eyes			
Pain	☐	☐	
Loss of vision	☐	☐	
Double vision	☐	☐	
Flashing lights or spots	☐	☐	
Nose/Ear Throat			
Ringing in ears	☐	☐	
Loss of hearing	☐	☐	
Nosebleeds	☐	☐	
Loss of sense of smell	☐	☐	
Sinusitus	☐	☐	
Sores in mouth	☐	☐	
Loss of sense of taste	☐	☐	
Dry mouth	☐	☐	
Hoarseness	☐	☐	

Cardiac			
Chest pain	☐	☐	
Irregular heartbeats	☐	☐	
Shortness of breath	☐	☐	
Swollen legs or feet	☐	☐	
Heart murmurs	☐	☐	
Cramps in legs	☐	☐	
Pain in feet or toes	☐	☐	
Varicose veins	☐	☐	
Respiratory			
Chronic dry cough	☐	☐	
Repeated pnuemonias	☐	☐	
Gastrointestinal			
Decreased appetite	☐	☐	
Nausea	☐	☐	
Vomiting	☐	☐	
Gas	☐	☐	
Genitourinary			
Difficulty in urination	☐	☐	
Frequent need to urinate	☐	☐	
Inability to hold urine	☐	☐	
Rash or ulcers	☐	☐	
Sexual difficulties	☐	☐	
Musculoskeletal			
Joint or muscle pain	☐	☐	
Muscle weakness or			
Tenderness	☐	☐	
Joint swelling	☐	☐	
Neck or back pain	☐	☐	
Major orthopedic injuries	☐	☐	
Neurologic			
Headaches	☐	☐	
Dizziness	☐	☐	
Fainting	☐	☐	
Muscle spasm	☐	☐	
Loss of consciousness	☐	☐	
Sensitivity or pain in the			
hands and feet	☐	☐	
Memory loss	☐	☐	
Psychiatric			
Depression	☐	☐	
Sought psychiatric			
Counseling or treatment	☐	☐	
Skin and Breast			
Bruise easily	☐	☐	
Skin rashes / hives	☐	☐	
Sensitivity to sun	☐	☐	
Hair loss	☐	☐	

Color changes in hands or feet with cold	☐	☐	
Endocrine			
Intolerance to hot or cold	☐	☐	
temperature	☐	☐	
Fingernail changes	☐	☐	
Increased thirst	☐	☐	
Hematologic/Lymphatic			
Anemia	☐	☐	
Bleeding tendency	☐	☐	
Clotting tendency	☐	☐	
Allergic/Immunologic			
Rhinitis	☐	☐	
Asthma	☐	☐	
Skin sensitivity	☐	☐	
Latex allergies	☐	☐	

MEDICAL HISTORY:
Please list conditions that is or has been under medical care.

____
____
____

MEDICATIONS: **EXAMPLE: ADVIL 250mg ONCE DAILY**

ALLERGIES:

FAMILY HISTORY OF NEUROLOGIC DISORDER OR CARDIOVASCULAR DISORDER:

Maternal Grandparents:____
Paternal Grandparents:____

Parents:____
Siblings:____

SOCIAL HISTORY:

Tobacco Use: Current___________ packs/day
Past ___________ packs/day Year Quit____________________

Alcohol Intake: Current___________ drinks/day
Past ___________ drinks/day

Illicit Drugs Current Substance(s) ____
Past Substance(s) ____

Exposure to Toxic Elements: ____

Do You Live Alone? __________ If not, with whom? _______________________________

Occupation: ____

____ ______________________________
Patient Signature or Person Filling Out Form Date

I have personally reviewed the above information:

____ ______________________________
Pamela L. Alvarez, M.D. Date

CONSENT

I give Valley Neurology my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews. I have been given for review the Notice of Privacy Practices.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Valley Neurology is not required to agree with the request.

I understand that I may revoke this consent at any time. To do so, a written request will be required.

________________________________ ____________________

Signature Date

____

Print Name

24910 Las Brisas Rd., Suite 115
Murrieta, CA 92562
(951) 698-7366

Appointment Arrival Policy

We appreciate your help in keeping delays to a minimum by arriving on time for your appointment. Please note that tardiness of greater than 10 minutes after your appointment time will need to be rescheduled. Unfortunately, the next available appointment may be several weeks from the current date.

Thank you for your consideration.

____

Printed Name

____

Signature

Our Patient Payment Policy

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

All patients must complete our *Patient Registration Form. We believe that a good relationship is based on understanding and open communications. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your balance.*

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, MasterCard and American Express credit cards, as well as Debit Cards. For your convenience, our billing office is staffed Monday through Thursday from 8:30 AM to 5:00 PM and Fridays from 8:30 AM to 12:30 PM. The phone number is (951) 698-7366.
You are expected to make payment in full upon receipt of a billing showing your balance due or according to the terms below:

Balance Due	Terms
$100 or less	Payment in full within 30 days
$101-$500	3 months
$501-$1000 & over	6 months

Other payment plans or options may be available upon completion of a financial statement analysis. Please contact our Patient Financial Services for this information and/or when your billing address changes. A monthly billing charge will be added to all accounts not paid in full within 45 days of service.

When is my account delinquent?

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond 90 days are considered delinquent and may be forwarded to our collection agency and will have a service fee/billing fee added.

How are my Medicine Refills handled?

Please do not wait until your prescription has completely run out prior to calling us for your refill.

What about Co-Payment?

Co-Payment is always due at the time of service. If the decision is made to see a patient who does not have his/her co-pay, this patient's insurance will be notified in writing that it occurred which could result in a loss of insurance.

Is Interest charged?

Patients with an outstanding balance over 60 days with be charged interest of 12% p.a.

Phone calls to the Doctor

The doctor will not be doing telephone medicine, if you need to talk to the doctor, we will give you an appointment. Calling the doctor after hours will result in a charge which insurances do not pay-making you responsible.

Do I Need A Referral?

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 at the office, 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.

What about missed appointments?

As a rule, we always call patients to remind them of their upcoming appointment. We would appreciate your help and courtesy of a call if you are unable to keep an appointment so we may schedule another patient. Please notify our office at least twenty-four (24) hours prior to the appointment time. We reserve the right to charge you a missed appointment (no show) fee of $50.00 and three (3) non-cancelled missed appointments (no shows) are grounds for patient discharge.

Paperwork Fees

Forms 1-3 pages will be charged $40.00. Additional fees will apply for forms over 3 pages.
Chart copies to patient will be charged $20.00 (please note that you are provided visit notes and test results, if any, after each visit, so keep them to avoid the fees).

Legal Fees:

Any patient sent to collections are will be responsible for all collection fees. If a patient is taken to small claims court the patient will be responsible for all fees/charges.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my *responsibility.*

I authorize my *insurance benefits be paid directly to Valley Neurology.*

I authorize Valley Neurology to release pertinent medical information to my *insurance company when requested,* or *to facilitate payment of* a *claim.*

Printed Name ______________________________

Signature ______________________________ **Date** ______________

HIPAA NOTICE OF PRIVACY PRACTICES

Valley Neurology
24910 Las Brisas Road, Suite 115
Murrieta, CA 92562

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 applies to the information and records we have about your health status and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

For Payment: We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care, for example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

SPECIAL SITUATIONS:
We may use or disclose health information about you without your permission for the following purposes subject to all applicable legal requirements and limitations.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Required By Law: We will disclose health information about you when required to do so by federal, state or local law.
Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
Workers Compensation: We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks: We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you re involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process subject to all applicable legal requirements.
Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* If you give us *Authorization* to use of disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you.

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we may use to make decisions about your care. You must submit a written request to Jose S. Alvarez in order to inspect and/or copy, mailing or other associated supplies.
Right to Amend: If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information.
Right to Accounting of Disclosures: You have the right to request an accounting of disclosures.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations.
We are Not Required to Agree to Your Request: If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit a *Request for Restricting Uses and Disclosures and Confidential Communications Form* information to Jose S. Alvarez.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. This notice was published on April 14, 2003.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Jose S. Alvarez at (951) 698-7366. You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact Jose S. Alvarez at (951) 698-7366.
This notice describes the information privacy practices followed by our employees, staff and other office personnel. Signature below is acknowledgement that you have received this Notice of our Privacy Practices.

Print Name__________________________ Signature________________________________ Date_________________

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice. that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children,

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including. without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must he communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator ,

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall he stayed pending arbitration.
The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitrat:ion agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05: however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim. if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services ______________________

Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ______________________ ____________
Physician's or Authorized Representative's Signature Date

By: ______________________ ____________
Patient's or Patient Representative's Signature Date

Pamela L. Alvarez, MD Inc. dba Valley Neurology
24910 Las Brisas Rd., #115, Murrieta, CA 92562

____
Print Patient's Name

____
Print or Stamp Name of Physician. Medical Group,

____
(if Representative: Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to he filed in Patient's medical records
(9-13)