KERN COUNTY NEUROLOGICAL MEDICAL GROUP, INC.
1705 28TH STREET BAKERSFIELD, CA 93301-1902
(661) 322-3008 FAX (661) 322-5507

Patient registration instructions and helpful tips for your visit.

Thank you for choosing Kern County Neurological Medical Group, Inc. for your care.
Prior to your appointment, you will need to complete this patient registration below.
You will also find helpful hints for your appointment below.
Please complete the forms and either FAX, EMAIL or MAIL
back to our office to expedite your visit time.

FAX: 661.869.1834
EMAIL: kcnmg@kernneuro.com
ADDRESS: 1705 28th Street, Bakersfield, CA 93301
661.322.3008 Office

HELPFUL TIPS FOR YOUR FIRST VISIT.

Please bring all Xrays, CT scans or MRIs to your appointment. If your films are on a CD/DVD (PACS/imaging viewing system) you do not have to bring hard copies. Please contact our office (661-322-3008) to see if your films can be accessed in our office.
Insurance information and card
Information about previous treatments and all medications
Co-payment or minimum payment (given at appointment time) for uninsured patients
List of questions for your physician

Thank You
Kern County Neurological Medical Group, Inc

YOUR APPOINTMENT: ____

STATEMENT OF FINANCIAL POLICY

Kern County Neurological Medical Group Inc. is a provider for many insurance plans and we will be listed in your group's provider list if we are participating in your plan. We will bill your insurance directly and receive payment directly from them. Your co-payment is due at the time of service. If for any reason you are not able to pay your co- payment at the time of service an additional $10.00 will be added to your statement. Also, any services that your insurance will not cover are your responsibility.

If you have HMO insurance, it requires authorization for any of your treatment here in the office or if the Doctor refers you elsewhere. If this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred, and will be required to sign a financial waiver. If your insurance subsequently authorizes the services, your payment will be refunded upon receipt of insurance payment.

If we are not a participating provider for your insurance plan, we will bill your insurance directly if you have provided us with complete information to do so. You may receive a statement for the entire charge prior to your insurance paying. You may wait to pay us until after the insurance has paid its portion providing the insurance company pays within 30 days.

If you do not have insurance, payment is expected at the time of service. We accept Visa, MasterCard and American Express for your convenience. If payment in full is not possible at the time of service, payment plans are available and can be arranged in our Business Office upon your request.

If you need our doctor to complete forms such as disability or Department of Motor Vehicles, there will be a $25 fee per form to be completed.

Statements are mailed monthly to patients with an outstanding balance. If you are unable to pay your balance within 30 days, please contact the Billing Office at (661) 322-3008 ext. 204 or email them at **billing@kernneuro.com** to make payment arrangements.

A 48 hour advanced notice is required if you must cancel or change your appointment.
If you are new to our practice and miss your initial appointment without notifying our office, all future
appointments must be guaranteed with a credit card. A second missed appointment without notice will result in a missed appointment charge of $25.00 for general medical visits, or a $50.00 charge for a missed diagnostic study appointment.

For established patients who miss an appointment without giving a 48 hour advanced notice, there is a $25.00 charge for general office visits, and a $50.00 charge for all missed diagnostic testing or study appointments. **Our policies are created to allow for effective scheduling and to ensure all patients wishing to be seen may be accommodated. Please help us better serve you by notifying us as soon as possible if you must change or cancel your appointment.**

I have read and understand Kern County Neurological Medical Group In.'s financial and claims filing policies.

Print Patient's Name____

Patient's Signature________________________________**Date**____________________

Responsible Parties Signature (if other than patient) ________________________**Date**__________

Prescription Refill and Diagnostic Testing Policy

PATIENT NAME: ____ Date ___________________

Thank you for consulting Kern County Neurological Medical Group Inc. We have developed the following policies to help make your follow-up care go smoothly.

PRESCRIPTION REFILLS:

IF YOU FILL YOUR PRESCRIPTION THROUGH A LOCAL PHARMACY, you should call your pharmacy **several** days before you are ready for a refill. Do not call our office as this will delay your refill. Your pharmacist will call us / send us for authorization if necessary. ***Phoning your pharmacy directly, several days early, is the fastest way to get your prescription medication refilled.***

If you:

A) Fill a prescription through a mail-in-service, or
B) Fill a prescription due to a vacation or medication lost
C) Need a written prescription for refills for any other reason

Please call our office several weeks before you need your refill. Most mail-in-services have a limit on the amount of medication you can receive at any time. We will make every effort to get the necessary amounts for you. Ultimately, it is your prescription benefit that will determine how your prescription is filled.

LAB TEST, MRI's, CT SCAN, EEG's, EMG/NCV'S ETC:

Depending upon your insurance, you may have several choices as to where you may go for the outside tests your doctor recommends. If you have insurance and want to keep your costs as low as possible, we recommend that you call your insurance company to be sure you are using an approved provider of these services and they have received proper authorization. ***Ultimately, it is your responsibility to know your insurance plan benefits.***

Please sign and date that you have read and understood these policies.

X____ Date:________________________________

____

Print Name

PERMISSION TO FURNISH MY MEDICAL INFORMATION

1. <u>FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES</u>

I hereby give my consent to Kern County Neurological Medical Group, Inc. to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available. Unless otherwise indicated, you will leave a message on my answering machine or voice mail with any routine results, instructions or appointment reminders when I am not immediately available.

Approved Person(s)	Relationship to Me
________________________________	________________________________
________________________________	________________________________
________________________________	________________________________

- ❑ I hereby instruct Kern County Neurological Medical Group, Inc. to furnish information **<u>only</u>** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- ❑ Other special instructions regarding furnishing my medical information: ______________________________

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2. <u>FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS</u>

I understand that Kern County Neurological Medical Group, Inc. will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc) **about me with my Primary Care Physician and/or the Provider or entity that referred me to Kern County Neurological Medical Group, Inc..**

<u>In addition</u>, I hereby give my consent to Kern County Neurological Medical Group, Inc. to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Name and Contact Information	**Send copies**	**OK to discuss**
____	☐	☐
____	☐	☐
____	☐	☐

X______________________________________ ____________
Signature **Date**

Print Name ________________________________

Name: ____ **Birthdate** ____________________________

Email Address: ____SEX ___**Female** ___**Male**

Contact Preference: ___ Home Number ___ Cell Phone ___ Email

Ethnicity __________________ **Race** ________________ **Preferred Language** __________________

Pharmacy Name ____________________________**Location** __________________________________

Referring Physician _________________________ **PCP** _____________________________________

Facility _______________________________________ **Fax** _________________________________

Chief Complaint: ____

Medications – Please list all of the medications you are currently taking. Include aspirin, birth control pills hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Allergies

____

____

Past Medical History

Check if you have had any of these problems. Give details.

- □ Angina
- □ Asthma
- □ Blindness, part or full
- □ High blood pressure
- □ High cholesterol
- □ Irregular heart beats

- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Double vision
- ☐ Fainting
- ☐ Head trauma
- ☐ Headache
- ☐ Hearing problem
- ☐ Heart attack
- ☐ Heart failure
- ☐ Hepatitis
- ☐ Herniated disc
- ☐ Nervous breakdown
- ☐ Numbness
- ☐ Polio
- ☐ Psychiatric conditions
- ☐ Sciatica
- ☐ Seizures (epilepsy)
- ☐ Speech problems
- ☐ Stroke
- ☐ Swallowing problems
- ☐ Ulcers
- ☐ Venereal infections
- ☐ Vertigo
- ☐ Walking problems

Surgical Procedures – List chronologically

Operations	Hospital & City	Date
1.		
2.		
3.		
4.		
5.		

Family History
Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):
Check if positive **Relationship**

☐ Alcoholism ____________________

☐ Cancer ____________________

☐ Diabetes ____________________

☐ Heart Disease ____________________

☐ Mental Illness ____________________

☐ Migraine ____________________

☐ Seizures ____________________

☐ Stroke ____________________

☐ Tuberculosis____________________

Social History

Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Check any of the following that you have used and state amount:

☐ Caffeine How much per day? ______________________________

☐ Alcohol How much per day? ______________________________

☐ Tobacco How much per day? ______________________________

Have you ever smoked ______________________________

Recent Lab Work:
Lab Name______________________________ Date: __________________

MRA/MRI/CT/XRAY Scans
Radiology Name: ______________________________ Date: __________________

OTHER DIAGNOSTIC TEST

____

<u>FOR OFFICE USE ONLY:</u>

Height: ______________________ Weight: __________________ Pulse: ______________________

BP: __________________________

NOTES: