GARY A. BELAGA, M.D.
NEUROLOGY

PATIENT REGISTRATION FORM

LAST NAME ____ FIRST NAME ____ MIDDLE ____ BIRTH DATE ____

ADDRESS ____ CITY/STATE ____ ZIPCODE ____ GENDER ____

HOME TELEPHONE ____ MOBILE PHONE ____ LANGUAGE ____ MARITAL STATUS ____

OCCUPATION ____ EMAIL ADDRESS ____ REFERRING DOCTOR ____

SOCIAL SECURITY NUMBER ____ EMPLOYER ____ MEDICATION ALLERGIES ____

INSURANCE INFORMATION

PRIMARY INSURANCE ____ ADDRESS POLICY ____ NUMBER ____

POLICY HOLDER ____ BIRTH DATE ____ RELATIONSHIP TO PATIENT ____ SOCIAL SECURITY NUMBER ____

EMERGENCY INFORMATION

NAME OF CONTACT: ____ RELATIONSHIP ____

EMERGENCY NUMBERS: ____ TELEPHONE ____ WORK / CELLULAR

DISCLOSURE

I assign all medical benefits to which I am entitled, including Medicare, Medi-Cal, Private & other insurance plans to GARY A. BELAGA, M.D. I understand that I am financially responsible for all charges whether or not the bill is paid by the insurance company. I authorize ASSIGNEE to release all information, if needed to secure payment. A photocopy of this AGREEMENT shall be considered as valid as the original. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. NOTE: in order to control billing costs, we request that the charges for office visits be paid at the time that services are rendered. The patient is responsible for paying deductible and co-payment sums for each medical office visit with the doctor. Automatic telephone reminders for subsequent appointments will be made 24 hours prior to scheduled visits. Missed appointments without the courtesy of prior notification/cancellation will be charged $50.

Credit Card Number: ____ **Security Code:** ____ **Exp Date:** ____

SIGNATURE ____ DATE ____ PRINTED NAME ____

Tice Valley Plaza
1814A Tice Valley Boulevard
Walnut Creek, CA 94595

PHONE (925) 239-7141
FAX (888) 838-1981
E-MAIL belagamed@gmail.com

1. What is your primary complaint—the reason for your visit?

____

____

____

2. When did your symptoms begin? ____

3. If you became disabled, when? ____

4. If you have been previously treated for this condition, please provide details:

____

____

____

5. List ALL Current Medications:

____

____

____

____

6. Please list your preferred pharmacy and its location:

____

7. Tell us about any illnesses in your family (parents, siblings, etc.):

____

____

8. Please list any information about past illnesses, injuries, hospitalizations, or surgery:

____

____

____

____

9. Please describe your personal habits and activities (tobacco use, alcohol consumption, hobbies, physical fitness, etc.) and any other issues in your life:

____

____

____

____

10. Review of systems: (check those which apply to you)

CONSTITUTIONAL	Y/N	RESPIRATORY	Y/N	HEMATOLOGY	Y/N
Weight change		Cough		Easy Bruising	
Fatigue		Coughing Blood		Gum bleeding	
Fever		Wheezing/Hay Fever		Enlarged Glands	
		Chills			
EYES		**GASTROINTESTINAL**		**MUSCULOSKELETAL**	
Glasses/Contacts		Heartburn/Reflux		Joint Pain/Swelling	
Eye pain		Nausea/Vomiting		Stiffness	
Double Vision		Constipation		Muscle Pains	
Cataracts		Bowel Habit Change		Back Pain	
Blind Spots/Blurring		Diarrhea		Neck Pain	
Flashing Lights		Jaundice		Imbalance	
Pupillary Changes		Abdominal Pain		Tremor	
		Black or Bloody Stools		Weakness	
CARDIOVASCULAR		**GENITOURINARY**		**SKIN**	
Murmur		Burning/Frequency		Rash/Sores	
Chest Pain		Night Voiding		Pigmentation Changes	
Palpitations		Blood in Urine		Itching/Burning	
Fainting		Loss of Control		Moles	
Loss of Breath		Erectile Problems		Hives/Eczema	
Unable to Lie Flat		Testicular Problems			
Ankle Swelling					
ENDOCRINE		**PSYCHIATRIC**		**NEUROLOGICAL**	
Loss of Hair		Anxiety/Depression		Numbness/Tingling	
Excessive Hair		Mood Swings		Seizures/Blackouts	
Heat/Cold Intolerance		Sleep Problems		Memory Loss	
				Tinnitus/Hearing Loss/Vertigo	
MENSTRUAL				Involuntary Muscle Activity	
Irregularity				Trouble Chewing,/Swallowing,	
Heavy Bleeding				Speech Problems	
Pain				Headaches/Migraines	
Pregnancy				Weakness/Gait Problems	

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HIPAA
PRIVACY CONSENT

The Health Insurance Portability and Accountability Act of 1966 (HIPAA) established a "Privacy Rule" to help ensure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consents for uses and disclosures of health information about the patient in order to carry out treatment, payment, or health care operations.

As our patient, you should know that we respect the privacy of your personal medical records and will do all that we can to secure and protect that privacy. We strive to always take responsible precautions in order to protect your privacy. When it is appropriate or necessary, we provide the minimum necessary information only to those we feel are in need of your healthcare information regarding treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We fully support your access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with the physician and not with patient's), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be done in writing. Under the law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information. If you choose to give consent in this document, at some time in the future you retain the right to request to refuse all or part of your Personal Health Information. You may not, however, revoke actions that have already taken place and which relied upon this order previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our Privacy Notice (Compliance Assurance Notifications to Our Patients), to request restrictions, and to revoke consent in writing.

PATIENT: ______________________________ SIGNED: ______________________________

DATE: ________________

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ARBITRATION AGREEMENT

Article 1

It is understood that any dispute as to medical malpractice, that is, as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely rendered, or whether any harm resulted from such medical services, will be determined by submission to arbitration as provided by California law and not by a lawsuit or the resorting to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2

a. Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other healthcare provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs and assigns of the foregoing individuals and entities. The provider signing this Agreement signs on behalf of all of the foregoing individuals and entities, and intends to bind each of them to the full extent permitted by law.

b. Treatment covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory and binding arbitration.

c. Other Providers (if Applicable). Patient understands that he or she may at times receive treatment from one or more healthcare providers who will take call for or otherwise practice jointly with the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such healthcare providers will be subject to compulsory and binding arbitration.

d. Coverage of Prenatal Claims (if Applicable). Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory and binding arbitration.

Article 3

a. Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Provider to Patient, Patient will promptly notify Provider so that Provider may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statue of limitations for 90 days.

b. Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement, Patient may initiate arbitration by notifying Provider to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Provider will designate an arbitrator to act on Provider's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties allied with Providers shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C. C. P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the laws of the State of California which shall apply to the same extent as if the dispute were pending before a Superior Court of this State.

d. Interpretation of Agreement. If any part of this Agreement is held unenforceable, it shall be severed and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applies to all care previously rendered by Provider to Patient.

Article 4

a. Rescission. Once signed, this Agreement covers all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

NOTICE: By signing this contract, you are agreeing to have any and all issues of medical malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of this contract.

PATIENT: ______________________ SIGNED: ______________________

PROVIDER: Gary A. Belaga, M.D DATE: ______________

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