THE NEUROLOGY GROUP
ADULT & PEDIATRIC NEUROLOGY

2895 N. TOWNE AVENUE, POMONA, CA 91767 (909) 267-7495 (909) 982-2719
630 N.13th AVE., SUITE B UPLAND, CA 91786 FAX (909) 946-9931 (909)625-8753

COPY FOR PATIENT TO KEEP

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SURJIT K. KAHLON, M.D. INC. LEGAL DUTY

Surjit K. Kahlon, M.D. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Surjit K. Kahlon, M.D. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Surjit K. Kahlon, M.D. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Surjit K. Kahlon, M.D. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We also provide information when required by law.

In any other situation, Surjit K. Kahlon, M.D. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Surjit K. Kahlon, M.D. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Surjit K. Kahlon, M.D. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Surjit K. Kahlon, M.D. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Surjit K. Kahlon, M.D. health information practices or if you have a complaint, please contact the following person:

Privacy Officer
Surjit K. Kahlon, M.D. Inc.
2895 N. Towne Ave., Pomona, Ca. 91767
Phone: 909-982-2719 909-267-7495
Fax: 909-946-9931

APPOINTMENT & CANCELLATION POLICY

BY APPOINTMENT ONLY

The Neurology Group sees patients by appointment only. We make every effort to provide prompt medical care to all of our patients. If you arrive in our clinic as a *walk-in*, please understand that you will be asked to schedule an appointment for a different time.

It is your responsibility to know when your next appointment is scheduled. You may request a reminder call as a courtesy; however, the responsibility of remembering your appointment is still yours regardless of whether or not we are able to reach you by phone.

LATE ARRIVALS

We make every effort to maintain appointment time commitments and we request that you extend the same courtesy to us. If you are running late, please call our clinic to reschedule. We understand that special circumstances can arise, which may cause you to run a few minutes behind. On occasion we are able to work-in late arrivals into the schedule; however, this is at the discretion of our front office staff. If you are more than 15 minutes late for an appointment, to help avoid delays in treatment and extensive waiting times, we may ask you to reschedule.

MISSED APPOINTMENTS (*NO SHOWS*)

The staff at The Neurology Group respects your time and we ask for the same courtesy. Missed appointments (*no shows*) affect our ability to provide timely attention to our patients. When a patient does not *show up* for their appointment, another patient loses an opportunity to be seen. If you are unable to make your appointment, we respectfully ask that you notify our clinic at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or *no show and* you will be charged $75 *no show* fee. **Protocol for** *No Shows***:**

If you fail to attend your appointment you will be charged a **$75** *no show* fee. In addition, a course of action will be determined based on the clinic team's review of your case and individual situation. You are directly responsible for payment of the *no show* fee on or before your next appointment. The *no show* fee cannot be billed to your insurance company.

PLAN ACCORDINGLY

Please remember that it is your responsibility to monitor your medication usage and to plan for your monthly follow up visits if you need refills. The Neurology Group does not consider it an emergency if you run out of medication as a result of a cancelled or missed (*no showed*) follow up visit. If you arrive at the clinic without an appointment, expecting to be seen for a refill, an appointment will be scheduled for you and you will be asked to return at that time. It is against our policy to *call-in* a prescription to a pharmacy for prescribed medications if the request is not submitted within our 72 hour turnaround time under any circumstance. Please plan your monthly follow up visits accordingly, taking holidays, weekends, and other non-clinic days into consideration.

RETURNING AFTER DISCONTINUING SERVICES

If you are an established patient and have not seen us for twelve (12) consecutive months, you will be required to complete a comprehensive screening and orientation session as part of our new patient evaluation (full intake).

THANK YOU FOR YOUR PATIENCE

We value you as our patient and know your time is valuable and we are always looking for ways to improve our ability to manage the rapid growth of new patients. It may seem that you are waiting a long time or that patients who arrive after you are being taken first. Please understand that waiting patients may not necessarily get *called back* in the order they arrive at our clinic. This is due to simultaneous appointment schedules, which are specific to multiple doctors in our clinic.

PATIENT NAM E: _____

SIGNATURE: _____ ***DATE:*** _____

Name:_____

CONSTITUTIONAL

Weight Change	Yes___No___
Fever	Yes___No___
Fatigue	Yes___ No___
Weakness	Yes___ No___
Chills	Yes___ No___

ENT/RESPIRATORY

Change in voice	Yes___ No___
Sore Throat	Yes___ No___
Ringing in ears	Yes___ No___
Difficulty swallowing	Yes___ No___

PULMONARY

Chronic cough	Yes___ No___
Othopnea-trouble breathing when lying down	Yes___ No___
Coughing up blood	Yes___ No___

CARDIOLOGY

Chest pain	Yes___ No___
Palpitations	Yes___ No___
Leg Swelling	Yes___ No___
Shortness of breath	Yes___ No___
Irregular Heart Beat	Yes___ No___

GASTROENTEROLOGY

Blood in stool	Yes___ No___
Diarrhea	Yes___ No___
Vomiting	Yes___ No___
Constipation	Yes___ No___
Nausea	Yes___ No___
Abdominal pain	Yes___ No___

DERMATOLOGY

Rash	Yes___ No___
Excessive sweating	Yes___ No___

ENDOCRINOLOGY

Diabetes	Yes___ No___
Urinating frequently	Yes___ No___
Thyroid dysfunction	Yes___ No___

EYES

Diminished Vision	Yes___No___
Visual changes	Yes___ No___
Double vision	Yes___ No___
Eye irritation	Yes___ No___

HEMATOLOGY

Easy Bruising	Yes___ No___
Varicose veins	Yes___ No___

ALLERGY/IMMUNE

Nasal/seasonal allergies	Yes___ No___
Runny nose	Yes___ No___
Stuffy nose	Yes___ No___
Itchy eyes	Yes___ No___
Asthma	Yes___ No___

GENITOURINARY

Difficulty urinating	Yes___No___
Blood in urine	Yes___No___
Erectile or other sexual dysfunction	Yes___ No___

SLEEP

Day time sleepiness	Yes___ No___
Snoring	Yes___ No___

MUSCULOSKELETAL

Joint Stiffness	Yes___ No___
Joint Pain	Yes___ No___
Leg cramps	Yes___ No___
Shooting leg pain	Yes___ No___
Back Pain	Yes___ No___

NEUROLOGY

Headache	Yes___ No___
Tingling	Yes___ No___
Seizure	Yes___ No___
Dizziness	Yes___ No___
Memory problems	Yes___ No___
Tremors	Yes___ No___
Loss of strength in specific body area	Yes___No__
Loss of sensation in specific body part	Yes___No__
Trouble with balance	Yes___ No___
Trouble with coordination	Yes___ No___
Gait abnormality	Yes___ No___
Falls	Yes___ No___
Weakness	Yes___ No___

Medication List

Pharmacy name & Location: _____

_____

Please List Any Allergies to Medications here:
1. _____ 2._____ 3. _____

4. _____ 5. _____6. _____

Medication	Dose	How many times a day?	Date Medication started	Prescribing doctor	Reason for Medication (Ex: Diabetes)	Any Side Effects?
Over the Counter Medications/ Diet Product/ Herbal Product						

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DEMOGRAPHIC SHEET

Date: _____

Patient Name_____DOB: _____

Race/ Ethnicity_____

Current Mailing Address: _____

Primary Phone Number: _____

Secondary Phone Number: _____

Primary E-mail Address: _____

Primary/Referring Providers Name: _____

Have you ever smoked before: YES \ NO

If yes how long ago? _____

Frequency: 1-5 6-10
Half a pack a day 1 pack a day

Emergency Contact:

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

Pharmacy Information:

Name: _____

Address:_____

City & Zip code: _____

Phone number: _____

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Acknowledgement of Receipt of Notice of Privacy Practices
PATIENT INFORMATION CONSENT FORM

I have read and fully understand The Neurology Group Notice of Information Practices. I understand that The Neurology Group may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to my treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that The Neurology Group will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Neurology Group Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____ _____
Patient Name Date

_____ _____ _____ _____
Patient or Guardian Signature Date updated Patient or Guardian Signature Date update

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ _____ Relationship:_____ Name: _____ Relationship: _____

Name:_____ Relationship:_____ Name:_____ Relationship: _____

_____
Patient or guardian signature

INSURANCE/PAYMENT AUTHORIZATION FORM

I understand that charges for medical services in this office are my responsibility. Appropriate efforts will be made by this office to bill my insurance, workman's comp, etc. if applicable, however I understand that co-pays, deductibles, and ultimately the total amount of my bill is my responsibility and I will be expected to settle my account in a timely manner. I authorize the release of medical information to process claims. I authorize payments under my insurance programs to be made directly to The Neurology Group for any services furnished to me. I also designate that any settlement from litigation first be applied to my medical bills from this office. This authorization also permits the release of information by HCFA (its intermediates or carriers) on any UNASSIGNED Medicare claims to the above. I further permit copies of this authorization to be used in place of the original.

_____ ***Date:*** _____

Patient (or responsible party) signature

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MEMBER INSURANCE WAIVER

Dear ALL INSURED PATIENTS: DATE:_____

If verification of coverage for your health plan benefits cannot be made at this time, services will be provided to you at this visit; however, in the event your coverage is not effective, you will be held responsible for payment. If in the event your health plan denies payment for services rendered, you, the patient will be held financially responsible. We will make every effort to bill your health plan before we bill the patient.

Patient Name: _____ Social Security No. _____

Subscriber's Name: _____ Social Security No._____
Address: _____City_____ST_____Zip code_____
Subscriber's Phone No. (Day) (_____)_____(Evening)(_____)_____
Insurance ID No. _____ Date of Birth (subscriber) _____
Subscriber's Employer _____Phone No.(____)_____

Patient or Guardian's Signature _____Date signed _____

Patient or Guardian's printed name _____

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Adult Intake Forms

DATE: _____

NAME: _____ AGE:_____

DATE OF BIRTH:_____SEX:_____RACE:_____

PLACE OF BIRTH:_____HAND USED FOR WRITING:_____

OCCUPATION:_____

REFERRING PHYSCIAN:_____PHONE:_____

PRIMARY PHYSCIAN:_____PHONE:_____

WHY ARE YOU BEING SEEN TODAY: _____

_____

HEALTH PRIOR TO PRESENT ILLNESS: _____

APPROX. DATE OF ONSET OF PRESENT ILLNESS: _____

TYPE OF ONSET SUDDEN – WITHIN 24 HOURS SPECIFY: _____

GRADUALLY – MORE THAN ONE DAY: _____

PROGRESSION OF ILLNESS: WORSENING _____ SAME _____ IMPROVING _____

NAME OF PREVIOUS DOCTORS SEEN FOR THE ABOVE ILLNESS: _____

_____

THEIR TREATMENT FOR THE PROBLEM: _____

_____

PREVIOUS SPECIAL EXAMINATIONS	**DATE OF EXAM: APPROX.**
EEG (BRAIN WAVE) _____	_____
SPINAL TAP _____	_____
BRAIN SCAN _____	_____
ANGIOGRAM_____	_____
SKULL X-RAY_____	_____
CAT SCAN_____	_____
OTHER_____	_____

LAW SUIT OR COMPENSATION PENDING: YES _____ NO _____

NAME: _____

PAST MEDICAL HISTORY:

MEDICAL ILLNESS: _____

HOSPITALIZATIONS AND SURGERIES: _____

_____

PACEMAKER:_____YES _____NO METAL IN BODY:_____YES _____NO

MENTAL ILLNESS: _____

ACCIDENTS: _____

MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

RECENT INFECTIONS: _____

IMMUNIZATIONS UP TO DATE: YES NO EXPLAIN _____

FOREIGN TRAVEL: YES NO WHAT COUNTRY AND HOW LONG: _____

ANIMAL BITES: YES NO WHAT KIND OF ANIMAL: _____

FAMILY HISTORY	**AGE**	**STATUS OF HEALTH**
MOTHER	_____	_____
FATHER	_____	_____
BROTHER	_____	_____
SISTERS	_____	_____
DAUGHTERS	_____	_____
SONS	_____	_____

FAMILY ILLNESS: (INCLUDING PARTICULAR ILLNESS THAT RUN IN YOUR FAMILY, IE. MUSCULAR DYSTROPHY, DIABETES, HYPERTENSION)

_____

WORK HISTORY OCCUPATION_____

EXPOSURE TO TOXINS: YES NO PREVIOUS OCCUPATION_____
HIGHEST LEVEL OF EDUCATION COMPLETED: _____MARITIAL STATUS_____

HABITS:	COFFEE	YES	NO	CUPS PER DAY_____
	TEA	YES	NO	CUPS PER DAY_____
	ALCOHOLS	YES	NO	HOW MUCH _____
	SMOKING	YES	NO	HOW MANY _____

SELF ASSESSMENT (Please use a sentence that you feel best describes yourself) _____

_____

WHAT TYPE OF PERSON DO YOU FEEL YOU ARE NOW (IE. HARD WORKING, AMBITIOUS, SHY, OUTGOING) _____
WHAT TYPE OF PERSON ARE YOU USUALLY? _____