



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: 3090 S. Durango Dr. #101 Las Vegas, NV 89117 PH: (702) 737-5506

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 Representative

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 days at 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 or Authorized Representative: _____ **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 or Authorized Representative

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.

Furthermore, 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 ensure 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 or Authorized Representative

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OFFICE POLICIES

1. Office hours are: Monday through Thursday from 8:00 a.m. to 5:00 p.m. The office is closed on Friday Saturday and Sunday.
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 they 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 during office visits and 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. Nevada State Board of Medical Examiners PER NRS 629.051 Healthcare Record Retention:
 - Medical records available for 5 years after their receipt or production.

Patient Signature or Authorized Representative

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 authorization **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 you're out of medication
- Provide your Insurance Company with any requested information
- Pay all co-payments and deductibles at the time of your appointment

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 or Authorized Representative

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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 currently 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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TRAUMATIC BRAIN INJURY SCREEN TOOL

Epworth Sleepiness Scale (ESS)

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 choose the **most appropriate number** for each situation:

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

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

Situation

Chance of Dozing (0-3)

Sitting and reading _____

Watching TV _____

Sitting, inactive in a public place (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 circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

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 injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you now suffer from any of the symptoms given below. As many of these symptoms occur normally, 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 mild problem
- 3 = A moderate problem
- 4 = A severe problem

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

Headache.....	0	1	2	3	4
Feelings of Dizziness.....	0	1	2	3	4
Nausea and/or Vomiting.....	0	1	2	3	4
Noise Sensitivity,	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 |