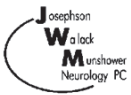


PATIENT REGISTRATION INFORMATION

IN ORDER TO PROCESS YOUR CLAIM PROPERLY AND ADHERE TO THE HIPAA REQUIREMENTS ALL APPLICABLE INFORMATION MUST BE COMPLETED BELOW.

For Office Use Only:					
Account Number: _____			JWM MD: _____		
Date HIPAA Form Signed: _____			Notes: _____		
Last Name:		First Name:		Middle Name:	
Middle Name 2:		Maiden Name:		Credentials:	
Prefix: <input type="radio"/> Mr <input type="radio"/> Mrs <input type="radio"/> Ms <input type="radio"/> Dr			Suffix: <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="radio"/> Sr <input type="radio"/> Jr		
Date of Birth:		Sex: <input type="radio"/> Male <input type="radio"/> Female		Religion:	
Marital Status: <input type="radio"/> Married <input type="radio"/> Single <input type="radio"/> Divorced <input type="radio"/> Unknown					
Drivers License State: Number:			Social Security Number:		
Address Line 1:			Address Line 2:		
Zip Code:		City:		State:	
Contact Information:		Email Address:		Home Phone:	
Work Phone:		Cell Phone:		Fax Number:	
Pager:		Which Number do you consider your primary phone number: <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell <input type="radio"/> Pager			
What is your Preferred Communication Method: <input type="radio"/> Patient Portal <input type="radio"/> Home Phone <input type="radio"/> Work Phone <input type="radio"/> Cell <input type="radio"/> Text <input type="radio"/> Email					
Local Pharmacy Name:			Mail Order Pharmacy Name:		
Address:			Address:		
Phone:		Fax #	Phone:		Fax #
Employer Name:			Occupation:		
Address:			Phone #:		
Responsible Party (Guarantor of the Account - statements will be sent to this address.) <input type="radio"/> Same as above.					
Name:		<input type="radio"/> Male <input type="radio"/> Female		Relationship to Patient:	
Date of Birth:		Home Phone:		Cell Phone:	
Work Phone:		Address:			
Email Address:					
Emergency Contact:					
Name:		<input type="radio"/> Male <input type="radio"/> Female		Relationship to Patient:	
Date of Birth:		Home Phone:		Cell Phone:	
Work Phone:		Address:			
Email Address:					
Primary Care Physician:			Referring Physician:		



PATIENT REGISTRATION INFORMATION - Continued
 IN ORDER TO PROCESS YOUR CLAIM PROPERLY AND ADHERE TO THE HIPAA
 REQUIREMENTS ALL APPLICABLE INFORMATION MUST BE COMPLETED BELOW.

PRIMARY INSURANCE:	
Name of Insurance Company:	
Claims Address:	
Policy Holder Name:	Patient Relationship to Policy Holder:
Policy Holder Social Security Number:	Policy Holder Date of Birth:
Policy Number:	Group Number:
Effective Date:	Office Copay:

SECONDARY INSURANCE:	
Name of Insurance Company:	
Claims Address:	
Policy Holder Name:	Patient Relationship Policy Holder:
Policy Holder Social Security Number:	Policy Holder Date of Birth:
Policy Number:	Group Number:
Effective Date:	Office Copay:

Worker's Compensation and/or Accident Information (if applicable)				
Date of Injury	Job Related	<input type="radio"/> Yes <input type="radio"/> No	Auto Related	<input type="radio"/> Yes <input type="radio"/> No

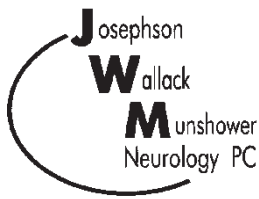
Worker's Compensation Information:	
Name of Employer	Case Number:
Contact Person	Phone Number:
Claims Address:	

Auto Accident Information:	
Name of Insurance Company:	
Claim Address:	
Policy Holder Name:	Patient Relationship to Policy Holder:
Policy Holder Social Security Number:	Policy Holder Date of Birth:
Policy Number:	Claim Number:

I attest that all of the information presented is true and correct to the best of my ability and knowledge:

Signature: _____ Date: _____

Witness: _____ Date: _____



FINANCIAL POLICIES, TERMS, CONDITIONS AND RELEASES

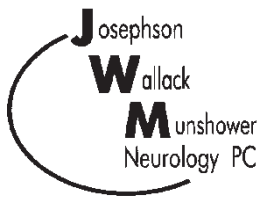
Financial Policies and My Financial Responsibility:

- I acknowledge and accept full financial responsibility for services provided by Josephson Wallack Munshower Neurology PC (JWM).
- JWM will accept assignment of benefits from me for my insurance and will bill my insurance as a courtesy but it is my responsibility to ensure my insurance company pays for the services provided promptly.
- I authorize JWM to file an appeal on my behalf with my insurance company should the situation arise that an appeal is required in order to obtain payment.
- I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including deductibles and coinsurance.
- I understand that payment of copayment or coinsurance is expected at time of service, as well as any prior balance that I owe. I agree to pay any balance due after insurance pays within 30 days.
- Patients without insurance coverage are considered self-pay accounts. Liability cases are also considered self-pay accounts. JWM does not accept attorney letters or contingency payments. Payments for all self-pay accounts are due in full at the time of service.
- Self-pay patients will receive a 30% discount from charges when payment in full is made at time of service.
- Our offices accept CASH, Checks, Money Orders, VISA, MasterCard, American Express and Discover. One or all of these cards may be used to pay your bill, and may be kept on file by us to facilitate billing. Always ask for a receipt when making payment. If you have a credit balance after paying for a service JWM may apply it to any outstanding balances on your account.
- There will be a \$25 service charge on all returned checks.
- I shall be responsible for any attorney fees, court costs, and collection agency fees as well as any pre-judgment and/or post-judgment interest at the current legal rate.

Proof of Identity: I agree to bring my government-issued photo identification and my insurance card(s) on every visit.

Insurance Pre-certification / Prior Authorization or Referral Approval: Some insurance companies require pre-certification, prior authorization or a referral from your primary care physician before certain services are provided. It is your responsibility to ensure that pre-certification, prior authorization, or a referral is obtained. It is your responsibility to ensure the services are obtained within the dates that the pre-certification, prior authorization and/or referral are approved. Failure to do any of the above will make you financially responsible for all denied payments.

Assignment of Benefits: I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other plans to Josephson, Wallack, Munshower Neurology PC. This assignment will remain in effect until revoked by me in writing. I hereby agree to pay Josephson Wallack Munshower Neurology PC the charges for all medical services rendered.



FINANCIAL POLICIES, TERMS, CONDITIONS AND RELEASES

TCPA Consent: The Telephone Consumer Protection Act (TCPA) regulations define "prior express written consent". I acknowledge under the TCPA that by providing my land line and/or cell phone number, that I am giving my prior express written consent that Josephson Wallack Munshower Neurology PC and its affiliates and business partners, have the authorization to call via auto-dialer, pre-recorded voice messages, SMS messages and live calls for any communication that would be associated with my account in this practice.

Email Consent: I acknowledge that by providing my email address, that I am giving my express written consent that Josephson Wallack Munshower Neurology PC (JWM) and its affiliates, have authorization to contact me by the email address I have provided for any non-urgent communications that would be associated with my account at JWM. JWM uses encrypted email when Protected Health Information is included in communications related to patients.

Patient Portal Consent:

- JWM provides a patient portal to facilitate secure and confidential communications between you and the practice.
- You are encouraged to sign up to use the portal.
- This will enable us to quickly send you test results, respond to prescription refill requests, respond to your questions and inquiries, and facilitate setting up future appointments. It will also allow you to access and print portions of your health record.
- DO NOT USE the portal in an emergency situation.
- You will be required to acknowledge and agree to the portal's use each time you sign on to use it.

Late Arrival: Patients should arrive 30 minutes prior to their scheduled appointment time for each visit. Failure to arrive 30 minutes prior to your appointment may require rescheduling.

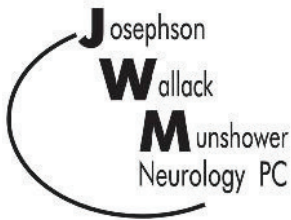
Missed Appointments: Appointment must be cancelled 24 hours in advance or there will be a \$50 charge.

Release of Information: I hereby authorize Josephson Wallack Munshower Neurology PC (JWM) to furnish such professional information as may be necessary to complete my insurance claim from the medical records compiled during my treatment and JWM is hereby released from all legal liability that may arise from the release of the information requested.

I hereby accept and acknowledge all of the Policies, Terms, Conditions and Consents above by signing below:

Signature: _____ Date: _____

Witness: _____ Date: _____



Comprehensive Neurological Expertise
Compassionate Patient Care

HEALTH HISTORY AND REVIEW OF SYSTEMS

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____

Check (X) below any illness the patient has had:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Asthma
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Behavioral Problems
<input type="checkbox"/> Bleeding Tendencies
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cancer-Tumors
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Cystic Fibrosis
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Eczema
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Eye Disease
<input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hernia
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Measles
<input type="checkbox"/> Meningitis
<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Mumps
<input type="checkbox"/> Muscle Weakness
<input type="checkbox"/> Otitis Media
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Seizures
<input type="checkbox"/> Skin Diseases
<input type="checkbox"/> Stomach Trouble
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Urinary Tract/
Bladder Infection
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Gynecologic Problems | <input type="checkbox"/> Allergies(Food/Drug)
Please List:

_____ |
|---|--|--|--|

LIST OTHER ILLNESSES:

OPERATIONS: (TYPE)	DATE	HOSPITAL
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCIES:

FRACTURES:

LIST MEDICATIONS NOW TAKING, INCLUDING
VITAMINS, OVER-THE-COUNTER MEDICATIONS,
AND BIRTH CONTROL PILLS.

IMMUNIZATION	YEAR	IMMUNIZATION	YEAR
<input type="checkbox"/> Diphtheria	_____	<input type="checkbox"/> Smallpox	_____
<input type="checkbox"/> Polio	_____	<input type="checkbox"/> Pertussis	_____
<input type="checkbox"/> Tetanus	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Hem. Infl.	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Rubella	_____		

History and Review of Systems Reviewed by:

Physician **Date**

HABITS

(Please indicate past and current usage and frequency per day.)

- Cigarettes AMOUNT
- Beer
- Wine
- Whiskey
- Other

EDUCATION

- Grade School YEARS COMPLETED
- High School
- College (no.of years)
- Graduate
- Other

TYPE OF WORK

NUMBER OF CHILDREN

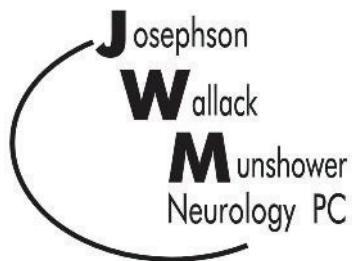
MARITAL STATUS: Married Single Divorced Other

FAMILY HISTORY: (Check below if any of the conditions have occurred on either side of patient's family.)

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Gastrointestinal Disease | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Mental Disease | |
| <input type="checkbox"/> Cancer or Tumors | <input type="checkbox"/> Migraine | |
| <input type="checkbox"/> Cardiovascular Disease (Heart) | <input type="checkbox"/> Pulmonary Disease (Lung) | |
| <input type="checkbox"/> Congenital Deformities | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Thyroid Disease | |

LIST OTHER ILLNESSES:

	IF LIVING Health Status				Known Illnesses	AGE AT DEATH	IF DECEASED Cause of Death
	A G E	G O O D	F A I R	P O O R			
Father							
Mother							
Brothers							
Sisters							



Comprehensive Neurological Expertise
Compassionate Patient Care

REVIEW OF SYSTEMS

Name: _____ Date: _____

Do you have now or have you had within the past year?

Weight loss/ Appetite Change _____	YES _____	NO _____
Thyroid problems _____	YES _____	NO _____
Fevers/Chills _____	YES _____	NO _____
Sinus problems _____	YES _____	NO _____
Vision problems _____	YES _____	NO _____
Hearing problems _____	YES _____	NO _____
Seasonal or environmental allergies _____	YES _____	NO _____
Neck Pain _____	YES _____	NO _____
Back Pain _____	YES _____	NO _____
Joint Pain _____	YES _____	NO _____
Chest Pain _____	YES _____	NO _____
Rashes _____	YES _____	NO _____
Diabetes _____	YES _____	NO _____
Breathing problems _____	YES _____	NO _____
Heart disease _____	YES _____	NO _____
High blood pressure _____	YES _____	NO _____
Kidney problems _____	YES _____	NO _____
Stomach problems _____	YES _____	NO _____
Bowel Problems _____	YES _____	NO _____
Nausea/Vomiting _____	YES _____	NO _____
Anemia _____	YES _____	NO _____
Depression _____	YES _____	NO _____
Psychiatric problems _____	YES _____	NO _____
Cancer _____	YES _____	NO _____
Stroke _____	YES _____	NO _____
Seizures _____	YES _____	NO _____
Headaches _____	YES _____	NO _____
Gynecologic Problems _____	YES _____	NO _____

Patient Signature: _____ Date: _____

JWM REGISTRATION INFORMATION (CONTINUED)
RACE, ETHNICITY, AND PRIMARY LANGUAGE
(Requested at the Direction of the Federal Government)

Patient Name: _____ **Date:** _____

Race:

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian
- White
- Other Pacific Islander
- More Than One Race
- Do Not Want to Disclose

Ethnicity:

- Hispanic or Latino
- Not Hispanic or Latino
- Do Not Want to Disclose

Primary Language:

- American Sign Language
- Arabic
- Armenian
- Brazilian Portuguese
- Chinese
- Chinese (Cantonese)
- Chinese (Mandarin)
- Croatian
- Czech
- Danish
- Dutch
- English
- Farsi
- Filipino
- Finnish
- French
- French Canadian
- French Creole
- German
- Greek

Primary Language (continued)

- Gujarati
- Hebrew
- Hindi
- Hmong
- Hungarian
- Indian
- Japanese
- Khmer
- Korean
- Lao
- Maori
- Mien
- Navajo
- Norwegian
- Oromo
- Other
- Persian
- Polish
- Portuguese
- Russian
- Slovak
- Somali
- Spanish
- Swahili
- Swedish
- Tagalog
- Thai
- Tigrinya
- Turkish
- Ukrainian
- Undefined
- Urdu
- Vietnamese
- Visayan
- Yiddish