Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

NEW PATIENT PACKET – PLEASE READ BEFORE SUBMITTING

Email the completed packet and all required documents to:
occhildneuro@gmail.com

BEFORE YOUR CHILD CAN BE SCHEDULED
Your packet must be **complete and all forms signed** before an appointment can be scheduled.

Please include:
☐ **All forms completed and signed**
☐ **Front and back of your child's insurance card**
☐ **Previous evaluations/testing**, including neuropsychological or psychological evaluations, EEGs, MRIs, or other relevant testing. **If these have been performed, the reports must be received before scheduling.**
☐ **Developmental/ADHD evaluations:** Vanderbilt forms completed by **both a parent and a teacher**

Unable to type into the PDF?
You may print the forms, complete them by hand, scan them, and email them to us.

SCHEDULING & WAITLIST
Once all required information has been received, our office will contact you regarding scheduling.
Your child will automatically be added to our cancellation/waitlist, and we will contact you if an earlier appointment becomes available.

IMPORTANT VISIT INFORMATION
• New patient visits are **60 minutes**; follow-up visits are **30 minutes**.
• **All visits are in person.** Telehealth is not available.
• **The patient/child must be present for the entire visit.**
• Please arrive on time. **Late arrivals may result in cancellation.**

PLEASE NOTE: INCOMPLETE PACKETS CANNOT BE SCHEDULED.
Return completed packet to: occhildneuro@gmail.com



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Patient Demographic Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

Today's Date: _____Age: _____ Sex:_____

Child's Legal Guardian(s):_____

Parent/Guardian's Name:_____

Parent/Guardian's Occupation:_____

Parent/Guardian's Cell Phone: (_____) _____ DateofBirth:_____

Parent/Guardian's Email Address: _____

Parent/Guardian's Name:_____

Parent/Guardian's Occupation:_____

Parent/Guardian's Cell Phone: (_____) _____ Date of Birth: _____

Parent/Guardian's Email Address: _____

Patient's Home Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone: (_____) _____

Alternate Home Address:_____

City:_____ State: _____ Zip Code: _____

Child's Primary Care Physician:_____

Physician's Phone Number: (_____) _____

Physician's Fax Number: (_____) _____

Pharmacy Name: _____

Pharmacy Phone Number: (_____) _____

Pharmacy Fax Number: (_____) _____

Who has referred this child: _____

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Parent Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	Date of Birth:

Form Completed By: Mother ☐ Father ☐ Other: _____

Referring Physician: _____

Child Profile

What concerns do you have about your child: (please a brief summary of the main concerns)?
When were the problems first noticed? Have they progressed? How have they been handled so far?

What has your child been told about coming for this evaluation?

Past/Current Treatment History

Please list or describe any chronic medical problems (asthma, diabetes, developmental delays, etc).
Please describe any major illnesses, surgeries, or hospitalizations.

Is your child currently taking any medications (including supplements/vitamins)? No ☐ Yes ☐ If yes, specify:

Does your child have any allergies? No ☐ Yes ☐ If yes, specify:

Are your child's immunizations up to date? Yes ☐ No ☐ If no, please explain:

Has your child had vision and hearing screening performed either by your physician at the school? If yes, please specify when, by whom and results:

Has your child had previous neurological, developmental/behavioral, psychological, or psychiatric evaluations and/or treatment (e.g., medication, counseling, tutoring, speech, physical or occupational therapy, not described above and by whom?

Patient Name:	Date of Birth:

Birth History

Was your child born two or more weeks before the "due date"? No☐ Yes ☐

If yes, how many weeks early was your child born? _____ weeks early

How much did your child weigh at Birth _____

Biological Father's age at birth of your child _____ Biological Mother's age at birth of your child _____

Number of pregnancies prior to this child _____ Number of miscarriages prior to this child _____

Were there any problems during the pregnancy, labor/delivery or following the birth? No ☐ Yes ☐

If yes, please specify:

Was your child born by C-Section? No ☐ Yes ☐

If yes, please specify why:

Were any substances or medication used by the mother during the pregnancy? No☐ Yes☐

If yes, please specify (e.g., prescription medication, alcohol, tobacco, etc.)'

Developmental History:

(Please *write in* age. Ages in *parenthesis* are *approximate normal limits.)*

***Check this box and skip the following history if all milestones were on time*:** ☐

Gross Motor:	***Fine Motor:***
Rolled over (4-5 mos) _____ Sat without support (6-7 mos) _____ Walked alone (12-16 months) _____ Runs (15-18 mos) _____ Catches a ball (3 years) _____ Hops on one foot 2-3 times (4 years) _____	Copies circle (3 years) _____ Copies Square (5 years) _____ Adaptive /Self help: Drinks from a cup (12 – 15 mos) _____ Uses a spoon (15-24 mos) _____ Undresses completely (3 years) _____ Dresses Completely (4 years) _____
Language Development:	***Social/Emotional Development***
Babbles (6 mos) _____ Understands "NO" (9-10 mos) _____ 3-5 word vocabulary (12 mos) _____ Follows 1 step command with gestures (12 mos) _____ Can point to several body parts (16-17 mos) _____ 2-word phrases (24 mos) _____ Follows 2 step command (24 mos) _____ 3 word sentences (3 years) _____	Temperament as a baby (e.g. easy, colicy): Shy with strangers (7-8 mos) _____ Plays cooperatively with peers (4 yrs) _____ Current temperament/mood (e.g. irritable, anxious, happy):

Are there any current problems or concerns with development not mentioned already?

Patient Name:	Date of Birth:

Patient **Review of Systems**

Has your child had any problems mentioned below that you haven't already described?

	Y	N	Explain
Weight loss or gain			
Weakness			
Rash			
Itching			
Light or dark skin color changes			
Changes in hair growth or loss			
Headaches			
Double vision			
Neck stiffness or pain			
Chest pain			
Palpitations			
Fainting/passing out			
Heart murmurs			
Shortness of breath			
Wheezing			
Appetite changes			
Indigestion/reflux			
Nausea, vomiting or diarrhea			
Recent changes in bowel habits			
Change in urinary frequency			
Bed wetting			
Problems with menstruation			
Joint pain, swelling or redness			
Convulsions			
Staring spells			
Tremor			
Incoordination (ataxia, tremor)			
Anxiety / Depression			
Anemia			
Bleeding Tendency			
Previous Blood Transfusions			
Lymph node enlargement or tenderness			

Patient Name:	Date of Birth:

Family **Medical History (*other* than patient)**

Please include all pertinent ***FAMILY history*** for first and second-generation ***FAMILY members***.

	Y	N	***Family*** **Member's relationship to child**
Trouble learning to read			
Trouble with arithmetic			
Trouble with writing			
Attention Deficit/Hyperactivity disorder			
Other school problems			
Speech problems			
Language delay			
Behavior problem in childhood			
History of physical or emotional abuse			
Depression			
Anxiety/Phobia/panic disorders			
Other Mental illness			
Drinking problems			
Drug Abuse			
Seizures			
Mental Retardation			
Autism			
Headaches/Migraines			
Tourette Syndrome			
Neurologic Conditions			
Congenital Anomalies			
Diabetes			
High blood pressure			
Irregular Heartbeat or rhythm			
Heart attack before 40 years old			
Thyroid condition			
Deafness			
Blindness			
Any other disorders in the family			

Patient Name:	Date of Birth:

Social history

Child's School: _____ City: _____

Teacher's Name: _____ Grade: _____

Type of Classroom: Regular ☐ RSP ☐ Special Day Class _____

IEP/504:_____

This child is currently living with:

☐ Biological mother and biological father

☐ Biological mother

☐ Biological father

☐ Adoptive parents. Is your child aware that he/she is adopted? _____

☐ Foster parents

☐ Other (specify) _____

The biological parents of this child are currently:

☐ Married to each other (Years married: ___)

☐ Divorced from each other

☐ Separated from each other

☐ Never married to each other

Please list all people who are currently living in this child's household (name, age, and relationship to child):

Name	Age	Relationship

Other Concerns

Are you concerned about issues not covered in this questionnaire? Please describe:

Thank you for completing this questionnaire. It will be reviewed as a valuable first step in evaluating your child.



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Patient Insurance Information

PLEASE COMPLETE IN BLACK INK

Patient Name:	Date of Birth:

Primary Insurance Carrier:_____

Member ID:_____

Group No:_____Plan Code:_____

Rx BIN:_____Rx PCN:_____

Rx GRP:_____PPO or HMO :_____

Covered Parent/Guardian:_____

Parent/Guardian Date of Birth:_____

Parent/Guardian Social Security Number: _____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Primary Phone: (_____) _____

Secondary Insurance Carrier:_____

Member ID:_____

Group No:_____Plan Code:_____

Rx BIN:_____Rx PCN:_____

Rx GRP:_____PPO or HMO :_____

Covered Parent/Guardian:_____

Parent/Guardian Date of Birth:_____

Parent/Guardian Social Security Number: _____

Address (if different):_____

City: _____ State: _____ Zip Code: _____

Secondary Insurance Policies Insurance companies require we follow the "birthday rule" which states that the primary insurance coverage comes from the plan of the parent whose birthday (month and day) arrives first in the year. The other parent's plan may provide secondary coverage. The birth year is not taken into consideration. Charges calculated based on the Primary Insurance. If your Primary Insurance is Aetna, each appointment will be charged at our Out-of-Network visit rate. We will provide you with a Superbill, for you to submit to both your Primary and Secondary insurance for reimbursement.

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Patient Name:	Date of Birth:

Insurance & Financial Policy 2026

We are dedicated to providing high-quality care and supporting you in understanding your insurance and financial responsibilities. Please read the following policy carefully and sign below to acknowledge your understanding and agreement.

Insurance Plans

Dr. Przeklasa Auth is an *in-network provider* with the following insurance plans:

- Providence/Mission Hospital Allied Physicians HMO
- Hoag HMO
- Cigna PPO
- Anthem Blue Cross PPO
- Blue Shield of California PPO
- United Healthcare/UMR PPO

For all other insurance plans, Dr. Przeklasa Auth is considered *out-of-network*, and you will be responsible for payment of all charges not covered by your plan.

Payments & Billing

- Your insurance company requires us to collect **copayments, coinsurance, and/or deductible amounts** at the time of service.
- After we receive the **Explanation of Benefits (EOB)** from your insurer, any remaining balance will be charged to the credit card we have on file **within 48 hours**.
- Insurance regulations require that these patient responsibilities be collected. Failure to do so may be considered fraud.

Missed Appointments & Late Cancellations

If you are unable to keep your scheduled appointment, please notify us at least **24 hours in advance**. Appointments missed or canceled with less than 24 hours' notice will result in a fee:

- **$500** for new patient visits
- **$200** for follow-up visits

Insurance Updates

If your insurance coverage changes, please notify our office **prior to your next visit** to avoid claim issues and ensure proper billing.

Acknowledgment and Consent

I have read and understand the above Insurance & Financial Policy. I agree to the terms outlined, and I authorize Dr. Przeklasa Auth's office to charge my credit card for any patient-responsible balance after insurance has processed my claim.

Patient Name:	Date of Birth:

Insurance & Financial Policy 2026

Person Financially Responsible:

Name:_____

Cell Phone: (_____) _____

Email Address: _____

Home Address:_____

City: _____ State: _____ Zip Code: _____

Credit Card Authorization (***Visa and Mastercard ONLY***)
Card Type: VISA or MASTERCARD

Name on Card: _____

Card Number: _____

Home Address: _____

Verification Code: _____

Expiration Date: _____

_____

Signature

Date: _____

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Medication Policy

Effective December 1, 2022

Dr. Przeklasa will provide you with enough medication until your next follow-up appointment. Your child will need to be seen in the office for follow-up visits until he or she is stable on the medication. Frequent follow-ups are necessary in the beginning stages to assess for any side effects and to assist with adjusting the medication to find the proper dosage. Once your child is stable on medication, office visits will typically be spaced out to every 4-6 months.

With regard to stimulant medications, they are strictly controlled by the DEA. The original prescription must be sent electronically under controlled procedures in order to be filled. These medications are only written for a 30-day supply without refills.

Any medication refills, changes, or lost prescriptions requested, in between visits, will be subject to a $25 charge.

If your insurance requires a prior authorization for medication, it can take up to seven business days. All prior authorizations are performed on Mondays and Thursdays. Please be sure that your pharmacy sends us the required documentation, we cannot proceed with a prior authorization without the appropriate pharmacy codes.

Thank you for your cooperation.

Patient Name: _____

Parent Name: _____

Date: _____

Parent Signature: _____

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Patient Name:	Date of Birth:

Authorization to Consent to Treatment of a Minor

I, the undersigned parent or legal guardian of:
Child's Name: _____ (a minor),
hereby authorize **Melissa Przeklasa Auth, M.D.**, to evaluate, diagnose, and treat my child as deemed medically necessary during office visits.
This authorization is provided in accordance with **Section 25.8 of the California Civil Code**.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

Administrative Fees

Please review the following office policies regarding non-visit-related services:

- There is a **$30 fee** for completing special forms, writing letters, or providing documentation related to medical conditions or treatments.
- All **prescriptions** are issued **electronically** only, in compliance with federal regulations.

By signing below, I acknowledge and accept these administrative policies.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian

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Patient Name:	Date of Birth:

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Melissa Przeklasa Auth, M.D. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided by Melissa Przeklasa Auth, M.D. describes such uses and disclosures more completely.)

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available in the reception area, and that a copy of any amended Notice of Privacy Practices is also available on this medical practice's website.

Melissa Przeklasa Auth, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Office Manager; 30131 Town Center Drive # 237; Laguna Niguel, CA 92677; (949) 495 - 6100.

With this consent, Melissa Przeklasa Auth, M.D. may call, mail, or email my home or other alternative location (including leaving a message on voicemail) in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Melissa Przeklasa Auth, M.D. may use my PHI for continuity and coordination of my treatment. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Our office may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

Furthermore, with this consent, I acknowledge and authorize the use of AI Scribe technology to document and transcribe my medical visits. I understand that AI Scribe may be utilized to assist in the creation of clinical documentation to enhance accuracy and efficiency in my medical records. I understand that AI Scribe is used as a tool by my healthcare provider and that my PHI will continue to be handled with the highest level of security and confidentiality. I also understand that I may request clarification on how AI Scribe is used and that I have the right to opt out of its use at any time by submitting a written request to the office. While AI Scribe enhances documentation, I acknowledge that the physician remains responsible for reviewing and ensuring the accuracy of all medical records. Additionally, I understand that PHI processed by AI Scribe will be used only for medical documentation purposes and not for any other use.

I have the right to request that Melissa Przeklasa Auth, M.D. restrict how she uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Melissa Przeklasa Auth, M.D. to use and disclose my PHI to carry out TPO, including the use of AI Scribe for documentation purposes.

I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Melissa Przeklasa Auth, M.D. may decline to provide treatment to me.

_____

Signature of Legal Guardian Date

_____

Print Name of Legal Guardian Date

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records.

Note: Special authorization is required to release records related to minors, HIV status, psychiatric/mental health care, and substance use treatment.

I. Authorization to Release Information

I hereby authorize:

Provider/Facility Name: _____

Address: _____

Phone/Fax Number: _____

To release medical information **to/from**:

Melissa Przeklasa Auth, M.D.
30131 Town Center Drive, Suite #237
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612

II. Purpose of Release

This medical information/records will be used for the following purpose(s):

_____

III. Scope of Authorization

Please select one:

- **Unlimited:** All medical records, *excluding* records related to substance use, mental health, or HIV (unless otherwise authorized below).
- **Limited:** Only the following specific medical records:

  _____

Additional Authorizations (Initial next to each that applies):

- Genetic Information __ __
- Drug/Alcohol/Substance Use Treatment __ __
- HIV Diagnosis/Treatment __ __
- Tests for HIV Antibodies ___ _
- Psychiatric/Mental Health Records __ __

IV. Duration of Authorization

This authorization is effective immediately and will remain in effect until:_____
(insert expiration date or event).

V. Restrictions

This information may not be further used or disclosed without an additional signed authorization, unless such disclosure is specifically required or allowed by law.

A photocopy or facsimile of this signed authorization is as valid as the original.

VI. Patient Information

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

VII. Signature

Signature of Patient or Legal Representative:_____

Relationship to Patient (if not self):_____

Date: _____