16405 Sand Canyon Avenue Suite #220

Irvine, CA 92806

P: 949.753.1882

PATIENT INFORMATION					
NAME (LAST, FIRST, MIDDLE)		DOB	SEX	SSN#	
HOME ADDRESS					
CELL PHONE	HOME PHONE	EMAIL ADDRESS			
PRIMARY PHYSICIAN	REFERRING PHYSICIAN		REFERRAL SOURCE		
PREFERRED PHARMACY					
NAME OF PHARMACY		PHONE#		FAX#	
STREET ADDRESS					
INSURANCE INFORMATION					
PRIMARY INS CARRIER		MEMBER ID#			
SECONDARY INS CARRIER		MEMBER ID#			
EMERGENCY CONTACT					
NAME		PHONE#			
RELATIONSHIP TO PATIENT		SECONDARY PHONE#			

I hereby authorize and consent to examination and treatment as deemed necessary by the physician of NervePro Corporation. I authorize release of information to my insurance carrier should it be necessary. I hereby assign all medial, including major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to NervePro Medical Corporation. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I further authorize the release of all medical information necessary to secure payment. The undersigned agrees to pay any costs incurred by NervePro Medical Corporation in the collection of amounts due including, but not limited to, reasonable attorney fees.

____________________________________ __________________

PATIENT/GUARDIAN SIGNATURE DATE

MEDICAL HISTORY FORM

NAME:____

AGE:_____________ RACE:_____________________

CHIEF COMPLAINT TO NEUROLOGIST:____

DATE SYMPTOMS STARTED:______________ MEDICATION ALLERGIES:_____________________________________

PLEASE CHECK THE TESTS YOU HAVE COMPLETED: ☐ EEG ☐ MRI BRAIN/SPINE ☐ PET/CT SCAN ☐ EMG/NCV

MEDICATIONS:	**DOSE/MG:**	**FREQUENCY:**	**START DATE:**	**REASON USED:**
…………………………………………	………………	……………………	……………………	……………………………………………………………
…………………………………………	………………	……………………	……………………	……………………………………………………………
…………………………………………	………………	……………………	……………………	……………………………………………………………

OPERATIONS:	**DATE:**	**MAJOR ILLNESSES:**	**ONSET:**
…………………………………………	………………	……………………………………………………	……………………………………
…………………………………………	………………	……………………………………………………	……………………………………
…………………………………………	………………	……………………………………………………	……………………………………

CHECK IF YOU HAVE:

GENERAL
- ☐ FEVER
- ☐ MALAISE
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS
- ☐ ANEMIA

EYE
- ☐ EYE PAIN
- ☐ GLAUCOMA
- ☐ BLURRED VISION
- ☐ DOUBLE VISION
- ☐ TEMP LOSS OF VISION

SKIN
- ☐ RASH
- ☐ PSORIASIS
- ☐ MELANOMA
- ☐ ACNE
- ☐ SKIN CANCER

EAR/NOSE/THROAT
- ☐ HEARING LOSS
- ☐ TINNITUS
- ☐ HOARSE VOICE
- ☐ VERTIGO

GENITO URINARY
- HEMATURIA
- PROSTATE
- INCONTINENCE
- KIDNEY STONES
- BLADDER INFECTION

CARDIOVASCULAR
- ☐ CHEST PAIN
- ☐ PALPITATION
- ☐ PACEMAKER
- ☐ HEART FAILURE
- ☐ FOOT EDEMA
- ☐ VALVE DISEASE
- ☐ ATRIAL-FIBRILATION

RESPIRATORY
- ☐ ASTHMA
- ☐ SHORTNESS OF BREATH
- ☐ EMPHYSEMA
- ☐ COUGH
- ☐ HEMOPTYSIS
- ☐ SLEEP APNEA

GASTROINTESTINAL
- HEARTBURN
- NAUSEA
- LIVER DISEASE
- GALL BLADDER
- SWALLOWING DIFF
- BLOOD IN STOOL

MUSCLE SKELETAL
- ☐ NECK PAIN
- ☐ BACK PAIN
- ☐ JOINT PAIN
- ☐ CRAMPS
- ☐ CARPAL TUNNEL
- ☐ GAIT TROUBLE
- ☐ JOINT REPLACEMENT

NEUROLOGICAL
- STROKE
- SEIZURES
- MEMORY LOSS
- SPEECH TROUBLE
- TREMORS
- NUMBNESS
- HEADACHE

LIST ANY FAMILY ILLNESSES:……

TOBACCO USE:………………………………………………………………… PACK/DAY:……………………………………………………………

CAFFEINE:……………………………………………………………………… SERVING/DAY (COFFEE,COLA,ETC):……………………………

ALCOHOL USE:………………………………………………………………… DRINKS PER DAY/WEEK/MONTH:……………………………

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for NervePro Medical Corporation to use and disclose my protected health information (PHI) to carry out treatment, payments, and any healthcare operations(TPO). I have the right to review the Notice of Privacy Practices prior to signing this consent. I can download a copy of the revised Notice of Privacy Practices from the NervePro website www.nervepro.com. I can also obtain a hard copy of the Notice of Privacy Practices by submitting a written request to the office staff at NervePro.

Additionally, I authorize NervePro Medical to disclose, discuss, and transmit my protected health information with the following individual(s) and provider(s):

Providers:

1) Name:______________________________________ 2) Name:_____________________________________
Ph:_________________ Fax:_________________ Ph:________________ Fax:_________________

Individuals/Family Members:

1) Name:______________________________________ 2) Name:_____________________________________
Ph:_________________ Relation:______________ Ph:_______________ Relation:_____________

3) Name:_______________________________________

Ph:___________________ Relation:________________

By signing this, I authorize NervePro Medical Corporation to use and/or disclose protected health information (PHI) about me through the above conduit(s), to the above individual(s), and provider(s). I understand that when my information is disclosed it may be subject to redisclosure by the recipient and therefore, may no
longer be protected by the federal HIP PAA privacy rule. I understand I have the right to revoke or limit this authorization at any time. I understand NervePro Medical Corporation reserves the right to revise its Notice of Privacy Practices at any time. If I chose to do so, I understand that a written revocation or itemized limitation of the information to be disclosed must be submitted to NervePro Medical Corporations Privacy Office at:
16405 Sand Canyon Avenue, Suite #220, Irvine, CA 92618

____ ________________________________

PATIENT NAME (PRINTED) DATE

____ ________________________________

SIGNATURE RELATIONSHIP TO PATIENT (if applicable)

AUTHORIZATION TO PAY

I __________________________ hereby authorize my insurance company/companies, __________________, to

(PRINT NAME) (NAME OF INSURANCE)

make payment directly to **Bruce Cleeremans, MD/NervePro Medical Corporation** utilizing my insurance benefits which may be due for services rendered by said physician. I further accept liability for medical devices/products/services prescribed and dispensed to me by the above physician should they, for any reason, not be a reimbursable expense by my insurance company.

*We attempt to refer you to providers, labs, and imaging facilities that are contracted with your health plan; However, we are listed as a provider for over 100 health plans, and it is not possible for us to know the details of each individual plan since each policy has coverage levels specific to the needs of the subscriber. Insurance companies are constantly updating their coverage criteria internally without sending notification to providers.

IT IS YOUR RESPONSIBILITY TO KNOW THE DETAILS OF YOUR HEALTH PLAN

If you are in doubt as to whether a medication, procedure, lab test, diagnostic study, or imaging service is covered or you are unsure where it must be performed, please call your plans member services department to verify. Our office is not responsible for any out-of-pocket costs that may incur due to the use of an out of network provider, facility, or by completing tests, or procedures that are not previously authorized by your insurance.

______ HMO Benefits – Do you have a valid authorization from your referring doctor? YES NO

(INITIAL)

______ PPO Benefits – I understand that my charges may be subject to deductible & copayments.

(INITIAL)

______ MEDICARE/SUPP Plan – I understand that I am responsible for the balance not paid by my insurance.

(INITIAL)

______ SELF PAY (NO INS) – I understand that I am responsible for the entire balance incurred from my visit.

(INITIAL)

____ ____________________________

SIGNATURE DATE