

Central California Neurology
Medical Corporation

Dr. Dale A. Helman M.D.

Dr. Borina Dramov M.D.

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Monterey, CA 93940
(831) 655-7855

PATIENT REGISTRATION FORM

Name (First M Last): _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work/Cell #: _____ Preferred Language: _____

Employer: _____ Phone#: _____

Date of Birth: _____ Sex: M F (circle one) Race: _____ Ethnicity: _____

Marital Status: _____ SS#: _____ Driver's License #: _____

Preferred Pharmacy: _____ Preferred Lab: _____

Primary Care Physician: _____ Phone#: _____

Guardian Name (if minor): _____

Address (if different from above): _____

Primary Insurance Carrier: _____

Primary Insured's Name: _____ Employer: _____

Primary Insured's SS#: _____ Primary Insured's DOB: _____

Policy/Member ID#: _____ Group #: _____

Relationship to Patient: Self Spouse Dependent (circle one)

Secondary Insurance Carrier: _____

Primary Insured's Name: _____ Employer: _____

Primary Insured's SS#: _____ Primary Insured's DOB: _____

Policy/Member ID#: _____ Group #: _____

Relationship to Patient: Self Spouse Dependent (circle one)

Emergency Contact: _____ **Phone #:** _____

Whom may we thank for referring you?: _____

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to Dale A. Helman, MD, (CCNMC) This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance.

X _____
Signature of Patient or Personal Representative

Date

Central California Neurology Medical Corporation
HEALTH QUESTIONNAIRE

Name (First M Last): _____

CIRCLE ONE

1.) Height: _____ Weight: _____ lbs

2.) Do you have any drug allergies? YES NO

Please List: _____

3.) Do you have any other allergies? YES NO

Please List: _____

4.) Do you had any of the following:

- YES NO Valley fever (hay fever) or asthma?
YES NO Seizures/Strokes?
YES NO Cancer?
YES NO Diabetes
YES NO Blood clots/Phlebitis
YES NO Kidney/Bladder infections
YES NO Reaction to general/local anesthesia
YES NO Cortisone

5.) Are you currently taking any medications? YES NO

Please List: _____

6.) Have you had any previous surgeries? YES NO

Please List: _____

7.) Do you have any known contagious diseases? YES NO

If so please list?: _____

8.) Habits: Do you smoke? YES NO

Number of packs per day?: _____ Number of years?: _____

Do you use alcohol? Drinks per week?: _____ YES NO

9.) Do you have a pacemaker, stints, aneurysm clips or any metal in your body? YES NO

If so please list?: _____

10.) Are you claustrophobic? YES NO

11.) Check off the cause of your visit today: () Car accident () Work injury () Sports injury () Home

() Other: _____

Please provide any other health information you deem important:

X _____
Signature of Patient or Personal Representative

Date

**Central California Neurology Medical Corporation
Summary of Notice of Privacy Practice**

The Health Insurance Portability and Accountability act of 1996 (“HIPAA”) requires that, effective April 14, 2003, we provide you a printed copy of Notice of Privacy Practices. For your convenience, we are providing this brief summary. A copy of our full Notice is available, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received this summary. A copy of the full Notice is available upon request.

Your Rights As A Patient

You have rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information

We are permitted to use your protected health information for treatment purposes, payment and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

Disclosures Of Protected Health Information Requiring Your Authorization

For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures Of Protected Health Information Not Requiring Your Authorization

We are not required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Restrictions To Use And Disclosure

You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, only the minimum amount of such information will be used to accomplish the intended goal.

Access To Protected Health Information

You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments To Medical Records

You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical records.

Accounting Of Disclosures Of Protected Health Information

You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations.

Complains Related To Perceived Violations Of Your Privacy Rights

You may register a complaint about any of our privacy practices with our Privacy Officer or with the Secretary of Health and Human Services.

Use and disclosure of protected health information is required by federal law known as The Health and Insurance Portability and Accountability Act of 1996 (HIPAA).

Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I _____, acknowledge that
(printed name of patient or personal representative)

Central California Neurology Medical Corporation, has provided a written copy of their summary Notice of Privacy Practices to (check one) _____ myself _____ or other, specify _____.

X _____
Signature of Patient or Personal Representative

Date

**Central California Neurology Medical Corporation
Assignment of Benefits Agreement
Release of Billing Information**

Central California Neurology Medical Corporation believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

- 1. **PAYMENT-** Is expected at the time of your visit. We will accept cash or check. Payment will include any unmet deductible, co-insurance, co-pay amount or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.
- 2. **INSURANCE-** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan’s network, you may be responsible for partial or full payment. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for your care are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer’s member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be “not covered”, you will be responsible for the complete charge. Payment is due upon receipt of statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

- 3. **LATE CHARGES-** We can assess a 12% fee annually to be applied to all patient balances of 90 days or older.
- 4. **RETURNED CHECKS-** Will incur a \$25.00 service charge. You will be asked to bring cash or a money order to cover the amount of the check plus the service charge.
- 5. **ACCOUNTING PRINCIPLES-** Payment and credits are applied to the oldest charge first, except for insurance payments which are applied to the corresponding dates of service.
- 6. **COMPLETING INSURANCE FORMS, COPYING MEDICAL RECORDS, ETC.-** Requires office staff time and time away from patient care for our doctors. We may require pre-payment for completing forms, copying medical records, or for extra transcription by the doctors. The charge is determined by the length and complexity of the form or letter.
- 7. **MISSED OR CANCELED APPOINTMENTS-** We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.
- 8. If you have questions in regard to any of your billing statements our accounts receivable staff is available to assist you.

I have read and understand the practice’s Assignment of Benefits Agreement and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Assignment of Benefits Agreement to (check one) _____ myself _____ or other, specify _____.

X _____
Signature of Patient or Personal Representative

Date