

GILBERT NEUROLOGY

JONATHAN W. HODGSON, D.O.
KENNETH E. ROOT, JR., D.O., F.A.C.N.

TELEPHONE: (480) 926-0644

FAX: (480) 926-0645

2730 S. VAL VISTA DR., STE. 146
GILBERT, AZ 85296

Dear New Patient:

Thank you for your recent request for an appointment with Dr. Root, Dr. Hodgson, or Dr. DeJesus.

We are pleased to schedule your appointment as follows:

Date: _____ Check in Time is _____ am/pm

You need to arrive 15-30 minutes prior to your scheduled appointment time.

There is a possibility you will not be able to be seen if you do not arrive as requested before the scheduled time of the appointment due to the paperwork and chart preparations required by our staff.

Please fill out the enclosed paperwork beforehand in black ink and bring it with you to the appointment.

Remember to bring the following to your appointment:

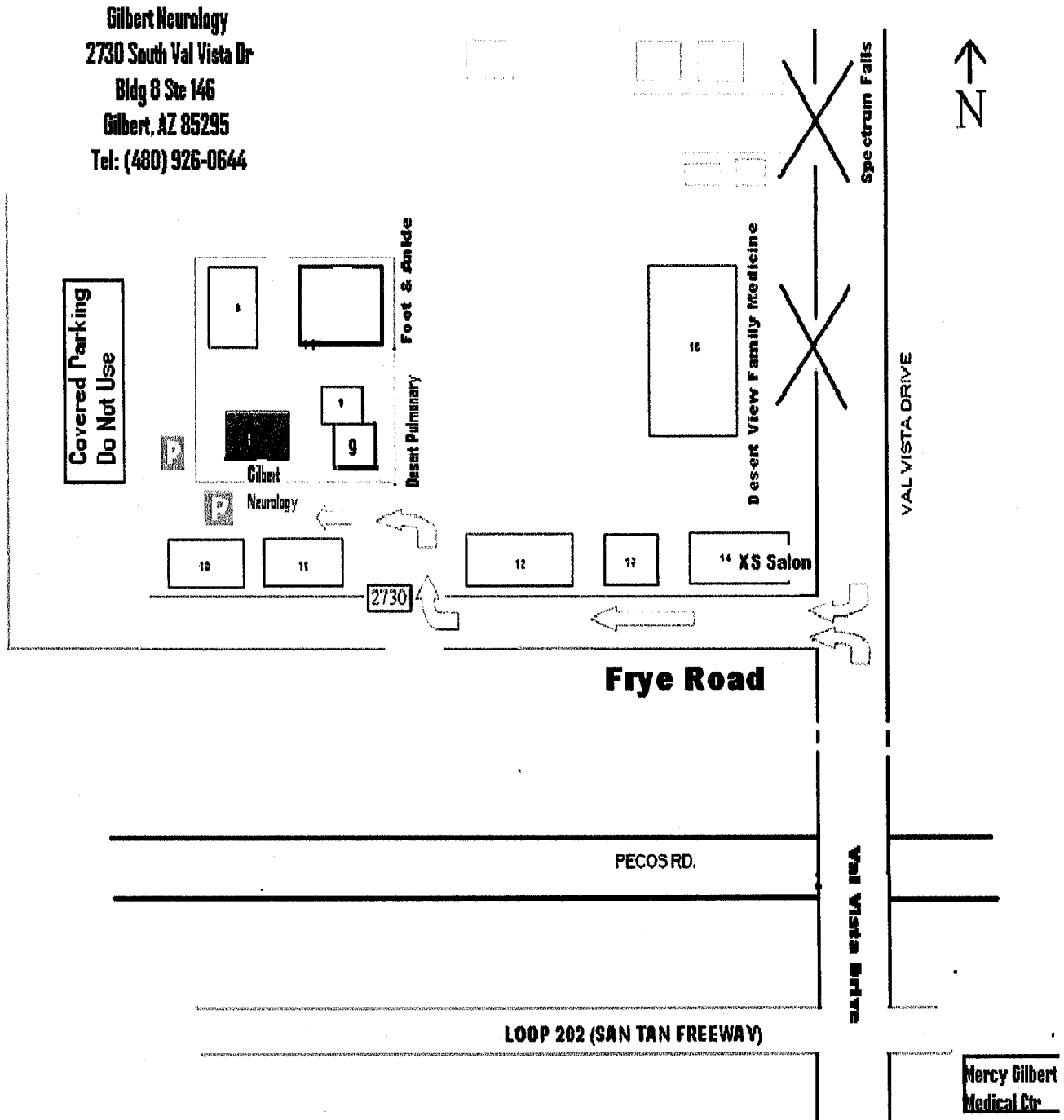
- 1 Completed paperwork**
- 2 Current Insurance cards**
- 3 Any appropriate recent lab test results, medical reports, and MRI – CT – X-rays completed for the specific condition for which you will be seeing the doctor**
- 4 Referral form from your primary care physician if your health plan requires it**

If you have any questions, please call Gilbert Neurology at (480) 926-0644, or fax us at (480) 926-0645

Thank you!

Directions to Gilbert Neurology

We are located in Gilbert, just North of the SOUTHERN loop of the 202 (San Tan Freeway) on the West side of Val Vista Drive. From I-10 East (towards Tucson), the 101 South, or surface streets, take the 202 (San Tan Freeway) East to Val Vista Drive. Turn left at end of ramp on to Val Vista. Go 0.8 miles [thru 3 lights]; turn Lt on Frye (a small side street) and take the first right into the "Spectrum Falls" complex; we're in Bldg 8, Ste. 146.



Gilbert Neurology, P.C. Financial Responsibility

2730 South Val Vista Drive, Suite 146 Gilbert, AZ 85296 (480) 926-0644 Fax (480) 926-0645

Patient Name _____

I understand a \$25 charge will be made for broken appointments unless 24-hour notice is given.

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. Your insurance company determines insurance benefit payments. I understand I will be responsible for the portion not covered by my insurance.

I understand I will pay my co-pay at the time of my visit. We accept cash, Visa and MasterCard credit cards and personal checks.

I understand there is a \$25 charge for a Non-Sufficient Funds (NSF) check.

I understand there is a charge (\$15-\$40 as determined by Physician) for all forms deemed appropriate, filled out by the Physician (e.g. Disability, FMLA, etc.). When dropping forms off, I must allow 5-7 days for completion.

I understand that Gilbert Neurology does not accept liens; worker's compensation or MVA/auto claims and am responsible for any insurance claims denied for such. If my medical insurance denies or takes back any monies provided, I understand I am responsible to pay all claims in full timely.

I understand that I am responsible for all charges if it is determined that the insurance information I have provided is not correct.

Due to the large amount of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.

Delinquent accounts will be turned over to an attorney or collection agency without notice. **Accounts will be considered delinquent if unpaid after 60 days of the billing date.** In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize my insurance company to make payment directly to: Gilbert Neurology, P.C.

Signature of patient (or parent / guardian) _____

Print Name _____

Date _____

Gilbert Neurology, L.L.C.

Kenneth Root, DO, Jonathan Hodgson, DO, Mildred Dejesus, MD, Kathleen LuPone, APRN
2730 S. Val Vista Drive, Suite 146, Gilbert, AZ 85296

Name: _____ Date of appointment: _____

What is the main problem you are having? _____

Is this due to an accident? ___Y ___N ___Don't Know Is a legal case pending? ___Y ___N ___Maybe

Age _____ R___ L___ HANDED

PLEASE
LEAVE
THIS BOX
BLANK

Have you had any Tests done already? (e.g., MRI, Cat scan, EMG, X-rays, Ultrasound, etc...)

| <u>Test / X-Ray</u> | <u>Approximate Date Done</u> | <u>Result</u> |
|---------------------|------------------------------|---------------|
|---------------------|------------------------------|---------------|

ALLERGIES: Do you have any allergies to any medicine? _____

What **MEDICINES** are you taking?

| <u>Name of Medicine</u> | <u>Dosage</u> | <u>Times per Day</u> | <u>For What</u> | <u>Approx. Date Started</u> |
|-------------------------|---------------|----------------------|-----------------|-----------------------------|
|-------------------------|---------------|----------------------|-----------------|-----------------------------|

-
-
-
-
-
-
-
-

What over the counter (OTC) medicines, vitamins or herbal supplements are you taking?

Name of OTC/Vit/Herb Dosage Times per Day For What Approx. Date Started

-
-
-
-
-

Have you stopped any medicine recently or used other medicine in the past for this problem?

Do you take birth control pills, patch or implant? Y N What? _____

PAST MEDICAL HISTORY Do you have any other medical problems such as:

| <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | | <u>Yes</u> | <u>No</u> | |
|------------|-----------|-----------------|------------|-----------|---------------------|------------|-----------|-------------------------------|
| ___ | ___ | diabetes | ___ | ___ | ulcers | ___ | ___ | heart problem |
| ___ | ___ | kidney problem | ___ | ___ | hepatitis | ___ | ___ | stroke |
| ___ | ___ | thyroid problem | ___ | ___ | cancer | ___ | ___ | arthritis |
| ___ | ___ | fibromyalgia | ___ | ___ | seizures | ___ | ___ | asthma/emphysema |
| ___ | ___ | TMJ | ___ | ___ | depression | ___ | ___ | anxiety |
| ___ | ___ | lung disease | ___ | ___ | high cholesterol | ___ | ___ | headache |
| ___ | ___ | eye disease | ___ | ___ | osteoporosis | ___ | ___ | chronic pain in: |
| ___ | ___ | anemia | ___ | ___ | high blood pressure | ___ | ___ | back ___ neck ___ other |

Other medical conditions: _____

PAST SURGICAL HISTORY Please list surgeries or operations in the past and approximate dates.

FAMILY HISTORY

Do you have any family members with similar problems as you? Y N

Do you have any family members with?

| | | | | | | | |
|-------------|---|---|------|--------------|---|---|------|
| brain tumor | Y | N | who? | stroke | Y | N | who? |
| seizures | Y | N | who? | heart attack | Y | N | who? |
| headaches | Y | N | who? | aneurysm | Y | N | who? |

SOCIAL HISTORY:

Level of Education: _____

Marital Status: Single Married Divorced Widowed

Number of Children: _____

Do you use tobacco? Y N How much? _____

Do you drink alcohol? Y N How much? _____

Do you drink caffeine? Y N How much? _____

What is your occupation or major daytime activity? _____

Have you been unable to work or carry out your usual daytime activities due to this problem?

___ able to work ___ have trouble working ___ have missed some work
___ less productive ___ can not work ___ have not worked since _____

In the past 3 months:

how much work or school have you missed because of this problem? _____

how many visits to the ER, Urgent Care treatment? _____

Have you ever abused drugs or alcohol? Y N if yes explain: _____

Review of Systems History Check only if recent or significant.

Name: _____

Date:

Updated:

General

| | | |
|--|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Trouble walking | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Fatigue/tiredness | <input type="checkbox"/> Clumsy |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Dull taste/smell | <input type="checkbox"/> Joint pains |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Fever | |

Dermatological

| | | |
|-------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Bruise easily |
|-------------------------------|-----------------------------------|--|

EENT

| | | |
|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw click | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Drooling |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dry mouth | |

Cardiac, Circulatory, Respiratory

| | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> High BP | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Irregular hrt beat | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Short of breath | | |

Gastrointestinal

| | | |
|---------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Stomach cramps |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | |

Genital and Urinary

| | | |
|---|--|--|
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Hesitancy urinate |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urge to urinate | <input type="checkbox"/> Impotence |

Pregnancy and Gynecology (Women only)

| | | |
|--|--|------------------------------------|
| <input type="checkbox"/> # of pregnancies | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Duration of period (days) | |

Neurological and Psychological

| | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety or tension | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Moodiness/temper | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Stress |

**GILBERT NEUROLOGY, L.L.C.
HIPAA PRIVACY NOTICE**

Purpose of this Notice

At Gilbert Neurology, L.L.C. we are committed to treating and using protected health information about you responsibly. We are also required by federal law to take reasonable steps to ensure the privacy of your health information.

The use and disclosure of Protected Health Information (PHI) is regulated by the federal law, the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules in 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulation will supersede this Notice if there is any discrepancy between the information in this Notice and the regulation.

Effective Date

The effective date of this Notice is April 14, 2003.

Privacy Officer

Gilbert Neurology, L.L.C. has designated a Privacy Officer to oversee the administration of privacy at this office and to receive complaints. The Privacy Officer is the Practice Administrator and may be contacted as follows:

Gary Almy
Gilbert Neurology, L.L.C.
2730 South Val Vista Drive, Suite 146
Gilbert, AZ 85295
(480) 926-0644 ext. 21

Your Protected Health Information

Each time you visit Gilbert Neurology, L.L.C. a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information serves as the basis for planning your care and treatment. It is also a means for communicating among the many health professionals who contribute to your care, is a legal document describing the care you received, and is the means by which you or a third-party payer can verify that services billed were actually provided.

The term "Protected Health Information" (PHI) includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by Gilbert Neurology, L.L.C. in spoken, written, electronic, or any other form.

When Gilbert Neurology can disclose your PHI

Under the law, Gilbert Neurology, L.L.C. may disclose your PHI, without authorization, in the following cases:

At your request. If you request it, Gilbert Neurology, L.L.C. is required to give you access to your or your dependent's PHI.

As required by an agency of the government. In general, Gilbert Neurology, L.L.C. does not need you to sign a valid authorization to release your PHI if required by law or for public health and safety purposes. Gilbert Neurology, L.L.C. is allowed to use and disclose your PHI without your authorization under the following circumstances:

- When required by law
- When permitted for purposes of public health activities
- When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of such abuse.
- When required for judicial or administrative proceedings (e.g. subpoena or discovery request)
- When required for law enforcement purposes
- When required to be given to a coroner or medical examiner
- For research, subject to certain conditions
- To comply with workers' compensation or other similar programs established by law

For treatment, payment or health care operations. Gilbert Neurology, L.L.C. and its business associates will use PHI, without a signed valid authorization or your opportunity to restrict or object, when carrying out treatment, payment or health care operations.

Implicit authorization to release PHI and process for restriction. In addition to disclosures mandated by law, and disclosures to individuals or entities you have specifically authorized, Gilbert Neurology, L.L.C. will assume your authorization for release of PHI to the following:

- Your spouse, if you do not restrict or object
- Your legal representative with a valid power of attorney, your court-ordered (approved) guardian, or your conservator, if you do not restrict or object.
- Your designated personal representative, if you have not revoked your personal representative
- Either parent of a minor child, if you do not restrict or object

You may specifically restrict authorization by submitting a signed, written request for restrictions to the Privacy Officer noted on page one.

Your Individual Privacy Rights

Although your health record is the physical property of Gilbert Neurology, L.L.C., the information in your record does belong to you and, therefore, you have rights related to its uses and disclosures. Except as otherwise indicated in this Notice, uses and disclosures of your PHI will be made only with your signed valid authorization, subject to your right to revoke your authorization.

In addition, you have the following rights:

You may inspect and receive a copy of your PHI.

You have the right to amend your PHI.

You have the right to receive an accounting of PHI disclosures:

At your request, Gilbert Neurology, L.L.C. will provide you with an accounting of disclosures made by Gilbert Neurology, L.L.C. The accounting will not include disclosures made before April 14, 2003.

You have the right to receive a paper copy of this Notice upon request.

Your personal representative:

You may exercise your rights to your PHI by designating a personal representative. You must designate your personal representative before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed and signed letter designating your personal representative.

- Gilbert Neurology, L.L.C. will automatically consider a parent or guardian as the personal representative of an unemancipated minor (a child generally under age 18) unless applicable law requires otherwise or you restrict such disclosure.
- Personal representative designations may be revoked at any time by submitting a written statement of revocation. This statement must be received by the Privacy Officer prior to a revocation becoming effective.

You have the right to file a complaint if you believe your privacy rights have been violated.

To exercise one or more of these rights, you should submit a signed, written statement detailing your request to the Privacy Officer listed on page one of this Notice. Gilbert Neurology, L.L.C. is not required to agree to your request if the Privacy Officer determines it to be unreasonable, for example, when a custodial parent is seeking treatment for your minor child or when it would interfere with Gilbert Neurology, L.L.C.'s ability to file a claim.

Responsibilities of Gilbert Neurology, L.L.C.

Gilbert Neurology, L.L.C. is responsible for the following items:

Maintain privacy of your health information. Gilbert Neurology, L.L.C. is required by law to maintain the privacy of your PHI.

Notice Distribution: Gilbert Neurology, L.L.C. is required to provide you with notice of its legal duties and privacy practices. This Notice is effective beginning on April 14, 2003. However, Gilbert Neurology, L.L.C. reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by Gilbert Neurology, L.L.C. If a privacy practice is changed, a revised version of this Notice will be provided to patients.

Disclosing only the minimum necessary PHI: When using or disclosing PHI, Gilbert Neurology, L.L.C. will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment
- Uses or disclosures made to you
- Disclosures made to the DHHS
- Uses or disclosures required by law (e.g. Public Health Agencies)
- Uses or disclosures required for compliance with legal regulations (e.g. subpoenas)

Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer as follows:

Gary Almy, Gilbert Neurology, L.L.C.
2730 South Val Vista Drive, Suite 146
Gilbert, AZ 85295
(480) 926-0644 ext. 21

There will be no retaliation for filing a complaint. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the DHHS.

If you need more information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact Gilbert Neurology, L.L.C.'s Privacy Officer.

Gilbert Neurology, L.L.C.

2730 South Val Vista Drive Ste. 146, Gilbert, Arizona 85296

Privacy Notice

(480) 926-0644

I have received the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Gilbert Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Gilbert Neurology upon request.

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Gilbert Neurology and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

| | |
|-------|-------------------------|
| _____ | _____ |
| Name | Relationship to Patient |
| _____ | _____ |
| Name | Relationship to Patient |

MESSAGES:

Y ___ N ___ It is ok to leave a message on my home voice mail #: _____

Y ___ N ___ It is ok to leave a message on my work voice mail #: _____

FAXES: When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, by its very nature, is not confidential.

| | |
|-------------------|---------------|
| _____ | _____ |
| Patient Name | Date of Birth |
| _____ | _____ |
| Patient Signature | Date |