PREMIER NEUROLOGY INSTITUTE

Dr. Naveed Vehra

Dr. Ming-Jai Liu

Patient Information

Patient Date of Birth	Gender:

Name:
Address:
City, State, Zip:
Home Phone:
Mobile Phone:
Work Phone:
Email:
Pharmacy/Address:

Emergency Contact Information

Name:
Relationship to you:
Phone:
Mobile Phone:

Employment Information

Occupation:
Employer Name:
Address:
City, State, Zip:
Phone:

Authorization to release medical information to Family, Caretaker or Other:

I _____ patient or POA give PNI consent to provide the following individual(s) HPI to the following individuals:

1. Full Name: _____, Relationship _____
2. Full Name: _____, Relationship _____
3. Full Name: _____, Relationship _____

This authorization expires one-year from the noted signature date below.

Patient or POA signature: **Date:**

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Primary Physician & Referral Information

Primary Physician:
Address, City, State, Zip:
Phone:
Referring Physician:
Address, City, State, Zip:
Phone:

Primary Insurance Information

Primary Insurance Name:
Claims Address:
City, State, Zip:
Phone:
Policy Number:
Group Name:
Policy Holder Name:
Policy Holder Address:

Secondary Insurance Information

Secondary Insurance Name:
Claims Address:
City, State, Zip:
Phone:
Policy Number:
Group Name:
Policy Holder Name:
Policy Holder Address:

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Medical History

Please check major diseases you have had. Please list any others not listed

	Diabetes		Cancer
	Heart Disease		Lung Disease
	Kidney Disease		Blood Disease
	Stroke		High Blood Pressure
	Other		Thyroid Disease
	Please explain any checked above:		Gastro

Please check any of the following symptoms you have had over the last few months

	CONSTITUTIONAL		NEUROLOGICAL		MUSCULOSKELETAL
	fatigue		difficulty concentrating		joint pain
	fever		speech difficulties		recent neck injury
	loss of appetite		seizures		joint swelling
	EYES		blackout spells		muscle cramps
	eye pain		tremors		additional symptoms
	double vision		incoordination		ENDOCRINE
	blurred vision		loss of balance		polyuria
	scotoma		tingling or numbness		weight gain
	sudden visual loss		falls		weight loss
	transient visual loss		head injuries		PYSCHIATRIC
	HEENT		daytime hypersomnolence		anxiety
	headaches		arm pain		delusions
	vertigo		seizures		depression
	loss of hearing		stroke		suicidal ideation
	additional symptoms		additional symptoms		hallucinations
	tinnitus		difficulty with fine motor skills		HEMI-LYMPH
	additional symptoms		arm weakness		easy bleeding
	CARDIOVASCULAR		hand weakness		easy bruising
	chest pain		leg weakness		blood transfusions
	irregular heartbeat		slowness of movements		INTEGUMENT
	syncope		unusual movements		rash
	postural light headedness		tics		itching
	additional symptoms		restless legs at night		pigmentation changes
	RESPIRATORY		difficulty sleeping		additional symptoms
	shortness of breath		loud snoring		GASTROINTESTINAL
	wheezing		memory loss		reflux
	cough		leg pain		blood in stools
	hoarseness		gait difficulties		diarrhea
	asthma		dizziness		

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Personal Medical History Continued

Smoker? (yes / no) if so, amount & frequency	Do you drink caffeine? (yes / no) If so, amount & frequency	Weight/Height
Do you drink alcohol? (yes / no) If yes, amount & frequency		

Do you have a *Pacemaker*? Y N

Do you have a *Defibrillator*? Y N

Other (*loop recorder, Stents, Shunts, etc.*) Y N

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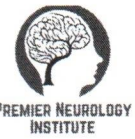

List all medications you are currently taking

Drug Name	Dosage	Times/Day
Recreational drug use. What and how much?		

Please list any surgeries you have had
Please list all known allergies

- ALL copayment and account balances are due at the time services are rendered. We accept cash, check, Visa or MasterCard.
- Inform the front office receptionist of any change in demographics or insurance. Failure to do so may lead to an account balance.
- If you have an insurance plan that requires a paper referral or authorization number, it is your responsibility to make sure the referral has been completed by your primary care physician and is in our office for your scheduled appointment time.
- If we do not have a referral or authorization number, your appointment will be rescheduled.

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- Please allow at least 24-hour notice when canceling or rescheduling an appointment, sowe may use that appointment time for another patient.

- Please allow 24-48 hours for your prescription to be refilled. WE WILL NOT REFILL MEDICATIONS OVER THE WEEKEND.

- For Test Results, please contact our office 4-5 days after your procedures.

- Please allow 14 working days for your tests or procedures to be scheduled. (MRI, bone scan, physical therapy, etc.). Either our office or the contracted facility will contact you to schedule an appointment. Please contact our office (602) 649-1555 if you do have not been contacted after 14 days to schedule your test/procedures.

Signature	Date

Cancellation Policy - I understand and agree to the following:

It is my responsibility to notify: The Premier Neurology Inst. (602-649-1555) 24 hours prior to the scheduled appointment if I am unable to keep the schedule appointment.

I agree that I will be billed an amount of $35.00 in the event that I miss an appointment or fail to cancel 24 hours prior to the scheduled appointment. This amount will not be submitted to my insurance.

Signature	Date

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I_____have read a copy of the Premier Neurology Institute notice of patient privacy practices.

Signature	Date

IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN A REFERRAL IF REQUIRED BY YOUR INSURANCE.

I UNDERSTAND THAT I AM FINANCIALLY RESPOINSIBLE FOR ANY CO-PAYMENTS, DEDUCTIBLES, COINSURANCE AND ALL CHARGES WHICH ARE NOT COVERED BY MY INSURANCE. I UNDERSTAND THAT VERIFICATION OF COVERAGE IS NOT A GUARANTEE OF PAYMENT OF BENEFITS, INSURANCE BENEFIT PAYMENT IS DETERMINED BY YOUR INSURANCE COMPANY WHEN THE CLAIM IS RECEIVED. I UNDERSTAND I WILL BE RESPONSIBLE FOR THE PORTION NOT COVERED BY MY INSURANCE.

I UNDERSTAND THAT THE PHYSICIAN DOES NOT ACCEPT LIENS.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES IF IT IS DETERMINED THAT THE INSURANCE INFORMATION, I HAVE PROVIDED IS NOT CORRECT AND THAT IT IS MY RESPOINSIBILITY TO NOTIFY THE PHYSICIAN IF THERE ARE ANY CHANGES IN MY INSURANCE WHATSOEVER.

DUE TO A LARGE AMOUNT OF INSURANCE PLANS MTD POLICIES, *IT IS IMPOSSIBLE FOR THE PHYSICIAN AND STAFF TO KNOW WHAT SERVICES ARE/OR ARE NOT COVERED.* **IT IS THE PATIENT'S RESPONSIBILITY TO BE AWARE OF THE SERVICES COVERED BY YOUR HEALTH PLAN.**

I UNDERSTAND THAT DELIQUENT ACCOUNTS WILL BE TURNED OVER TO AN ATTONEY OR COLLECITON AGENCY WITHOUT NOTICE. IN THE EVENT MY ACCOUNT IS TURNED OVER FOR COLLECITONS, I AM RESPONSIBLE FOR ALL REASONABLE COLLECTIONS, COURT AND ATTORNEY COSTS AT THE TIME THE ACCOUNT IS CONSIDERED DELINQUENT. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO THE DOCTOR. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MY CLAIM.

Signature	Date

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PREMIER NEUROLOGY INSTITUTE

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AUTHORIZATION TO RELEASE MEDICAL RECORDS TO PNI

Patient Name	Date of Birth
Previous Name	Social Security Number OR MR#

I request and authorize: _____
to release healthcare information of the patient named above to:

Name: Premier Neurology Institute
Address: 18275 N 59th Ave, Bldg. H146
City, State, Zip: Glendale, Az., 85308

This request and authorization apply to: (please list)

ALL MEDICAL RECORDS/INFORMATION PERTAINING MY HEALTH CARE

(yes / no)	
	Authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.
	I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Definitions: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simples, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereous, HIV (Human Immunodeficiency Virus), AIDS (acquired immunodeficiency syndrome), and gonorrhea.

This authorization expires 365 days after it is signed.

Signature	Date

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Today's Date:________________

Patient Name:________________________________ **Phone Number:**________________

☐ MALE FEMALE | **Primary Insurance:** ________________ **ID:** ________________

Date of Birth: ___/___/___ (MM DD YY) **Have you had a VSAT Test in the past(circle answer):** ☐YES ☐NO

SECTION 1

- ☐ Are you pregnant?
- ☐ Do you have a pacemaker or defibrillator?
- ☐ Do you have a pain or insulin pump?
- ☐ Do you have any electrical or metal implants or sensors of any kind?

SECTION 2 - *Have you ever been diagnosed with any of the following cardiovascular disease or symptoms?*

- ☐ Peripheral Vascular Disease (circulation disorders in blood vessels)?
- ☐ Do you have or have you had chronic ulcer(s)? (Stage II, III, or IV)
- ☐ Raynaud's Syndrome (discoloration of fingers and/or toes when exposed to changes in temperature, cold or hot or emotional event)?
- ☐ Do you have hypertension (high blood pressure)?
- ☐ Do you often experience abdominal pain?
- ☐ Do you have or have you had gangrene?
- ☐ Embolism of the upper limb/limbs (artery obstruction in thearms)?
- ☐ Beurger's disease (inflammation or clotting in blood vessels in hands or feet)?

SECTION 3 - *Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?*

- ☐ Multiple Sclerosis?
- ☐ Pain in your arms or legs?
- ☐ Pain in your neck often (Cevicalgia)?
- ☐ Hypotension (very low bloodpressure)?
- ☐ Hands and feet get cold easily?
- ☐ E.S.R.D. (End stage renal disease)?
- ☐ Dizzy and/or light headed when you standup?
- ☐ Bell's Palsy?
- ☐ Carpal Tunnel (chronic pain, numbness, or tingling in the hand)?
- ☐ Pain in your lower back (Lumbago)?
- ☐ Pain in your upper back (Thoracic Pain)?
- ☐ Rapid Heart Rate (Tachycardia)?
- ☐ Tingling or numbness in hands, arms, legs, orfeet?
- ☐ Often experience a lack of coordination whenactive (Ataxia)?

SECTION 4 - *Personal and Family History*

- ☐ Do you have a history of CVA or TIA (stroke or mini-stroke)?
- ☐ Has anyone in your immediate family (blood relatives) been diagnosed with cardiovasculardisease (CVD), or have you had a heart attack?
- ☐ Do you have diabetes?
- ☐ Has anyone in your immediate family (blood relatives) passed away from Sudden CardiacDeath Syndrome (SCD)?
- ☐ Do you smoke or have you ever smoked?
- ☐ Do you have high cholesterol?

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimizes your quality of care through access to your healthcare data, as part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines.

Patient Signature	Provider Signature	
FOR OFFICE USE ONLY	Continuous BP (XXX/XX mmHg) BP1:	BP2: BP3:

*****Once Completed Email to: angelica@medscopelabs.com*****