675 Ygnacio Valley Rd #A102
Walnut Creek, CA 94596
925-938-5252 (phone)
925-938-1343 (fax)
www.eastbayneurology.com

Timothy Wei, MD, PhD
Lauren Johnson, MS, NP-BC

# WELCOME TO OUR PRACTICE

Dear Friend,

Thank you for coming to us for your neurologic evaluation and care. For your convenience, we are enclosing forms to be filled out, along with a map with directions to our office.

In order for our doctors 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.

As we are committed to serve our patients with respect, courtesy and responsiveness, we do expect that you keep your appointment to respect the time the physicians put aside specifically for you. Therefore, we would ask you to call for cancellations at least 24 hours earlier if you cannot make it, so that we can use the time to serve others who might need to be taken care of urgently. Just a kind reminder, as we mentioned to you over the phone, for any missed appointment or cancellation shorter than 24 hours of notice, we will charge you for $100.

Please make sure to fill out the enclosed information and bring it with you on the day of your scheduled appointment. This will help physician to facilitate your care.

Your appointment is on:

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| DAY | DATE | TIME |

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,

Timothy Wei, M.D. and Staff

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# DIRECTIONS

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

Take Highway 680 south to Walnut Creek, Take Exit 47 for N Main St toward Walnut Creek. Keep right at the fork, follow the sign for the North Main St. Turn right at N. Main St. Keep on driving till hitting Ygnacio Valley Road. Turn left at Ygnacio Valley Road and stay in the right hand lane. You will pass N. Broadway. As soon as you pass the N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately next to the And Oil gas station).

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

Take Highway 680 North to Walnut Creek. Exit at Ygnacio Valley Road. Make a right onto Ygnacio Valley Road and stay in the right hand lane. You will pass N. California Blvd, then N. Main St, then N. Broadway. As soon as you pass the N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately next to the And Oil gas station).

**FROM THE EAST:** (Concord, Clayton)

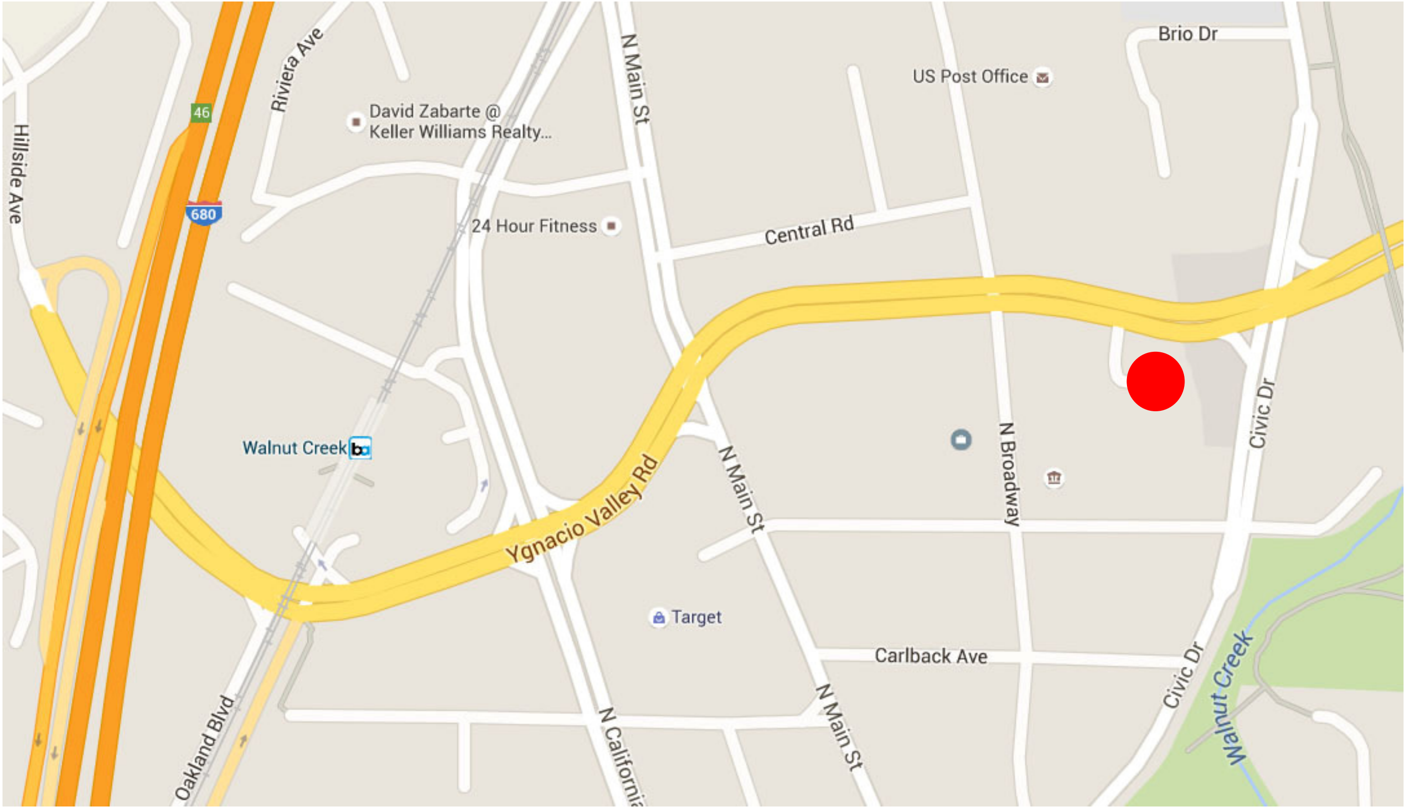
Take Ygnacio Valley Rd, west to Walnut Creek. Take a left U-turn on N. Broadway. Stay in the right hand lane. We are the first right turn (Walnut Creek Financial Plaza, immediately next to the And Oil gas station).

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

Take Higway 24 East to Walnut Creek. Exit at Ygnacio Valley Road. Make a right onto Ygnacio Valley Road and stay in the right hand lane. You will pass N. California Blvd, then N. Main St, then N. Broadway. As soon as you pass the N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately next to the And Oil gas station).

**TAKING BART**

Take off in Walnut Creek, exit to Ygnacio Valley Road, You will pass N. California Blvd, then N. Main St, then N. Broadway. As soon as you pass the N. Broadway, we are the first right turn (Walnut Creek Financial Plaza, immediately next to the And Oil gas station).


Brio Dr
US Post Office
David Zabarte @
Keller Williams Realty...
Riviera Ave
N Main St
Hillside Ave
46
680
24 Hour Fitness
Central Rd
Walnut Creek
N Broadway
Civic Dr
N Main St
Ygnacio Valley Rd
Target
Carlback Ave
Civic Dr
Walnut Creek
Oakland Blvd
N California
N Main St

## ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

675 Ygnacio Valley Rd, A102
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 East Bay Neurology.

**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 **Timothy Wei, M.D. or staff** to leave messages at the following:

□ DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN THE CALL
□ YES □ NO-Home phone______________ □ YES □ NO-Work phone______________
□ YES □ NO-Cell phone _______________ □ YES □ NO-Other phone______________

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 |
|---|---|---|
| | | |
| | | |

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:________________________________________

# <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 $150.00 if you are a new patient or scheduled for a procedure and $75.00 if you are a return patient. This charge is NOT covered by your insurance company, and will be collected before you make your future appointment with us.** Repeated "No Shows" or cancelled appointments, without at least 24 hours notice, may result in dismissal from our practice. ___________ (initial)

**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 with our office manager 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*

*Name(print):*______________________________________

# NEW PATIENT INFORMATION RECORD
## PLEASE PRINT CLEARLY

### PATIENT INFORMATION

| PATIENT'S NAME | GENDER<br>☐ MALE ☐ FEMALE ☐ OTHER | DATE OF BIRTH | AGE | SOCIAL SECURITY NO. |
|---|---|---|---|---|
| MARRITAL STATUS<br>☐ SINGLE<br>☐ MARRIED<br>☐ WIDOWED<br>☐ DIVERCED<br>☐ SEPERATED | ETHNIC GROUP<br>☐ EUROPEAN<br>☐ HISPANIC<br>☐ ASIAN/PACIFIC ISLANDER<br>☐ AFRICAN AMERICAN<br>☐ ARAB/MIDDLE EASTERN<br>☐ JEWISH<br>☐ NATIVE AMERICAN<br>☐ OTHER | EMPLOYMENT STATUS<br>☐ FULL TIME<br>☐ PART TIME<br>☐ UNEMPLOYED<br>☐ LAID OFF<br>☐ DISABLED<br>☐ RETIRED | | PREFERRED LANGUAGE |

| STREET ADDRESS ☐ PERMANENT ☐ TEMPORARY | CITY | STATE | ZIP CODE |
|---|---|---|---|

| HOME PHONE | BUSINESS PHONE NO. | CELL PHONE NO. | E-MAIL ADDRESS | DRIVER'S LIC NO. |
|---|---|---|---|---|

| SIGNIFICANT OTHER'S NAME | |
|---|---|

| SPOUSE'S ADDRESS (IF DIFFERENT) | CITY | STATE | ZIP CODE |
|---|---|---|---|

| HOME PHONE | BUSINESS PHONE NO. | CELL PHONE NO. | E-MAIL ADDRESS | DRIVER'S LIC NO. |
|---|---|---|---|---|

### 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 | | | |

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**Please answer the following questions to help with your office visit:**

**GENERAL INFORMATION**

Name ______________________________ Age ____________ Date ____________

Handedness: _______Right handed _______Left handed _______Ambidextrous
Sex: _______Male _______Female _______Other

How did you hear about us? ______________________________

**INFORMATION RELATED TO YOUR CURRENT PROBLEM OR CONDITION**

For what problem/condition are you seeing the doctor? (please explain in your own words)

______________________________
______________________________
______________________________
______________________________
______________________________

Approximately how long has this been present ______________________________

Has your problem or condition been:

Getting worse? _______
Staying about the same? _____
Getting better? _______

Please list any things that make your problem or condition better:

______________________________

Please list any things that make your problem or condition worse:

______________________________

Please list any other doctors you have seen about this problem:

______________________________

Please list any tests you have had done for this problem (and results, if known):

______________________________

Please list any medication you are **allergic** to or you have the adverse reaction:

_______________________________________________________________________________

Please list all medications that you are **currently taking** (including non-prescription medications):

| Name | Dose | How often do you take it? |
|---|---|---|

1. ______________________________________________________________________
2. ______________________________________________________________________
3. ______________________________________________________________________
4. ______________________________________________________________________
5. ______________________________________________________________________
6. ______________________________________________________________________
7. ______________________________________________________________________
8. ______________________________________________________________________

Which pharmacy you are using? Local: ____________________________________________

Mail order: ____________________________________________

**PAST MEDICAL HISTORY**

Do you have (or have you had) any of the following medical conditions? (please circle all that apply)

| | | |
|---|---|---|
| High blood pressure__________ | Arthritis______________________ | Anxiety__________________ |
| Diabetes____________________ | Thyroid disease______________ | Depression_______________ |
| High cholesterol_____________ | Anemia________________________ | Bipolar disorder___________ |
| Heart disease/heart attack_____ | Epilepsy/seizures_____________ | Schizophrenia_____________ |
| Stroke/TIA___________________ | Migraine_______________________ | Parkinson's disease________ |
| Irregular heart beat___________ | Neuropathy ___________________ | Dementia ________________ |
| GERD/Acid reflux______________ | Kidney stones/disease ________ | Cancer (type)_____________ |
| Asthma/emphysema___________ | Multiple sclerosis ____________ | Brain aneurysm___________ |

Others______________________________________________________________________

Have you had any of the following surgeries?

| | | |
|---|---|---|
| Appendectomy ________ | Heart bypass ______________ | Heart pacemaker _______________ |
| Cataracts_______________ | Valve replacement__________ | Hysterectomy__________________ |
| Gallbladder_____________ | Sinus surgery______________ | Hernia surgery_________________ |

Other surgeries ______________________________________________________________

**FAMILY HISTORY** (please check any diseases that occur or have occurred in your blood relatives)

| | | |
|---|---|---|
| Diabetes_______________ | Multiple sclerosis__________ | Parkinson's disease____ |
| Heart disease____________ | Brain tumor __________ | Headaches__________ |
| Stroke _______________ | Brain aneurysm __________ | Tremors___________ |
| High blood pressure________ | Depression/other mental illness__ | Cancers___________ |
| Epilepsy/seizure __________ | Dementia ______________ | Others (please list) |

**SOCIETY HISTORY**

Are you: _____Single _____Married

Are you: ___Full time employed ___Part time employed ___Student _____ Laid off _____ Retired

Do you smoke cigarettes? ____Yes ___No ____Quit How much_______________

Do you drink alcoholic beverages? _____Yes ___No ____Quit What type? (beer, wine, liquor)

How much____________________ How often_______________

Do you drink or eat caffeine-containing food or beverages _____Yes _____No

How much____________________ How often____________________

**DO YOU HAVE FOLLOWING SYMPTOMS? PLEASE CIRCLE**

| | |
|---|---|
| **General** | fever, chills, weight loss, weight gain, fatigue |
| **Sleep** | insomnia, trouble falling asleep, trouble staying asleep, early morning awakening, involuntary leg movement while asleep, loud snoring, stopping breathing while asleep |
| **Eyes** | blurred vision, loss of vision, double vision, eye pain or redness, drooping eyelid |
| **Ears** | hearing loss, ringing in the ears, spinning sensation or lightheaded |
| **Nose/sinuses** | frequent runny nose, frequent sinus trouble, nosebleeds |
| **Mouth/throat** | hoarseness, difficulty swallowing, choking sore throat, bleeding gums, dry mouth, drooling |
| **Heart** | chest pain, palpitation |
| **Lungs** | cough, frequent productive cough, coughing up blood wheezing |
| **Gastrointestine** | nausea, vomiting, diarrhea, constipation, stomachache/abdominal pain, blood in the stools |
| **Genitourinary** | difficulty urinating, frequent urination, burning on urination, loss of urine control |
| **Muscles/bones** | joint pain or swelling, neck stiffness or pain, back stiffness or pain, muscle aches/cramping |
| **Vascular** | poor circulation, leg swelling, varicose veins |
| **Endocrine** | Heat or cold intolerance, excessive sweating, thirst, hunger or frequent urination |
| **Blood** | easy bleeding or bruising |
| **Neurological** | headaches, fainting or passing out spells, seizures, lightheadedness, vertigo, localized weakness or numbness, poor balance, difficulty walking, falling, tremors, difficulty speaking, slurring of speech, poor coordination, trouble controlling arms or legs |
| **Psychiatric** | moodiness, excessive worrying or anxiety, excessive crying, tension, depression |

What medications did you take **in the PAST** for your headaches?

**Acute Medications (check all that apply)**

_______Sumatriptan (Imitrex)
_______Rizatriptan (Maxalt)
_______Zolmitriptan (Zomig)
_______Eletriptan (Relpax)
_______Migranal NS
_______Midrin/Epidrin
_______Ultram(tramadol)/Ultracet
_______Darvocet
_______Oxycodon
_______Methadone
_______Depakon (Depakote iv)
_______Magnesium infusion
_______Indomethacine (Indocin)
_______Naratriptan (Amerge)
_______Almotriptan (Axert)
_______Frovatriptan (Frova)
_______Dihydroergotamine (D.H.E.)
_______Treximet
_______Fiorinal /Fioricet (Butalbital) with or without codeine
_______Tylenol w/codeine
_______Vicodin
_______MS Contin
_______Fentanyl/Duralgesic Patch
_______Toradol injection
_______Thorazine
_______Celebrex

**Anti-Nausea Medications**

_______Metaclopramide (Reglan)
_______Zofran
_______Prochlorperazine (Compazine)
_______Phenergan

**Prophylactic or Daily Medications**

_______Amitriptyline (Elavil)
_______Doxepine (sinequan)
_______Flexeril (cyclobenzaprine)
_______Timolol
_______Topiramate (Topamax)
_______Depakote (valproic acid)
_______Lyrica
_______Zoloft (sertraline)
_______Lexapro
_______Paxil (paroxetine)
_______Clonidine
_______Zyprexa
_______Zanaflex (tizanidine)
_______Lithium
_______ Calan (verapamil)
_______Nortriptyline (Pamelor)
_______SOMA (carisoprodol)
_______Inderal (propranolol)
_______Corgard (nadolol)
_______Neurontin(gabapentin)
_______Lamictal (lamotrigine)
_______Remeron
_______Celexa
_______Cymbalta
_______Wellbutrin (bupropion)
_______Effexor
_______Seroquel
_______Prednisone
_______Baclofen

Other medications you took in the past:

**Nutritional Supplement/Herbal Supplements/Minerals**

_______Vitamin B2 _______Magnesium _______Co-Q10 _______Feverfew _______Butterbur

_______Others (please list)

**Alternative Treatments**

_______Biofeedback _______Massage _______Chiropractic Adjustment _______Yoga
_______Acupuncture _______Acupressure