



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)

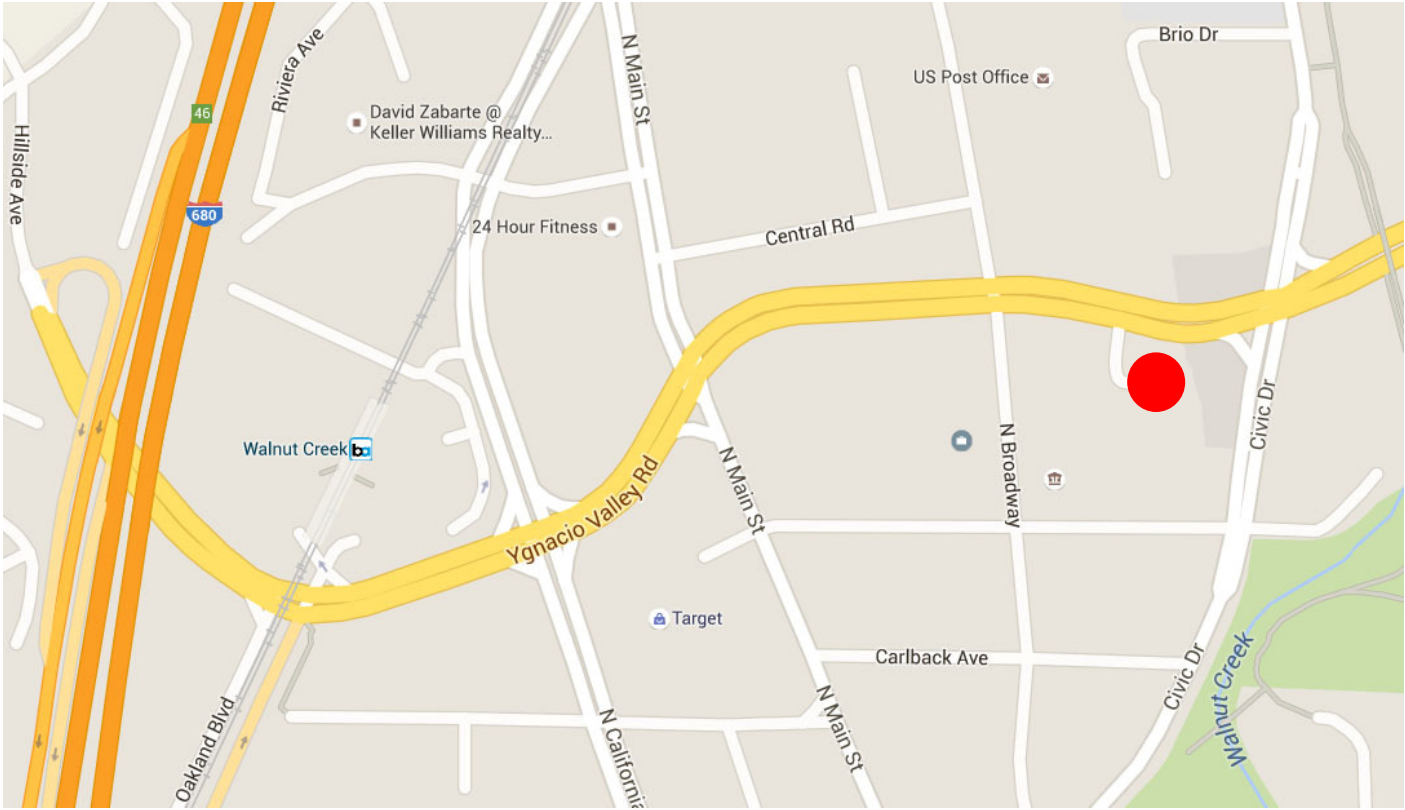
Take Ygnacio Valley Rd, west to Walnut Creek. Take a left U-turn on N. Broadway. Stay in the right hand lane. We are the first right turn (Walnut Creek Financial Plaza, immediately next to the And Oil gas station).

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

Take Highway 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).



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

675 Ygnacio Valley Rd, A102
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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.

PROTECTED 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
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Name	Relationship	Address or phone
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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: _____

IMPORTANT INFORMATION FOR OUR VALUED PATIENTS

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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER		DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
MARRITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVERCED <input type="checkbox"/> SEPERATED		ETHNIC GROUP <input type="checkbox"/> EUROPEAN <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ARAB/MIDDLE EASTERN <input type="checkbox"/> JEWISH <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER		EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> LAID OFF <input type="checkbox"/> DISABLED <input type="checkbox"/> RETIRED		PREFERRED LANGUAGE
STREET ADDRESS <input type="checkbox"/> PERMANENT <input type="checkbox"/> 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 SUBSCRIBER	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
Gastrointestinal	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