SouthernCalifornia
Movement Disorder Specialists

www.socalmds.com

65 North Madison Ave., Suite 410
Pasadena, CA 91101

Phone: (626-792-6683
Fax: (626) 793-5475

Date: _____

PATIENT INFORMATION:

Last name: _____ First name: _____ Middle Initial: _____
Street Address: _____ Apartment # _____
City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____ E-mail address: _____
Driver's License: _____ SS#: _____
Date of Birth: _____ Sex: □Male □ Female Race: _____ Ethnicity: _____

Marital Status: □Single □Married □Widowed □Divorced Alcohol Use: □ Yes □ No
Smoking/Tobacco Status: □ Current □ Former □ Never □ Social

PATIENT'S EMPLOYER:

Employer: _____ Occupation: _____ Telephone #: _____

SPOUSE'S INFORMATION:

Name of Spouse: _____ Telephone #: _____ Cellphone #: _____
___

PERSON NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____
Telephone Number: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Primary Care Physician: _____ Telephone #: _____ Fax #: _____
Pharmacy: _____ Telephone #: _____ Fax #: _____

INSURANCE (If you have more than one insurance carrier, please list the primary carrier first)

Primary Insurance: _____ Insured Person: _____ CO-PAY $ _____
Secondary Insurance: _____ Insured Person: _____
Please list name of insured person if other than the patient. _____

CARRIERS REQUIRE WE SEND COPIES OF YOUR INSURANCE CARD. PLEASE FURNISH US WITH YOUR INSURANCE CARD(S) FOR PHOTOCOPYING. ALL CO-PAYMENTS ARE PAID AT THE TIME OF SERVICE PER YOUR INSURANCE CONTRACT.

TO MEDICARE PATIENTS: MEDICARE DOES REQUIRE WE ENTER THE NAME OF THE REFERRING PHYSICIAN ON YOUR CLAIM FORM. WITHOUT THIS INFORMATION, THE CLAIM CANNOT BE PROCESSED.

How were you referred to us? □ Friend/Relative: _____ □ Internet Site: _____ □ Other: _____

Assignment of Benefits / Financial Agreement

I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Jerome P. Lisk M.D. &Southern California Movement Disorder Specialists, all medical 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 hereby authorize Dr. Jerome P. Lisk & Southern California Movement Disorder Specialists to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Consent For Treatment

I do hereby give the healthcare providers of Southern California Movement Disorder Specialists consent to perform all medical health care services, permission to diagnose and treat me until this permission is revoked in writing.

_____ _____
Signature of Insured/Guardian Date

New Neurology Patient

NAME: **Date:**

AGE:

Please write down why you are here today and symptoms you are having
(Location, Severity, Duration, Time of Onset, What Makes It better or Worse)

_____
_____
_____
_____

Medical Problems and year diagnosed:

1. _____ yr_____
2. _____ yr_____
3. _____ yr_____
4. _____ yr_____
5. _____ yr_____
6. _____ yr_____

Surgeries and year performed:

1. _____ yr_____
2. _____ yr_____
3. _____ yr_____
4. _____ yr_____
5. _____ yr_____
6. _____ yr_____

ALLERGIES:

Drug Allergies: _____ Adverse Reactions: _____

Drug Allergies: _____ Adverse Reactions: _____

Drug Allergies: _____ Adverse Reactions: _____

Food Allergies: _____ Adverse Reactions: _____

Environmental Allergies: _____
_____

Reactions: _____

Family Medical History--please list any health problems of all family members.
(Please indicate paternal and maternal relatives).

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Maternal Grandparent(s): _____

Maternal Aunt(s): _____

Maternal Uncle(s): _____

Paternal Grandparent(s): _____

Paternal Aunt(s): _____

Paternal Uncle(s): _____

Current Medication List

Patient Name _____

☐ Not currently taking ANY medications.

DOB _____

Medication Name

1. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

2. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

3. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

4. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

5. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

6. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

7. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

8. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

9. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

10. _____ _____ mg
☐_____ tablet(s) _____ times per ☐day ☐bedtime ☐week ☐month
☐ Time(s) of day _____
☐ As needed

Symptoms:

(*Please circle any new symptoms you are having*)

CONSTITUTIONAL: Fever, weight loss, fatigue, night sweats, light headed/dizziness, vertigo.

EYES: Blurriness, double vision, dryness, color vision loss, eye pain.

ENT: Loss of hearing, ear, and inner ear problems, difficulty swallowing solids or liquids, nose bleeds, horsiness, ringing in ears.

CARDIOVASCULAR: syncope (passing out), near syncope, palpitations, trouble breathing while lying flat, wake up from sleep with shortness of breath, chest pain with activity, chest pain with rest.

RESPIRATORY: pneumonia, pain when taking a deep breath, blood in sputum, wheezing, cough, history of Tuberculosis, shortness of breath.

GASTROINTESTINAL: aspiration while eating, nausea, vomiting, diarrhea, constipation, abdominal distention, abdominal pain, food getting stuck while eating, blood in stool, bowel incontinence, heart burn, reflux, pain when swallowing.

GENITAL URINARY: urinary incontinence, urinary hesitancy, urinary urgency, urinary frequency, and painful urination, flank pain, loss of urine control, bloody urine.

MUSCLES/SKELETAL: Joint pain, joint swelling, and back pain, warm joints, neck pain

SLEEP: Excessive/loud snoring, can't fall asleep or stay asleep, unable to fall asleep, wakes up at night, falling asleep during daytime, excessive limb movements while sleeping, waking up confused, acting out dreams or Sleep Apnea

ALLERGIES: Runny nose, sneezing, watery eyes, postnasal drip, nasal congestion

PSYCHIATRIC: Depression, Hallucination, stress, anxiety, suicidal plans

SouthernCalifornia
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Authorization to Discuss Personal Health Information

Patient: _____,

I give permission to Southern California Movement Disorder Specialists, and its affiliate providers to discuss my personal health information and data *(excluding HIV/AIDS test results/diagnosis)* with the following named people:

Name: (please print)	Initials:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature Date

HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control of your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

TREATMENT:
We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides cares to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT:
Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS:
We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of an appointment.

We may use or disclose your PHI in the following situations without your authorization: As required by law; public health issues as required by law, communicable disease, health oversight, abuse or neglect, Food and Drug Administration requirement, legal proceedings, law enforcement, coroners office, funeral directors, organ donation, research, criminal activity, military activity and national security, workers compensation. Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on this use or disclose indicated in the authorization.

The following is a statement of your rights with respect to your protected health information (PHI).

You have the right to inspect and copy your PHI: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your PHI: This means that you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also require that any part of your PHI not be disclosed to family members or friends who may be involve in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state, in writing, the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosed your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively.

You have the right to have your physician amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy of any such rebuttal.

You have the right to receive an accounting certain disclosers we have made, if any of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Privacy Officer Contact Information:
Tanai Smith
Business Manager
Telephone: (626) 792-6683
Fax: (626) 793-5475
Address: Southern California Movement Disorder Specialists
65 N. Madison Ave., Suite 410
Pasadena, CA. 91101

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMNETS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change it *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Patients Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I wish to have the following restriction to the use or disclosure of my health information:

_____

_____

_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: