Tariq Javed, M.D.
*Neurological Surgery*



(NEW PATIENT PACKET 4 PAGES)

# NEW PATIENT INFORMATION

NEUROLOGICAL / NEUROSURGICAL EVALUATION
(Please complete pages 1 through 4 completely)

Patient Name: _____ Date of Visit: _____ Male / Female Age_____

Physician Requesting Consultation: _____Primary Care M.D. _____

Height _____ Weight _____

**HISTORY OF PRESENT ILLNESS**

Chief Complaint (Reason why you are here) _____

_____

Where are you having pain and unusual symptoms? _____

When did these symptoms start? _____ Symptoms started ☐Suddenly ☐Gradually

Are your complaints due to: ☐ACCIDENT ☐ INJURY ☐RECENT ILLNESS ☐OTHER_____

If this problem is due to an accident, is it work-related? ☐No ☐Yes Date of Accident _____

How did accident/injury occur?_____

Have you experienced similar symptoms prior to accident – injury?_____

Are you currently able to work? ☐No ☐Yes If no, last date of work _____

What tests have been done to evaluate this problem? _____

Which Physicians have seen you for this problem? _____

**REVIEW OF SYSTEMS** (Place 'X' in the box next to symptoms you are currently having)

**CONSTITUTIONAL:** ☐Fever ☐Fatigue ☐Weight Loss or Gain

**EYES, EARS, NOSE, THROAT:** ☐Hearing Loss ☐Ringing in Ears ☐Visual Loss ☐Double Vision ☐Nose Bleeds

**CARDIOVASCULAR:** ☐Heart Symptoms ☐Chest Pain ☐Irregular Heart Beat ☐Shortness of Breath

**RESPIRATORY:** ☐Shortness of Breath ☐Excessive coughing ☐Wheezing

**GASTROINTESTINAL:** ☐Nausea ☐Vomiting ☐Abdominal Pain ☐Constipation ☐Diarrhea

**HEMATOLOGICAL / LYMPHATIC:** ☐Anemia ☐Easy Bruising ☐Spontaneous Bleeding

**GENITAL/URINARY:** ☐Frequency / Pain Urinating ☐Difficulty Passing Urine ☐Blood in Urine ☐Sexual Dysfunction

**PSYCHIATRIC:** ☐Anxiety ☐Mood Swings ☐Other_____

**ENDOCRINE:** ☐Excessive Thirst ☐Excessive Urination ☐Excessive Sweating

**NEUROLOGICAL:** ☐Seizures ☐Paralysis ☐Memory Loss

**MUSCULOSKELETAL:** ☐Cramping ☐Weakness ☐Fatigue of Muscles ☐Joint Pain / Inflammation

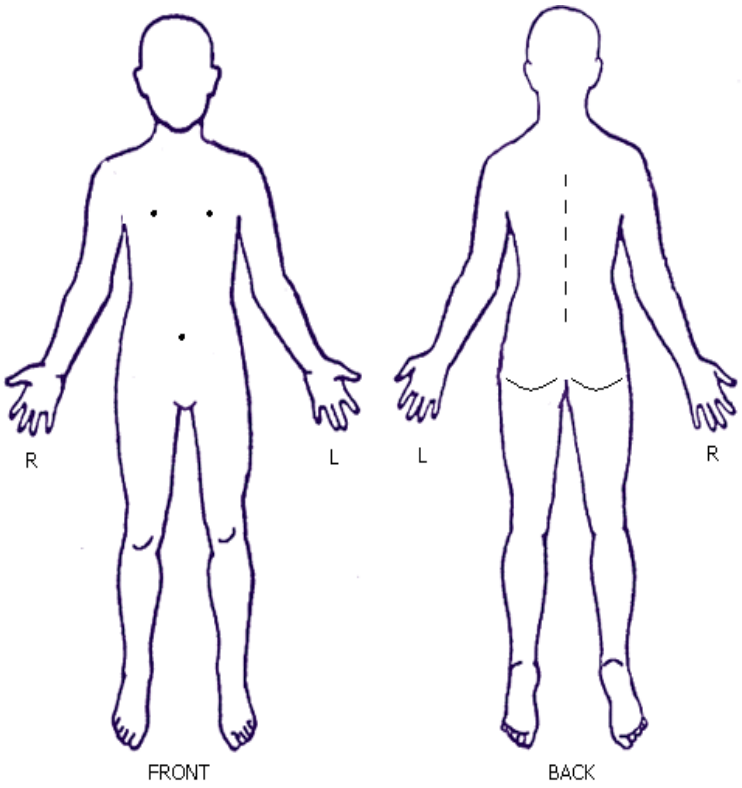
**INTEGUMENTARY:** ☐Skin Rashes ☐Other _____

I certify that the above CHIEF COMPLAINT, HISTORY OF PRESENT ILLNESS, FAMILY HISTORY AND SOCIAL HISTORY are accurate to the best of my knowledge.

_____Date: _____
Your Signature Date of Visit

Patient Name: _____ Date of Visit:_____

**Shade areas of pain, numbness and tingling *(please be specific)***




| | WORSE | BETTER | N/A |
|---|---|---|---|
| Walking | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ |
| Sitting | ☐ | ☐ | ☐ |
| Lying Down | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ |
| Bowel Movement | ☐ | ☐ | ☐ |
| Driving | ☐ | ☐ | ☐ |
| Coughing/Sneezing | ☐ | ☐ | ☐ |
| Rising from Sitting | ☐ | ☐ | ☐ |

Is there weakness of your arms? ☐ Yes ☐ No
Is there weakness of your legs? ☐ Yes ☐ No
How long can you sit with no / minimal pain? _____
How long can you stand with no / minimal pain?_____
How long can you walk with no / minimal pain? _____

**Have you had trouble controlling your bowels or bladder?**
☐ Yes ☐ No If yes, is this a new problem? ☐ Yes ☐ No

**What studies have you had for your symptoms?**
☐ Xrays ☐ CT Scan ☐ MRI ☐ Bone Scan ☐ Myelogram

☐ EMG / nerve test ☐ Bloodwork ☐ Discogram ☐ Other

**What treatments have you had for this pain?**
☐ Medications ☐ Physical Therapy ☐ Chiropractic

☐ Steroid Injections ☐ Surgery

☐Alternative treatment (massage therapy, acupuncture, etc)

PAIN SCALE **None 0 1 2 3 4 5 6 7 8 9 10 Worst**

LOCATION OF SEVERE PAIN _____

Expectation from visit:

_____

**PLEASE DO NOT WRITE BELOW LINE**

BP:_____ P:_____ R:_____

# PATIENT FINANCIAL POLICY

As our office strives to hold down the cost of patient care, it is important for you to understand your financial responsibility for your medical care. It is also important for you to understand what your insurance policy covers and does not cover. Each patient's insurance policy is different and because of this, it is impossible for our staff to know the details of your policy. It is your responsibility to understand your policy.

**MANAGED CARE PATIENTS:** It is your responsibility to obtain all necessary referrals and/or authorization from your primary care physician. You will not be seen without a current valid referral. If you chose to be seen without a referral, your visit will be self pay and we will not file to your insurance. All co-payments are due at the time of service.

**COMMERCIAL INSURANCE PATIENTS:** We will be happy to file our medical services to your insurance company as a courtesy to you. However, you are fully responsible for all charges incurred. Please note your insurance may have their own "Usual, Customary, and Reasonable (UCR)" fee schedule. This is your insurance company's fee schedule and we are not obligated to adjust our fees to match their UCR fees.

**AUTO INSURANCE PATIENTS:** We will be happy to file our medical services to your automobile insurance company as a courtesy to you. However, you are fully responsible for all charges incurred.

**WORKER'S COMPENSATION:** You are responsible for assisting us in obtaining authorization from your case manager or adjuster for all office visits. We will bill your employer or worker's compensation insurance plan. You are only responsible for payment if your claim is controverted.

**MEDICARE PATIENTS:** We are a participating provider with Medicare. We will file a claim with Medicare on your behalf. Please note Federal Law requires us to collect your yearly deductible and co-insurance amounts. If you have a secondary insurance we will bill your secondary insurance after Medicare pays.

**SELF-PAY PATIENTS:** You are responsible for payment of services on the day you are seen.

# PAYMENT POLICY AND PAYMENT ARRANGEMENTS

All patient due balances must be paid in full at the time of your visit. On accounts that are 30 days past due a 1.5% interest will be charged per month. Failure to make payment on your account will result in your dismissal from the practice and your account will be turned over to an outside collection agency for payment. Please note we have a $25.00 returned check fee on all checks returned to us from our bank for non-sufficient funds.

## IMPORTANT INFORMATION

**PLEASE READ CAREFULLY:** All charges or co-payments, if applicable, are due at the time of services. All professional services rendered are charged to the patient. I am responsible for all fees regardless of insurance coverage unless the services are covered under a contractual agreement between the Medical Practice and your insurance carrier. I understand I am responsible for any amount not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize Tariq Javed, M.D. to release any information acquired in the course of my examination or treatment to: (Insurance Company or Attorney). A copy of this authorization shall be considered as valid as an original.

I authorize any holder of medical or other information about me to release to my insurance company, Social Security Administration, Health Care Financing Administration and intermediaries or carriers of any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment.

**Signature**_____ **Date:**_____

**Patient Acknowledgment of Understanding**

**Dr. Tariq Javed Privacy Practices**

**Patient's name:** _____

**Date of birth:** _____ **SSN:** _____

I understand that the patient's health information is private and confidential. I understand that Dr. Javed, works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Dr. Javed may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Dr. Javed has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgment.

Dr. Javed may update this Acknowledgment and "Notice of Privacy Practices". If I ask, Dr. Javed, he will provide me with the most current "Notice of Privacy Practices".

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location.

Dr. Javed has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist Dr. Javed by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to receive/review a current copy of Dr Javed Notice of Privacy Practices.

_____ _____

**Signature** **Date**

_____

Relationship to patient if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)