Michael Stein, M.D.
Neurology
1844 San Miguel Drive, Suite 316,
Walnut Creek, California 94596

TEL (925) 465-5252   FAX (925) 938-1343

WELCOME TO OUR PRACTICE

Dear Patient,

Thank you for calling our office for an appointment. For your convenience, we are enclosing forms to be filled out, along with a map with directions to our office.

In order for Dr. Stein to make an appropriate assessment, our office should have medical records pertinent to your visit. Please make sure that your referring physician or your primary care physician sends us a copy of your most recent consultation, clinical notes, labs and/or x-ray studies. You may bring any relevant records that you have as well.

Please make sure to fill out the enclosed information and bring it with you on the day of your scheduled appointment.

If you have any questions, please call of office at (925) 938-5252. If you are unable to keep your appointment, please call to cancel or reschedule at least 48 hours prior to your visit. Thank you for this courtesy. We look forward to meeting you.

Sincerely,

Michael Stein, M.D. and Staff

M I C H A E L S T E I N, M. D.
Neurology
1844 San Miguel Drive, Suite 316
Walnut Creek, California 94596
Telephone (925) 938-5252 FAX (925) 938-1343

NEW PATIENT INFORMATION RECORD

PLEASE PRINT CLEARLY

PATIENT INFORMATION

PATIENT'S NAME		MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY		CITY	STATE		ZIP CODE
HOME PHONE	BUSINESS PHONE NO.	CELL PHONE NO.	E-MAIL ADDRESS		DRIVER'S LIC NO.
PATIENT'S A MINOR ☐ YES☐ NO IF YES, REMAINDER OF FORM SHOULD BE COMPLETED BY PARENT		OCCUPATION (INDICATE IF STUDENT			
PATIENT'S EMPLOYER		PHONE NO.	E-MAIL ADDRESS		HOW LONG EMPLOYED?
EMPLOYER'S ADDRESS		CITY	STATE		ZIP CODE
SPOUSE'S NAME		HOME PHONE NO.	OTHER RESPONSIBLE FAMILY MEMBER		
SPOUSE'S ADDRESS (IF DIFFERENT)		CITY	STATE		ZIP CODE
SPOUSE'S EMPLOYER		PHONE NO.	E-MAIL ADDRESS		HOW LONG EMPLOYED?
NAME OF NEAREST RELATIVE OR FRIEND		HOME PHONE NO.	E-MAIL ADDRESS		RELATIONSHIP
ADDRESS		CITY	STATE		ZIP CODE

REFERRING INFORMATION

NAME OF REFERRING PHYSICIAN	CITY AND STATE	ZIP CODE	PHONE NO.
PRIMARY CARE PHYSICIAN	CITY AND STATE	ZIP CODE	PHONE NO.
FRIEND OR RELATIVE	CITY AND STATE	ZIP CODE	PHONE NO.

BILLING INFORMATION

If injury and/or treatment is the result of industrial accident or personal injury, please give name and policy number of responsible insurance company

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE		STREET ADDRESS, CITY, STATE, AND ZIP CODE			PHONE NO.
NAME OF INSURANCE COMPANY		MEMBER ID#		GROUP NUMBER	
NAME OF SUBCRIBER		RELATIONSHIP TO PATIENT		D.O.B. OF SUBSCRIBER & SOCIAL SECURITY	
NAME OF SECONDARY OR OTHER INSURANCE COMPANY, ADDRESS					
DRIVERS LICENSE NO.	INJURY CAUSED BY ACCIDENT? ☐ YES ☐ NO		MEMBER ID#	GROUP NUMER	PHONE NO.

Michael Stein, M.D.
Neurology-Electroencephalography
Electromyography
1844 San Miguel Drive, Suite 316, Walnut Creek, California 94596
TEL (925) 465-5454 FAX (925) 938-1343

DIRECTIONS

FROM THE NORTH: (Benicia, Vallejo, Martinez, Concord)

Take Highway 680 south to Walnut Creek, exit North Main Street. Stay in the right lane and take the southbound turnoff. Continue on Main Street, South, through downtown Walnut Creek. Make a left onto Mt. Diablo Blvd. Just past the Safeway, make a right onto San Miguel Drive. Come up the hill, about 2 blocks. We are on the left hand side, in the back. There is a large sign that says RIDGECREST EAST.

Or

Take Highway 680 to the South Main Street exit (past the North/South Main Street Exit and past the Olympic Blvd. exit). Stay in the left hand lane, make a left and go under the freeway. Make a right turn onto Newell, go up the hill and make a left turn onto San Miguel Drive. We are in the Ridgecrest Complex on the right side, in the back in Suite 316.

FROM THE SOUTH: (Danville, Pleasanton, San Jose)

Take Highway 680 North to Walnut Creek. Exit at South Main Street. Make a right onto Newell Ave. (Kaiser will be on your left). Come up the hill and make a left turn onto San Miguel Drive. We are in the Ridgecrest Complex on the right side, in the back in Suite 316.

FROM THE EAST: (Concord, Clayton)

Take Ygnacio Valley Rd. West to Walnut Creek. Take a left turn on Civic and then make a left turn onto Broadway. Then make a left onto Mt. Diablo Blvd. Make a right onto San Miguel Drive (just past the Safeway). Come up the hill. We are in the Ridgecrest Complex on the left hand side. Our office is in the back in Suite 316.

FROM THE WEST: (Lafayette, Orinda, Berkeley, San Francisco)

Take Higway 24 East to Walnut Creek. Exit Mt. Diablo Blvd. in Walnut Creek. Make a right on San Miguel Drive (just past the Safeway). Come up the hill, about 2 blocks. We are in the Ridgecrest Complex on the left hand side. Our office is in the back in Suite 316.

MAP ON THE BACK

MAPQUEST
Edmund Ct
Summit Rd
0
200m
600ft
Civic Dr
Locust St
Lincoln Ave
N Broadway
Mt Pisgah Rd
Village Ct
Walker Ave
Tahoe Ct
Alberta Ter
Sierra Dr
Walnut Blvd
W Holly Dr
Summit Cir
Alwin Rd
Ahwahnee Ct
Howe Homestead Park
Eckley Ln
Craddock Ct
Cypress St
Commercial Ln
N Main St
Mt Diablo Blvd
Broadway Pl
Margarido Dr
San Miguel Dr
Watkins Ln
El Camino Corto
N
W
E
S
Caminar Way
Olympic Blvd
Broadway Plaza
S Broadway
Holcomb Ct
Analisa Ln
Oak Knoll Loop
Brubaker Dr
El Camino Ter
Nob Hill Dr
Newell Hill Pl
Treecrest Pl
Botelho Dr
S California Blvd
Oak Knoll Ct
Oakdene Ct
Newell Ave
Nursery Ln
Meadow Creek Ct
S Main St
Andrea Dr
Bronson Ln
Santa Rita Dr
San Miguel Dr
45B
680
Circle Dr
Adeline Dr
Opal St
Blackwood
Shady Glen Rd
Lilac Dr

<u>IMPORTANT INFORMATION FOR OUR VALUED PATIENTS</u>

FINANCIAL POLICY

INSURANCE – CASH PATIENTS

Patients are financially responsible for services provided and are expected to pay at the time of service. As a courtesy, we will bill your insurance; however, you will need to provide complete billing information at the time of your visit. It is your responsibility to know exactly what procedures, visits, drugs and labs your plan covers. Any time that you receive a new insurance card, you must bring it with you so that we can update your chart. If we have to rebill because of incorrect insurance information, there will be a $15.00 service charge.

We accept you as a patient with the understanding that you know your coverage and benefits. In the event that your insurance company denies a claim, payment for that date of service is due immediately upon receipt of statement.

HMO / PPO PATIENTS

If you are a member of an HMO/PPO, you are required by your health plan to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. Co-payments will be collected at the time of service. Non-covered services must be paid at the time of service. If our staff has to bill for a co-payment, there will be an additional $15.00 service charge.

MEDICARE

We are participating providers in Medicare, which means that we accept Medicare assignment as payment in full, once your deductible and co-payments have been made. We will bill Medicare for you, as well as your supplemental insurance. You must provide us with valid cards from Medicare and other insurance. Without these documents we cannot bill your insurance and payment will be expected from you at the time of your visit. The patient is only responsible for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

CANCELLATIONS / NO SHOWS

If you are scheduled to see the physician and are unable to keep your appointment, please contact our office as soon as possible so we may schedule your time for another patient. If you cancel appointments with less than 24 hours notice, you may be subject to a charge consistent with the time allowed for the visit. Failure to show up for your appointments creates gaps in our schedule and affects our ability to provide appropriate care to all of our patients. "No Shows" and/or cancellations with less than 24 hours notice may result in a charge of $50.00. **This charge is NOT covered by your insurance company.** Repeated "No Shows" or cancelled appointments, without at least 24 hours notice, may result in dismissal from our practice.

COMPLETION OF FORMS / PHOTOCOPYING OF MEDICAL RECORDS

Completion of various forms and/or letters will be charged a flat fee of $25.00. If you are going to request your personal medical records you will also be charged a fee of $25.00 and up depending on the thickness of your medical file.
If you are experiencing financial hardship, please speak directly with Dr. Stein regarding a possible payment plan.
We accept MasterCard and Visa. We **DO NOT** accept American Express or Discover.
A $25.00 charge will be applied for all returned checks.

Signed: ____ *Date:* _________________________
I acknowledge that I have read the above financial policy

Past Medical/Social/Family History

Name: ____ **Date:** ________________

Past and current medical illnesses (Check all that apply)

Bleeding disorder Congestive heart failure Coronary artery disease (angina, heart attack)

Diabetes (diet control) Diabetes (diet & pills) Diabetes (insulin required)

Disc/spine disease Gallbladder disease High blood pressure HIV/AIDS

Kidney disease Liver disease Lung disease Pancreatitis

Parkinson's disease Pulmonary embolism Phlebitis Rheumatoid arthritis

Stomach ulcers Stroke/TIAs Thyroid disorder Tumor (brain)

Cancer (describe below) Chemotherapy (describe below) Other (describe below)

Past surgeries/procedures (list below)

List all prescription medications, over the counter medications, vitamins and supplements that you currently take (include dosage and frequency taken).

The information on this form provided by the patient and/or family members was personally reviewed and/or amended by me.

____

Provider Signature **Date**

-----Continued on reverse side -----

Do you take aspirin? Yes No **Do you take ibuprofen?** Yes No

List all allergies to medications (check all that apply and/or write in additional information) .

penicillin amoxicillin erythromycin sulfa keflex

other: ____

Are you allergic to any of the following (check all that apply and describe reaction).

shellfish iodine latex MRI contrast ("dye") CT contrast ("dye")

IVP contrast ("dye") angiogram contrast ("dye")

other: ____

Are you a smoker? Yes No How many years? (_____) How many packs/day (______)

Do you drink alcohol? Yes No How many drinks per week? (_____)

Do you use illicit ("street") drugs? Yes No describe: ____________________

Do you engage in risky sexual behavior (unprotected sex)? Yes No

Are you pregnant? Yes No

Could you be pregnant? Yes No When was your last period?

Do any of your blood relatives have (did have) any of the medical conditions noted below.

(Use the following key and circle affected family members for each condition below.)

[M = mother, GM = grandmother, S = sister, A = aunt]

[F = father, GF = grandfather, B = brother, U = uncle]

Condition								
Asthma	M	GM	S	A	F	GF	B	U
Bleeding disorder	M	GM	S	A	F	GF	B	U
Brain tumor	M	GM	S	A	F	GF	B	U
Cancer	M	GM	S	A	F	GF	B	U
Depression	M	GM	S	A	F	GF	B	U
Diabetes	M	GM	S	A	F	GF	B	U
Heart disease	M	GM	S	A	F	GF	B	U
High blood pressure	M	GM	S	A	F	GF	B	U
Parkinson's disease	M	GM	S	A	F	GF	B	U
Rheumatoid arthritis	M	GM	S	A	F	GF	B	U
Seizure disorder (epilepsy)	M	GM	S	A	F	GF	B	U
Stomach ulcers	M	GM	S	A	F	GF	B	U
Tuberculosis (TB)	M	GM	S	A	F	GF	B	U

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

1844 San Miguel Drive Suite 316
Walnut Creek, CA 94596
925-938-5252

"We respect your right to privacy and understand that your medical information is personal to you. Your personal health information is confidential and this notice is intended **in summary** to help you understand how our practice uses and discloses your personal health information and what right you have with respect to your medical information."

How We May Use and Disclose Your Information:

Medical Treatment:

- We may need to share information relating to your medical care, records, treatment with other physicians, nurses, health care professionals and the Neurological Research Institute of the East Bay.

Payment:

- We may need to disclose personal health information about you with your health plan and/or referring physician in order to obtain prior authorization for treatment, or to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

Healthcare Operations:

- We may use and disclose your personal health information to business associates who need to provide a service for our medical practice; examples are our transcriptionist and medical biller.

Appointment Reminders:

- Our practice may use and disclose medical information about you to provide you with reminders that you have an upcoming appointment. If you have any special requests about these reminders, please notify us.

Please select all that apply. Sign and date below.

PROCTECTED HEALTH INFORMATION

Laboratory, x-ray or scan results, medical records, medications, billing matters and/or any correspondence pertaining to Protected Health Information

I hereby authorize Michael Stein, MD or staff to leave messages at the following:

□ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN THE CALL

□ YES □ NO-Answering machine or voice mail.

□ YES □ NO-Home phone___________ □ YES □ NO-Work phone______________

□ YES □ NO-Cell phone ____________ □ YES □ NO-Other phone______________

□ YES □ NO-Please mail results or correspondence to: _________________________

____

If you would like your Protected Health Information disclosed to other family members or friends, please indicate their name and relationship. Only the names listed will be given information.

Name	Relationship	Address or phone
________________________	________________________	________________________
Name	Relationship	Address or phone

I hereby acknowledge that I have read this Notice of Privacy Practices. I further acknowledge that the entire Notice of Privacy Practices is in the waiting room for review, and you will be offered a **complete** copy of the Privacy Practices upon request.

Signed:____ Date:______________________

Print Name:____