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: (_____) _____ Date of Birth: _____

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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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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Parent Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	**Date of Birth:**

Form Completed By: Mother: ___ Father: ___ Other: _____

Referring Doctor or Pediatrician:_____

Child Profile

What concerns do you have about your child? *Please a brief summary of the main concerns.*

When did you first notice these issues? Have the concerns changed or progressed over time?

What steps have been taken so far to address them (e.g., evaluations, interventions, strategies at home or school)?

What has your child been told about the reason 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 using any prescription medications, over-the-counter drugs, supplements, or vitamins?

Does your child have any allergies? No: ___ Yes: ___

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

Has your child had vision and hearing screenings performed by a physician or at school?
If yes, please indicate when the screening was done, who performed it, and the 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? Please list all past medications, including doses and duration of use.

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?

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 your child's age when each milestone was reached. ***(Ages in parentheses reflect typical developmental ranges.)***

___**Check box and skip the section below if all developmental milestones were achieved 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 additional concerns about your child's development—physical, cognitive, social, or emotional—that have not already been discussed?

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	Relationship to Patient/Child	Age Diagnosed
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/emotional abuse				
Depression				
Anxiety/Phobia/panic disorders				
Other Mental illness				
Drinking problems				
Drug Abuse				
Seizures				
Mental Retardation/Intellectual Disability				
Autism				
Headaches/Migraines				
Tourette Syndrome/Tic Disorder				
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: _____
Any recent changes in academic performance? _____
Type of Classroom: Regular: ___ RSP: _____ Special Day Class: _____
IEP: _____

Outside interests:

Is your child involved in any sports, music, groups, extracurricular activities?

What does your child do for fun?

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

Do you have any concerns that were not addressed in this questionnaire? If so, 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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Headache Questionnaire

*PLEASE COMPLETE IN **BLACK INK***

Patient Name:	Date of Birth:

Please have your child (age 12+) complete independently if possible; otherwise, fill out together.

Headache History
Age when headaches began: _____
Have your headaches changed over time? ☐ Yes ☐ No
If yes, how? _____

Average number of headaches (past 3 months): ___ per week ___ per month
How long does a typical headache last untreated? Minutes: _____ Hours: _____ Days: _____
Time of day headaches usually start: _____

Do you have more than one type of headache? ☐ Yes ☐ No
If yes, describe: _____
Do you feel a warning before it starts? ☐ Yes ☐ No
If yes, describe: _____

Triggers & Warning Signs
Check all that apply:

☐ Hunger
☐ Dehydration
☐ Menstrual period
☐ Stress
☐ Sleep changes
☐ Certain foods
☐ Weather changes
☐ Exercise
☐ Other: _____

Aura or warning symptoms (check any):

☐ Flashing lights
☐ Blind spots
☐ Blurry vision
☐ Numbness
☐ Weakness
☐ Trouble speaking
☐ Other: _____

Patient Name:	Date of Birth:

Pain Description

Pain type (check all):

___ Throbbing
___ Pressure/squeezing
___ Dull
___ Sharp/stabbing
___ Band-like
___ Other: _____

Location (check all):

___ Behind one eye (___L / ___R)
___ Behind both eyes
___ Forehead/temples
___ Top of head
___ Back of head
___ All over
___ Other: _____

Only on one side? ___ Yes ___ No

Pain rating (0 = no pain, 10 = worst): ___/10

Associated Symptoms

Check all that happen during a headache:

___ Nausea
___ Vomiting
___ Sensitivity to light
___ Sensitivity to sound
___ Sensitivity to smell
___ Worse with movement
___ Other: _____

Medications & Treatments

Current medications (headache-specific):

Medication & Dose	Days per Week	Used Daily or As Needed?
		___ Daily ___ As needed
		___ Daily ___ As needed
		___ Daily ___ As needed

Do these medications work well? ___ Yes ___ No

Any side effects? _____

Other treatments tried (leave blank if never used):

Treatment	Still Using?/Dose	If stopped, why?
Topiramate (Topamax)	___ Yes ___ No	
Amitriptyline / Nortriptyline	___ Yes ___ No	
Cyproheptadine	___ Yes ___ No	
Ibuprofen / Tylenol / Excedrin	___ Yes ___ No	
Imitrex / triptans	___ Yes ___ No	
Supplements	___ Yes ___ No	
Botox / Acupuncture / Other	___ Yes ___ No	

Patient Name:	Date of Birth:

Impact on Daily Life

Situation	Number of Days
Missed full days of school	
Missed part of a school day	
Functioned <50% at school	
Missed other activities (sports, friends)	
Did activity but <50% effort	

Do headaches affect:

___ Family life? If yes: _____

___ Friendships/social life? If yes: _____

___ Things you want to do? If yes: _____

Lifestyle & Sleep

Sleep quality: ___ Very good ___ Good ___ Not good ___ Very poor

If poor, why? _____

Do you snore? ___ Yes ___ No

Bedtime / wake time:

Weekdays: Bed ___ / Wake ___

Weekends: Bed ___ / Wake ___

Meals per day: _____

Days/week you eat breakfast: _____

Cups of water/juice/milk per day: _____

Cups of caffeine per day: _____ (coffee, soda, tea, energy drinks)

Is your child on any special diet? (e.g., gluten-free, ketogenic)

No ___ Yes ___ If yes, specify: _____

Exercise/Sports? ___ Yes ___ No

If yes, what & how often? _____

Hours/day on screens (school + games/devices): _____

Patient Name:	Date of Birth:

Mood & Stress

Stress in life? ___ Yes ___ No

If yes, explain briefly: _____

Over the past 2 weeks, how often have you...

Problem	Not at All	Several Days	> Half the Days	Nearly Every Day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐
Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you're a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or, the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

If any problems above:

How hard has this made life at school/home/socially?

___ Not at all ___ Somewhat ___ Very ___ Extremely

Family History

Do family members have headaches/migraines? ___ Yes ___ No

If yes, who: ___ Mom ___ Dad ___ Sibling ___ Other: _____

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Headache Diary

Patient Name:	Date of Birth:

Date	Time (Start/Finish)	Preceding Symptoms	Intensity (1-10)	Quality of pain	Associated Symptoms	Medication (dosage)	Treatment Response	Triggers

KEY: Preceeding Symptoms: Aura/prodrome of nausea, flashing lights, halos, etc.
Quality of pain: Throbbing, dull ache, sharp/stabbing, etc.
Associated Symptoms: Nausea, vomiting, sound sensitivity, etc.
Treatment Response: Good/fair/poor relief
Triggers: Strong odor, poor sleep, specific food, etc.

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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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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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Medication Policy

Effective 2025

We are committed to the safe and effective treatment of your child. Please review the following guidelines related to prescription medications, stimulant regulations, and insurance authorization procedures.

Medication and Follow-Up Appointments

- Medications will be prescribed in amounts sufficient to last **until your child's next scheduled follow-up appointment**.
- Follow-up visits are required to monitor response, assess side effects, and make any needed adjustments, especially when starting a new medication.
- Frequent visits may be necessary during the initial treatment phase.
- Once your child is **stable on medication**, follow-ups are typically scheduled every **4 to 6 months**.
- All prescriptions are issued **electronically only**, through a secure system.

Stimulant Medications

- Stimulant medications (e.g., for ADHD) are **Schedule II controlled substances** regulated by the **DEA**.
- Stimulants are written for **30-day supplies only** and **do not include refills**. A new prescription must be issued each month.

Prior Authorizations

- If your child's medication requires **insurance prior authorization**, processing may take **up to 7 business days**.
- All prior authorizations are handled on **Mondays and Fridays** only.
- We cannot begin the authorization process until we receive the **required documentation and pharmacy codes** from your pharmacy. Please contact them directly to ensure the necessary information is sent to our office.
- If your insurance denies the prior authorization request, we will proceed with submitting an **appeal** on your behalf. Please note that this process may take **7 to 10 business days**.

If you have any questions about these policies or need help coordinating care with your pharmacy or insurance, please don't hesitate to contact our office. Thank you for your understanding and cooperation.

Patient Name: _____

Parent Name: _____

Parent Signature: _____

Date: _____

Name, address and phone number of your primary pharmacy:

_____

_____

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Patient Name:	Date of Birth:

Patient Consent for Use and Disclosure of Protected Health Information

I consent to the use and disclosure of my protected health information (PHI) by Dr. Melissa Przeklasa Auth, M.D., for the purposes of treatment, payment, and healthcare operations (TPO). These uses are described more fully in the Notice of Privacy Practices, which I acknowledge receiving. A copy is also available in the reception area and on the practice's website.

Communication & Coordination

With this consent, Dr. Przeklasa Auth and her staff may contact me via phone, voicemail, email, or mail regarding appointment reminders, clinical updates (such as lab results), and other communications necessary for my care. My PHI may be shared with healthcare professionals involved in my treatment (e.g., labs, pharmacies, or family members actively involved in my care).

AI Scribe Technology for Clinical Documentation

I understand that Dr. Przeklasa Auth may use AI Scribe technology during my visits to support accurate and efficient clinical documentation.

- AI Scribe may assist in transcribing and summarizing visits, but Dr. Przeklasa Auth remains responsible for reviewing and ensuring the accuracy of all medical records.
- My PHI will be handled with strict confidentiality and used only for documentation purposes.
- I may opt out of AI Scribe at any time by submitting a written request to the office.
- I am welcome to ask questions about how AI Scribe is used.

Privacy Rights & Limitations

- I may request limitations on how my PHI is used or disclosed; while the practice is not required to agree, it will honor any accepted restrictions.
- I may revoke this consent in writing at any time. Revocation will not affect any prior disclosures made in reliance on my consent.
- I understand that refusing or revoking consent may result in the practice declining to provide further treatment.

_____

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: _____