Foothills Neurology, P.C. New Patient Registration

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048

Tel: (480)961-2365 Fax: (480)961-2382

First Name:__________ Last Name:__________ Middle:__________ Date of Birth:__________

Street Address:__________ City:__________ State:__________ ZIP:__________

Gender: M F

Home Phone: __________ ☐ Home phone is the same as cell phone

Mobile Phone: __________ ☐ None

Can we send you Text reminders? Y N

Work Phone: __________

Email:__________ ☐ No Email

What is your preferred way for us to contact you?

- ☐ Home Phone ☐ Ok to leave message
- ☐ Work Phone ☐ Ok to leave message
- ☐ Cell Phone ☐ Ok to leave message
- ☐ Mail
- ☐ Patient Portal On-Line

The U.S. Government would like the following information:

Marital Status: Single Married Divorced Widowed Other

Primary Language:__________ ☐ Decline

Race:__________ ☐ Decline

Ethnicity:__________ ☐ Decline

Which Pharmacy would you like us to send your prescriptions to?

__________ __________

Pharmacy Cross Streets or Address or Phone Number

Which Laboratory would you like to go to if we send you for blood work?

__________ __________

Lab Cross Streets or Address or Phone Number

Family Doctor:__________ Which Office? __________

Referring Doctor:__________ Which Office? __________

Emergency Contact:__________ Relation:__________

Emergency Contact Phone:__________

Primary Insurance:__________ **Insurance ID #**__________

Please bring your insurance card for us to copy

Secondary Insurance: __________

If the patient is not the primary policy holder...

Name of Primary: __________ DOB:__________ Gender: M F

The Patient is the primary policy holder's: Spouse Child Other

Patient Signature __________ Date__________

Foothills Neurology, P.C. Financial Responsibility

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048 Tel: (480)961-2365 Fax: (480)961-2382

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. Your insurance company determines insurance benefit payments. I understand I will be responsible for the portion not covered by my insurance.

I understand that Foothills Neurology *does not* accept liens, worker's compensation or MVA/auto claims and I am responsible for any insurance claims denied for such. If my medical insurance denies or takes back any monies provided, I understand I am responsible to pay all claims in full in a timely manner.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days of the billing date. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Patients are responsible for making sure that Dr. Stuart Hetrick is *in network* with your insurance provider. We verify insurance eligibility, *but we do not verify* that we are in each individual network.

Due to the large amount of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.

This is what you need to know:

- **You have to pay for services that your insurance company says are your responsibility.**
- **If your insurance is not active on the day of your appointment, you will have to pay the whole bill.**
- **Your co-pay must be paid before each visit.**
- **We will charge you $50 if you miss your appointment unless 24-hour notice is given.**
- **There is a $25 charge for a Non-Sufficient Funds (NSF) check.**

I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize my insurance company to make payment directly to: Foothills Neurology, P.C.

Signature of patient (or parent/guardian)______________________________

Print Name______________________________

Date______________________________

Foothills Neurology, P.C. Privacy Notice

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048 Tel: (480)961-2365 Fax: (480)961-2382

I have received the HIPAA Privacy Notice and HIPAA Omnibus Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Foothills Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Foothills Neurology upon request.

FAXES: When expedient, I authorize the transmittal of my records by FAX to doctors, pharmacies, insurance companies, or upon my request. I understand that transmission by FAX, by its very nature, is not confidential.

______________________________ ______________

Patient Name Date of Birth

______________________________ ______________

Patient Signature Date

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Foothills Neurology and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

______________________________ ______________________

Name Relationship to Patient

______________________________ ______________________

Name Relationship to Patient

MESSAGES:

Y N It is ok to leave a message on my home voice mail #: ___________________

Y N It is ok to leave a message on my work voice mail #: ___________________

Foothills Neurology, P.C. Cancellation Notice

4530 East Muirwood Drive Suite 111, Phoenix, AZ 85048 Tel: (480)961-2365 Fax: (480)961-2382

CANCELLATION POLICY

At Foothills Neurology, our goal is to provide quality care in a timely manner. We have implemented an Appointment/Cancellation Policy which enables us to better utilize available appointments for our patients in need of care.

A “no show” is someone who missed an appointment without canceling it by 12:00 p.m. (1) one working day in advance. No-shows inconvenience those individuals who need access to neurological care in a timely manner. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to a provider.

Without notification by 12p.m. (1) one business day before your scheduled appointment, you will be charged for the missed appointment. The charge will occur for any reason even those outside of your control, ie: car troubles, illness, or transportation issues, etc.

I AGREE TO PAY A $50 FEE IF I DO NOT CANCEL MY APPOINTMENT BY 12 P.M. THE BUSINESS DAY PRIOR TO MY APPOINTMENT

Your signature indicates that you understand the above and accept the financial responsibility for any appointment missed without prior notification.

Signature:________________________________ Date:_________________

Print Name :______________________________ DOB:________________

Foothills Neurology, P.C. Hyperhidrosis History Form

Stuart Hetrick, DO 4530 E. Muirwood Drive, Suite 111, Phoenix, AZ 85048

Name: ____ Date of appointment: __________________

What is the main problem you are having? ____

Is this due to an accident? ___Y ___N ___Don't know Is a legal case pending? ___Y ___N ___Maybe

Age ______

PLEASE LEAVE THIS BOX BLANK

Have you had any Tests done already? (e.g., MRI, Cat scan, EMG, X-rays, Ultrasound, etc…)

Test / X-Ray	Approximate Date Done	Result

***ALLERGIES*: Do you have any allergies to any medicine? ____**

What *MEDICINE* or *DRUG STORE PRODUCTS* are you taking?

Name of Medicine	Dosage	Times per Day	For What	Approx. Date Started

-
-
-
-
-
-

Have you stopped any medicine recently or used other medicine in the past for this problem?

Do you take birth control pills, patch or implant? Y N What?______________________________

PAST MEDICAL HISTORY **Do you have any other medical problems such as:**

Yes	No		Yes	No		Yes	No	
___	___	diabetes	___	___	ulcers	___	___	heart problem
___	___	kidney problem	___	___	hepatitis	___	___	stroke
___	___	thyroid problem	___	___	cancer	___	___	arthritis
___	___	fibromyalgia	___	___	seizures	___	___	asthma/emphysema
___	___	TMJ	___	___	depression	___	___	anxiety
___	___	lung disease	___	___	high cholesterol	___	___	headache
___	___	eye disease	___	___	osteoporosis	___	___	chronic pain in:
___	___	anemia	___	___	high blood pressure			___back ___neck ___other

Have you had any other surgeries, hospitalizations or other medical problems? If so list them:

Do you have any other problems for which you have been seeing a *doctor* or *chiropractor* on a regular basis?

FAMILY HISTORY

Do you have any family members with similar problems as you? Y N

Do you have any family members with?

brain tumor	**Y**	**N**	**who?**	Stroke	**Y**	**N**	**who?**
Seizures	**Y**	**N**	**who?**	heart attack	**Y**	**N**	**who?**
Headaches	**Y**	**N**	**who?**	Aneurysm	**Y**	**N**	**who?**

SOCIAL HISTORY:

Do you use tobacco? Y N How much? ___________________________

Do you drink alcohol? Y N How much? ___________________________

What is your occupation or major daytime activity? ____

If you are pregnant or thinking of getting pregnant please check here: ☐

(ROS) Do you have any other symptoms that you feel are important but have not already mentioned?

___fever/chills	___blurred vision	___double vision	___jaw pain with chewing
___chest pain	___eye pain	___trouble urinating	___difficulty swallowing
___palpitations	___constipation	___diarrhea	___shortness of breath
___joint pain	___stomach pain	___trouble sleeping	___numbness/tingling
___nose bleeds	___dizziness	___swollen glands	___**other (please explain)**

What part of your body sweats too much?

- ☐ Arm pits
- ☐ Hands
- ☐ Feet
- ☐ Face or head
- ☐ All over
- ☐ Just one spot ____
- ☐ Other ____

Do other people (friends, family or others) notice that you sweat too much?

- ☐ No
- ☐ Yes

How long has the excessive sweating been going on?

- ☐ 2-3 months
- ☐ 3-6 months
- ☐ over 6 months

Do you know why you sweat too much?

- ☐ No
- ☐ Yes if yes, why? ____

Do you sweat excessively on

- ☐ Both sides of your body?
- ☐ Just one side of your body?

Does your excessive sweating impair your daily activities in any way?

- ☐ No
- ☐ Yes how? ____

Does your excessive sweating occur:

- ☐ Constantly?
- ☐ Multiple times a day?
- ☐ Once a day or so?
- ☐ 1-2 times per week?
- ☐ less than once a week?

At what age did you first start experiencing excessive sweat? ______________________

Do you have a parent, sibling or child who sweats like you do?

- ☐ No
- ☐ Yes who? ____

Do you sweat during sleep?

- ☐ No
- ☐ Yes

My excessive sweating is: (please choose the most appropriate response)

_____ Never noticeable and never interferes with my daily activities.

_____Tolerable but sometimes interferes with my daily activities.

_____ Barely tolerable and frequently interferes with my daily activities.

_____ Intolerable and always interferes with my daily activities.

Diagnostic criteria: focal visible sweating for >6 months w/o apparent cause
with 3 or more of the following: ____B/L; ____impairs daily activity; ____> 1 episode/week;
____onset <25; ____positive family hx; ____ceases during sleep.