Patient Demographic Form

PATIENT INFORMATION

Last Name **First Name** **Middle Initial** **Nickname/AKA**

Date of Birth **Social Security Number** **Gender** ☐ Male ☐ Female ☐ Non-Binary

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other **Language** (other than English)

Race ☐ African American ☐ American Indian/ Alaskan Native ☐ Hispanic ☐ Asian/Pacific Islander ☐ White – Non Hispanic ☐ Other

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ☐ Cell ☐ Fax

Email Address **Employment** ☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student Full-Time

Employer **Employer Phone**

PHYSICIAN REFERRAL INFORMATION

Primary Care Physician **Referring Physician**

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

Relationship to Patient ☐ Self (If self, skip to Emergency / Next of Kin) ☐ Spouse ☐ Parent ☐ Other

Last Name **First Name** **Middle Initial**

Date of Birth **Social Security Number**

Home Address **Apt #** **City** **State** **Zip Code**

Home Phone **Work Phone** **Other Phone** ☐ Cell ☐ Fax

Employer **Employment** ☐ Active Duty Military ☐ Employed Full-Time ☐ Not Employed ☐ Student Full-Time

Employer Phone

INSURANCE INFORMATION

Insurance Name **Member ID Number** **Group Number**

Secondary Insurance **Member ID Number** **Group Number**

EMERGENCY CONTACT INFORMATION

Last Name **First Name** **Relationship to Patient**

Home Phone **Work Phone** **Other Phone** ☐ Cell ☐ Fax

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Physician. I understand that I am financially responsible for any balance. I also authorize Integrated Neurology and Pain Management/ Amar Anand MD or insurance company to release any information required to process my claims.

Patient/GuardianSignature_____ **Date**_____

INPM
INTEGRATED NEUROLOGY & PAIN MANAGEMENT

155 Glen Cove Marina Road Suite 100, Vallejo, CA 94591
P - 707.980.6636 F - 707.980.6692
1455 Montego Suite 101, Walnut Creek, CA 94598
P - 925.557.1552 F - 707.980.6692

1. **Insurance Payment Authorization and Release:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit, prior to you seeing the physician. Please contact your insurance carrier with any questions you may have regarding your coverage. All patients must provide their actual insurance card(s) and Identification card to the receptionist at the time of check-in, no photocopies, or pictures will be accepted.
2. **Referral and Co-payments:** Your insurance may not require a referral, but our office policy is that you must be referred to our office by your PCP or treating physician. All co-payments must be paid at time of service. This is your contract with your insurance and failure on our part to collect said co-payment can be considered fraud. We accept cash, check, and all major credit or debit cards for payments.
3. **Non-covered Services:** Please be advised that sometimes all of the services you receive may not be covered or not considered medically necessary by Medicare or other insurance carriers. It is your responsibility to inform Dr. Anand/ INPM and his staff if you do not want these services performed.
4. **Coverage Changes:** If your insurance benefits or insurance company changes for any reason, you are responsible for notifying our office before your next visit. Failure to provide us with adequate notice to make these corrections or request required authorizations will result in any denied balances to be the patient's financial obligation.
5. **Medical Records/Form Fees:** Please allow 7-10 working days for form completion and 30 days for medical records requests. Fee schedule is as followed: Complete records - >50 pages no charge - <50 pages $0.05/page Subpoena - $40 Forms (Disability/DMV/Etc) - $25+
6. **Prescription Refills:** To avoid duplicate prescriptions, all routine refill requests must be made via your pharmacy first. Do not wait until you are out of medication. Allow 72 hours notice to review and refill your request. Refill requests will only be processed Monday through Friday during normal business hours. Controlled drug prescriptions must be picked up in the office and will not be refilled after hours, or on weekends. Please note all controlled medications also require a signed controlled substance contract on file with this office.
7. **Appointments:** Our physician and staff know your time is important and we hope you understand the value of our time as well. Every patient will receive the attention they require. Therefore if you are not on time or arrive in the 15 minute grace period to your appointment it may be necessary to reschedule your appointment. **Our office requires a 24 hour notice if you are unable to keep your appointment or you will be charged a $25.00 No Show/ Late Cancelation Fee.** Be advised leaving a voicemail on our phone the day before your appointment constitutes sufficient notice and you will not be charged.
8. **Appointment Reminders:** As a courtesy we try to confirm your appointments a day before you are to be seen, this is a courtesy to you. It is your responsibility to keep track of your appointments whether we call you or not. Failure to show up to an appointment because "no one called to remind me" will result in a No Show Fee..

I have read and understand the above and agree to abide by the set guidelines.
A copy of these policies can be provided to me upon request.

_____ _____

Patient/ Guardian Signature Date

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Department of health Care Services Privacy Office

Authorization for Release of Protected Health Information

I, _____, hereby authorize _____ to
(Name of Patient) *(Facility Name that holds information)*
release the following health information: _____

_____

To: Integrated Neurology and Pain Management, Amar AnandMD
Address: 155 Glen Cove Marina Rd Suite 100, Vallejo, CA 94591
Phone: 707.980.6636
Fax: 707.980.6692

For the the purpose of: Treatment of a Neurological Condition

This Authorization is in effect for 3 years from date of signature, which at that time it will expire.

I understand that by signing this authorization:

- I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed.
- I have the right to withdraw permission for release of my information. If I sign this authorization to use or disclose information I can revoke that authorization at any time. The revocation must be in writing and will not affect information that has already been used or disclosed prior to receipt of withdrawn permission.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment or my eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically
- required or permitted by law.

_____ _____
Signature of Patient/ Personal Representative *Date Signed*

_____ _____

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- I have received notice of privacy practices and/or I have been provided with a chance to review it.

- I agree that voicemail messages regarding my appointments, prescriptions refills, tests/labs, and all other **protected health information** (PHI) may be left for me on voicemail or answering machine at the following phone numbers:
  - **Please Check each box that applies to each number listed below**

  - (_____) _____ - _____ - Home / Work / Cell
    - It is okay to leave a call back number **ONLY**
    - It is okay to leave a message with another person
    - It is okay to leave a message on voicemail

  - (_____) _____ - _____ - Home / Work / Cell
    - It is okay to leave a call back number **ONLY**
    - It is okay to leave a message with another person
    - It is okay to leave a message on voicemail

- **I agree to allow my spouse access to my PHI:** _____

- **I agree to allow the following people (other than spouse) access to my PHI:**

  - _____

  - _____

- I understand that I can change any of the above information at any time by giving written notice to Integrated Neurology and Pain Management. *(as allowed and defined in the Health Insurance Portability and Accountability Act of 1996)*

_____ _____
Patient Name (Please print clearly) *Date*

_____
Signature of Patient/ Guardian/ Parent
(If patient is a minor, under 18, the responsible parent must sign)

_____ _____
Parent/ Guardian Name *Relationship to Patient*

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Please answer the following questions to assist us in giving you the best treatment possible:

General Information

Name:_____

Dominant hand: Right / Left / Ambidextrous Sex: Male / Female / Nonbinary

Height:_____ Weight:_____

Social History

Do you drink Alcohol: Y / N How often?_____ Day / Week / Month / Year

Do you Smoke? Y / N Cigarettes / Cigars / Vaping How often?_____ Day / Week / Month

Do you drink caffeinated beverages? Y / N How Many?_____ Day / Week / Month

Current Problem or Condition

Please Explain in the space provided below what the purpose of today's visit will be:

_____

_____

_____

_____

Approximately how long has this issue been present:_____ Days / Months / Years

Has your condition been: Getting worse / Staying the same / Improving

Please list anything that helps alleviate your condition:

_____

_____

Please list anything that causes your condition to worsen: _____

_____

Have you seen other Physicians for this condition? _____

Please list any medications you have taken in the past for your condition: _____

_____

_____

Please list any and all symptoms that you have experienced regarding today's issue (Currently or Previously):

_____

_____

_____

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Past Personal/Family Medical History

Please Check the boxes that apply to yourself as well as each member of your family:

	Diabetes	Heart Disease	Stroke	Hight Blood Pressure	Epilepsy/ Seizure	Multiple Sclerosis	Brain Tumor	Brain Aneurysm	Depression
Self									
Mother									
Father									
Brother									
Sister									
Grand-mother									
Grand-father									

	Dementia	Parkinsons Disease	Headaches	Tremors	Cancer	Other Conditions (Please List)
Self						
Mother						
Father						
Brother						
Sister						
Grand-mother						
Grand-father						

Surgical History

Please list any surgical procedures you have had (Please include the year it was performed):

_____

_____

_____

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Pharmacy

Which Pharmacy do you currently use? _____

Medications

Please list any and all medications you are currently taking (Please include all non-prescription medications as well):

Medication Name	Dose (Mg)	Times a day taken

Allergies

Please list any and all medication allergies and their reactions:

Medication Name	Reaction