NEW PATIENT REGISTRATION
DATE: ____ / ____ / ____

OMAR B. CABAHUG, M.D., P.C.

Neurology

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	ADDRESS		
SUITE OR APARTMENT#	CITY		STATE	ZIP CODE	SEX
EMPLOYED YES ☐ NO ☐	EMPLOYER/SCHOOL	MOBILE PHONE	HOME PHONE		
EMAIL:			WORK PHONE		
DATE OF BIRTH / /	SOCIAL SECURITY #	MARITUAL STATUS SINGLE ☐ MARRIED ☐ OTHER ☐			
PRIMARY CARE PHYSICAIN:	PCP PHONE #:	REFERRING PHYSICIAN:	PHONE #:		

PRIMARY INSURANCE COMPANY INFORMATION

SUBSCRIBER NAME (INSURED)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH / /
EMPLOYER	ADDRESS	PHONE #	
PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER SS #	GROUP #	
ADDRESS	CITY / STATE / ZIP CODE	PHONE	

SECONDARY INSURANCE COMPANY INFORMATION

SUBSCRIBER NAME (INSURED)	RELATIONSHIP TO PATIENT	SEX	DATE OF BIRTH / /
EMPLOYER	ADDRESS	PHONE #	
PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER SS #	GROUP #	
ADDRESS	CITY / STATE / ZIP CODE	PHONE	

EMERGENCY CONTACT

LAST NAME	FIRST NAME	RELATIONSHIP	PHONE #

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY

RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE

ASSSIGNMENT AND RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESSING OF THIS CLAIM.
I hereby consent to examination, testing, and treatment by the attending physician.

SIGNATURE: DATE:

Omar B. Cabahug, M.D., P.C.
Diplomate of Neurology
Neurology & Neurodiagnostics
2500 Wigwam Parkway Ste. 112 Henderson, Nevada 89074

PATIENT HISTORY SHEET

Reason for visit today _____
_____

Check here if in auto accident _____ Check here if injury or illness is work related _____

Please list all previous surgeries and dates performed _____
_____
_____
_____
_____

Please list all previous and currently known medical illnesses _____
_____
_____
_____
_____

Occupation _____
Allergies _____

Do you smoke? Y / N Date Quit _____ Alcohol Consumption Y / N Drinks per day ____

Please list all current medications with dose and number of times a day taken including non-prescription medicines.

_____
_____
_____
_____
_____
_____
_____
_____

Please list recent physicians & specialists seen

_____
_____

History of Family Illness

_____
_____

SYSTEM REVIEW NAME: _____ DATE: _____

Please circle if you have recently had the following:

GENERAL

Fatigue Overall Weakness Obesity Weight gain/loss loss of appetite fever
Chills sweats insomnia headache loud snoring anemia cancer

EYES, EARS, NOSE, THROAT

Vision problems eye problem hearing loss ringing in ears nose congestion
runny nose Allergies postnasal drip bloody nose sinus pain
Mouth/tongue sore tooth decay Sore throat hoarseness neck lump

HEART VASCULAR

Chest pain high blood pressure short of breath on exertion or lying down swollen ankles
palpations skipped heartbeats dizziness lightheadedness loss of consciousness
Heart murmur leg pain when walking varicose veins phlebitis

LUNGS

Pneumonia asthma chronic bronchitis shortness of breath couth phlegm/sputum wheezing
coughing up blood abnormal chest X-ray previous smoker tuberculosis

DIGESTIVE

Heartburn burping trouble swallowing abnormal pain ulcers nausea
vomiting jaundice hepatitis gall bladder disease diarrhea constipation
Excess gas vomiting blood black or tarry stools rectal bleeding hemorrhoids hernia

GENITO-URINARY

Trouble passing urine stones blood in urine loss of urine control urgency frequency
Decreased sex drive sexually transmitted disease (what kind? _____)

Males: decrease in urine flow erection difficulty penile discharge or lesion
Females: heavy or abnormal menstrual period vaginal discharge dryness breast lump hot flashes
Last period _____ # of pregnancies _____ live births ____ miscarriages or abortions_____

MUSCULO-SKELETAL

Arthritis	joint pain	stiffness	swelling	muscle aches	gout	osteoporosis		
Where?	Shoulder	arm	elbow	wrist	hand	---- right / left		
	Hip	thigh	knee	leg	ankle	foot	---- right / left	
	Neck	mid-back		low back				

NEUROLOGICAL

Stroke weakness of one extremity tingling or burning sensation numbness imbalance while walking
tremor Memory loss seizure vertigo altered speech

PSYCHIATRIC

Depression moodiness poor motivation loss of enjoyment anxiety panic stress

ENDOCRINE

Diabetes diabetic complications frequent thirst & urination hot or cold intolerance
Thyroid problem excess hair growth abnormal hair loss

SKIN rash lesion mole dryness itching psoriasis discoloration nail abnormality

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PATIENT QUESTIONARE

1. Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

_____

_____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name: _____ Phone: _____

Name: _____ Phone: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office sent if other than your home.

_____

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL"

_____ YES _____ NO

5. Please print the telephone number where you want to receive information about your appointments, lab and x-ray results or other health care information if other than your home phone number:

( ) - _____ - _____

****I am fully aware a cell phone is not a secure and private line****

6. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail?

_____ YES _____ NO

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE: _____

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2500 Wigwam Parkway Ste. 112 Henderson, Nevada 89074

PHARMACY INFORMATION:

Pharmacy Name: _____

Pharmacy Address: _____

Cross Streets: _____

Phone: _____

Fax: _____

Omar B. Cabahug, M.D., P.C.
Diplomate of Neurology
Neurology & Neurodiagnostics
2500 Wigwam Parkway Ste. 112 Henderson, Nevada 89074
Phone: 702-914-6994 Fax: 702-914-5880

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby request my medical records be released to Omar B. Cabahug, M.D., P.C., and 2500 Wigwam Parkway, Suite 112, Henderson, NV 89074.

TO: _____

_____

_____

PHONE: _____

FAX: _____

D.O.B.: _____

SS#: _____

DATE: _____

REMARKS: Urgent ____ For Your Review ____ Reply ASAP ___ Please comment _____

_____

_____

_____

_____

SIGNATURE: _____

Omar B. Cabahug, M.D., P.C.
Diplomate of Neurology
Neurology & Neurodiagnostics
2500 Wigwam Parkway Ste. 112 Henderson, Nevada 89074

Effective Date: 1/1/2011

TESTING AND AUTHORIZATION INFORMATION

- Your neurologist has recommended that you obtain testing. Patients reserve the right to decline testing at any time.
- Please be aware that an authorization is not guarantee of payment or coverage.
- All dictations will take 7-10 business days to be processed.
- Authorizations begin once the dictation is processed and depends on the time your insurance company takes to process your information and records. Most insurance takes 72 hours up to 4 weeks to authorize.
- Upon receiving authorizations, orders will be sent to a contracted facility. It is your responsibility to verify that the facility is in network with your insurance company. If you are not sure if the facility we have recommended is within your network, check your provider book or call the phone number on the back of your insurance card.
- If your procedure is denied by your insurance company, we welcome your pursuit in the appeals process directly with your insurance company. **OUR OFFICE DOES NOT PARTICIPATE IN THE PEER TO PEER PROCESS.**
- Once orders are faxed to the radiology facility, **a contracted scheduler from your selected facility will contact you directly,** or if you choose, you may contact the facility at your own convenience. We **do not** schedule any radiology or testing done outside of our office. This is patient's **responsibility.**
- Our office **DOES NOT** obtain prior authorizations or handle billing services rendered in the following areas; including but not limited to: **all lab work, lab services, IVIG, plasmapheresis both inpatient and outpatient, hospital procedures and home health care procedures.**

I have read and agree to the above conditions and terms of the office of Omar B. Cabahug, M.D., P.C.

Printed Name: _____

Signature: _____ **Date:** _____

Omar B. Cabahug, M.D., P.C.
Diplomate of Neurology
Neurology & Neurodiagnostics
2500 Wigwam Parkway Ste. 112 Henderson, Nevada 89074

Effective Date: 1/1/2011

Regarding All Testing, Lab and Radiology Results:

Some of our patients have had questions regarding how they receive their results; we have developed this summary regarding our process for giving patient's results.

Due to HIPAA regulations test results will not be given over the phone. You will receive all test results in our office, at the time of your scheduled follow-up appointment.

ALL results, including lab work, radiology (X-rays, CT's, MRI's etc.), and all other testing, are given to the patient in person at their **follow-up visit.** We believe that it is imperative for every patient to understand the results for their test and the recommended treatments or follow-up. Many times it is also necessary to prescribe and educate regarding medications and orders to further or continued treatment. We believe that this happens most efficiently and with the most accuracy in person.

We do not give results or physician interpretation of results over the phone, fax, email or by mail. The patient is always welcome to receive a copy of the test results, without interpretation, if requested and in-person. Physician interpretation, future orders, or guidance will **only be given** at an appointment with the physician.

The only exceptions to this are STAT tests, done the same day. It is the patient's responsibility to call us by the end of the day or the next morning for results of STAT testing.

Please understand that this policy applies to all patients.

Thank You,

Dr. Omar Cabahug and Staff

I have read and agree to all of the above conditions and terms of the office of Omar B. Cabahug, M.D., P.C.

Printed Name: _____

Signature: _____ **Date:** _____

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NOTICE OF OFFICE POLICIES

Please initial:

APPOINTMENT TIMELINESS AND CANCELLATION:

Please be prompt for appointments. If you are **15 minutes late,** we will have to reschedule your appointment. **NO EXCEPTIONS.** You may also have an extended waiting period that cannot be anticipated in advance. We require a **24 hour advanced cancellation notice.** If you **fail to show up or fail to cancel your appointment within 24 hours a no call/no show fee of $75.00 will be charged to your account. NO EXCEPTIONS.** We reserve the right to refuse service to any new patient missing an initial appointment to establish care.

BILLING:

We bill for doctor's services and on site testing only. **Any fees for lab work, outside testing and other outside services are billed separately by the testing facility.** If your insurance company does not pay within 60 days, we reserve the right to begin billing you directly. All accounts will be considered delinquent after 90 days. Delinquent accounts will be replaced with a collection agency. Any and all accounts placed with a collection agency will be subject to all reasonable collect and court costs.

FINANCIAL RESPONSIBILITIES:

All payments, including co-payments, co-insurance, deductibles and deposits are due **before** services are rendered. Your insurance card must be presented at every visit. If your insurance plan changes or is terminated, you must notice the office **immediately**. If you fail to do this, you are financially responsible for any and all services that are rendered. We accept checks, cash, Master card and Visa. All returned checks will incur an additional processing fee of **$25.00** each. If this occurs your check will no longer be accepted. If your account is sent to collections, you will be responsible for any fees incurred to collect the outstanding balance.

INSURANCE INFORMATION:

Your insurance policy is a contract between you and your insurance company. Our relationship is with you, and you are ultimately responsible for services provided, regardless of your insurance. Not all services are covered by your insurance company. It is your responsibility to know what is covered and what is not. Fees for non-covered services are due at the time that the services are rendered. Though we will help you to the best of our ability, you are responsible for any communication with your insurance.

NARCOTICS AND CONTROLLED SUBSTANCES:

Due to recent DEA regulations, patients should be receiving narcotic prescriptions from one physician only. Any patient who needs ongoing narcotic prescriptions will be referred to a Pain Management Specialist for those prescriptions and further pain management. Controlled substances will not be continuously refilled. *

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NOTICE OF OFFICE POLICIES

Please initial:

____ **PATIENT COMMUNICATION:**

Our Doctor believes in spending adequate time with each patient at their office visits. Due to these time constraints, our doctor does not routinely return patient phone calls personally. Any medical questions or messages should be left with our medical assistant, who will communicate with our doctor or ordering provider after clinic hours. The medical assistant will then contact you with the physician's directions. You may also have an extended waiting period that cannot be anticipated in advance due to the volume of calls received and patient's seen.

PLEASE BE ADVISED, IF YOU ARE EXPERIENCING AN EMERGENT OR LIFE THREATENING SITUATION, PLEASE SEEK THE ER AND/OR CALL 911 FOR IMMEDIATE CARE.

Please be advised all calls left after hours, on weekends, or holidays will be returned the next office business day. Please try to call on our normal business hours Monday-Friday 8:30 a.m. – 5:30 p.m.

I have read and agree to all of the above conditions and terms of the office of Omar B. Cabahug, M.D., P.C.

Printed Name: _____

Signature: _____ **Date:** _____

*

Omar B. Cabahug, M.D., P.C.
Diplomate of Neurology
Neurology & Neurodiagnostics
2500 Wigwam Parkway Ste. 112 Henderson, Nevada 89074

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Dear Patient,

Thank you for choosing Omar B. Cabahug, M.D., P.C. as your health care provider. We appreciate the opportunity to assist you with your medical needs.

1. Insured patients- co-payments, deductible and/or 20% of charges are **DUE AT THE TIME SERVICES ARE RENDERED.**

2. Cash patients - payment for services are **DUE AT THE TIME SERVICES ARE RENDERED.**

WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD ONLY

• *PLEASE BE ADVISED THAT AS OF JUNE 1st 2014, THERE WILL BE AN ADDITIONAL FEE OF 2% CHARGE ON ALL CREDIT CARD TRANSACTIONS.*

3. We will bill your secondary insurance as a courtesy to you, but we will only bill them **one time.**

4. If your insurance company does not pay your claim within 30 days, we ask that you contact your insurance company. If your insurance company does not pay in full within 60 days, you will be responsible to pay the balance. Not all services are covered by your insurance; some insurance select certain services that they do not cover. You are responsible for knowing what is not covered by your insurance. Payment for these services due when treatment is given.

5. **It is your responsibility to verify that the doctor you are seeing is a provider for your insurance!**

6. You are responsible for any and all collections fees, legal fees and court costs associated with efforts to collect payment on your account.

*

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FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

7. **A returned check will be subject to a $25.00 return check fee. NO EXCEPTIONS.**

8. All letters, forms, or other paperwork (i.e. DMV, FMLA, ADA, LTD, etc.) requiring the physician's or ordering provider's signature will have a minimum charge of **$15.00 - $35.00**. Please be advised that all charges are subject to be more than the minimum fee depending on the type or complexity of paperwork requested. All documents must be submitted to our office require a minimum of **two weeks** in advance **prior to due date.** This **does not** include weekends or holidays.

9. All medical record requests will take a minimum of **48-72 hours** to be processed. This excludes weekends and holidays. **NO EXCEPTIONS.** There will be a charge of **$0.60 cents per page, payable in advance** at the time of your request. You must request the records in person and be the person picking up the documents. This is to ensure your privacy.

10. All prescription refill request will take a minimum of **48-72 hours** to be processed. This excludes weekends and holidays. **NO EXCEPTIONS.** It is **patient's responsibility** to ensure that your medication does not run out before a refill has been secured. When a refill is needed, the preferred method is to contact your pharmacy and have them send a refill request to our office. The medical assistant, doctor, and/or ordering provider are the only people that can issue your refill request.

11. Due to the fact that we have limited space and cannot store your films/CDs. We ask that once the doctor has reviewed your films/CDs at your appointment, you take them home. Any films left at our office past the current calendar year in which they were taken, will be viewed as abandoned property and destroyed.

I have read and agree to all of the above conditions and terms of the office of Omar B. Cabahug, M.D., P.C.

Printed Name: _____

Signature: _____ **Date:** _____

NAME: _____ **DOB:** _____ **DATE:** _____

INFORMED CONSENT FOR CONTROLLED SUBSTANCE TREATMENT FOR PAIN

* *This form is from the state of Nevada and it is required to be signed off. If the following does not apply to you, please input* ***N/A*** ***(not applicable)*** *with your initial.*

(Please initial each numbered paragraph and sign below to indicate your understanding of all parts of this document.)

Nevada law requires a patient's informed consent before a controlled substance can be initially prescribed to treat the patient's pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substance carries with it some additional responsibilities which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.

POTENTIAL RISKS AND BENEFITS OF USING A CONTROLLED SUBSTANCE FOR THE TREATMENT OF PAIN INCLUDING RISKS OF DEPENDENCY, ADDICTION AND OVERDOSE

_____ I understand there are potential risks and benefits associated with the use of controlled substances for the treatment of pain, and I understand these risks and benefits regarding the medication that I am being prescribed. I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing.

_____ Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises. I understand that I may become physically dependent to these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety and sleep disruption.

_____ I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana), this risk is increased.

_____ My practitioner has discussed with me a form of the controlled substance, if available, that is designed to deter abuse, along with the risk and benefits of using that form of controlled substance.

PROPER USE OF THE CONTROLLED SUBSTANCE

_____ My practitioner has discussed how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

TREATMENT PLAN AND REFILLS

_____ I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. A main goal of treatment is to use the minimum amount of controlled substance to increase function rather than remove all pain.

_____ I understand my practitioner's protocol for addressing any request for refills.

_____ I understand than my medication is my responsibility and if it lost or stolen, the medication may not be replaced until my next appointment, at the judgment of my prescriber.

FOR WOMEN IN THE AGES BETWEEN 15 and 45

_____ It is my responsibility to tell my practitioner if I am, or have reason to believe that I am pregnant, or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency of the controlled substance and neonatal abstinence syndrome (withdrawal).

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I provide consent for the prescription of controlled substances for the treatment.

_____	_____	_____
Patient's name printed	**Patient's signature**	**Date**

For a legal guardian:

_____	_____	_____
Patient's Guardian printed	**Patient's Guardian signature**	**Date**

PRESCRIPTION MEDICATION AGREEMENT

Nevada law requires a patient to enter into a "Prescription Medication Agreement" if a controlled substance is to be continued for more than 30 days for treatment of pain. I understand that this agreement will be updated every 365 days, or if there is a change to my treatment plan. I understand that attempting to reduce my pain in my responsibility and that treatment of pain with controlled substances carries with it some additional responsibilities of which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law
(***Please initial each numbered paragraph and sign below to indicate your understanding of all parts of this document.***)

Regarding my treatment plan and the goals of my treatment of my pain, including the appropriate use of a controlled substance.

_____ I understand that part of my goals of my pain management therapy may be to minimize or even to discontinue the use of controlled substances. There may be various reasons that my practitioner will recommend taper or discontinuation of a controlled substance. Some of these reasons may include, but are not limited to: a reduction of pain symptoms by other means; the presence or development of side effects; any signs of misuse, abuse, diversion, or addition; refusal to comply with diagnostic studies or other aspects of the treatment plan; attempts to obtain medication from other providers; use of illicit drugs or other medications that may interact with the controlled substance; or any other reason that my practitioner may deem it in my best interest to reduce or discontinue the controlled substance.

_____ I agree to inform my practitioner of any other controlled substance prescribed to me or taken by me.

_____ I will immediately disclose to my practitioner of any alcohol consumed by me and of any marijuana products, including cannabinoids, I may use or consume while taking the controlled substance for the treatment of my pain.

_____ I understand how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

_____ **I hereby authorize my practitioner to obtain records from other practitioners or clinics, and speak to other practitioners about my current or prior medical care.**

_____ It is my responsibility to provide the office or clinic with my current and updated contact information in order to facilitate communication.

_____ I authorize my practitioner and my pharmacy to cooperate fully with any city, state, or federal law enforcement agencies investigation, including, but not limited to Drug Enforcement Administration, State Board of Pharmacy, or State Occupational Licensing Boards.

I understand that if I violate any part of this agreement, I may be denied prescriptions for controlled substances and I may be discharged from the clinic.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I agree, to abide by the rules of this Prescription Medication Agreement while continuing to receive prescriptions of controlled substances for treatment.

_____	_____	_____
Patient's name printed	**Patient's signature**	**Date**

For a legal guardian:

_____	_____	_____
Patient's Guardian printed	**Patient's Guardian signature**	**Date**