KERN COUNTY NEUROLOGICAL MEDICAL GROUP, INC

Account #_____

Today's Date: _____

First Name: _____ M.I. _____ Last Name: _____

SSN: _____ - _____ - _____ Sex: ☐**Male** ☐**Female** Date of Birth: _____

Email Address: _____

Marital Status: ☐Single ☐ Married ☐Divorced ☐Widowed ☐Legally Separated

Employment Status: ☐Employed ☐Retired ☐Disabled ☐Student ☐Unemployed Work Phone: _____

HOME INFORMATION

Address : _____

Please check your appointment reminder preference (one only):

☐Phone Call: _____ ☐ E-mail address:_____ ☐Text Message: _____

REFERRAL INFORMATION

Referring Physician _____ Phone: _____

Primary Care Medical Doctor: _____ Phone: _____

INSURANCE INFORMATION/RESPONSIBLE PARTY

Primary Insurance: _____ ID:_____ GROUP: _____

If the insured/guarantor is someone other than the patient, please complete the following:

First Name: _____ M.I. _____ Last Name: _____

Sex: ☐Male ☐Female Date of Birth: _____ SSN: _____

Relationship to: ☐Self ☐Spouse ☐Dependent ☐Other:

Secondary Insurance:_____ ID:_____ GROUP: _____

If the insured/guarantor is someone other than the patient, please complete the following:

First Name: _____ M.I. _____ Last Name: _____

Sex: ☐Male ☐Female Date of Birth: _____ SSN: _____

Relationship to: ☐Self ☐Spouse ☐Dependent ☐ Other:

EMERGENCY CONTACT INFORMATION (NOT LIVING WITH THE PATIENT)

Name: _____ Relationship to Patient: _____ Phone: _____

INSURANCE ASSIGNMENT, AUTHORIZATION AND NON COVERED BENEFITS WAIVER

I hereby assign benefits to be paid directly to Kern County Neurological Medical Group (KCNMG) and authorize the clinic to furnish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid by insurance.

I understand certain tests or procedures are not a covered benefit within my insurance plan or policy. These **tests may include but are not limited** to nerve conduction studies, electromyography (EMG), and Botox injections. I know that if I have any questions regarding what is or is not covered under my insurance plan or policy; I should contact my insurance carrier prior to having the test/procedure performed. If I have a test or procedure performed that is not a covered benefit within my insurance plan or policy due to medical necessity or any services deemed part of a third-party liability such as, but not limited to, Worker's Comp and Motor-Vehicle Accident, I **understand I am responsible for payment in full** for the incurred charges. I understand that KCNMG will consider this waiver current for today's visit and any future visits.

X _____

Signature of responsible party / Signature of patient (or parent, if minor) Date

KERN COUNTYNEUROLOGICAL MEDICAL GROUP, INC.
1705 28TH STREET BAKERSFIELD, CA 93301-1902
(661) 322-3008 FAX (661) 322-2137

Financial Policy (KCNMG)

Thank you for choosing us as your healthcare provider. Please review and sign where indicated.

INSURANCE: We participate in most local HMOs, major PPOs, Medicare, and other commercial insurances. As a courtesy, we will file all your claims to your insurance providers. Your insurance is a contract between you and the insurance company. Please make sure to contact your insurance to ensure that services will be covered prior to your appointment. Our office will verify if you have an active insurance coverage at the time of service, however, verification or approved authorization is not a guarantee of payment. Your insurance will make the determination of payment based on your plan provisions. **Any non-covered charges are still your responsibility**. For Self-pay, all fees are paid at the time of service. Please inform our office of any changes to your insurance before your appointment, you may be responsible for all charges denied by your insurance for failure to provide us your updated insurance information on a timely manner.

PAYMENTS: All co-pays, co-insurance, and unmet deductibles are paid at the time of service. These are your financial obligation as part of your contract with your insurance company. **If you are unable to pay your coinsurance/deductible, or co-payment at the time of visit, your appointment may need to be rescheduled.** Previous balance are required to be paid in full, unless, a signed payment arrangement has been made. You are expected to adhere to the scheduled payment plan signed, and keep your account current. Your account may be sent to external Collection Agency and reported to Credit Bureau if no payments are made after three (3) mailed statements and/or you have failed to comply with the signed payment arrangement. You will be responsible for any collection, interest or legal expenses associated with the collection efforts.

NO SHOW/ CANCELLATION: There is a $25 no show fee charge for any doctor's appointment and $50 no show fee for any test/procedure appointments not cancelled 24 hours prior to scheduled appointment. Continued care is essential to your health and failure to adhere to agreed upon plan of care may have significant consequences to your health. Hence, three (3) consecutive no-shows and/or four (4) cancellation/reschedule of appointments may result to **dismissal** from KCNMG. You will refer back to your primary care physician.

MEDICAL RECORDS/BILLING FEES: A fee of up to $40 **due prior** to complete any forms such as disability, DMV paperwork, etc and up to $35 is **due prior** to copying Medical/Billing records. Fees are calculated based on length of forms and volume of medical /billing records. Please allow 7-10 business days for completion.

RETURNED CHECK: You will incur a $25 fee for each check returned due to non-sufficient funds. You will be asked to pay with other forms of payments the total amount of the check plus the $25 returned check fee prior to receiving any services from our office.

DISMISSAL/TERMINATION OF SERVICES: If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your doctor. You have to find a doctor in another practice.

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Common Reasons for Dismissal

- Failure to keep appointments, frequent no-shows, cancellations/reschedule
- Noncompliance, which means you won't follow physician instructions about an important health issue
- Disruptive behavior (abusive to staff or other patients)
- Failure to pay your bill

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I have read and acknowledged the above financial policies.

Signature_____ Date_____

Patient/Guarantor

Printed name_____ DOB_____

Account#: _____

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KCNMG Patient Portal Opt-Out Request Form

I request that my health information *not* be viewable through the KCNMG Patient Portal (https://phr.cgmus.com/).

Please initial that you have read and understand each the following statements.

_____ I request and understand that by submitting this Opt-Out Request Form, my health information will ***not*** be viewable by health care providers through CGM Patient Portal except in emergency situations.
_____ I understand that I am free to opt back in at any time and can do so by registering at the front desk.

I understand this request only applies to sharing my health information through the Patient Portal system. I recognize that when I see a health care provider for treatment, that provider may request and receive my medical information from other providers using other methods permitted by law, such as fax, mail, secure messaging, or other means.

Patient First Name:	**Patient Last Name:**	**Account Number:**
Previous Names or Nicknames:		**Date of Birth (mm / dd / yyyy)**
Mailing Address:		**Last 4 digits of Social Security Number:**
City, State, Zip Code:		
Contact Phone Number		

_____
Signature of Patient (or Authorized Representative)
If under 18 years, signature of parent or guardian

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PERMISSION TO FURNISH MY MEDICAL INFORMATION

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to Kern County Neurological Medical Group, Inc. to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available. Unless otherwise indicated, you will leave a message on my answering machine or voice mail with any routine results, instructions or appointment reminders when I am not immediately available.

Approved Person(s)	Relationship to Me
_____	_____
_____	_____
_____	_____

- ❑ I hereby instruct Kern County Neurological Medical Group, Inc. to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- ❑ Other special instructions regarding furnishing my medical information: _____

_____

_____

_____

_____

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that Kern County Neurological Medical Group, Inc. will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc) **about me with my Primary Care Physician and/or the Provider or entity that referred me to Kern County Neurological Medical Group, Inc..**

In addition, I hereby give my consent to Kern County Neurological Medical Group, Inc. to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Name and Contact Information	**Send copies**	**OK to discuss**
_____	☐	☐
_____	☐	☐
_____	☐	☐

X _____ _____
Signature **Date**

Print Name _____

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Account #:_____

PatientName:_____

Ethnicity_____**Race**_____**Preferred Language** _____

Referred: _____**Location** _____

OMNI **CLINICAL SIERRA VISTA** **NATIONAL HEALTH SERVICES**

Other _____

Recent Lab Work:
Lab Name_____Date: _____

_____

MRA/MRI/CT/XRAY Scans
Radiology Name:_____Date: _____

Complaint: _____

Medications – Please list all of the medications you are currently taking. Include aspirin, birth control pills hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?

Allergies

_____

_____

Past Medical History

Check if you have had any of these problems. Give details.

- □ Angina
- □ High cholesterol
- □ Cancer
- □ Numbness
- □ Dizziness
- □ Sciatica
- □ Head trauma
- □ Stroke
- □ High blood pressure
- □ Blindness, part or full
- □ Nervous breakdown
- □ Diabetes
- □ Psychiatric conditions
- □ Fainting
- □ Speech problems
- □ Hearing problem
- □ Asthma
- □ Irregular heart beats
- □ Depression
- □ Polio
- □ Double vision
- □ Seizures (epilepsy)
- □ Headache
- □ Others (Pls write on the NOTES area below)

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Surgical Procedures – List chronologically

Operations	**Hospital & City**	**Date**
1.		
2.		
3.		
4.		
5.		

Family History
Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father): Check if positive **Relationship**

Seizures _____ **Stroke** _____ **Cancer** _____

Diabetes _____ **Migraines** _____ **Alcoholism** _____

Other _____

NOTE: Any additional information you might us want to know

Prescription Refill and Diagnostic Testing Policy: IF YOU FILL YOUR PRESCRIPTION THROUGH A LOCAL PHARMACY, call your pharmacy SEVERAL days before you need a refill. Your pharmacist will call us/send us your refill request or authorization if needed. CALLING YOUR PHARMACY DIRECTLY, IS THE FASTEST WAY TO GET YOUR PRESCRIPTION REFILLED.

Mail in services, Written Prescription, and Prescription needed for vacation or lost of medication: CALL THE OFFICE AT 661.322.3008. Ultimately, it is your prescription benefit that will determine how your prescription is filled.

BLOOD TEST, MRI, CT SCANS, EEG, EMG, NCV TEST: Depending upon your insurance, you may have several choices as to where you may go for outside diagnostic/tests your doctor recommends. If you have insurance and want to keep cost as low as possible, we recommend you call your insurance company to be sure your are using an APPROVED provider or APPRIVED facility. **Ultimately, it is your responsibility to know your insurance plan benefits.**

PLEASE SIGN AND DATE THAT YOU HAVE READ AND UNDERSTOOD THESE POLICIES.

X_____ **Date:** _____