PARKSIDE MEDICAL GROUP INC.

1310 SAN BERNARDINO RD. STE 102 UPLAND, CA 91786 • (909) 608-2008 FAX (909) 608-7705

GENERAL INFORMATION

PATIENT NAME_____ BIRTH DATE____/____/____ AGE_____
(LAST) (FIRST)

ADDRESS_____ CITY, STATE_____ ZIP_____

PLEASE CIRCLE: MALE FEMALE MARRIED SINGLE DIVORCED WIDOWED

PHONE ( )_____ SS#_____ DL#_____

PRIMARY LANGUAGE_____ DO YOU NEED AN INTERPRETER? YES NO

HOW WERE YOU REFERRED TO OUR OFFICE? _____

IS YOUR VISIT TODAY RELATED TO AN ILLNESS OR INJURY FROM YOUR WORK? YES NO

EMPLOYMENT INFORMATION

EMPLOYER_____ PHONE ( ) _____

ADDRESS _____ CITY, STATE_____ ZIP_____

INSURANCE/BILLING INFORMATION

RESPONSIBLE PARTY_____RELATIONSHIP_____ DOB_____

EMPLOYER OF RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT) _____

INSURANCE_____ PHONE ( ) _____

ADDRESS_____CITY, STATE_____ ZIP_____

POLICY HOLDER_____ RELATION TO PATIENT_____

INSURED SS#_____ POLICY/GROUP# _____

ADJUSTER _____ CLAIM #_____

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IN CASE OF EMERGENCY PLEASE CONTACT:

_____ PHONE ( ) _____

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PATIENT RESPONSIBILITY

Due to stringent rules adopted by the Federal Government (HIPAA-Health Insurance Portability and Accountability Act) with regard to patient confidentiality, the responsibility of delivery of medical testing results and medical records will be the responsibility of the patient. Many facilities will no longer provide a copy of your medical testing or records via fax or mail without an authorization signed by you on the date it is being requested. This is for your protection but our office is unable to obtain your testing results with a phone call. It is your responsibility to assure that the results of any testing from other facilities are faxed to our office in time for your next appointment.

I authorize Parkside Medical Group Inc. to obtain medical records, testing, x-rays or any pertinent information to assist in evaluation and treatment of my medical condition. This authorization shall remain in effect for 1 (one) year unless revoked by me in writing.

_____ _____

RESPONSIBLE PARTY DATE

Insurance Benefit Assignment/Consent to Disclose Medical Information

Medicare – Authorization & Benefit Assignment

I request that payment of authorized **Medicare** benefits be made to Parkside Medical Group for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any Personal Health Information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of Personal Health Information necessary to pay the claim. In Medicare assigned areas, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Name of Beneficiary **HIC (Medicare Number)**

Insurance – Authorization & Benefit Assignment

I hereby authorize Parkside Medical Group to furnish Personal Health Information to insurance carriers concerning my illness and treatment and I hereby assign to Parkside Medical Group all payment for medical services rendered to my dependents or myself. I understand I am responsible for patient deductibles and any amount not covered by the insurance. Laboratory, radiology and other ancillary services provided in connection with the physician's office will be billed separately. Co-pays must be made at the time of service and a fee of $25.00 will be added to any returned check balances. I understand and agree to give at least 24 hours notice if I am unable to keep an appointment. Failure to do so will result in a "No-Show" charge of $25.00 added to my account balance.

_____ _____

Responsible Party Signature **Date**

Consent to Treatment

The undersigned consents to all treatment, including emergency treatment or services, which may include, but are not limited to, laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered to the patient under the general and specific instructions of the patient's physician.

_____ _____

Responsible Party Signature **Date**

Consent to Treatment of a Minor

I hereby consent to and authorize for my minor child:

_____ _____

Name of Minor Child **Minor's Birth Date**

diagnostic and/or therapeutic treatment including emergency treatment or services which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures rendered under the general and specific instructions of the physician. I am a legal guardian or parent with the legal authority to give consent to treatment.

_____ _____

Parent/Guardian Signature **Date**

Does the minor child live with you? YES NO Your phone number if different from child: _____

Patient's Rights

You may refuse to give consent and may object to any part of this form. If so, please ask to speak with us about that. If you choose to give consent in this document, you may revoke your consent in the future in writing. This right, and other rights that you have in regard to your Personal Health Information use and disclosure, are detailed in our Privacy Notice. If you did not receive a copy of this Privacy Notice, please ask for one and read it carefully. We value you as a patient and strive to achieve the highest standards in our service to you.

PARKSIDE MEDICAL GROUP

To Our Patients;

Your privacy is of utmost concern to us. Please take a moment to complete this information so that we only contact you and/or leave messages where you want.

	OK to contact you at this number To confirm, cancel or reschedule an appointment information?	Is it OK to leave a message?
1. _(_____)_____ Home Phone	☐ Yes ☐ No	☐ Yes ☐ No
2. _(_____)_____ Work Phone	☐ Yes ☐ No	☐ Yes ☐ No
3. _(_____)_____ Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No
4. _____ E-Mail Address	☐ Yes ☐ No	☐ Yes ☐ No
5. _(_____)_____ Emergency Contact	Relationship: _____	

ACKNOWLEDGMENT

Physician: _____ **Telephone:** _____

Address: _____

_____

Patient's Name: _____ **DOB:** ____/__/____

Address: _____ **Telephone:**_____

_____

Advanced Directives

This acknowledgment that the physician, or on his/her staff members, has provided me information concerning Advanced Directives.

1. I am age 18 or older. (Circle one) YES NO

2. I realize that I have the option of putting together Advanced Directives for my healthcare. My physician has provided me written information concerning these Advanced Directives. I understand that it is my responsibility to provide my doctor(s) with any documents that are required to carry out my Advanced Directives.

3. I am aware that Advanced Directives may be any one of the following:

a. **A Durable Power of Attorney for Health Care.**
b. **The Declaration in the A natural Death Act – Ex. A Living Will**
c. **I may write down my wishes on a piece of paper so that my family may us the document, in deciding my medical treatment, in the event I am unable to do so.**

Patient's Signature: _____ **Date:**_____

This document will become part of my medical record.

Parkside Medical Group, Inc.

Mohsen Ali, M.D., Board Certified Neurologist • William S. Baek, M.D., Board Certified Neurologist
Rajan Chopra, M.D., Board Certified Neurologist
EEG, EMG, EP, BOTOX

ACKNOWLEDGE OF NOTICE REGARDING

PRIVACY OF INFORMATION

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to provide you, the patient, a Notice of our Privacy Practices. The notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

En conformidad con el acto de la Portabilidad y de la Responsabilidad del seguro medico de 1996 (HIPPA), nos otros es requerido que laproporcione al paciente el Aviso de la Practicas de la Privacidad. Este aviso describe como la informacion de la salud sobre usted puede ser utilizada y ser divulgada, y com ousted puede tener el acceso a esta informacion. Por favor lea esta informacion cuidadosamente.

.....

I hereby acknowledge that I was given a copy PARKSIDE MEDICAL GROUP'S

Notice of privacy Practices to read. I was also given the opportunity to have a copy to take with me if I desired. In addition, a Notice of Privacy Practices is posted in the patient waiting area.

I understand that I may request in writing that you restrict how my private information is used to disclose to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to agree to my requested restrictions, but if you do not agree, then you are bound to abide by such restrictions.

_____ _____

Signature **Date**

_____

Print Name

If not signed by patient, please indicate relationship: _____

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PATIENT_____ **DOB**_____

ALLERGIES_____

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

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PARKSIDE MEDICAL GROUP
ADULT HISTORY/ NEUROLOGY

DATE _____

☐ MALE

PATIENT NAME _____ ☐ FEMALE AGE BIRTHDATE _____

1. **Referred by:** _____

2. **Why were you referred to Dr. Ali?**

   _____

3. **What other medical conditions do you have?**

   _____

4. **Do you have any allergies?** ☐ Yes ☐ No

   Please list _____

5. **Do you take any medications regularly?** ☐ Yes ☐ No

   Please list name and dosage _____

6. **Past medical history: (Check any that you have had)**

☐ Asthma	☐ Diabetes	☐ Alcohol Problem
☐ Tuberculosis	☐ Thyroid Disease	☐ Drug Use
☐ Heart Attack	☐ Jaundice	☐ Tobacco Use
☐ High Blood Pressure	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ High Cholesterol	☐ Gallstones	☐ Mental Illness
☐ Cancer	☐ Arthritis	☐ Other (please state)
☐ Glaucoma	☐ Anemia	_____
☐ None of the above		_____

7. **Family History: (Check any diseases your family members have had)**

☐ Diabetes	☐ High Blood Pressure	☐ Heart Attack
☐ Stroke	☐ Cancer	☐ Other _____

DOCTOR'S COMMENTS: _____

_____

_____

REVIEWED BY: _____