**YING PENG** MD PhD
comprehensive neurology care

333 Corporate Dr, Ste 110, Ladera Ranch, CA 92694
phone • (949) 215-6662
fax • (949) 215-6663
email • office@pengmd.com

# ADULT NEUROLOGY PATIENT PACKET

**General Information**

Patient's Name: _____________________________________________ DOB: ___ /___ /_______ Age: ______ Sex: ______

Home Address: ________________________________________________________________________________________

Phone: _____________________________________ Secondary Phone (Optional): __________________________________

Email Address: _____________________________________________________

**Emergency Contact**

Contact's Name: ______________________________________________ Relationship: _____________________________

Contact's Phone: ______________________________________________

**Primary Care Physician**

Name of Physician: ____________________________________________________________________________________

Clinic Address: ________________________________________________________________________________________

Phone: ______________________________________________ Fax: ______________________________________________

**Referring Physician** (Or check box if same as Primary: ☐ )

Name of Physician: ____________________________________________________________________________________

Clinic Address: ________________________________________________________________________________________

Phone: ______________________________________________ Fax: ______________________________________________

**Preferred Pharmacy: Name and Address**

__________________________________________________________________________________________________________

**Insurance: Subscriber Information**

Subscriber's Name: __________________________________ DOB: ___ /___ /_______ SS # ______-______-___________

*Social Security Number is required for billing and collections purposes. If you have any questions, please ask our staff.

**Insurance: Carrier and Eligibility Information**

Insurance Name: __________________________________________________ Type: ☐ HMO ☐ POS ☐ EPO ☐ PPO

Policy ID # ___________________________ Group ID # __________________________ Effective Date: ___ /___ /_______

Insurance Phone Number on Card: _____________________________________________

Employer Name: _________________________________________ Employer Phone: ______________________________

**Please Describe the Reason for Your Visit:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Handedness: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Have you had falls recently? ☐ Yes ☐ No

**Medical History**

Past Medical History - Briefly describe any past medical events (Hospitalizations and/or Surgeries):

______________________________________________________________________________

______________________________________________________________________________

Mental Health History - Briefly describe any mental health events (Hospitalizations):

______________________________________________________________________________

______________________________________________________________________________

**Medication History**

Please list any medication(s) the patient is currently taking:

| Medication Name: | Strength: | When taken (morning, evening, twice daily, etc.): |
|---|---|---|
| ______________________ | ___________ | ______________________________ |
| ______________________ | ___________ | ______________________________ |
| ______________________ | ___________ | ______________________________ |
| ______________________ | ___________ | ______________________________ |

Does the patient have any drug allergies? If so, please specify: ________________________________

______________________________________________________________________________

**Family Medical History** (On both parent's side of the family including siblings, grandparents, aunts, uncles, cousins, etc.)

Neurological Diseases:

______________________________________________________________________________

______________________________________________________________________________

Systemic Diseases:

______________________________________________________________________________

______________________________________________________________________________

**Social History**

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Education level: ☐ High School or GED ☐ College or University

What is your occupation (or retired)? ________________________________________

Do you smoke? ☐ Yes ☐ No

- If yes, how many packs per day? ________ What age did you start? ________

Did you quit smoking? ☐ Yes ☐ No

- If yes, how many years did you smoke? ________

Do you consume alcohol? ☐ Yes ☐ No

- If yes, how much? _________________________________________________

Do you use any recreational drugs? ☐ Yes ☐ No

- If yes, list name(s): ________________________________________________

Have you ever used any recreational drugs? ☐ Yes ☐ No

- If yes, list name(s): ________________________________________________

## Orientation

Patient care is our primary priority and concern. This brief orientation has been prepared to familiarize you with our policies. We want your relationship with us to be a positive experience. Please **initial each line** below, acknowledging that you have read and understand the policies. If you have questions, please ask our staff.

**Appointments:**

_______ Appointments should be made in advance by calling us at (949) 215-6662 or by emailing us at office@pengmd.com. To minimize wait times and maximize office productivity **patients who are more than 10 minutes late** are subject to reschedule.

_______ Our office does not provide childcare supervision during appointments. No children under age 12 may be left unaccompanied in the waiting room.

_______ Please bring a photo ID to your visit.

_______ Co-pays are due at the time of the appointment and bills are payable within 30 days of receipt. We bill insurance on your behalf; however, the balance due is your responsibility.

_______ Our office does not permit photography, video, or audio recording in the office.

**Cancellations/No Shows:**

_______ Our specialty practice has a "No Show" fee of $100: charged if you do not cancel 48 hours in advance. An exception will be made for an emergency. A 48-hour notice is needed so that we can offer your appointment time to another patient. A "No Show" fee must be paid prior to scheduling another appointment. Two "No show" will result in being discharged from the clinic.

**Emergencies and After-Hours Care:**

_______ If the patient is experiencing an EMERGENCY, call 911 or go to the nearest emergency room. For URGENT matters after hours, you can call our office and follow the voice prompts to page Dr. Peng directly.

**Updating Information:**

_______ It is the patient/legal guardian's responsibility to update the office of any changes to the address, insurance, or phone number on file.

**Form Fee:**

_______ There is a form fee for school medication forms, disability forms, IHSS, DMV, jury duty, financial affairs, narrative reports, and for copies of medical records. This is not the insurance's responsibility, but the responsibility of the patient or their legal guardian.

**Controlled Medications:**

_______ Controlled medications are not given outside of an appointment. It is the responsibility of the patient/legal guardian to schedule timely appointments to receive refill prescriptions and to securely store controlled medications.

**Authorization to Communicate Using Emails:**

_______ I authorize Ying Peng MD, PhD Inc. to email me regarding my protected health information (PHI).

**Authorization to Leave Messages:**

_______ I authorize Ying Peng MD, PhD Inc. to leave messages regarding my protected health information (PHI) on my telephone answering machine or with a family member or other designated party.

## Notice of Privacy Practices

This notice is to inform you of our privacy practices and how we maintain the confidentiality of your protected health information (PHI). We understand that this information is personal and completely confidential, so this policy is designed to explain to you how we handle your information.

Your confidentiality is maintained by restricting access only to employees who need access to your PHI in order to process services. Also, we have implemented appropriate physical electronic and procedural safeguards to protect your PHI against any unauthorized use of disclosure. Our staff is required to complete and annually review a training program designed to protect your PHI.

Although there are many safeguards to protect your PHI, there are some instances where Federal and State laws allow us to use/disclose your information without your consent. They are:

1. To provide your health care services
2. To bill and collect payments for the health care services provided
3. To provide you with treatment alternatives
4. To inform you about health benefits and services
5. To remind you about your appointments
6. To complete health care operations such as to resolve an appeal or grievance
7. When required by law
8. For public health activities
9. For reports about child and other types of abuse or neglect or domestic violence
10. For health oversight activities
11. For lawsuits and other legal disputes
12. For law enforcement purposes
13. To report to coroners, medical examiners, or funeral director
14. For tissue or organ donations
15. For research
16. To avert a serious threat to the health and safety of you or others
17. For national security and intelligence/military activities
18. In connection with services provided under worker's compensation laws
19. To family members or other persons who are involved in your care or payment of care
20. To create a directory that includes your name, your location at the facility, your general condition, and your religious preference when you are in an affiliated hospital

Ying Peng, MD, PhD, Inc. may have access to pharmacy prescription fill histories and may view this information for purposes of keeping accurate medication records.

You may agree or object to this disclosure. If you cannot agree or object because you are incapacitated or otherwise unavailable, we will use our professional judgment.

If you are a parent, you may control your minor child's PHI. There are some cases where we are permitted or even required by law to deny your access to your child's PHI, such as when your child can legally consent to medical services without your permission.

There are some types of PHI, such as HIV test results or mental health information, which are protected by stricter laws. However, even this PHI may be used or disclosed without your written authorization if required or permitted by law. All other uses and disclosures of your PHI require your written authorization.

If you need an authorization form, we will provide one for you or your personal representative to complete.

When you receive the form, please fill it out and return it to Ying Peng MD, PhD Inc.

You may revoke or modify your authorization at any time by notifying us in writing. Please note that your revocation or modification may not be effective in some circumstances, such as when we have already taken action relying on your authorization.

You also have the right to review and copy any of your PHI that we possess. If you wish to see your PHI, please write to us and we will tell you when and where you can review your PHI in our possessions within our normal business hours. If you would like a copy of the information we have, please notify us in writing. If we provide you with a copy, we may charge a reasonable administrative fee for copying your PHI to the extent permitted by applicable law. If we deny your request for review or copy of your PHI, we will explain the reason. If we do not have your PHI, but know who does, we will tell you whom to contact. If you wish to have your PHI corrected or updated, please notify us in writing as to what you want changed and why. We will respond to you in writing, either accepting or denying your request. If we deny your request, we will explain why. You may also provide us an addendum that is no longer than 250 words in length for each item you believe is incorrect. Please clearly indicate that you want the addendum to be included in your PHI. We will attach your addendum to the record(s) of your PHI. Your amended PHI will be available for your review upon request.

You have the right to request an accounting of certain disclosures that we make of your PHI. Please note that certain disclosures, such as those made for treatment, payment, or health care operations, need not be included in the accounting we provide to you. We will respond to your request within a reasonable period of time, but no later than 60 days after we receive your written request. You have the right to request and receive a paper copy of this Notice.

You have the right to request restrictions on how we use and disclose your PHI for our treatment, payment, and health care operations. All requests must be made in writing. Upon receipt, we will review your request and notify you whether we have accepted or denied your request. Please note that we are not required to accept your request for restrictions. Your PHI is critical for providing you with quality health care. We believe we have taken appropriate safeguards and internal restrictions to protect your PHI, and that additional restrictions may be harmful to your care.

You have the right to request that we provide your PHI to you in a confidential manner. For example, you may request that we send your PHI by an alternate means (e.g., sending by a sealed envelope, rather than post card) or to an alternate address (e.g., calling you at a different telephone number, or sending a letter to you at your office address rather than your home address). We will accommodate any reasonable requests, unless they are administratively too burdensome, or prohibited by law.

We must follow the privacy practices set forth in this Notice while in effect. If you have any questions about this Notice, wish to exercise your rights, or file a complaint; please direct your inquiries to: Attention: Dr. Ying Peng.

You may contact your Health Plan with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint against us.

We will use and disclose your PHI to the fullest extent authorized by law. We reserve the rights as expressed in the Notice. We reserve the right to revise our privacy practices consistent with the law and make them applicable to your entire PHI we possess, regardless of when it was received or created. If we make material or important changes to our privacy practices, we will promptly revise our Notice. Unless law requires the changes, we will not implement material changes to our privacy practices before we revise our Notice. You may request updates to this notice at any time. This notice is effective: October 1, 2013.

## Acknowledgement:

HIPAA regulations require us to provide to you – the patient or personal representative – a copy of our Notice of Privacy Practices. **Please sign below acknowledging receipt of the information.**

Patient or Responsible Party Signature: ____________________________________________ Date: ____ /____ /________

Patient or Responsible Party Printed Name: ________________________________________________________

# Notice of Patient Financial Responsibility

As a courtesy to our patients, we have enrolled in numerous insurance programs, and we will make every effort to verify coverage and bill your insurance company correctly. However, **we cannot guarantee Dr. Peng is in-network with every plan**. We recommend that you call your insurance plan before the appointment to verify your benefits and network status with your specific plan.

To help assist you in verifying the correct information we are providing you with Dr. Peng's information below:

| **Individual NPI**: 1528156429 **Group NPI**: 1548697352 **Tax ID**: 463539094 |
|---|

Please be advised that you are responsible for payment of services should you fail to notify us of any changes in your insurance information before services are rendered. This would include plan restrictions, lapses in coverage, changes in your medical group or IPA, health plan, primary physician, referring physician, benefits, and eligibility.

Please **<u>initial each line</u>** below acknowledging that you have read and understand the financial policy of our office:

_______ We are pleased to assist you by billing your insurance. However, the patient is required to provide us with the most correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not correct or updated.

_______ It is the patient's responsibility to confirm with their insurance company that Dr. Peng is in their insurance plan's network. I understand that if Dr. Ying Peng is an "Out-of-Network Provider" for my insurance plan, I am financially responsible for all charges incurred for services rendered.

_______ Patients are responsible for the payment of copays, coinsurances, and deductibles. It is the responsibility of the patient to know and understand their medical insurance benefits. Payment in full is due at the time of service. For your convenience, we accept cash, check, and most major credit cards at our office.

_______ I understand that if I write a check that is returned for any reason, I will be charged an additional fee of $25.00.

_______ Dr. Peng's office will bill insurance in a timely manner. If my insurance has not paid my claim within 60 days from the date insurance was billed, I will be responsible for payment. I also agree that I am responsible for any charges that my insurance company will not cover. I understand that failure to pay my account or make suitable financial arrangements may result in my account being placed in a state of delinquency. If this becomes necessary, I agree to pay all collection fees, which include but are not limited to: collection fees and interest, court fees, attorney fees and any other fees for the collection of my account balance. If your account is sent to collections, you/the patient will be discharged from the practice.

_______ Dr. Peng exhausts all effort to research and resolve aged accounts prior to sending to an outside agency. In the event that your account is sent to a collection agency, additional fees (up to 30% additional fee and 1.8% interest daily) will incur, that are separate and are in addition to charges for services rendered by our office.

_______ The patient (or patient's parent/guardian) is ultimately responsible for the payment of treatment and care.

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company; and thereby authorize insurance benefit payment be paid directly to physician for services rendered to the patient. A copy of this agreement may be used in place of the original.

**Please sign below acknowledging receipt of the information.**

Patient or Responsible Party Signature: ___________________________________________ Date: ____/____/________

Patient or Responsible Party Printed Name: _______________________________________________________

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## Important Notice Regarding Stimulant/Controlled Medications

Stimulants/controlled medications are abusable and therefore highly regulated by law. For the safety of our patients and to maintain good prescribing practices, we follow DEA guidelines. This is how we follow guidelines to maintain safe and responsible prescribing:

- **Prescriptions are not written without an appointment**.
- During your appointment, Dr. Peng will determine when your next appointment will be needed, and she will prescribe enough medication to last until the next appointment. Dr. Peng can provide prescriptions for up to a **maximum of 90 days**.
- After your appointment, office staff will offer to schedule your next appointment. If you are unable to schedule your next appointment at that time, it is recommended that you call the office to schedule *as soon as you are able* so that you can reserve an appointment that is convenient for you.

*If you run low or out of medication and need an appointment, we will do our best to schedule an appointment for you as soon as possible, however your preferred appointment time may not be available on short notice.*

Patients/Parents should be aware of the following:

- It is the responsibility of the patient/parent to keep medications secure. Lost or stolen medications will not be replaced. If medication is lost or stolen, you should notify the prescriber immediately.
- Medication must only be taken by the person to whom it is prescribed. It is unlawful to give, sell, or lend medication to anyone, including family members.
- Medications should be taken only as prescribed. If you feel a dosage change is needed, you should call the prescriber first.
- You must inform Dr. Peng of all medications prescribed by other doctors, especially other controlled substances.

We value the health, wellbeing, and safety of our patients. Please help us to provide the best care. Thank you!

Patient Name: ________________________________________________ Date of Birth: ____ /____ /_______

Patient/Legal Guardian Signature: ________________________________ Today's Date: ____ /____ /_______