Adult & Child Neurology

Medical Associates, Inc.

Mary Kay Dyes, M.D. • Thanh Le, M.D. • Nicole Cobo, MD • Jasmin Dao, M.D., Ph.D
Karissa Poppell, PA-C

New Patient Demographics

Today's Date: _____

PATIENT INFORMATION

Last Name: _____First Name: _____MI: _____

Date of Birth: _____ Age: _____ Sex: M / F SSN: _____

Address:_____City:_____

State: _____Zip: _____Home: _____ Cell:_____

Work: _____ Marital Status: _____

If married, spouse's name & birthdate: _____

MOTHER: _____**FATHER:** _____ (If applicable)

Home: _____ Home: _____

Work: _____ Work: _____

Cell: _____ Cell: _____

Email: _____ Email: _____

Referring/Primary Care MD: _____**MD Phone**: _____

MD Address: _____

EMERGENCY CONTACT (other than parents)

Name: _____Phone: _____Relationship: _____

PRIMARY INSURANCE: Subscriber's Name: _____ ☐ Same as patient ☐ Spouse ☐ Parent ☐

Other Subscriber's Date of Birth: _____Subscriber's Social Sec. #: _____

Subscriber's Address: _____

Insurance Name: _____IPA: _____

Policy ID#: _____Policy Group #: _____

Employer: _____Employer Phone: _____

Employer Address: _____

SECONDARY INSURANCE and/or OTHER PARENT

Subscriber's Name: _____ [ ] Same as patient [ ] Spouse [ ] Parent [ ]

Other Subscriber's Date of Birth: _____Subscriber's Social Sec. #: _____

Subscriber's Address: _____

Insurance Name: _____ IPA: _____

Policy ID#: _____ Policy Group #: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

A COPY OF YOUR INSURANCE CARD AND CO-PAY IS REQUIRED AT THE TIME OF EVERY VISIT

ADULT & CHILD NEUROLOGY MEDICAL ASSOCIATES, INC

1.Consent for Medical Treatment: I do voluntarily consent to such care encompassing diagnostic (including encephalogram studies) and therapeutic procedures, medical photography and videography, and medical treatment, as may be ordered by my physician his/her assistants or designees, as is necessary in his/her judgment.
Initials: _____

2. Authorization to Release Information: I agree that my physician and staff may give out written or verbal information concerning my hospital records, to any insurance carrier or agent is authorized to, have access to, and to make copies of my medical records.
Initials: _____

3. Authorization to Pay Insurance Benefits: I hereby assign all benefits due me by my insurance carrier to be paid directly to Adult & Child Neurology Medical Associates, Inc. I understand that if I do not pay my co-pay at the time of the visit, I will not be seen.
Initials: _____

4. Non-Cancelled Appointments: I understand that when I make an appointment and do not call within 24 hours to cancel, another patient could have that appointment time and I will be charged $25.00.
Initials: _____

5. Financial Agreement: I hereby agree to pay all statements not covered by insurance for services rendered by the physician and medical staff at the end of the medical service. Any balance not paid within 30 days of receipt of the statement will be considered in default unless financial arrangements have been made with MedX Billing, our billing service.
Initials: _____

6. Special Letters / Forms: I understand that if I request a letter or form describing any medical conditions and/or treatments, I will be charged a fee for this service.
Initials: _____

Consent for Purpose of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my protected health information by **Adult and Child Neurology Medical Associates. Inc.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations **of Adult and Child Neurology Medical Associates, Inc.** I understand that diagnosis or treatment of me by Mary Kay Dyes, M.D. Thanh Le, M.D., Nicole Cobo, M.D., Jasmin Dao M.D., Ph.D., and/or Karissa Poppell, PA-C, may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry our treatment, payment or health care operations of the practice; however, **Adult and Child Neurology Medical Associates, Inc.** is not required to agree to restrictions that I may request. However, if Adult and Child Neurology Medical Associates, Inc. agrees to a restriction that I request, the restriction is binding on Adult and Child Neurology Medical Associates, Inc. and Mary Kay Dyes, M.D. Thanh Le, M.D Nicole Cobo, M.D., Jasmin Dao M.D.,Ph.D. and Karissa Poppell, PA-C.

I have the right to revoke this consent, in writing, at any time, except to the extent Mary Kay Dyes, M.D. Thanh Le, M.D Nicole Cobo, M.D., Jasmin Dao M.D., Ph.D. and Karissa Poppell, PA-C. and **Adult and Child Neurology Medical Associates, Inc.** have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Adult and Child Neurology Medical Associates, Inc.'s** Notice of Privacy Practices prior to signing this document. The **Adult and Child Neurology Medical Associates, Inc.'s** Notice of Privacy Practices has been provided to me. This Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Adult and Child Neurology Medical Associates, Inc.** The Notice of Privacy Practices for **Adult and Child Neurology Medical Associates, Inc**. is available at 2880 Atlantic Avenue. Suite 260. Long Beach. CA. 90806. This Notice of Privacy Practices also describes my rights and **the Adult and Child Neurology Medical Associates, Inc.'s** duties with respect to my protected health information.

Adult and Child Neurology Medical Associates, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Piracy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The undersigned certifies that he/she has read the foregoing, receiving a copy if requested thereof, and is the patient or duly authorized by patient as patient's general agent to execute the above and accept its terms.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Relationship of Personal Representative of Patient