# Gilbert Neurology

3507 S. Mercy Rd. Ste 101 Gilbert AZ 85297
(480) 926-0644 Phone (480) 926-0645 Fax

# Patient Registration

1452 N. Higley Rd.Gilbert, AZ 85234

**Patient Name:**_____ Gender:___M___F **Date:**_____

Street Address:_____ S.S. #_____

City, State, Zip:_____ **Date of Birth:**_____

Home: (___)_____ Cell: (___)_____

E-mail address:_____

Local Address: _____ ____married ____single ____divorced

City, State, Zip: _____ ____ widowed ____ partnered

Preferred language: ___English ___Spanish ___Other_____ Race: ___American Indian ___ Asian ___African American ___White

Ethnicity: ___Hispanic or Latino ____Not Hispanic or Latino ___Hispanic or Latino ___ Other

Employer:_____ Work Phone: (___)_____

**Referring Physician:**_____ Phone: (___)_____
Last name First Name

Address:_____ Practice Name:_____

**Primary Care Physician:**_____ Phone: (___)_____
Last Name First Name

Address:_____ Practice Name:_____

**Pharmacy:**_____ Phone:(___)_____

Address:_____ City, State, Zip:_____

**Mail Order Pharmacy:**_____ Phone:(___)_____
Address:_____ City, State,Zip:_____

**Primary Insurance:**_____ ID #:_____
Address:_____ Group #:_____
City, State, Zip:_____ EffectiveDate:_____

**Secondary Insurance:**_____ ID #:_____
Address:_____ Group #:_____
City, State, Zip:_____ Effective Date:_____

**If the Patient is Not the Primary Insured**

**Name of Primary Insured:**_____ Date of Birth:_____
Relationship to Patient:_____ S.S.#:_____
Employer:_____ Phone: (___)_____

**Emergency Contact:**_____ Relation to Patient: _____
Address:_____
City, State, Zip:_____ Phone: (___)_____

Do you have a living will? _____yes _____no Do you have a Power of Attorney? ____yes _____no

Signature:_____ Date:_____
Circle one: Patient / Parent / Guardian

# Gilbert Neurology

**Jonathan Hodgson, DO, Ajo Joy, MD, Brian Beck, MD, Michelle Raphael, DO, Jaime Rawson, DO**
**Paarth Shah, MD, Celeste Fine, NP, Jonathan Henriquez, NP, Jon Helman, NP**
3507 S. Mercy Rd. Ste.101, Gilbert, AZ 85297 1452 N. Higley Rd. Gilbert, ,AZ 85234

**Name:** _____ **DOB:**_____ **AGE:**____ **Date of appointment:** _____

**What is the main problem you are having?** _____

**Is this due to an accident?** ___**Y** ___**N** ___**Don't Know** **Is a legal case pending?** ___**Y** ___**N** ___**Maybe**

**R**___ **L**___ **HANDED** **Who referred you to Gilbert Neurology?**_____

**Allergies:** None

Include allergies to medications and other medical products (ex: tape, latex and iodine)

| **Name of medicine or product:** | **Description of reaction:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**What *MEDICINES* are you taking?**

| **Name of Medicine** | **Dosage** | **Times per Day** | **For What** | **Approx. Date Started** |
|---|---|---|---|---|
| • | | | | |
| • | | | | |
| • | | | | |
| • | | | | |

**What over the counter (OTC) medicines, vitamins or herbal supplements are you taking?**

_____

**Have you stopped any medicine recently or used other medicine in the past for this problem?**

_____

**Do you take birth control pills, patch or implant?** **Y** **N** **What?** _____

***PAST MEDICAL HISTORY*** **Check those that apply (active or inactive)**

| | | |
|---|---|---|
| anxiety | fibromyalgia | neuropathy |
| anemia | headache | osteoporosis |
| asthma/emphysema | heart disorder | rheumatoid arthritis |
| cancer | hepatitis | seizures |
| type?_____ | high blood pressure | stroke |
| brain aneurysm | high cholesterol | thyroid disorder |
| dementia | kidney disorder | TMJ |
| depression | lupus | stomach ulcer |
| diabetes | multiple sclerosis | chronic pain in: |
| eye disorder | | __back ___neck ___other |

Other medical conditions: _____

**Name:**_____ **DOB:**_____

***SURGICAL HISTORY*** None

Type of Surgery and reason Year

_____ _____

_____ _____

_____ _____

***FAMILY HISTORY***

Do you have any family members with similar problems as you? **Y N**

Do you have any family members with?

Autoimmune disease ☐ **Y** ☐ **N** who? _____ stroke **Y** ☐ **N** who?_____

seizure disorder **Y** ☐ **N** who?_____ neuropathy **Y** ☐ **N** who?_____

headaches ☐ **Y** ☐ **N** who?_____ brain aneurysm **Y** ☐ **N** who?_____

***SOCIAL HISTORY:***

Marital Status: Single Married Divorced Widowed Partnered

Do you use tobacco? Yes No Cigarettes-pks/day_____ Chew -#/day _____

Number of years_____ Year quit_____

Do you drink alcohol? Yes No How much? _____

Do you currently use recreational or street drugs? Yes No

What is your occupation or major daytime activity? _____

In the **past 3 months:**
How many visits to the ER, Urgent Care for treatment?_____

What facility?_____

**Have you had any Tests done already? (e.g., MRI, Cat scan, EMG, X-rays, Ultrasound, etc…)**

| **Test / X-Ray** | **Approximate Date Done** | **Result** | **Facility** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Review of Systems History**-Please circle any symptoms you have

Patient Name: _____DOB: _____Date: _____

**General**

| | | | |
|---|---|---|---|
| Poor Appetite | Trouble Walking | Muscle Cramps | Weight Loss |
| Lack of Sleep | Fatigue/Tiredness | Clumsy | Joint Pains |
| Cold Hands/Feet | Dull taste/smell | | |

**Dermatological**

| | | | |
|---|---|---|---|
| Rash | Dry Skin | Bruise easily | Itching |

**ENT**

| | | | |
|---|---|---|---|
| Dizziness | Jaw Click | Facial Pain | Ringing in Ears |
| Double Vision | Poor Hearing | Drooling | Dry Mouth |

**Cardiac, Circulatory, Respiratory**

| | | | |
|---|---|---|---|
| High BP | Swollen Ankles | Fainting | Shortness of Breath |
| Chest Pain | Irregular Heart Beat | Palpitations | |

**Gastrointestinal**

| | | |
|---|---|---|
| Nausea | Vomiting | Stomach Cramps |
| Constipation | Diarrhea | |

**Genital and Urinary**

| | | |
|---|---|---|
| Unable to hold urine | Kidney Stones | Hesitancy to Urinate |
| Frequent urination | Urge to Urinate | Impotence |

**Pregnancy and Gynecology (women only)**

| | | |
|---|---|---|
| ____# of pregnancies | Hot flashes | Menopause |
| Irregular Periods | Duration of periods_____# of days | |

**Neurological**

| | | | |
|---|---|---|---|
| Dizziness | Weakness | Tremor | Seizures |
| Poor Memory | Numbness/Tingling | | |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Back Pain | Swelling of joints | Muscle or joint pain | Stiffness |

**Psychiatric**

| | | | |
|---|---|---|---|
| Anxiety or tension | Depression | Stress | Moodiness/Temper |

**Comments**:_____

_____

# GILBERT NEUROLOGY

JONATHAN W. HODGSON, DO
AJO JOY, MD
BRIAN BECK, M.D.
MICHELLE RAPHAEL, DO
JAIME RAWSON, DO
PAARTH SHAH, MD
CELESTE FINE, NP
JONATHAN HENRIQUEZ, NP
JON HELMAN, NP

TELEPHONE: (480) 926-0644
FAX: (480) 926-0645

1452 N. HIGLEY RD.
GILBERT, AZ 85234

3507 S. MERCY RD., STE. 101
GILBERT, AZ 85297


**Consent to Obtain External Prescription History**

I, _____ , whose signature appears below, authorize Gilbert Neurology and its affiliated providers to view my external prescription history via the RxHub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by your provider and staff.

My signature certifies that I read and understand the scope of this consent and that I authorize the access.

_____ _____
Patient Name DOB

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

# Gilbert Neurology, P.L.L.C. Financial Policy

3507 S Mercy Rd., Suite 101 Gilbert, AZ 85297 (480) 926-0644 Fax (480) 926-0645
1452 N. Higley Rd. Gilbert, AZ 85234 (480) 926-0644 Fax (480 926-0645

**Patient Name**_____

*****PLEASE INITIAL ALL OF THE FOLLOWING*****

_____ **Unless 24-hour notice is given, I understand that there will be a $25 charge for broken appointments and a $50 charge for procedures and infusions.**

_____I understand that I am financially responsible for any copayments, deductibles, coinsurance and all charges which are not covered by my insurance. I understand that verification of coverage does not guarantee payment of benefits. My insurance company determines insurance benefit payments. I understand I will be responsible for that portion of all charges not covered by my insurance.

____I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

____**Due to the large number of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.**

____**I understand that I am responsible for my co-pay at the time of my visit. We accept cash, all major credit cards, and personal checks.**

____I understand that there is a $25 charge for a Non-Sufficient Funds (NSF) check.

____I understand that there is a $25 charge for all forms deemed necessary and filled out by the Physician OR Nurse Practitioner (e.g. Disability, FMLA, etc.) and I understand that I need an appointment with the Doctor or Nurse Practitioner to fill out these forms.

____I understand that Gilbert Neurology does not accept liens; worker's compensation, or MVA/auto claims and that I am responsible for any insurance claims denied as such. If my medical insurance denies or takes back any monies provided, I understand that I am responsible to pay all claims in full.

____If my account is not paid in full within 90 days, I understand that it will be considered delinquent. No additional appointments will be made for patients with delinquent accounts until they are brought current. Delinquent accounts will be turned over to a collection agency.

____I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

____I hereby authorize my insurance company to make payment directly to: Gilbert Neurology, P.L.L.C.

____**I have read and I understand the above Financial Policy and I agree to abide by its terms. No changes to this policy by the patient will be acknowledged. Questions may be directed to the billing office.**

**Signature of patient (or parent / guardian)** _____

**Print Name** _____ **Date**_____

# Gilbert Neurology

480-926-0644 480-926-0645-fax

## Patient Communication and Consent

Patient Name: _____Date of Birth: _____

There are occasions when Gilbert Neurology may have to call to discuss Confidential Protected Health Information. Please let us know how you would like us to get this information to you:

____ Ok to call my home/cell phone and leave a message on the answering machine

____ Ok to call my home but DO NOT leave a message

____ Do Not call my home phone but call this number ( ) _____

____ Do Not leave message with family member

Who may receive information regarding your Protected Health Information?
Check all that apply.

____ Spouse Name and date of birth: _____

____ Children Name and date of birth _____

Name and date of birth _____

Name and date of birth _____

____ Parents Names and date of birth: _____

____ Significant Other/Friend Name and date of birth: _____

_____

I have received a copy of the Notice of Privacy Practices from this provider and authorize the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to Gilbert Neurology.

I hereby authorize Gilbert Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Gilbert Neurology upon request.

Signature: _____Date: _____

# GILBERT NEUROLOGY, P.L.L.C.
# HIPAA PRIVACY NOTICE

**Purpose of this Notice**
At Gilbert Neurology, P. L.L.C. we are committed to treating and using protected health information about you responsibly. We are also required by federal law to take reasonable steps to ensure the privacy of your health information.

The use and disclosure of Protected Health Information (PHI) is regulated by the federal law, the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules in 45 Code of *Federal Regulations* Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulation will supersede this Notice if there is any discrepancy between the information in this Notice and the regulation.

**Effective Date**
The effective date of this Notice is April 14, 2003.

**Privacy Officer**
Gilbert Neurology,P. L.L.C. has designated a Privacy Officer to oversee the administration of privacy at this office and to receive complaints. The Privacy Officer is the Practice Administrator and may be contacted as follows:

Judy Herrmann
Gilbert Neurology, P.L.L.C.
3507 S. Mercy Rd. Ste 101
Gilbert, AZ 85297
(480) 926-0644 ext. 21

**Your Protected Health Information**
Each time you visit Gilbert Neurology,P. L.L.C. a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information serves as the basis for planning your care and treatment. It is also a means for communicating among the many health professionals who contribute to your care, is a legal document describing the care you received, and is the means by which you or a third-party payer can verify that services billed were actually provided.

The term "Protected Health Information" (PHI) includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by Gilbert Neurology, P.L.L.C. in spoken, written, electronic, or any other form.

**When Gilbert Neurology can disclose your PHI**
Under the law, Gilbert Neurology,P. L.L.C. may disclose your PHI, without authorization, in the following cases:

*At your request.* If you request it, Gilbert Neurology, P.L.L.C. is required to give you access to your or your dependent's PHI.

*As required by an agency of the government.* In general, Gilbert Neurology, P.L.L.C. does not need you to sign a valid authorization to release your PHI if required by law or for public health and safety purposes. Gilbert Neurology, P.L.L.C. is allowed to use and disclose your PHI without your authorization under the following circumstances:

- When required by law
- When permitted for purposes of public health activities
- When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of such abuse.
- When required for judicial or administrative proceedings (e.g. subpoena or discovery request)
- When required for law enforcement purposes
- When required to be given to a coroner or medical examiner
- For research, subject to certain conditions
- To comply with workers' compensation or other similar programs established by law

*For treatment, payment or health care operations.* Gilbert Neurology, P.L.L.C. and its business associates will use PHI, without a signed valid authorization or your opportunity to restrict or object, when carrying out treatment, payment or health care operations.

*Implicit authorization to release PHI and process for restriction.* In addition to disclosures mandated by law, and disclosures to individuals or entities you have specifically authorized, Gilbert Neurology,P. L.L.C. will assume your authorization for release of PHI to the following:

- Your spouse, if you do not restrict or object
- Your legal representative with a valid power of attorney, your court-ordered (approved) guardian, or your conservator, if you do not restrict or object.
- Your designated personal representative, if you have not revoked your personal representative
- Either parent of a minor child, if you do not restrict or object

You may specifically restrict authorization by submitting a signed, written request for restrictions to the Privacy Officer noted on page one.

**Your Individual Privacy Rights**
Although your health record is the physical property of Gilbert Neurology, P.L.L.C., the information in your record does belong to you and, therefore, you have rights related to its uses and disclosures. *Except as otherwise indicated in this Notice, uses and disclosures of your PHI will be made only with your signed valid authorization, subject to your right to revoke your authorization.*

**In addition, you have the following rights:**

*You may inspect and receive a copy of your PHI.*
*You have the right to amend your PHI.*
*You have the right to receive an accounting of PHI disclosures:*
At your request, Gilbert Neurology, P.L.L.C. will provide you with an accounting of disclosures made by Gilbert Neurology, P.L.L.C. The accounting will not include disclosures made before April 14, 2003.

*You have the right to receive a paper copy of this Notice upon request.*
*Your personal representative:*
You may exercise your rights to your PHI by designating a personal representative. You must designate your personal representative **before** the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed and signed letter designating your personal representative.

- Gilbert Neurology, P.L.L.C. will automatically consider a parent or guardian as the personal representative of an unemancipated minor (a child generally under age 18) unless applicable law requires otherwise or you restrict such disclosure.
- Personal representative designations may be revoked at any time by submitting a written statement of revocation. This statement must be received by the Privacy Officer prior to a revocation becoming effective.

*You have the right to file a complaint if you believe your privacy rights have been violated.*

To exercise one or more of these rights, you should submit a signed, written statement detailing your request to the Privacy Officer listed on page one of this Notice. Gilbert Neurology, P.L.L.C. is not required to agree to your request if the Privacy Officer determines it to be unreasonable, for example, when a custodial parent is seeking treatment for your minor child or when it would interfere with Gilbert Neurology, P.L.L.C.'s ability to file a claim.

**Responsibilities of Gilbert Neurology, P.L.L.C.**
Gilbert Neurology, P.L.L.C. is responsible for the following items:
*Maintain privacy of your health information.* Gilbert Neurology, P.L.L.C. is required by law to maintain the privacy of your PHI.

*Notice Distribution:* Gilbert Neurology, P.L.L.C. is required to provide you with notice of its legal duties and privacy practices. This Notice is effective beginning on April 14, 2003. However, Gilbert Neurology, P.L.L.C. reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by Gilbert Neurology, P.L.L.C. If a privacy practice is changed, a revised version of this Notice will be provided to patients.

*Disclosing only the minimum necessary PHI:* When using or disclosing PHI, Gilbert Neurology, P.L.L.C. will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment
- Uses or disclosures made to you
- Disclosures made to the DHHS
- Uses or disclosures required by law (e.g. Public Health Agencies)
- Uses or disclosures required for compliance with legal regulations (e.g. subpoenas)

*Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.*

**Complaints**
If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer as follows:

Judy Herrmann, Gilbert Neurology, P.L.L.C.
3507 S. Mercy Rd. Ste 101
Gilbert, AZ 85297
(480) 926-0644 ext. 21

There will be no retaliation for filing a complaint. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the DHHS.

**If you need more information**
If you have any questions regarding this Notice or the subjects addressed in it, you may contact Gilbert Neurology, P.L.L.C.'s Privacy Officer.