Gobinder S. Chopra, MD

BOARD CERTIFIED IN NEUROLOGY

Gobinder S. Chopra, M.D.

PLEASE PRINT CLEARLY

Patient Name: ____ Age: _______ Date of Birth: ___________________

Social Security#: _______________________________________ Marital Status: __________________________________

Ethnicity _______________________Preferred Language _________________ Race _______ Decline to specify__________

P.O. BOX's are not accepted.

Home Address: ____ Apt#: _____________

City: ____ State: _____________________ Zip: ________________

Home Phone (   ) _____________________ Work (   ) _____________________ Cell (   ) ____________________

Can we text you? Yes_____ No____

Email Address: ____ (For **Appointment Confirmations**)

Patient's Employer: ____ Occupation: _________________________________

****

Referring Doctor (or Primary Care Doctor): ____________________________________ Phone: _____________________

****

INSURANCE INFORMATION ***(Please bring Drivers License/Photo ID and Insurance cards to window to be copied)***

Primary Insurance: ____ Phone: _____________________________

Name of Policy Holder: ____ ID/Policy#: _________________________________

Policy Holder Date of Birth: _______________ Group #: ____________________ Social Security#: _____________________

Mailing Address for Claims: ____

Secondary Insurance: ____ Phone: _____________________________

Name of Policy Holder: ____ ID/Policy#: _________________________________

Policy Holder Date of Birth: _______________ Group #: _____________________ Social Security#: ____________________

Mailing Address for Claims: ____

Attorney Name: ____ Phone: ______________________________

Assignment of Benefits/Payment and Insurance Coverage/Collections Policy

I hereby authorize my insurance carrier(s) to pay: Gobinder S. Chopra, MD directly for all services. I authorize the release of **ALL** medical records or other information requested to assist in claims processing. I understand that I am fully responsible for any and all services not covered by said insurance carrier(s). I will come prepared to pay all co-payments and or deductibles etc. otherwise my appointment will be rescheduled. I understand that after 45 days my unpaid co-pay/deductible/balances etc will be forwarded to Allied Collection Agency. **If my account is forwarded to Collections:** I am fully responsible for all cost to transfer my account to **Allied Collections**.

_______ **By initialing I authorize this office to process my credit card payments by phone or mail to pay for balances or charges.**

____ ___________________

Patient Signature or Authorized Person   Date

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RELEASE OF INFORMATION

Due to the confidential nature of your medical care, it is against the law to release and/or discuss your care or test results with anyone other than you, the patient, corresponding physicians and your insurance company. Please see the posted Privacy Notice for further explanation.

Therefore, please list the names and phone numbers of those persons to whom you want us to release information regarding your care. This will include all medical records, including psychological or psychiatric impairment (s), drug abuse, alcoholism, sickle cell anemia, AIDS, or test for an infection of HIV and its results.

If you do not list your spouse, mother, father, sister, brother, friend, or attorney etc., they will not be privileged to any of the information regarding your medical care or condition.

We will not discuss any information with anyone not listed on this sheet. Thank you (Please re-read the above sentence)

____
Name Phone# Relationship to you

____
Name Phone# Relationship to you

____
Name Phone# Relationship to you

____
Name Phone# Relationship to you

____
Name Phone# Relationship to you

We will be sending copies of your results and reports to your referring and or primary care doctor. Additional copies that you request will be provided to you upon a within 30 business days at the cost of $0.60 cents per page.

Please give the name and phone number of a reliable person that we may contact in case of an emergency. **This is very important!** Should an emergency arise, we need someone to contact.

Emergency Contact Name: ____

Phone: (Home) ________________________ (Cell) _______________________

Patient Signature: ____________________________**Today's Date:** ___________

Valid for 1 year unless otherwise revised by patient

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CONSENT TO RELEASE INFORMATION

I hereby authorize the release of any and all medical records, test results or other information contained in my medical chart to Gobinder S. Chopra, MD from any doctor or medical facility where medical services have been rendered to me. This release shall be made to include any records considered sensitive, i.e., psychological or psychiatric impairment(s) or condition(s); drug or alcohol, abuse or treatment(s); sickle cell anemia, AIDS, or test for infection with HIV.

I further understand that this consent to release information will allow Gobinder S. Chopra, MD to release any information in my medical chart to my insurance company regarding billing claims and request for information; my selected pharmacy and/or pharmacist; referring doctors or other doctors/specialist who are treating me or to whom I am being referred to for additional care; and hospital or medical facility where I have obtained medical treatment or where treatment may be sought or to any person whom I have listed in the release of information. I understand that this includes records considered sensitive, i.e., psychological or psychiatric impairment(s) or condition(s); drug or alcohol, abuse or treatment(s); sickle cell anemia, AIDS, or test for infection with HIV.

____ ____________________

Patient Signature Date

ADDITIONAL ACKNOWLEDGEMENT

Please be advised that it is mandatory by Nevada Statute that if Gobinder S. Chopra MD becomes aware of any medical condition that may affect your ability to operate a motor vehicle this information will be released to the appropriate State Authority. This may result in a suspension of your driver's License.

Further, if at any time an attorney request records from this office said attorney must provide a Release for medical records which includes the above mentioned sensitive records release or subpoena the records by official process from an appropriate court of law. To insure confidentiality, this medical information will **only** be faxed to another medical facility. We do not fax to a private residence or attorney's office.

____ ____________________

Patient Signature Date

Acknowledgement of Review of Notice of Privacy Policy

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____________________________________ ____________________________

Signature of patient Date

For office use only

Notice of privacy practices sent/delivered on ____________Initials________________________

Signed Acknowledgement of Receipt received on _________________Initials________________

Patient refused or failed to Acknowledge Receipt on ________________ Initials______________

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OFFICE POLICIES

1. Office hours are: Monday through Thursday from 7:00 a.m. to 5:30 p.m. The office is closed on Friday Saturday and Sunday. There is a physician on call for the office 24 hours a day, seven days a week.

2. All patients are given the necessary time and attention at each visit therefore you may experience wait times beyond the scheduled appointment. If calling and you receive our voicemail please leave a detailed message. All calls are returned within 48 hours. If your call is urgent, please inform the operator so that she may direct you to the proper person. **IF YOUR SITUATION IS LIFE THREATENING, PLEASE CALL 911, OR GO TO THE NEAREST EMERGENCY ROOM.**

3. Please call at least 24 hours in advance to cancel or reschedule an appointment or you may incur a $50 no-show charge.

4. No Children are allowed when TESTING. You must comply with all testing instructions or your appointment will be rescheduled. There are no exceptions.

5. Completion of and Signatures for the entire "New Patient Packet" are required. You must have a valid photo ID and insurance cards at time of service. You are required to sign in upon arrival and you must sign your superbill after each visit.

6. You must bring a Translator (If not fluent in English). A witness or guardian is required if medically necessary. If being transported an attendant must accompany you for the entire visit. We will not assist in transporting, lifting or physically supporting patients who are not able to move independently. Your appointment will be rescheduled.

7. Compliance is not negotiable. Any act of Non-Compliance will result in immediate termination of care with no exceptions.

8. PER NRS 629.051 Healthcare records may be destroyed after 5 years.

____ ____________________

Patient Signature Date

By signing I confirm to have read, I understand and agree to all terms and will comply.

Please Visit our Website:

WWW.Chopramd.com

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PATIENT RESPONSIBILITIES

Most Insurance companies require authorization for the testing ordered by our doctor. We will do everything possible to get the necessary authorization on your behalf. We frequently run into delays depending upon the complexity of the authorization process set up by the individual insurance requirements. Normally we allow two weeks to obtain authorization. Please remember that your insurance may have specific requirements and **ULTIMATELY**, it is your responsibility to communicate with your insurance company if the situation warrants.
As a patient, it is your responsibility to:

* Follow through with all test & visits for test results as ordered.
* Inform us immediately of any Insurance, address, phone number etc. changes.
* Obtain all results of test ordered and communicate with your doctor at follow up visits.
* Inform us immediately if you are experiencing any difficulties with your medications.
* Inform us immediately if your symptoms change or worsen.
* Make sure you do not run out of medication. Call 1 week <u>before</u> out of meds.
* Provide your Insurance Company with any requested information.
* Pay all co-payments and deductibles at the time of your visit.

Your doctor cannot be responsible or held liable if you fail to follow through with test that have been ordered. Tests are ordered to help establish a specific diagnosis or rule out any serious disease processes, should they exist. You must complete the test ordered and follow up with the doctor to obtain test results. **WE DO NOT GIVE TEST RESULTS OVER THE PHONE.**

You, the patient, must actively participate in your care. Communication is vital in any doctor-patient relationship.

If your insurance company denies our request for diagnostic testing, we may be able to make arrangements so that you can complete the test as ordered.

By signing this form, you agree to assume your responsibilities as a patient, and have agreed to actively participate in your care and treatment.

_______________________________	_______________
Patient Signature	Date

Gobinder Chopra, MD

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PERSONAL MEDICAL HISTORY FORM

Date: _____________

Name: ____ Ht: ______ Wt: ______

Occupation: ______________________ Previous Occupation:______________________

Date of birth: ________________ Sex: Male Female (Circle One)

Are you: Right handed Left handed both (Circle one)

Reason for your visit today and how long you have had this problem:

____

Is your visit related to a MVA or Work related Accident Yes No (Circle one)

If yes are you currently off work? Yes No Date last worked if answered Yes__________

Do you have any NEW medical problems or symptoms? Yes No

If yes please explain____

Did you have any MRI, X-Ray, and/or CT testing ordered by another Physician since scheduling this appointment? Yes No If yes where and when?

____

Have you had any recent blood tests ordered by another Physician? (In last 6 months)Yes No If yes where and when?_______________________________________

Have you been to the Hospital since you scheduled this visit? Yes No If yes where and when? ____

Have you seen another Neurologist other than Dr. Chopra? Yes No If yes where and when____

Operations (Surgery) ___________________________ Date (s)________________

____ _________________

____ _________________

List medications which you take regularly:

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Type____Dose/Frequency______________

Diseases that run in your family:

Mother____

Father____

Other____

List medication you are allergic to: Type of reaction you have

____

____

List all Physicians that <u>currently</u> treat you for other conditions:

____

____

How did you hear about us?____

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Do you currently have or have you EVER had: (Please Circle)

Numbness:	Current	Past	NO
Where?________________________________			
Neuromuscular Disease:	Current	Past	NO
Double vision:	Current	Past	NO
Loss of hearing:	Current	Past	NO
Ringing in the ears:	Current	Past	NO
Dizziness:	Current	Past	NO
Loss of smell:	Current	Past	NO
Loss of taste:	Current	Past	NO
Loss of coordination:	Current	Past	NO
Loss of speech:	Current	Past	NO
Memory loss:	Current	Past	NO
Paralysis:	Current	Past	NO
High Blood Pressure:	Current	Past	NO
Sugar Diabetes:	Current	Past	NO
Stroke:	Current	Past	NO
Heart attack:	Current	Past	NO
Heart murmur:	Current	Past	NO
Heart failure:	Current	Past	NO
Irregular heartbeat:	Current	Past	NO
Rheumatic fever:	Current	Past	NO
Tuberculosis:	Current	Past	NO
Asthma:	Current	Past	NO
Cancer:	Current	Past	NO
What type? ____________________________			
Bleeding problems:	Current	Past	NO
Ulcers:	Current	Past	NO
Breathing problems:	Current	Past	NO

Glaucoma:	Current	Past	NO
Loss of eyesight:	Current	Past	NO
Loss of control of bladder:	Current	Past	NO
Loss of control bowel:	Current	Past	NO
Thyroid disorder:	Current	Past	NO
Sinus Disease:	Current	Past	NO
Digestive disorder:	Current	Past	NO
Kidney stones:	Current	Past	NO
Kidney disease:	Current	Past	NO
Arthritis:	Current	Past	NO
Severe injury to head:	Current	Past	NO
Severe injury to neck:	Current	Past	NO
Severe injury to back:	Current	Past	NO
Spinal meningitis:	Current	Past	NO
Encephalitis:	Current	Past	NO
Passing out spells:	Current	Past	NO
Seizures:	Current	Past	NO
Headaches:	Current	Past	NO
Anemia:	Current	Past	NO
Venereal disease:	Current	Past	NO
Liver Disease: (ex: Hepatitis)	Current	Past	NO
Emphysema:	Current	Past	NO
Exposure to toxic material:	Yes	NO	
When?________________________________			
Tested for AIDS:	Yes	NO	
Positive?	Yes	NO	
Allergic to X-ray dye: (iodine)	Yes	NO	
Do you Smoke:	Current	Past	NO
How many per day? ______________________			
Do you Drink:	Current	Past	NO
How many per day? ______________________			
Have you ever used Illegal Drugs	Current	Past	NO
What Kind? ____________________________			

-Females only-

Are you pregnant?	No Yes
Do you take birth control pills:	No Yes

If you answered NO to the question “Are you pregnant” please be advised that it is your responsibility to advise our doctor immediately should you become pregnant at any time while under our care.

Printed Name ____

Signed: ____ Date: ___________

I have read this and agree to comply