PASSAIC SLEEP MEDICINE and NEUROLOGICAL SERVICES (NEURO WELLNESS)

155 Prospect Avenue Ste 104, West Orange NJ 07042
Tel:973-928-3288 Fax:973-928-3286

LAST NAME_____________________________FIRST NAME_____________________________MI_______

DATE OF BIRTH________________________SS#_________________________LICENSE#_______________

ADDRESS____

APT#__________________________________

CITY______________________________________STATE_____________ZIP CODE___________________

HOME PHONE_____________________CELL#_______________________WK#______________________

EMAIL ADDRESS____

MALE_______FEMALE______ MARRIED______ SINGLE________ DIVORCED_______WIDOW______

EMERGENCY CONTACT NAME___________________________ RELATION___________________________

EMERGENCY CONTACT PHONE#____

PHARMACY NAME____________________________________

PHARMACY ADDRESS__________________________________

PHONE#_____________________________

CAN WE LEAVE A VOICEMAIL ON MESSAGE MACHINE: YES__________ NO__________

FT EMPLOYED____ PT EMPLOYED______ RETIRED______ DISABLED_____ STUDENT____

OCCUPATION___________________________________

EMPLOYER NAME________________________________PHONE__________________________________

EMPLOYER ADDRESS ____

CITY_____________________________STATE___________________ZIPCODE________________________

REFERRED TO OFFICE BY____

NAME OF PERSON COMPLETING FORM IF OTHER THAN PATIENT_________________________________

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PRIMARY INSURANCE NAME ____

ID NUMBER ____

RELATIONSHIP TO INSURED IF OTHER THAN PATIENT: ____

PRIMARY INSURED HOLDERS NAME________________________________

DATE OF BIRTH____________________

ADDRESS:____

SECONDARY INSURANCE NAME____

ID NUMBER____

RELATION TO INSURED IF OTHER THAN PATIENT: ____

INSURED NAME____

DATE OF BIRTH________________

COPY OF INSURANCE CARDS AND PICTURE ID ARE NEEDED AT TIME OF VISIT.
ALL COPAYS MUST BE COLLECTED AT TIME OF SIGN IN.
COPAY MAY BE PAID BY CASH, CREDIT CARD, OR CHECK.
A FEE OF $35.00 WILL BE CHARGED FOR ANY CANCELLED OR RETURNED CHECKS.
IF YOUR ADDRESS HAS CHANGED OR YOU HAVE CHANGED YOUR INSURANCE PLAN, IT IS YOUR RESPONSIBILITY TO INFORM THE OFFICE AND PROVIDE UPDATED INFORMATION IN A TIMELY MANNER.

NO SHOW CONSENT

Your copay is due at time of visit. Also, since we reserve a certain amount of time for each appointment, it is important that **if you need to reschedule you must give the office a 24-hour notice**. If not, we enforce a $100.00 Follow up visit no show fee and a $150.00 in-office Diagnostic testing fee for any no show appointments without prior 24-hour notification.

By signing below, you agree to the terms of this agreement.

Patient Signature___________________________________ Date: __________________________

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INSURANCE AUTHORIZATION

I request that payment of Authorized Medicare benefits and or Private insurance companies be made on my behalf to Passaic Sleep Medicine and Neurological Services (Neuro Wellness), Dr Fawad Mian, MD for any services furnished to me. I authorize the release of ALL medical information pertaining to myself, be released to the insurance companies and its agents along with any information necessary to determine these benefits or benefits payable for related services. I understand that I am responsible for any balance not covered by my insurance company (this includes co-insurances, deductibles).

Patient Signature:_________________________________Date:_______________________________

ASSIGNMENT OF BENEFITS/ FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits be made directly to **Passaic Sleep Medicine and Neurological Service (Neuro Wellness), Fawad Mian, MD** for services rendered.
I understand that I am financially responsible for all charges regardless of insurance coverage. Accounts 20 days past due will be considered in default and it may become necessary to refer my account to an attorney for collections. If my account is referred to an attorney for collections, I agree to be responsible to pay all amounts, including attorney's fees in the amount of 30% of the default amount placed for collections. The attorney's fees in the above amount shall become due and owing at the time the account is placed for collections and I understand that it will be assessed and added to the balance at that time. I also agree to pay simple interest at the rate of 1.5% per month on any balance in default. I authorize my medical records to be released as necessary to secure payment of benefits. I also agree that a photocopy of this agreement shall be as valid as the original.

Patient Signature:_________________________________Date_________________________________

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PATIENT AUTHORIZATION TO DISCLOSE/RELEASE PERSONAL HEALTH INFORMATION

Patient Name: ____

(First Name) (Middle Initial) (Last Name)

Address: ____

Date of Birth: _________________________

Recipient/Discloser: ____

I AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL RECORDS:

I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS, including information, records, copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with any medical condition or other related issues. This includes permission to release Potentially Sensitive Information, which may include treatment of my medical condition(s), mental illness, HIV, alcoholism, drug usage/dependency, sexually transmitted diseases, sexual assaults, abortion(s), and all communications to Medical Doctors, Psychologists and Psychotherapists, if any.

I GIVE PERMISSION TO RELEASE ONLY THE RECORDS AS SPECIFIED BELOW:

____

I release Passaic Sleep Medicine and Neurological Services (Neuro Wellness) PC and the Recipient/Discloser listed above and ANY of their Providers and Staff from all responsibilities or liabilities that may arise from this authorization. I may withdraw this authorization at ANY time by giving written notification to Passaic Sleep Medicine and Neurological Services (Neuro Wellness) PC and other parties as duly assigned.

Patient Name: ____ Patient Signature: ____________________________

Witness Name: _______________________________________ Witness Signature: ___________________________

Date: ____________________________________

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Patient Name: ____________________________ Date of Birth: _________________ Date: __________

General
[]Weight Gain/Loss
[]Fatigue
[]Fever or Chills
[]Lightheadedness
[]Night Sweats
[]Sleep Disturbances
Skin
[]Rashes
[]Lumps
[]Itching
[]Dry Skin
[]Discoloration
[]Skin cancer
[]Dry mouth
[]Sore throat
[]Hoarseness
[]Acne
[]Blistering of skin
[]Eczema
[]Hives
[]Moles/Keloids
ENT
[]Hearing loss
[]Ringing in ears
[]Earache
[]Drainage
[]Mouth Sores
[]Sinusitis
[]Blocked ear
[]Nosebleed
[]Sinus Pain
[]Swollen glands
Eyes
[]Vision loss/changes
[]Pain
[]Blurry or double vision
[]Flashing lights
[]Floaters/Specks
[]Itching/redness
[]Discharge

CNS
[]Numbness in face
[]Weakness in face
[]Face drooping
[]Loss of taste/smell
[]Slurred speech
[]Difficulty Speaking
[]Difficulty Swallowing
[]Vertigo
Respiratory
[]Cough
[]Sputum
[]Shortness of breath
[]Wheezing
[]Painful breathing
[]Irregular/fast heartbeat
[]Palpitations
Cardiovascular
[]Chest pain or discomfort
[]Tightness
[]Difficulty breathing lying down
[]Swelling in arms/legs
[]Poor circulation
[]Cyanosis
Gastrointestinal
[]Abdominal Pain
[]Difficulty swallowing
[]Heartburn
[]Change in appetite
[]Nausea
[]Change in bowel habits
[]Rectal Bleeding
[]Constipation
[]Diarrhea
Coordination
[]Difficulty walking
[]Falling to one side
[]Sensation of being pushed
[]Falls
[]Unsteadiness
[]Balance difficulties
[]Clumsiness reaching for objects

Neurologic
[]Dizziness
[]Fainting
[]Seizures
[]Weakness
[]Numbness
[]Tingling
[]Tremor
[]Headache
[]Syncope/Fainting
Mental Status
[]Confusion
[]Loss of consciousness
[]Difficulty expressing/ understanding speech
[]Personality problems
[]Memory problems
Endocrine
[]Hot/cold intolerance
[]sweating
[]Frequent Urination
[]Thirst
Psychiatric
[]Anxiety
[]Stressors
[]Depression
[]Memory loss
[]Mood swings
[]Psychiatric admissions
[]Hallucinations
[]Delusions
Sleep
[]Snoring
[]Difficulty sleeping
[]Awakening at night
[]Increased sleepiness
[]Trouble falling asleep
[]Sudden awakening
[]Excessive Leg movement
Musculoskeletal
[]Muscle or joint pain
[]Stiffness
[]Back/head/neck pain
[]Immobility/function loss
[]Pain ________________
(Location)