

WESTERN NEUROLOGY, PLLC

Kan Yu, MD, PhD

New Patient Registration

Please complete entire form in blue or black ink

Name: Last First MI Date of Birth:

SSN: - - Email:

Address: Street City State Zip Gender: M or F Age: Marital Status: S M D W

Race: (Circle one) American Indian / Asian / African American / Native Hawaiian or Pacific Islander / Caucasian

Ethnicity: (Circle One) Hispanic or Latino / Not Hispanic or Latino

Telephone: Home () Cell () Work ()

Employer: Occupation:

Street City State Zip

Primary Care Doctor: Primary Care Doctor's Phone #:

Name of Preferred Pharmacy: Pharmacy Phone # & Location:

Emergency Contacts:

Name: Phone: Relationship to Patient:

Name: Phone: Relationship to Patient:

Insurance Plan: ID #: Policy Owner: SS#: D.O.B: Employer of Policy Owner: Phone: Address: Street City State Zip Secondary Insurance: ID#: Policy Owner: SS#: D.O.B:

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with their regular rates and payment terms. If I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. I also understand that it is my responsibility to know when my insurance is active, when it terminates and to notify the office of any insurance changes and/or terminations prior to any visits. The office may also release medical records of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient Signature: Date:

HIPAA PRIVACY ACKNOWLEDGEMENT

I have received the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information. I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Western Neurology, PLLC 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 Western Neurology, PLLC upon request.

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Western Neurology, PLLC and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

Name Relationship to Patient

Name Relationship to Patient

MESSAGES:

Y ___ N ___ It is ok to leave a message on my home voice mail #: _____

Y ___ N ___ It is ok to leave a message on my work voice mail #: _____

FAXES: When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, by its very nature, is not confidential.

Patient Name

Date of Birth

Patient Signature

Date

Patient Financial Agreement / Payment Terms and Conditions

INSURANCE

Please realize that it is your responsibility to know what your insurance covers and does not cover and whether our doctor is in network or out of network with your specific plan. It is also your responsibility to know if a referral is required and if so, the referral must be received prior to being seen. Each patient's insurance benefits vary greatly. **Co-pays, deductibles, co-insurance and self pay amounts are due at the time of treatment.**

***If you have a secondary insurance that our doctor is not contracted with, you will be financially responsible for the remaining balance that your primary insurance does not cover.

ASSIGNMENT OF BENEFITS

All applicable insurance benefits are hereby assigned to Western Neurology, PLLC and/or to Kan Yu, MD, PhD.

LABORATORY & IMAGING SERVICES

During the course of diagnosis and treatment, Dr. Yu may order laboratory tests, diagnostic imaging or medical services performed outside of the office.

Depending on your individual insurance coverage, some or all of these tests may incur patient charges outside of what your insurance carrier provides. It is your responsibility to confirm with the service provider what your out-of-pocket expense may be.

Western Neurology, PLLC is in no way responsible for knowing the fees involved, or the actual charges incurred for the tests. All tests are ordered to accurately diagnose and manage your care and ongoing treatment. They are ordered specifically for this purpose.

THE DOCUMENT FEES:

There will be a \$35 fee for printed medical records from this office, and a \$95 fee for any other patient's forms for us to process.

It is required that you notify our office 24 hours in advance if you want to reschedule or cancel your appointment. If you fail to do so, there will be a \$30 charge.

FINANCIAL AGREEMENT

I agree to be responsible for all charges incurred and will provide payment as requested. If my account is sent to collections, I agree to pay collection fees and/or attorney fees. Delinquent accounts will also be assessed reasonable interest charges.

I HAVE READ AND UNDERSTOOD "THE WESTERN NEUROLOGY, PLLC PATIENT FINANCIAL AGREEMENT / PAYMENT TERMS AND CONDITIONS," AND AGREE WITH THE ARRANGEMENT.

I ALSO UNDERSTAND THAT I AM PRIMARILY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED.

Patient Name

Patient Signature

Date

WESTERN NEUROLOGY, PLLC
Kan Yu, MD, PhD

Medical Records Release/Request

3303 S. Lindsay Rd – Suite 118
Gilbert, AZ 85297
Phone: (480) 899-2212 Fax: (480) 899-2022

Name: _____ DOB: _____ Phone #: _____

PLEASE OBTAIN INFORMATION FROM/TO:

Western Neurology, PLLC
Kan Yu, MD, PhD
3303 S. Lindsay Rd, Suite 118
Gilbert, AZ 85297
Phone: (480) 899-2212
Fax: (480) 899-2022

PLEASE SEND INFORMATION TO/FROM:

Name of Provider/Clinic/Organization

Street Address

City, State, Zip Code
Phone: _____ Fax: _____

I AUTHORIZE the following information to be disclosed: (Please initial all that apply)

_____ Entire Record	_____ HIV Record	_____ Billing Records
_____ Immunization Record	_____ STD Record	_____ Other:
_____ Lab Tests	_____ Psychiatric/Mental Health	
_____ TB Test	_____ Alcohol/Substance Abuse	

REASON for disclosure of health information: (Please initial)

_____ At my request
_____ Continuing Care
_____ Insurance
_____ Other (please specify) _____

EXPIRATION of this Authorization (Please initial)

_____ 90 days after signature date _____ On this date: _____

ADDITIONAL PATIENT INFORMATION:

- I understand that I have the right to withdraw this authorization
- I understand that once my health care information is disclosed as I have authorized, it could be redisclosed by the recipient and is not longer protected by Western Neurology, PLLC.
- I understand that signing this authorization does not cancel any rights I have under other state or federal laws.

Patient Signature

Date

Pick-Up Records Mail Records Fax Records

PAST MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____
Last First MI

Medical Problems (Please check all that apply):

Gastro Intestinal

- Gallstones
- Pancreatitis
- Peptic Ulcer Disease
- Hepatitis
- Irritable Bowel Syndrome
- GERD

Heart/Lung

- Angina, Heart Attack
- CABG
- Congestive Heart Failure
- Mitral Valve Prolapse
- Arrhythmia
- Atrial Fibrillation
- High Blood Pressure
- High Cholesterol
- Stroke
- Asthma
- COPD ; Emphysema
- Obstructive Sleep Apnea

Metabolic / Misc

- Kidney Stones
- Chronic Renal Failure
- Headaches
- Diabetes Mellitus
- Seizures
- Chronic Fatigue Syndrome
- Fibromyalgia
- Rheumatoid Arthritis
- Osteoarthritis/DJD
- Osteoporosis
- Glaucoma
- Depression
- Bipolar Disorder

- Peripheral Polyneuropathy
- Carpel Tunnel Syndrome
- Back Pain
- Neck Pain
- Anxiety

Cancer

- Breast
- Skin
- Prostate
- Colon
- Other: _____

Other Symptoms:

Family History:

Mother: Alive or Deceased Age: _____

- Alzheimer's Disease
- Brain Aneurysm
- Cancer: (Type) _____
- Cardiovascular Disease
- Carpal Tunnel Syndrome
- Depression
- Diabetes
- Epilepsy
- Hypertension
- Migraines
- Multiple Sclerosis
- Parkinson's Disease

Father: Alive or Deceased Age: _____

- Alzheimer's Disease
- Brain Aneurysm
- Cancer: (Type) _____
- Cardiovascular Disease
- Carpal Tunnel Syndrome
- Depression
- Diabetes
- Epilepsy
- Hypertension
- Migraines
- Multiple Sclerosis
- Parkinson's Disease

Other Conditions:

Other Conditions:

Please document most recent date (Month & Year) for each of the following:

Flu Shot: _____ Pneumonia Shot: _____ Colonoscopy: _____

Mammogram: _____ Pap Smear: _____

HOSPITALIZATIONS / SURGERY / OUTPATIENT PROCEDURES: None

Please list Hospital Name, Condition / Procedure and age or approximate year
