NEW PATIENT INFORMATION

Today's Date		
Name: (*Last, First, MI*)		
Date of birth:	Home phone:	Cell Phone:
Current address:		
City:	State:	ZIP Code:
Race/Ethnicity:	Preferred language:	
Emergency Contact:		Phone:
Relationship with patient:		

Pharmacy	Address	Phone Number

INSURANCE INFORMATION

Primary Insurance _____

Policy ID _____ Group # _____

Secondary Insurance _____

Policy ID _____ Group # _____

Referring Doctor: _____

Clinic/Medical office: _____

NEW PATIENT HISTORY

Name: (*Last, First, MI*) _____ **DOB** _____

Reason for Today's Appointment:		
Past Medical History		
☐ Seizures	☐ Stroke or TIA	☐ High Cholesterol
☐ Diabetes	☐ Heart Disease	☐ Anemia
☐ Arthritis	☐ Ulcers	☐ Kidney Disease
☐ Bleeding Disorder	☐ Head Trauma	☐ Anxiety
☐ Depression	☐ Migraine	☐ Liver Disease
☐ Sleep Apnea	☐ Respiratory Problems	
Other Conditions:		
Prior Surgeries and Dates:		
Allergies:		
Name of Drug	**Reaction you had**	

Medications		
Name	Dosage	Frequency

Family History			
Father	Alive ☐	Deceased ☐	Significant Health Problems:
Mother	Alive ☐	Deceased ☐	Significant Health Problems:
Number of Siblings			Significant Health Problems:
Number of Children			Significant Health Problems:

Social History			
Marital Status:			Occupation:
Education:			Who lives with you?
Smoking?	YES ☐	NO ☐	If Yes, How Many packs per day?
			How Many years?
Alcohol?	YES ☐	NO ☐	If Yes, Amount per Week:
Marijuana?	YES ☐	NO ☐	If Yes, Frequency:
Other Drugs?	YES ☐	NO ☐	Which?

the neuron clinic

44045 Margarita Road #106, Temecula, CA 92592
Ph: (951) 462-4624 Fax: (951) 462-4625
450 4th Avenue #215, Chula Vista, CA 91910
Ph: (619) 425-3840 Fax: (619) 425-3842
Email: info@theneuronclinic.com
Website: theneuronclinic.com

CANCELLATION / NO SHOW POLICY

Effective March 17, 2021

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family.

Please, provide our office with a **24-hour Notice** to change or cancel an appointment.

Office appointments which are cancelled with less than a 24-hour notification or patient's who do not show up for their scheduled appointment will be subject to a **$50.00 Cancellation/No Show fee**.

This fee cannot be billed to the insurance company and must be paid on or before the next scheduled appointment.

After 2 consecutive unjustified no shows or 3 unjustified no shows per calendar year patient relationship with the Neuron Clinic will be terminated.

With my signature I acknowledge that I have read and understand the Cancellation/No Show Policy of The Neuron Clinic:

_____
Patient's Name

_____ _____
Signature Date

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PATIENT TERMINATION POLICY

Effective March 17, 2021

The Neuron Clinic providers and staff strive to create a pleasant working environment. We understand that there are times when you may be frustrated due to your current symptom(s) or personal situation(s). We will make every attempt to help you. However, this practice, under no circumstances, will tolerate:

- Verbal abuse for any reason.
- Physical abuse.
- Repeated failed appointments.
- Patient refusal to go to the Emergency Room as directed by a provider.
- Failure to follow provider orders regarding labs or referrals.
- Patient failure to follow prescription medication orders or discontinuation of medications without notifying The Neuron Clinic.

ANY VIOLATION OF THE ABOVE STATED CIRCUMSTANCES OR ANY FORM OF ABUSE IS GROUNDS FOR *IMMEDIATE* DISCHARGE FROM THE NEURON CLINIC. (THIS INCLUDES ANY/ALL FAMILY MEMBERS ASSOCIATED WITH OUR PRACTICE).

Print Patient Name: _____ Date: _____

Patient Signature _____Date: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS
(Page 1 of 2)

Chula Vista
Phone: (619) 425-3840 Fax: (619) 425-3842

Temecula
Phone: (951) 462-4624 Fax: (951)462-4624

Patient Name	Patient Date of Birth

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

I hereby authorize the disclosing physician or health care provider noted below to release medical information to the receiving physician or health care provider indicated:

FROM: _____ **TO:** **The Neuron Clinic**

(Disclosing physician or provider)

_____

(Street Address)

_____

(City, State, Zip Code)

Release records and information regarding: _____

(Patient's Name)

_____ _____ _____

(Date of Birth) ***(Social Security #)*** ***(Telephone Number)***

_____

(Address, City, State, Zip Code)

DURATION: This Authorization shall become effective immediately and shall remain in effect through _____ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This Authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requestor may not lawfully further use or disclose the health information unless another Authorization is obtained from me or unless the disclosure is specifically required or permitted by law.

AUTHORIZATION TO RELEASE MEDICAL RECORDS (page 2 of 2)

SPECIFY RECORDS: ☐ **Medical Information** ☐ **X-Ray/Other Imaging**

☐ **Psychiatric** _____ _____
Signature ***Date***

☐ **Drug/Alcohol** _____ _____
Signature ***Date***

☐ **HIV Test Results** _____ _____
Signature ***Date***

☐ **Genetic Testing** _____ _____
Signature ***Date***

☐ **Other (specify)** _____

_____ _____
Signature ***Date***

REQUESTED RECORDS TO BE PROVIDED VIA: ○ **Paper** ○ **CD/Other Portable Storage** ○ **via FAX**

I request that the health information released pursuant to this authorization be used for the following purposes only: _____

_____

_____ _____
Patient/Guardian Signature ***Date***

A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization and the copy is for me to keep.

_____ _____
Patient/Guardian Signature ***Date***

_____
Relationship to Patient (if signed by other than Patient)

CONFIDENTIAL INFORMATION MAY BE ACCESSED BY TNC EMPLOYEES FOR PURPOSES OF PHOTOCOPYING INFORMATION IN RESPONSE TO PROPERLY AUTHORIZED REQUESTS FOR COPIES OF MEDICAL RECORDS.

YOUR RECORDS FOR **2 YEARS** IS ALL THAT WILL BE COPIED UNLESS OTHERWISE REQUESTED. THERE MAY BE A CHARGE FOR RECORDS OLDER THAN 2 YEARS

THE COPYING PROCESS USUALLY TAKES 15 WORKING DAYS. RECORDS WILL NOT BE FAXED.

the neuron clinic

www.theneuronclinic.com

PERMISSION TO DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

I hereby grant permission to The Neuron Clinic (TNC) to speak to the following individuals about my health and disclose my health information including billing and insurance. I understand this authorization does not include information regarding HIV, psychiatric, drug and/or alcohol records, which must be authorized on a separate release.

	NAME	DOB
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____
Guardian	_____	_____
Caregiver	_____	_____
Sister	_____	_____
Brother	_____	_____
Friend	_____	_____
Emergency Contact	_____	_____
Other	_____	_____

You may discuss my (please check all that apply)

☐ Visit Notes ☐ Laboratory Results ☐ X-rays ☐ Reports ☐ All Services and Treatment Rendered

I understand that I may revoke this authorization at any time in writing.

Patient Name (please print)_____ Patient Date of Birth_____

Patient/Guardian Signature_____ Date_____

THE NEURON CLINIC
NOTICE OF PRIVACY PRACTICES

Effective May 1, 2019

It is the policy of The Neuron Clinic to maintain the privacy and security of protected information our patients and employees entrust to us. Specifically, The Neuron Clinic is aware of and abides by the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing regulations, other federal and state laws intended to protect privacy, and the contractual privacy and security requirements that apply to us.

Under HIPAA, The Neuron Clinic, must take steps to protect the privacy of your "protected health information" (PHI). PHI includes information that we have created or received regarding your health or payment for health care services. It includes both your health/mental health records and related personal information such as your name, social security number, address, and phone number. We are also required to:

- Provide you with this Notice of Privacy Practices (which may be amended from time to time), and
- Follow the practices and procedures in the Notice.

Please note that while not all The Neuron Clinic services involve the collection and use of protected health information as defined by HIPAA (including mental health information), we always strive to maintain strict confidentiality of your personal information whether or not the information may be considered protected health information under HIPAA rules.

Please acknowledge your understanding and acceptance of this Notice by signing the acknowledgment below. **Return the signed acknowledgement to the front desk or your service provider at The Neuron Clinic.**

If you have any questions about this Notice please contact your clinic service provider, or the Clinic Operations Manager at 619-658-1305

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, [print name]_____, acknowledge that I received a copy of the complete Notice of Privacy Practices for The Neuron Clinic.

_____ _____

Signature of patient (or personal representative*) Date

***If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:**

Personal Representative's Name:_____[print name]

Relationship to patient: _____

For TNC Office Use Only:

Acknowledgment of Notice of Privacy Practices could not be obtained for above-named person because:

☐ Individual refused to sign.

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other:_____

TNC staff:_____Date: _____