Movement Disorders Center of ARIZONA, LLC

*Caring Solutions. Improving Quality of Life.*

**PATIENT INFORMATION** Date _____

Name _____ SSN _____
(Last) (First) (M.I.)

Address _____

City _____ State _____ Zip Code _____

Hm# _____ Cell# _____ Wk# _____

Sex ☐ Male Age _____ DOB _____ ☐ Married ☐ Single ☐ Divorced

☐ Female ☐ Widowed ☐ Other

E-mail Address _____

Employed? ☐ No ☐ Yes Employer _____

Emergency Contact Name _____ PH# _____

Referring Physician _____ PH# _____

Primary Care Doctor _____ PH# _____

**PRIMARY INSURANCE**

Insurance Name _____ Insured's Name _____

Insured's DOB _____ Insured's SSN _____

Relationship to Insured _____ Insurance Ph# _____

Policy or ID# _____ Group# _____

**SECONDARY INSURANCE**

Insurance Name _____ Insured's Name _____

Insured's DOB _____ Insured's SSN _____

Relationship to Insured_____ Insurance Ph# _____

Policy or ID#_____ Group# _____

## CONTACT INFORMATION

I may be contacted in the following manner:

| | |
|---|---|
| OK to leave message with detailed information | ☐ Home ☐ Work ☐ Cell ☐ No |
| OK to leave call-back number only | ☐ Home ☐ Work ☐ Cell ☐ No |
| OK to send mail to | ☐ Home ☐ Work ☐ No |

Those who may receive information included in my medical records:

☐ Spouse Name _____ DOB _____

☐ Other Name _____ DOB _____

☐ Other Name_____ DOB _____

_____

Patient's Signature and Date

## ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance and assign directly to the *Movement Disorders Center of Arizona, LLC* all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The *Movement Disorders Center of Arizona,* LLC may use my healthcare information and may disclose such information to the above named insurance company/s and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of the Patient/Parent/Guardian Date

# Movement Disorders Center of Arizona

**Patient: _____DOB:_____ Date: _____**

**WHY ARE YOU HERE? _____ Referring Physician _____**

**Past Medical History** (Please circle or list any medical conditions (past and present) and current medications)

- ☐ Head injury / Concussion
- ☐ Loss of Consciousness
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Stroke / TIA
- ☐ Arthritis
- ☐ Asthma
- ☐ Cataracts
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Valve Replacement
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Kidney Disease / Failure
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ Pacemaker
- ☐ Pregnant at this time
- ☐ Prostate Disease
- ☐ Serious Injury
- ☐ Sickle Cell Disease
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ VD / Syphilis

Others (Please list):

1.
2.
3.

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**Review Of Systems** (Please check any of the following symptoms you have)

**Neurologic:**

- ☐ Balance Problems
- ☐ Confusion / Memory Loss
- ☐ Dizziness
- ☐ Headache
- ☐ Involuntary Movements
- ☐ Muscle Weakness
- ☐ Sleep Disturbance
- ☐ Speech Problems
- ☐ Swallowing Difficulties
- ☐ Tingling / Numbness
- ☐ Tremor
- ☐ Visual Disturbances
- ☐ Walking Problems

**General:**

- ☐ Fatigue / Loss of Energy
- ☐ Recent Weight Gain/Loss
- ☐ Fever / Chills

**ENT:**

- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Poor sense of smell
- ☐ Poor sense of taste
- ☐ Drooling

**Sleep:**

- ☐ Snoring/Witnessed Apnea
- ☐ Insomnia
- ☐ Excessive Sleepiness
- ☐ Wo Stroke or CHF

**Psychologic:**

- ☐ Depression
- ☐ Anxiety / Nervousness
- ☐ Hallucinations

**Pulmonary:**

- ☐ Cough
- ☐ Change Shortness of Breath

**Cardiovascular:**

- ☐ Chest Pain
- ☐ Irregular Heart Beats
- ☐ Poor Circulation
- ☐ Murmur

**Eye:**

- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Eye Lid Drooping
- ☐ Eye pain

**Genitourinary:**

- ☐ Bladder Control Problems
- ☐ Pain During Urination
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Urination at night

**Hematologic:**

- ☐ Bleeding
- ☐ Easy Bruising
- ☐ Anemia

**Musculoskeletal:**

- ☐ Neck Pain or injury
- ☐ Back Pain or injury
- ☐ Broken Bones
- ☐ Muscle pain

**Dermatology:**

- ☐ Rashes
- ☐ Birth Marks

**Gastrointestinal**

- ☐ Nausea / Vomiting
- ☐ Stomach Pain
- ☐ Blood in Stool
- ☐ Diarrhea
- ☐ Constipation

**Endocrine:**

- ☐ Temperature Intolerance
- ☐ Breast Discharge
- ☐ Irregular Periods

9500 E. Ironwood Square Drive, Suite 118 Scottsdale, AZ 85258 (480)526-5441 Fax:(480)526-5443
Website: www.movementdisorders.us Email: Info@movementdisorders.us

## Social History

Tobacco? ☐Yes ☐No ☐Quit — If yes, how much? packs/day: If quit, when?

Alcohol (beer, wine, liquor)? ☐Yes ☐No ☐Quit — If yes, how many drinks per day?

Drug Use? ☐Recent ☐Past ☐None

Caffeinated Bev? ☐Yes ☐No — If yes, how many cups per day?

Planning Pregnancy? ☐Yes ☐No

Handiness: ☐Right ☐Left ☐Both

## Family History (Please circle or list any illnesses in blood relatives)

- ☐Headache / Migraine
- ☐High Blood Pressure
- ☐Mental Illness
- ☐Diabetes
- ☐Arthritis
- ☐Stroke Heart Disease
- ☐Tremor
- ☐Cancer
- ☐Seizure / Epilepsy
- ☐Nerve / Muscle
- ☐Parkinson's Disease or Parkinsonism

Other:

**Allergies:**_____

| **List of Medications:** | **Dose:** | **Frequency:** |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |
| 3._____ | _____ | _____ |
| 4._____ | _____ | _____ |
| 5._____ | _____ | _____ |
| 6._____ | _____ | _____ |
| 7._____ | _____ | _____ |
| 8._____ | _____ | _____ |

**Surgeries & Dates(List):**

1._____

2._____

3._____

4._____

# Movement Disorders Center of Arizona, LLC
# Notice of Privacy Practices

This notice describes how health information about you as a patient of the Movement Disorders Center of Arizona, LLC (MDCA) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

**Use and disclosure of your health information in certain special circumstances**

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member or U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

**Your rights regarding your health information**

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise

required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the MDCA, subject to a minimum fee of $20.

4. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Dr. Virgilio Gerald H. Evidente. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, please contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact Dr. Virgilio Gerald H. Evidente. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. If a disclosure of your protected health information was made for a reason other than treatment, payment, or health operations, you have a right to retrieve an accounting of the disclosure.

If you have any questions regarding this notice of our health information privacy policies, please contact Dr. Virgilio Gerald H. Evidente.

# Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been presented with a copy of the MDCA's Notice of Privacy Practices.

_____ _____

Signature of Patient or Responsible Party Date

_____

Name of Patient

_____

Relationship to Patient

# Movement Disorders Center of Arizona, LLC
# Financial Policy

Thank you for choosing the Movement Disorders Center of Arizona, LLC (MDCA) as your health care provider. We are committed to providing quality medical care. In order to reduce potential confusion and misunderstandings, we have adopted the following Financial Policy and require you to read it and sign it prior to commencement of any treatment.

**Insurance**

Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy, we will file claims for those plans with which we have an agreement. If your insurance company does not pay within a reasonable amount of time, (The state of Arizona has a *Timely Pay and Grievance Law*, which requires insurance companies to respond/process claims within 30 days), we will look to you for payment.

All health insurance plans are not the same, and they do not always cover the same services. In the event that your health plan determines a service is "not covered", you will be responsible for the complete charge. This office is not responsible for disputing insurance company decisions regarding coverage. Payment is due upon receipt of a statement from our office. We expect that you know your insurance benefits including, but not limited to: deductible and co-payment amounts as well as laboratories, radiology facilities and hospitals contracted with your plan. It is your responsibility to notify our office when your insurance plan or benefits change. Any costs incurred by this office because of incorrect information provided to us by you, will be your responsibility. If you have insurance coverage with a plan with which we do not participate, or you have no health insurance plan, our charges for you care and treatment are due at time of service.

**Deductibles and Co-pays**

Our insurance contracts require us to collect deductibles and co-pays at the time of service.

**Minors**

A parent of legal guardian must accompany a minor patient on his or her first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have a written permission from the parent of legal guardian. The adult accompanying the minor patient is responsible for payment of the services at the time of service.

**Appointments**
We strive to provide the best possible service and availability to all of our patients. Our policy is to charge $100 for missed appointments unless cancelled at least 24 hours in advance. Your insurance company does not cover this charge. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

**Authorization to release of Medical Information**
I hereby authorize the MDCA to release any information to my insurance company for payment of my medical charges, or to review activities related to my health care provider's participation with my health plan. I assign the MDCA any and all benefits to which the patient or insured party is entitled for medical services rendered.

## Acknowledgement of Receipt of Notice of Financial Policy

I have read the Financial Policy of the Movement Disorders Center of Arizona, LLC. I understand and agree to the Financial Policy.

_____ _____
Signature of Patient or Responsible Party Date

_____
Name of Patient

_____
Relationship to Patient