2020 Wellness Way
Suite #300, Las Vegas,
NV 89106
Phone: 702.432.2233
Fax: 702.800.5456

LAS VEGAS NEUROLOGY CENTER

Dr. Paul H. Janda, D.O., J.D.
Residency Program Director
Dr. Robert W. Balsiger, D.O.
Dr. Jay P. Mahajan, D.O.
Dr. Simon Farrow, M.D.
Dr. Malihe Rivaz, M.D.
Dr. Aroucha Vickers, D.O.
Dr. Denise Tabelle, PhD.
Jennifer Walsh, APRN
Evita Tan, APRN

DEMOGRAPHICS

First Name: _____ Last Name: _____ MI: ___ Date of Birth: _____

Sex: Male ☐ Female ☐ Social Security Number: _____ _____ _____

Race: ☐ African American/Black
☐ American Indian/Alaskan Native
☐ Asian
☐ Caucasian/White
☐ Hawaiian Native/Pacific Islander
☐ Declined
☐ Other Race
☐ Unknown

Ethnicity: Hispanic/Latino ☐ Not Hispanic or Latino ☐ Declined ☐

Primary Language: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Widowed ☐

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ Cell Phone: (___) _____ Work Phone: (___) _____

Email: _____ Employed: _____

Employer: _____ Position Held: _____

Status: Full-time ☐ Part-time ☐ Retired ☐ Leave of Absence ☐ Unemployed ☐

Emergency Contact: _____ Relationship: _____ Phone: (___) _____

Were you referred to our office by a doctor? Yes ☐ No ☐ If so, who? _____

INSURANCE

Insurance: _____ ID #: _____ Group #: _____

HMO ☐ PPO ☐ POS ☐ Guarantor of insurance: Self ☐ Spouse ☐ Parent ☐ Other : _____

If insurance is through someone other than yourself, please list their name and date of birth:

_____ _____

**All HMO insurances require a referral from your primary care physician for your insurance to cover your services. If you do not have a referral, please let our office know so that we can contact your primary care physician.*

Secondary Insurance: _____ ID #: _____ Group #: _____

HMO ☐ PPO ☐ POS ☐ Guarantor of insurance: Self ☐ Spouse ☐ Parent ☐ Other : _____

If insurance is through someone other than yourself, list their name and date of birth:

_____ _____

Do you have an attorney or Worker's Compensation case currently open? If so, whom with?

_____

PRIMARY CARE DOCTOR & PHARMACY

Primary Care Doctor Name: _____ Phone: (___) _____

Pharmacy Name: _____ Phone: (___) _____

Address or major cross streets: _____

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POWER OF ATTORNEY

Are you able to provide medical care and make medical decisions for yourself? Yes ☐ No ☐

If no, who is and/or is there a Power of Attorney(P.O.A.)? _____

If there is a P.O.A., we will require a copy of the signed court documents stating such. Would you like P.O.A. information? Yes ☐ No ☐

FEE SCHEDULE

No show follow up appointments: $50.00

No show testing appointments: $100.00

Returned check fee: $25.00

Family Medical Leave forms: $25.00

Physician statement of medical treatment: $25.00

Detailed letters that require multiple pages: $25.00

Disability packages: $50.00

CONSENT TO MEDICAL CARE AND TREATMENT

I am being treated at Las Vegas Neurology Center, and I consent to all medical and surgical care, examinations and tests determined by my Physician that are necessary for me. Though I expect the care given will meet customary standards, I understand there are no guarantees concerning the results of my care. I also understand that if I do not follow my Physician's recommendations as they may relate to my health that the Physician and this Office will not be responsible for any injuries or damages that are the result of my non-compliance. I understand that if an employee or any individual associated with Physician Office is exposed to my blood or body fluids, I will be tested for the hepatitis viruses and the Human Immunodeficiency Virus (HIV). I also understand that I will receive education related to this testing and that I will not be charged for testing and education related to the exposure.

CONSENT TO HAVE PRESCRIPTIONS SENT ELECTRONICALLY

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Benefits data are maintained by Pharmacy Benefits Managers (PBM). By signing this consent form you are agreeing that Las Vegas Neurology Center can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

CONSENT TO BILL

Your signature below acknowledges that attached is a copy of the patient consent to the use and disclosure of Health Information for treatment, payment, or health operations in accordance with HIPAA. The information supplied on this form is complete and correct. I authorize the release of information necessary to file a claim with my insurance and assign benefits to Las Vegas Neurology Center. We will gladly file a claim on your behalf with your insurance company as a courtesy, however we cannot guarantee payment from your insurance company and you are ultimately responsible for any balance that is not paid by your insurance. All co-pays are due at the time of service. If your account balance becomes delinquent due to non-payment and no contact from the patient, you will be discharged from our practice and account balance will be sent to an outside collection agency and you will be responsible for all associated costs. Your signature below acknowledges this. Please ask our office staff if you have any questions, thank you for your cooperation.

Signature acknowledges schedule of fees, consent to medical care and treatment, consent to have prescriptions sent electronically, and consent to bill:

Print Name: _____ Date: _____

Signature: _____

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Do you have any of the following symptoms? Please check all that apply:

- ☐ Dizziness
- ☐ Headaches
- ☐ Numbness & Tingling
- ☐ Memory & Concentration Loss
- ☐ Blackouts & Seizures
- ☐ Muscle Weakness & Pain
- ☐ Unsteady Gait
- ☐ Tremors
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Joint Pain

PAST MEDICAL HISTORY:

Please check all that apply:

- ☐ Kidney Disease
- ☐ Cancer: _____
- ☐ Diabetes
- ☐ Parkinson's Disease
- ☐ Cardiovascular Disease
- ☐ High Blood Pressure
- ☐ Stroke or TIA's
- ☐ High Cholesterol

REVIEW OF SYSTEMS Please tell us about your current symptoms:

Constitutional:
- ☐ Body Aches
- ☐ Night Sweats

Eyes:
- ☐ Eye Discomfort
- ☐ Impaired Vision
- ☐ Change In Vision

HENT:
- ☐ Headaches
- ☐ Loss Of Hearing

Cardiovascular:
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Syncope
- ☐ Dyspnea On Exertion

Respiratory:
- ☐ Shortness Of Breath
- ☐ Wheezing
- ☐ Coughing

Gastrointestinal:
- ☐ Reflux
- ☐ Jaundice

Genitourinary:
- ☐ Urinary Retention
- ☐ Hot Flashes

Integument:
- ☐ Itching
- ☐ New Skin Lesion
- ☐ Change In Existing Skin Lesion

Musculoskeletal:
- ☐ Joint Pain
- ☐ Joint Swelling

Endocrine:
- ☐ Cold intolerance
- ☐ Heat Intolerance

Psychiatric:
- ☐ Anxiety
- ☐ Depression

Heme-Lymph:
- ☐ Lightheadedness
- ☐ Easy Bruising
- ☐ Easy Bleeding

RECENT HOSPITALIZATIONS

Hospital and Date (within the past 2 years): _____

SURGICAL HISTORY:

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FAMILY MEDICAL HISTORY:

SOCIAL HISTORY:

Do you drink alcohol? Yes ☐ No ☐ If yes, how often? _____

Do you smoke? Yes ☐ No ☐ If yes, how often? _____

MEDICATIONS LIST

Please list all of your current medications so that we may keep your file current.

Medication:	Milligrams:	Dosage:

ALLERGIES:

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General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I authorize the custodian of records of:

Provider Name: _____

To disclose/release the following records (check all that apply)

- ☐ All records
- ☐ Office Notes (previous 2 years)
- ☐ Labs/Pathology (previous 2 years)
- ☐ Radiology Records (previous 3 years)
- ☐ Other: _____

Please send the records listed above to:

Las Vegas Neurology Center
2010 Goldring Avenue Suite 306
Las Vegas, NV 89106

Fax: 702-800-5456

This authorization shall not be valid for greater than one year from the date of signature.

I understand that this authorization is voluntary and that I may refuse to sign this authorization.

Patient Signature: _____ Date: _____

Printed Patient Name: _____

Representative's Authority to sign for Patient (POA): _____

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Patient'consent'to'the'Use'and'Disclosure'of'Health'Information'for'Treatment,'Payment,'or'Healthcare'operations'in'accordance'to'HIPPA.'

I, _____ understand that as part of my health care, Las Vegas Neurology Center originates and maintains papers and/or electronic records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care of treatment. I understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which third party payers(s) can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the compe tence of healthcare professional

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information used and disclosures. I understand that I have the following rights and privileges:

- The right to review the notices prior to signing consents/disclosure
- The right to request restrictions as to how my health information may be used or disclose to carry out treatment, payment, or healthcare operations

I understand that Las Vegas Neurology Center is not required to agree with the restrictions requested. I understand that I may consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity (insurance company, referring physician, consulting physician, hospital, etc.) and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

In addition, I also give consent to Las Vegas Neurology Center to disclose my protected information to the following person and/or persons:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I fully understand and accept the terms of this consent.

Patient Signature: _____ Date: _____