NEUROCARE
OF NEVADA

6410 Medical Center St., Ste. A
Las Vegas, NV 89148
PH: (702) 796-8500 / FX: (702) 796-8502

Gobinder S. Chopra. MD
Board Certified in Neurology
Board Certified in Neurophysiology
Board Certified in Brain Injury Medicine
Board Certified IME
Certified Disability Examiner

PLEASE PRINT CLEARLY

Patient Name: _____ Age: _____ Date of Birth: _____
Social Security#: _____ Marital Status: _____
Ethnicity: _____ Preferred Language: _____ Race: _____ Decline to specify:_____
P.O. BOX's are not accepted.
Home Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____
Home Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____
Can we text you? Yes_____ No_____
Email Address: _____ (For **Appointment Confirmations**)
Patient's Employer: _____ Occupation: _____

Referring Doctor (or Primary Care Doctor): _____ Phone: _____

INSURANCE INFORMATION

(Please bring Drivers License /Photo ID and Insurance cards to window to be copied)

Primary Insurance: _____ Phone: _____
Name of Policy Holder: _____ ID/Policy#: _____
Policy Holder Date of Birth: _____ Group #: _____ Social Security#: _____
Mailing Address for Claims: _____
Secondary Insurance: _____ Phone: _____
Name of Policy Holder: _____ ID/Policy#: _____
Policy Holder Date of Birth: _____ Group #: _____ Social Security#: _____
Mailing Address for Claims: _____

Attorney Name: _____ Phone: _____

Assignment of Benefits/Payment and Insurance Coverage/Collections Policy

I hereby authorize my insurance carrier(s) to pay: Gobinder S. Chopra, MD directly for all services. I authorize the release of ALL medical records or other information requested to assist in claims processing. I understand that I am fully responsible for any and all services not covered by said insurance carrier(s). I will come prepared to pay all co-payments and or deductibles etc. otherwise my appointment will be rescheduled. I understand that after 45 days my unpaid co-pay/deductible/balances etc will be forwarded to Allied Collection Agency.

If my account is forwarded to Collections: I am fully responsible for all cost to transfer my account to **Allied Collections.**

_____ By initialing I authorize this office to process my credit card payments by phone or mail to pay for balances or charges.

_____ _____

Patient Signature or Authorized Person **Date**

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RELEASE OF INFORMATION

Due to the confidential nature of your medical care, it is against the law to release and/or discuss your care or test results with anyone other than you, the patient, corresponding physicians and your insurance company. Please see the posted Privacy Notice for further explanation.

Therefore, please list the names and phone numbers of those persons to whom you want us to release information regarding your care. This will include all medical records, including psychological or psychiatric impairment (s), drug abuse, alcoholism, sickle cell anemia, AIDS, or test for an infection of HIV and its results.

If you do not list your spouse, mother, father, sister, brother, friend, or attorney etc., they will not be privileged to any of the information regarding your medical care or condition.

We will not discuss any information with anyone not listed on this sheet. Thank you
(Please re-read the above sentence)

Name	Phone#	Relationship to you

We will be sending copies of your results and reports to your referring and or primary care doctor. Additional copies that you request will be provided to you upon a within 30 business daysat the cost of $0.60 cents per page.

Please give the name and phone number of a reliable person that we may contact in case of an emergency. **This is very important!** Should an emergency arise, we need someone to contact.

Emergency Contact Name: _____

Phone: (Home) _____ (Cell) _____

Patient Signature: _____ **Today's Date:** _____

Valid for 1 year unless otherwise revised by patient

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CONSENT TO RELEASE INFORMATION

I hereby authorize the release of any and all medical records, test results or other information contained in my medical chart to Gobinder S. Chopra, MD from any doctor or medical facility where medical services have been rendered to me. This release shall be made to include any records considered sensitive, i.e., psychological or psychiatric impairment(s) or condition(s); drug or alcohol, abuse or treatment(s); sickle cell anemia, AIDS, or test for infection with HIV.

I further understand that this consent to release information will allow Gobinder S. Chopra, MD to release any information in my medical chart to my insurance company regarding billing claims and request for information; my selected pharmacy and/or pharmacist; referring doctors or other doctors/specialist who are treating me or to whom I am being referred to for additional care; and hospital or medical facility where I have obtained medical treatment or where treatment may be sought or to any person whom I have listed in the release of information. I understand that this includes records considered sensitive, i.e., psychological or psychiatric impairment(s) or condition(s); drug or alcohol, abuse or treatment(s); sickle cell anemia, AIDS, or test for infection with HIV.

_____ _____

Patient Signature **Date**

ADDITIONAL ACKNOWLEDGEMENT

Please be advised that it is mandatory by Nevada Statute that if Gobinder S. Chopra MD becomes aware of any medical condition that may affect your ability to operate a motor vehicle this information will be released to the appropriate State Authority. This may result in a suspension of your driver's License.

Further, if at any time an attorney request records from this office said attorney must provide a Release for medical records which includes the above mentioned sensitive records release or subpoena the records by official process from an appropriate court of law. To insure confidentiality, this medical information will **only** be faxed to another medical facility. We do not fax to a private residence or attorney's office.

_____ _____

Patient Signature **Date**

Acknowledgement of Review of Notice of Privacy Policy

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Patient Signature **Date**

For office use only

Notice of privacy practices sent/delivered on _____ Initials_____

Signed Acknowledgement of Receipt received on _____ Initials_____

Patient refused or failed to Acknowledge Receipt on _____ Initials_____

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OFFICE POLICIES

1. Office hours are: Monday through Thursday from 7:00 a.m. to 5:30 p.m. The office is closed on Friday Saturday and Sunday. There is a physician on call for the office 24 hours a day, seven days a week.

2. All patients are given the necessary time and attention at each visit therefore you may experience wait times beyond the scheduled appointment. If calling and you receive our voicemail please leave a detailed message. All calls are returned within 48 hours. If your call is urgent, please inform the operator so that she may direct you to the proper person.

   IF YOUR SITUATION IS LIFE THREATENING, PLEASE CALL 911, OR GO TO THE NEAREST EMERGENCY ROOM.

3. Please call at least 24 hours in advance to cancel or reschedule an appointment or you may incur a $50 no-show charge.

4. No Children are allowed when TESTING. You must comply with all testing instructions or your appointment will be rescheduled. There are no exceptions.

5. Completion of and Signatures for the entire “New Patient Packet” are required. You must have a valid photo ID and insurance cards at time of service. You are required to sign in upon arrival and you must sign your superbill after each visit.

6. You must bring a Translator (If not fluent in English). A witness or guardian is required if medically necessary. If being transported an attendant must accompany you for the entire visit. We will not assist in transporting, lifting or physically supporting patients who are not able to move independently. Your appointment will be rescheduled.

7. Compliance is not negotiable. Any act of Non-Compliance will result in immediate termination of care with no exceptions.

8. PER NRS 629.051 Healthcare records may be destroyed after 5 years.

_____ _____

Patient Signature **Date**

By signing I confirm to have read, I understand and agree to all terms and will comply.

Please visit our website:
www.neurocareofnevada.com

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PATIENT RESPONSIBILITIES

Most Insurance companies require authorization for the testing ordered by our doctor. We will do everything possible to get the necessary authorization on your behalf. We frequently run into delays depending upon the complexity of the authorization process set up by the individual insurance requirements. Normally we allow two weeks to obtain **ULTIMATELY** it is your responsibility to communicate with your insurance company if the situation warrants.

As a patient, it is your responsibility to:

- Follow through with all test & visits for test results as ordered
- Inform us immediately of any Insurance, address, phone number etc. changes
- Obtain all results of test ordered and communicate with your doctor at follow up visits.
- Inform us immediately if you are experiencing any difficulties with your medications.
- Inform us immediately if your symptoms change or worsen
- Make sure you do not run out of medication. Call 1 week before out of meds.
- Provide your Insurance Company with any requested information.
- Pay all co-payments and deductibles at the time of you

Your doctor cannot be responsible or held liable if you fail to follow through with test that have been ordered. Tests are ordered to help establish a specific diagnosis or rule out any serious disease processes, should they exist. You must complete the test ordered and follow up with the doctor to obtain test results.
WE DO NOT GIVE TEST RESULTS OVER THE PHONE.

You, the patient, must actively participate in your care. Communication is vital in any doctor-patient relationship. If your insurance company denies our request for diagnostic testing, we may be able to make arrangements so that you can complete the test as ordered.

By signing this form, you agree to assume your responsibilities as a patient, and have agreed to actively participate in your care and treatment.

_____ _____

Patient Signature **Date**

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PERSONAL MEDICAL HISTORY FORM

Date: _____

Name: _____ Ht: _____ Wt: _____
Occupation: _____ Previous Occupation: _____
Date of birth: _____ Sex: ☐ Male ☐ Female
Are you: ☐ Right handed ☐ Left handed ☐ Both
Reason for your visit today and how long you have had this problem:

_____

Is your visit related to a MVA or Work related Accident? ☐ Yes ☐ No
If yes are you currently off work? ☐ Yes ☐ No Date last worked if answered Yes _____
Do you have any NEW medical problems or symptoms? ☐ Yes ☐ No
If yes please explain _____
Did you have any MRI, X-Ray, and/or CT testing ordered by another Physician since scheduling this appointment? ☐ Yes ☐ No
If yes where and when? _____
Have you had any recent blood tests ordered by another Physician? (In last 6 months) ☐ Yes ☐ No
If yes where and when? _____
Have you been to the Hospital since you scheduled this visit? ☐ Yes ☐ No
If yes where and when? _____
Have you seen another Neurologist other than Dr. Chopra? ☐ Yes ☐ No
If yes where and when? _____
Operations (Surgery) _____ Date (s) _____
_____ _____
_____ _____

List medications which you take regularly:

Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____
Type _____ Dose/Frequency _____

Diseases that run in your family:

Mother _____
Father _____
Other _____

List medication you are allergic to: **Type of reaction you have**

_____
_____

List all Physicians that <u>currently</u> treat you for other conditions:

_____
_____

How did you hear about us? _____

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Do you currently have or have you EVER had?

Numbness: ☐ Current ☐ Past ☐ No
Where?_____
Neuromuscular Disease: ☐ Current ☐ Past ☐ No
Double vision: ☐ Current ☐ Past ☐ No
Loss of hearing: ☐ Current ☐ Past ☐ No
Ringing in the ears: ☐ Current ☐ Past ☐ No
Dizziness: ☐ Current ☐ Past ☐ No
Loss of smell: ☐ Current ☐ Past ☐ No
Loss of taste: ☐ Current ☐ Past ☐ No
Loss of coordination: ☐ Current ☐ Past ☐ No
Loss of speech: ☐ Current ☐ Past ☐ No
Memory loss: ☐ Current ☐ Past ☐ No
Paralysis: ☐ Current ☐ Past ☐ No
High Blood Pressure: ☐ Current ☐ Past ☐ No
Sugar Diabetes: ☐ Current ☐ Past ☐ No
Stroke: ☐ Current ☐ Past ☐ No
Heart attack: ☐ Current ☐ Past ☐ No
Heart murmur: ☐ Current ☐ Past ☐ No
Heart failure: ☐ Current ☐ Past ☐ No
Irregular heartbeat: ☐ Current ☐ Past ☐ No
Rheumatic fever: ☐ Current ☐ Past ☐ No
Tuberculosis: ☐ Current ☐ Past ☐ No
Asthma: ☐ Current ☐ Past ☐ No
Cancer: ☐ Current ☐ Past ☐ No
What type? _____
Bleeding problems: ☐ Current ☐ Past ☐ No
Ulcers: ☐ Current ☐ Past ☐ No
Breathing problems: ☐ Current ☐ Past ☐ No

Glaucoma: ☐ Current ☐ Past ☐ No
Loss of eyesight: ☐ Current ☐ Past ☐ No
Loss of control of bladder: ☐ Current ☐ Past ☐ No
Loss of control bowel: ☐ Current ☐ Past ☐ No
Thyroid disorder: ☐ Current ☐ Past ☐ No
Sinus Disease: ☐ Current ☐ Past ☐ No
Digestive disorder: ☐ Current ☐ Past ☐ No
Kidney stones: ☐ Current ☐ Past ☐ No
Kidney disease: ☐ Current ☐ Past ☐ No
Arthritis: ☐ Current ☐ Past ☐ No
Severe injury to head: ☐ Current ☐ Past ☐ No
Severe injury to neck: ☐ Current ☐ Past ☐ No
Severe injury to back: ☐ Current ☐ Past ☐ No
Spinal meningitis: ☐ Current ☐ Past ☐ No
Encephalitis: ☐ Current ☐ Past ☐ No
Passing out spells: ☐ Current ☐ Past ☐ No
Seizures: ☐ Current ☐ Past ☐ No
Headaches: ☐ Current ☐ Past ☐ No
Anemia: ☐ Current ☐ Past ☐ No
Venereal disease: ☐ Current ☐ Past ☐ No
Liver Disease: ☐ Current ☐ Past ☐ No
(ex: Hepatitis)
Emphysema: ☐ Current ☐ Past ☐ No
Exposure to toxic material: ☐ Yes ☐ No
When?_____
Tested for AIDS: ☐ Yes ☐ No
Positive? ☐ Yes ☐ No
Allergic to X-ray dye: (iodine) ☐ Yes ☐ No
Do you Smoke: ☐ Current ☐ Past ☐ No
How many per day? _____
Do you Drink: ☐ Current ☐ Past ☐ No
How many per day? _____
Have you ever used
Illegal Drugs? ☐ Current ☐ Past ☐ No
What Kind? _____

Females only:
Are you pregnant? ☐ No ☐ Yes
Do you take birth control pills: ☐ No ☐ Yes

If you answered **NO** to the question **"Are you pregnant"** please be advised that it is your responsibility to advise our doctor immediately should you become pregnant at any time while under our care.

Printed Name: _____

Signed: _____ **Date:** _____

I have read this and agree to comply

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Epworth Sleepine

Name: _____ Today's Date: _____

Your age (Yrs): _____ Your sex (Male = M, Female = F): _____

How likely are you To doze off or fall asleep in the following situation, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to chose the **most approprite number** for each situation:

0 = would **never** doze
1 = **slight chance** of dozing
2 = **modrate chance** of dozing
3 = **high chance** of dozing

It is important that you answer each question as best you can.

Situation	**Chance of Dozing (0-3)**
Sitting and reading	
Wating TV	
Sitting, inactive in a public plase (e.g. a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstance permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alchool	
In a car, while stopped for a few minutes in the traffic	

THANK YOU FOR YOUR COOPERATION

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NAME: _____ DATE: _____

The Rivermead Post-Concussion Symptoms Questionnaire*

After a head iinjury or accident some people experince symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms give below As many of these symptoms occur normly, we would like you to compare yourself now with before the accident. For each one, please circle the number closest to your answer.

0 = Not experienced at all
1 = No more of a problem
2 = A mind problem
3 = A severe problem
4 = A severe problem

Compared with beforre the accident, do you know (i.e., over the last 24 hours) suffer from:

Headache.....	0	1	2	3	4
Feeling of Dizzines.....	0	1	2	3	4
Nausea and/or Vomiting.....	0	1	2	3	4
Noise Senssitivity,	0	1	2	3	4
easily upset by loud noise.....	0	1	2	3	4
Sleep Disturbance.....	0	1	2	3	4
Fatigue, tiring more easily.....	0	1	2	3	4
Being irritable, easily angered.....	0	1	2	3	4
Feeling Depressed or Tearful.....	0	1	2	3	4
Feeling Frustrated or impatient.....	0	1	2	3	4
Forgetfulness, poor memory.....	0	1	2	3	4
Poor concentration.....	0	1	2	3	4
Taking Longer to think.....	0	1	2	3	4
Blurred Vision.....	0	1	2	3	4
Light Sensitivity	0	1	2	3	4
Easily upset by bright light.....	0	1	2	3	4
Double Vision.....	0	1	2	3	4
Restlessness.....	0	1	2	3	4

Are you experiencing any other difficulties?

1. _____	0	1	2	3	4
2. _____	0	1	2	3	4

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MEDICAL LIEN

I, the undersigned patient (or legal guardian of a minor), grant to Dr. Gobinder chopra (hereafter "medical facility") a lien upon the recovery of any and all proceeds from any source obtained through settlement, judgment, for any medical services rendered to me or the minor, for tretment of injuries sustained or the exacerbation of any medical conditation(s) (hereafter "treatment") that or the minor have indicated, believe or did in fact arise out of an incident that occurred on or about the date set forth below (hereafter "incident"). I further authorise the medical facility to furnish my attorney with a full report of the examinations, diagnoses, treatments, prognoses, as well as billings for treatment for this incident. I hereby notify and authorize you, my attorney, to pay directly to the medical facility the unpaid amount due for services rendered.

I understand that apart from this lien, I am directly and fully responsible to the medical facility for the medical bills submitted by it for services rendered, even for bills incurred for the minor (as indicated below) who may reach the age of majority, for which I may be required to make a lump sum or periodic payments, at the election of medical facility. This lien is made solely for said medical facility's additional protection, and in consideration of its awaiting payment. Except as otherwise provided below, I intend for this lien to continue until all charges have been satisfied. I agree that the statute of limitations of my obligation to pay is tolled and does not begin to run while the medical facility is awaiting payment by way of this lien. I further understand that the payment of services is not contingent upon any settlement, judgment, or verdict that the minor or I may eventually recover.

Except as provided below, I agree never to rescind this lien, and I do not grant any attorney that may represent the minor or me the right to rescind it. However, if my first attorney does not promptly sign, acknowledge and return this lien to the medical facility within 10 (ten) days of receipt of this lien, or if the first attorney for any reson (e.g., withdraws, resigns, is released by me, or substituted by another attorney) no longer represents me or the minor child for injuries arising from this incident, then the Irrevocable Assignment of Proceeds that I have signed with this medical facility supersedes this lien and takes immediate effect. Alternatively, if an attorney modifies this lien in any way, then the Assignment of Proceeds supersedes this lien and takes immediate effect when the modification occurs. I agree to promptly notify medical facility of any change of my address or change or addition of attorney(s).

To my attorney: Please acknowledge this medical lien by signing below and returning it to the medical facility's office.

Date of Incident: _____ **DOB:** _____ **Print Name:** _____

Date: _____ _____

Signature of Patient or Legal Guardian of Minor

I, the undersigned attorney, state that I am the attorney of record for this patient; I acknowledge that I am in reciept of this lien; and I agree to observe its terms by withholding the sums from any settlement, judgment or verdicat that are owed to the medical facility, for their compensation or benifit. I also agree to promptly (1) notify the medical facility if I discontinue representation of this patient/client, and to (2) provide any subsequent attorney of the patient for this incident a copy of this lien, along with all of the medical facility's records and billings in my or my law firm's possession. In the event this lien is litigated, the prevailing party will be awarded attorney's fees an d costs.

Attorney Name: _____ **Attorney Signature:** _____

Attorney Phone Number: _____ **Attorney Address:** _____

Please sign, date and return one copy to medical facility's office within 10 days after reciept.
Also keep one for your records

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Patient Name: _____ DOB _____

SSN (Last Four): _____ DL State and No. _____

Insurance Campany: _____

Claim No (s).: _____ Date of Incident: _____

ASSIGNMENT OF PROCEEDS

I, the undersigned Patient (or as legal guardian of the minor Patient), (also referred to below as "Patient") of Dr. Gobinder Chopra ("Medical Provider"), without assigning any cause of action to this Medical Provider, unconditionally and irrevocably assign the proceeds of any settlement, judgment or verdict, up to the full amount of the unpaid medical services rendered by Medical Provider to Patient relating to the Date of Incident. I authorize these proceeds to be paid directly to GDP Consulting Inc, located at 8010 W . Sahara Ave., Suite 260, Las Vegas, Nevada 89117. i understand that agree that said office is authorized to contact the Insurance Company and me on behalf of the Medical Provider, to obtain information concerning the facts and status of Patient's case (e.g., completion of care, settlement status, insurance company information, etc.). Payment to a Patient, if a minor, shall be made by way of a minor's compromise, as required by low. The total amount owed, when it becomes a sum certain, will be provided to Insurance Company from one or more of the following sources: Patient, Medical Provider or GDP Cousulting Inc. Upon execution of this agreement, I authorize and direct the Medical Provider or GDP Consulting, to furnish the Insurance Company with all reports, findings, interpretations, impressions, treatments, diagnoses, and/or diagnostic studies that Medical Provider may perform or order for Patient received relating to the Date of Incident.

I fully understand that this assignment of proceeds is contingent upon the outcome of my claim or case, and if there is no recovery from the Insurance Company, or if less than the full amount is assignable to the Medical Provider then this assignment will not satisfy my obligation to pay the Medical Provider in full for sevices rendered. I fully understand that I remain directly and fully responsible to Medical Provider for all unpaid balances of medical bills associated with the sevices rendered to Patient, whether or not there is any financial recovery from the Insurance Company or other source. I agree that the statue of limitations for the Medical Provider to take action for the collection of any unpaid balance commences (1) six years after it is determined that this assignment of prosseds will not satsfy the amount owed or (2) six years after day of Patient's or parent/legal guardian's last payment towards the amount owed, whichever is later. The balance owed will accrue interest at the rate of 18 precent per annum from the date of the statute of limitations begins to run. Collection fees shall be the responsibility of the patient.

If Patient does not initially retain an attorney, but later decidest to retain one, then I agree to promptly (1) furnish Medical Provider with the attorney's contact imformation, and (2) notify patient's attorney concerning existence of this Assignment of Proceeds. In the event that the Patient is paid by way of settlement, judgment or verdict, patient agrees not to accept any money from either the Insurance Company or Patient attorney from any of the proceeds that have been assigned to the Medical Provider. Medical Provider shall be paid in full out of the first proceeds of any money paid by Insurance Company or Patient's attorney.

Print Name of Patient: _____ **Date:** _____

_____

Signature of Patient or Legal Guardian of Minor Patient

Medical Provider acknowledges that GDP Consulting Inc is granted limited power of attorney to enforce this Assignment of Proceeds, and to receive, endorse and deposite into its trust account any funds received.

Authorized Representation of Medical Provider: _____ **Date:** _____