



16 Pocono Road, Suite 205, Denville, NJ 07834  
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 \_\_\_\_\_ ZIP CODE \_\_\_\_\_

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 \$75.00 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:** \_\_\_\_\_

**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: \_\_\_\_\_

**CHECK OFF ALL THAT APPLIES:**

**GENERAL**

- Weight gain/loss
- Fatigue
- Lightheadedness

**CNS**

- Facial Numbness
- Facial Weakness
- Facial droopiness
- Loss of taste/smell
- Slurred speech
- Difficulty speaking
- Difficulty swallowing
- Vertigo
- CVA/Stroke

**COORDINATION**

- Difficulty walking
- Falling to one side
- Falls
- Balance difficulties
- Clumsiness

**MUSCULOSKELETAL**

- Muscle or joint pain
- Stiffness
- Back Pain
- Neck Pain
- Head Pain
- Elbow Pain
- Wrist Pain
- Shoulder Pain
- Knee Pain
- Immobility/Function loss
- Pain \_\_\_\_\_ (Location)

**ENT**

- Hearing loss
- Ringing in ears
- Sinusitis
- Sinus Pain
- Swollen Glands

**NEUROLOGIC**

- Dizziness
- Syncope/Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor
- Headache

**SLEEP**

- Awakening at night
- Increased sleepiness
- Difficulty falling asleep
- Sudden awakening
- Excessive leg movement

**GENITOURINARY**

- Loss of Libido
- Erectile Dysfunction

**SKIN**

- Rashes
- Acne
- Poor complexion
- Hair Loss
- Eczema

**MENTAL STATUS**

- Confusion
- Loss of consciousness
- Memory Loss
- Difficulty understanding speech
- Personality Issues

**CARDIOVASCULAR**

- Chest Discomfort/pain
- Palpitations

**ENDOCRINE**

- Thirst
- Frequent urination

**GASTROINTESTINAL**

- Abdominal pain
- Nausea

**EYES**

- Vision loss
- Pain in Eyes
- Blurry Vision
- Floaters
- Flashing lights

**RESPIRATORY**

- Cough
- Short of breath

**PSYCHIATRIC**

- Anxiety
- Depression
- Mood Swings
- Delusions
- Hallucinations

**ALLERGIES**

Medication \_\_\_\_\_ (Please list)

Food \_\_\_\_\_ (Please list)

OTHER \_\_\_\_\_ (Please list)