WESTERN NEUROLOGY, PLLC
Kan Yu, MD, PhD

New Patient Registration
****Please complete entire form in blue or black ink****

Name: ____ **Date of Birth**: __________________
Last First MI

SSN: ___________ - ________ - ___________ **Email:** ____

Address: ____ **Gender**: M F **Age**: __________
Street
____ Marital Status: S M D W
City State Zip

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 or Cross Streets:**___________________________

= =

Emergency Contacts:

Name: ______________________ Phone: ___________________ Relationship to Patient: ______________________

Name: ______________________ Phone: ___________________ Relationship to Patient: ______________________

Do we have your permission to leave messages on home or work voicemail? YES NO

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 <u>any</u> 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:** _____________________

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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 (spouse, 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
________ Immunization Record
________ Lab Tests
____
________ TB Test
____

________ HIV Record
________ STD Record
________ Psychiatric/Mental Health
________ Alcohol/Substance Abuse

________ Billing Records
________ Other:

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**

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PAST MEDICAL HISTORY

Patient Name: ______________________________ DOB: ______________ Date: _________

Medical Problems (Please check all that apply):

Gastro Intestinal
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ GERD

Cancer
- ☐ Breast
- ☐ Skin
- ☐ Prostate
- ☐ Colon
- ☐ Other: _____________

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

Other Symptoms:

____

Family History:

Mother: Alive or Deceased **(Circle One)** **Age:**________

Alcoholism
Alzheimer's Disease
Anemia
Anxiety
Asthma
Birth Defects
Brain Aneurysm
CAD
Cancer: (Type)____________
Cardiovascular Disease
Carpal Tunnel Syndrome
CHF
Congenital Anomaly
COPD
Crohn's Disease
Depression
Diabetes
Epilepsy
GERD
Hypercholesterolemia
Hypertension
Hypothyroidism
Kidney Disease
Liver Disease
Migraines
Multiple Sclerosis
Osteoarthritis
Osteoporosis
Parkinson's Disease
Pulmonary Disease
Stroke
Substance Abuse

Other Conditions:

Father: Alive or Deceased **(Circle One)** **Age:**________

Alcoholism
Alzheimer's Disease
Anemia
Anxiety
Asthma
Birth Defects
Brain Aneurysm
CAD
Cancer: (Type)____________
Cardiovascular Disease
Carpal Tunnel Syndrome
CHF
Congenital Anomaly
COPD
Crohn's Disease
Depression
Diabetes
Epilepsy
GERD
Hypercholesterolemia
Hypertension
Hypothyroidism
Kidney Disease
Liver Disease
Migraines
Multiple Sclerosis
Osteoarthritis
Osteoporosis
Parkinson's Disease
Pulmonary Disease
Stroke
Substance Abuse

Other Conditions:

____

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

Flu Shot: _______________ **Pneumonia Shot:** _______________ **Colonoscopy:** _______________

Mammogram: _______________ **Pap Smear:** _______________ Covid Vaccine: Brand:_______________
1st dose:______________ 2nd dose: _____________

HOSPITALIZATIONS / SURGERY / OUTPATIENT PROCEDURES: ☐ None

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

____

____

LAST NEUROLOGICAL EVALUATION: Date: ________________

PRIOR IMAGING:

MRI: Facility:____________________ Date: ___________ **CT Scan:** Facility:_________________ Date: _____________

X-Rays: Facility:_____________________ Date: ____________ **US:** Facility:_________________ Date: ______________

Other:____

MEDICATIONS: NONE or

Name	Strenth / Frequency	Name	Strength / Frequency

ALLERGIES/ADVERSE DRUG REACTIONS: NONE or **INCLUDE** allergies to medications / other medical products (tape, latex, and iodine)

Name of Medicine or Product:	Description of Reaction:

Illicit Drug use (includes occasional or past) NO YES If yes, explain: ____

Alcohol: Specify type, amount, and frequency

Current: ____

Past: ____

Tobacco: Current / Former Smoker / Never **(Circle One)**

Current: ____

Past:____