Capital Neurological Surgeons

New Patient Registration

If patient is a minor, each parent to fill out a copy of this form.

Patient Information

Last Name, First Name:		Date of Birth:	M / F
SSN:		Single / Married / Divorced / Widowed	
Email:			
Address:	City, State:		Zip:
Home Phone:	Work Phone:	Mobile Phone:	
Emergency Contact Name:		Phone:	

Employment Information

Occupation:	Employer:	
Address:	City, State:	Zip:

Insurance Subscriber / Parent Information

Last Name, First Name:		Date of Birth:	M / F
Address:	City, State:	Zip:	
Relation to Patient:			

Insurance Information`

Primary Insurance:	Secondary Insurance:
ID: #	ID: #
Group #:	Group #:
Plan:	Plan:
Primary Care Physician:	Primary Care Physician:
Phone:	Phone:

Medication List

Medication	Strength / Dosage	Frequency (Times per day or Days)

Allergy Information

Medication	Reaction	Medication	Reaction

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdara.cms.gov. Please let the front desk know if you would like a copy of your paperwork

Initial Here _______

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov or call (800) 633-2322

Initial Here _______

I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I assign medical and/or major medical insurance benefits to Capital Neurological Surgeons. I authorize Capital Neurological Surgeons to release all information necessary to secure payment and to file on my behalf any complaints to the California Insurance Commissioner. I also agree to allow Capital Neurological Surgeons and affiliates to contact me with patient satisfaction surveys in an effort to improve your patient care and overall experience

Signature: ________________________________ Date: ________________

CAPITAL NEUROLOGICAL SURGEONS, Inc.

Michael Chan, M.D.
Kevin Hsieh, M.D.

Patient's Name:___________________________ **My Provider's Name**___________________________

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in- person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from

the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to “autoremember” usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

Date	Signature

CAPITAL NEUROLOGICAL SURGEONS
1430 22nd Street
Sacramento, CA 95816
(916) 453-0911

INFORMED MEDICATION POLICY

Please read this form in its entirety.
Please initial each paragraph after you have read it.

The purpose of this agreement is to prevent misunderstandings about Capital Neurological Surgeons policy. This agreement is to help you and your provider to comply with all regulations regarding controlled pharmaceuticals.

Please read this form in its entirety. Please initial each paragraph after you have read it.

____ If I am currently under a pain management contract with another physician, I will have my pain medications pre-arranged and managed by that physician prior to surgery.

____ If I am found to be in violation of my current pain contract with another provider, I understand Capital Neurological Surgeons reserves the right to discontinue providing pain medications.

____ I understand that Capital Neurological Surgeons does not provide or manage pain management contracts.

____ I understand that Capital Neurological Surgeons will **ONLY** prescribe - Schedule II narcotics (Vicodin, Norco, Percocet, etc.) or Muscle Relaxants (Valium, Flexeril, etc.) for 90 days **ONLY** after a surgical procedure.

____ I understand that Capital Neurological Surgeons follows the California Medical Association guidelines, only providing a five day supply of Schedule II narcotics at a time.

____ I understand that Capital Neurological Surgeons will only dispense two refills after my surgical procedure. If a third refill is requested, a visit in person with my provider is required for re-evaluation.

____ I understand that each insurance company has different medication policies and that Capital Neurological Surgeons CANNOT change these plan specific policies or ensure medications are covered by insurance.

I CONSENT TO THE ABOVE POLICY

____ ____________
Patient's Name (Please Print) Date & Time

____
PATIENT'S SIGNATURE

Acknowledgement of Receipt of Notice of Privacy Practices

Capital Neurological Surgeons

Privacy Officer: Erika Petty, Practice Manager

(916) 453-0911

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be provided to me upon request, a copy will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: ______________________________ Date: ____________________

Print Name: ___________________________ Telephone: _______________

Date of Birth: __________________________

If not signed by the patient, please indicate:

Relationship:

- □ Parent or Guardian of a Minor Patient
- □ Guardian or Conservator of an Incompetent Patient
- □ Beneficiary or Personal Representative of a Deceased Patient

Name of Patient: ___________________________

HIPAA Right of Access Form for Family Member/Friend

I, ________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

***Name:* ____________________________ *Relationship:* __________________**

Contact Phone: ____

Health Information to be disclosed upon the request of the person named above -- (Circle either A or B):

A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): ____________________________

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

____ ____________________

Name of the Individual Giving this Authorization Date of birth

____ ____________________

Signature of the Individual Giving this Authorization Date