BAY AREA NEUROSCIENCES

George J. Counelis, M.D., FAANS, FACS

Dear Patient:

Please complete the attached paperwork PRIOR to arriving to your appointment. Incomplete paperwork AND/OR arriving late may result in your appointment having to be rescheduled.

We accept Visa, MasterCard, Discover and American Express as a method of payment for your insurance co-payment. This charge is due at the time of service. We do not accept cash or checks. Please note that there will be a charge for each form that has to be completed by the office.

You are responsible for bringing any studies (such as: MRI's, CT's, X-RAYS, CD's, etc.) if you were instructed to do so. Failure to provide your studies during your scheduled visit will cause your appointment to be rescheduled.

Please contact our office if you have any questions.

Thank you,
Bay Area Neurosciences Staff

PLEASE ARRIVE ABOUT 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME WITH COMPLETED PAPERWORK, INSURANCE CARDS AND PICTURE ID.

Telephone: 925-280-8200
Facsimile: 925-280-8201
100 N. Wiget Lane, Suite 160
Walnut Creek, CA 94598
www.bayareaneuro.com

BAYAREA NEUROSCIENCES

PATIENT INFORMATION FORM

Date: _____ **Social Security Number** _____-____-_____

Email Address _____ **Pharmacy**_____

Patient's Name: _____
Last Name **First** **MI**

Date of Birth:_____ ☐**Male** ☐**Female** **Marital Status: S M W D** **Age** _____

Race:_____ **Are you Hispanic? __Yes __No**

Language:_____ **Religion:**_ _____, /or☐ **Declines to specify**

Street Address: _____ **City:**_____

State/zip code:_____ **Home Phone#: (____)** _____-_____

Cell Phone#: (____) _____-_____ **Driver's License#:**_ _____

Patient's Employer: _____ **Work Phone#: (____)** _____-_____

Is this work-related? ☐**Yes** ☐ **No If yes, date of injury:** _____ **Claim#:**_____

Spouse's Name: _____ **SS#** _____ -_____- _____

PATIENT'S INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: _____

Insurance is through: ☐ **Patient** ☐**Spouse** ☐**Parent** ☐ **Other DOB of Insured:**_____

SECONDARY INSURANCE CARRIER: _____

Insurance is through: ☐**Patient** ☐**Spouse** ☐ **Parent** ☐ **Other DOB of Insured:**_____

If Patient Is a Minor, are parents ☐ **Married,** ☐**Divorced? Custodial Parent** _____

Custodial Parent's Home Phone: (____) _____-_____ **Work Phone: (____)**_____-_____
Custodial Parent's SS#: _____-____-_____ **Date of Birth:**_____

PHYSICIAN INFORMATION

Referring Physician's Name:_____ **City:** _____

Primary Care Physician: _____ **City:** _____

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact:_____

Phone #:(____) _____-_____ **Relationship to Patient:**_____

BAYAREA NEUROSCIENCES

PATIENT HISTORY FORM

DATE ____/____/_____ **REFERRING PHYSICIAN**_____

NAME _____ **PRIMARY CARE PHYSICIAN**_____

DOB ____/____/_____ **REASON FOR VISIT** _____

MEDICATIONS		
Please list all current medications (include vitamins)		
Name of Medication	**Dose**	**Frequency**

ALLERGIES	
Please list all drug allergies	
Drug	**Reaction**

PAST MEDICAL HISTORY

Please check whether you have had any of the following conditions

Diabetes	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No
High blood pressure/hypertension	☐ Yes ☐ No	COPD/emphysema	☐ Yes ☐ No
Coronary artery disease	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chronic renal failure	☐ Yes ☐ No	Dementia (e.g. Alzheimer's)	☐ Yes ☐ No
Atrial fibrillation	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
Type _____		Hepatitis C	☐ Yes ☐ No
Type _____		HIV	☐ Yes ☐ No

Others:

PAST SURGICAL HISTORY			
Please list all prior surgeries			
Surgery	**Year**	**Surgery**	**Year**

I, _____am aware that the physicians of this practice are licensed and regulated by the Medical Board of California. I understand that the Medical Board of California can be contacted at (800) 633-2322 or at www.mbc.ca.gov.

_____ _____

Signature **Date**

100 N. Wiget Lane, Suite 160 ● Walnut Creek, CA 94598 ● Telephone (925) 280-8200 ● Facsimile (925) 280-8201

BAYAREA NEUROSCIENCES

NAME _____ **DOB** _____

FAMILY HISTORY			
Please answer the following questions about your family members:			
Father	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Medical problems:		
Mother	☐ Alive ☐ Deceased	Age (or age at death):	Cause of death:
	Please list any significant medical problems:		
Sister	Please list any significant medical problems (if any):		
Brother	Please list any significant medical problems (if any):		
Family h/o	Please list any significant medical problems of other relatives (e.g., grandparents, uncles, aunts, etc.)		
Additional Space for Family History:			

SOCIAL HISTORY		
Drinks Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes how often? Daily - Weekly – Monthly – Socially - Rarely	
	☐ Beer ☐ Wine ☐ Liquor Amount? When was your last drink?	
Tobacco Use	Do you smoke? ☐ Yes ☐ No If yes, how many packs per day?	
	How many years did you smoke?	What year did you quit?
Drug Use	Do you currently use recreational drugs? ☐ Yes ☐ No Have you in the past? ☐ Yes ☐ No	
	Have you ever used intravenous drugs? ☐ Yes ☐ No	
Caffeine Use	If yes, what kind? Please circle: Coffee – Soda – Chocolate – Tea – Other? How many cups? How many sodas?	
Employment	Occupation (past or present):	
Social History	Marital Status, please circle one: Single , Married , Widowed , Divorced Who Lives in your home with you? _____ Do you have children? _____ If so how many _____	
Miscellaneous	Have you ever received a blood transfusion? ☐ Yes ☐ No	

BAYAREA NEUROSCIENCES

NAME _____ **DOB**_____

REVIEW OF SYSTEMS

Please check whether you have any of the following problems, either CURRENTLY OR REPEATEDLY:

Constitutional

Fever	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No

Other: _____

Neurologic/Psychiatric

Numbness	☐ Yes	☐ No
Tingling	☐ Yes	☐ No
Weakness	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Spinal cord injury	☐ Yes	☐ No
Headache	☐ Yes	☐ No

Other: _____

Respiratory

Shortness of breath	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Cough	☐ Yes	☐ No

Other:

_____

Cardiovascular

Chest pain	☐ Yes	☐ No
Irregular pulse	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No
Heart valve problem	☐ Yes	☐ No

Other: _____

Gastrointestinal

Abdominal pain	☐ Yes	☐ No
Nausea/vomiting	☐ Yes	☐ No
Indigestion/heartburn	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

Other: _____

Vascular

Cool Extremity	☐ Yes	☐ No
Pain in limb	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No

Other: _____

HEENT

Runny nose	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No

Other: _____

Metabolic/Endocrine

Excessive thirst	☐ Yes	☐ No
Too hot	☐ Yes	☐ No
Too cold	☐ Yes	☐ No

Other: _____

Immunologic

Hay fever	☐ Yes	☐ No
Food allergies	☐ Yes	☐ No

Other:

_____

Musculoskeletal

Joint pain	☐ Yes	☐ No
Back pain	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No

Other: _____

Hematologic

Easy bruising or bleeding	☐ Yes	☐ No
Blood clots in arms or legs	☐ Yes	☐ No
Anemia	☐ Yes	☐ No

Other: _____

Genitourinary

Back Pain	☐ Yes	☐ No
Cloudy Urine	☐ Yes	☐ No
Nausea		

Other: _____

Dermatologic

Rash	☐ Yes	☐ No
Boils/infections	☐ Yes	☐ No

Other: _____

PATIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT

I, the responsible party, certify that the above information is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges regardless of delays in insurance payment or denial of insurance coverage.

It is my responsibility to understand and have personally verified if my insurance is contracted with this practice and/or the doctor I am seeing.

I hereby authorize Bay Area Neurosciences to apply for benefits and receive payments directly on my behalf for covered services rendered. They may also disclose any or all parts of my clinical record to any insurance company covering services for the purpose of satisfying charges billed.

I further agree to pay all collection costs, attorney fees and any other collection costs that may be incurred in the attempt to collect outstanding patient responsibility amounts.

I also understand, that if any insurance payments are sent directly to me, it is my responsibility to send these monies directly to Bay Area Neurosciences immediately upon receipt.

I, the patient or the patient's representative, understand that all medical doctors at Bay Area Neurosciences are licensed and regulated by the Medical Board of California. I can verify this by contacting the Medical Board at (800) 633-2322 or via the internet at their website: **www.mbc.ca.gov.**

Signature of Patient, Parent or Legal Guardian

Relationship to Patient

Date

ADVANCE NOTICE TO OUT-OF-NETWORK PATIENTS

Welcome to Bay Area Neurosciences. This letter is to inform you that our practice is considered to be an "Out-of-network" provider for UnitedHealthcare, Anthem Blue Cross, Cigna, Aetna and HealthNet. If you wish to continue receiving medical care at our office, our services will be considered "out of network". We would be delighted to provide your care and wish to keep you fully informed about our policies surrounding the out-of-network billing process.

THE COST OF YOUR VISIT
The cost of your visit will be determined by the level of care provided by Dr. George J. Counelis.

We will collect our fee in advance of your appointment and this notice will serve as confirmation of your out-of-pocket fee. Any pre-determined out-of-pocket fee will be due at the time of the visit.

YOUR OUT-OF-POCKET COST
Since each insurance plan has a unique benefits package; we encourage you to contact your carrier to check your out-of-network coverage and current benefits. If your insurance plan offers out-of-network benefits, you may be eligible for reimbursement after you meet any deductible and/or out-of-pocket portions. In order to facilitate any available refunds to you, we will file a medical claim with your insurance company on your behalf.

GETTING A REIMBURSEMENT FROM YOUR INSURANCE COMPANY
Your insurance company *may* mail a reimbursement check directly to you. If our office receives reimbursement from your insurance company for fees you have already paid, we will reimburse you within 90-days of receipt of payment. You may also call your insurance company to ask questions or check the status of our claim(s).

SIGNATURE

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read this form and wish to establish myself as a patient with Bay Area Neurosciences and comply with the aforementioned policy regarding my out-of-network coverage.

The out-of-pocket expense for your visit on _____ is $_____

Signature of Patient or Personal Representative _____

Print Name of Patient or Personal Representative _____

Date _____

You also have the right to receive a copy of this form after you have signed it.
Please request copies from our office.

100 N. Wiget Lane, Suite 160, Walnut Creek CA 94598 • Tel. (925) 280-8200 • Fax (925) 280-8201

HIPAA/NOTICE OF PRIVACY PRACTICES – PAGE 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following' carefully.

The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our *computerized* system. Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record that allows both our physicians and staff and certain of the participating physicians of the Muir Medical Group IPA and their staffs' access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Muir Medical Group IPA systems and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Muir Medical Group IPA system only with the patient's express authorization or as otherwise specifically permitted or required bylaw.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information. * Our office may charge a reasonable fee to cover copying and mailing of these records to you.
- You have the right to request an alternate means or location to receive communications regarding your healthinformation.*
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

HIPAA/NOTICE OF PRIVACY PRACTICES – PAGE 2

We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person design11ted responsible for your care. Please designate who our offices CAN disclose your health Information to by checking the boxes below:

- ☐ OK to Spouse: _____
- ☐ OK to ALL family members: **Please list names of family members:**

  _____
- ☐ OK to Other: _____
- ☐ OK to leave health information on answering machine or voice mail

- ☐ DO NOT RELEASE MY INFORMATION to anyone other than myself (the patient).
- ☐ DO NOT RELEASE TO: _____

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, Lashini Samerawickreme, at (925) 280-8200.

This notice goes into effect as of June 1, 2015

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed:

Signed	**Date**
Print Patient's Name	**Date of Birth**

If the person signing is not patient please provide:

Name:_____
Relationship to Patient:_____