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 Traumatic Brain Injury (TBI) 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 PAPERWORK

(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 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 **Date**

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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 out of meds
- 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 **Date**

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PERSONAL MEDICAL HISTORY FORM

Date: ________________

Name: ____ Ht: ____________ Wt: ____________

Occupation: ____________________________ Previous Occupation:____________________________

Date of birth: ____________________ Sex: ☐ Male ☐ Female ☐ Other Please Specify ______________

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