Maria Choy, M.D.

Director
Board Certified Neurologist
EMG, Acupuncture, Homepathy

Welcome to Our Office

NEW PATIENT INFORMATION Date _____

PATIENT NAME (PRINT)	SOCIAL SECURITY #	MARITAL STATUS	GENDER	RELIGION
ADDRESS	CITY	STATE ZIP CODE	BIRTH DATE	AGE
PATIENT OR PARENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	HOME PHONE	CELL PHONE
EMPLOYER ADDRESS	CITY	STATE, ZIP CODE	BUSINESS PHONE	HOW LONG EMPLOYED
DRUG ALLERGIES				
SPOUSE OR PARENT	SOCIAL SECURITY #	BIRTH DATE	CELL PHONE	HOME PHONE
SPOUSE/PARENT EMPLOYER	EMPLOYER ADDRESS	CITY	STATE ZIP CODE	BUSINESS PHONE

HIPAA GOVERNMENT REQUIREMENT FOR MEDICAL RECORDS

RACE (circle): Asian Black Caucasian Other Declined

Ethnicity (Circle): Hispanic Non-Hispanic Declined

Language (Circle): English Spanish Other

Tobacco use (circle):

Never Smoked Non-smoker Smoker How many Packs per day? _____

Alcohol use: None, Occasional or # glasses/shots _____ per day or week

ALL PROFESSIONAL SEVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WIL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of Policy Holder _____ HIC Number _____

Request that payment of authorized Medicare/Other Insurance Company benefits be made either to me or on my behalf to _____ for any services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to Social Security Administration and Health Care Financing Administration or other intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to name the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of Social Security Act and 31 USC 3801-8 provides penalties for withholding this information)

Signature _____ Date _____

Central Jersey
Neurological Institute, PA

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NAME _____ **BIRTHDATE** _____ **TODAY'S DATE** _____

LIST ALL MEDICATIONS **HOME PHONE** _____ **CELL PHONE** _____

INCLUDING OVER THE COUNTER MEDICATIONS, SUPPLEMENTS, VITAMINS AND HOMEOPATHICS

DATE	DRUG	DOSE	DR PRESCRIBING

400 Belchase Dr #402 ~ Matawan, N.J. 07747-9759~ (732)591-5888

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Patient Name_____ **DOB** _____
Today's Date_____ **BP** _____ **Wt** ____ **HR** _____ **Ht** _____

Referring MD _____

Referring MD Address, phone #, and Fax # _____

Primary Care Doctor Address, Phone #, Fax # _____

REASON FOR VISIT _____

LOCATION _____ QUALITY _____
(WHERE IS PAIN/PROBLEM) (EX: SHARP, DULL, TINGLING)

SEVERITY _____ DURATION _____
(HOW BAD IS PAIN/PROBLEM) (HOW LONG HAVE YOU HAD PROBLEM/WHEN DID IT START)

TIMING _____ CONTEXT _____
(Does pain problem occur at specific time) (Where were you at start of problem)

WHAT ASSOCIATED PROBLEMS HAVE YOU BEEN HAVING? _____

WHAT MAKES PROBLEM WORSE/BETTER? _____

HAS THIS HAPPENED BEFORE? _____

FOR PRE-CERTIFICATION NEEDS:

Medications tried for this problem before, including over the counter meds. For how long?

_____

Physical Therapy tried? How long? _____

Chiropractor? How long? _____

PAST MEDICAL HISTORY (Please circle):

Diabetes	Hypertension	Arthritis	Cancer (type)
Stroke	Heart trouble	Gout	Convulsions
Bleeding tendency	Acute infections	Venereal disease	HIV positive
Hepatitis	Transfusions	Hereditary defects	Asthma

PREVIOUS HOSPITALIZATIONS OR SURGERIES

_____

_____

SOCIAL HISTORY (Circle)

Marital status: Single Married Separated Divorced Widowed Significant other
Use of Alcohol: Never Rarely Moderate Daily
Use of Tobacco: Never Previously but quit Current packs/day ____
Use of drugs: Never Type/frequency _____
Industrial exposure to: Dust Solvents Fumes

FAMILY HISTORY: Age Diseases If deceased, cause and age

MOTHER _____
FATHER _____
SIBLINGS _____

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The above has been reviewed by Doctor _____

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Patient Name_____ **DOB** _____
Today's Date_____ **BP** _____ **Wt** ____ **HR** _____ **Ht** _____

REVIEW OF SYSTEMS (circle or write in if relevant)

General: Fever, Chills, Night sweats, Recent Weight Change, Appetite, Fatigue, Headaches **No symptoms**	**Musculoskeletal:** Joint Pain, joint, stiffness, Joint Swelling, Muscle Aches, weakness of muscles or joints, muscle pain, cramps, neck pain, back pain, cold extremities, difficulties walking, **No symptoms**
Eyes: Wears glasses, eye injury, Change in Vision, Pain, Double Vision, Glaucoma, blurry vision **No symptoms**	**Skin:** Rashes, itching, change in skin color, change in hair or nails, Varicose veins **No symptoms**
Ears, nose, throat: Ear Pain, EarDischarge, Decreased Hearing, Ringing in the ears, hearing loss, nose bleeds, nasal discharge, sinus pain, Mouth Sores, Bad breath, Bleeding gums, Sore throat, swollen glands **No symptoms**	**Neuro:** Recurrent headaches, lightheaded or dizzy, convulsions or seizures, numbness or tingling, Tremors, Paralysis, Stroke, Transient Loss of Speech, or Vision, Memory Loss, Head injury **No symptoms**
Breasts: Lumps, Pain, Discharge **No symptoms**	**Psychiatric:** Memory loss or confusion, Anxiety, Nervousness, Depression, Sadness, Irritability **No symptoms**
Cardiovascular: Heart trouble, Chest Discomfort, Palpitations, short of breath walking, short of breath lying flat, swelling of feet or hands , heart murmur **No symptoms**	**Endocrine:** Gland problem, hormone problem, Thyroid disease, diabetes, excessive thirst or urination, heat or cold intolerance, dry skin, change in hat or glove size. **No symptoms**
Respiratory: Cough, Wheezing, Sputum, coughing blood, short of breath walking, short of breath lying flat, Chest Pain when breathing, Snoring, Daytime sleepiness, asthma, wheezing **No symptoms**	**Hematology:** Slow to heal after cuts, bleeding or bruising tendency, anemia, Phlebitis, Past transfusion, Enlarged glands, HIV positive. **No symptoms**
Gastrointestinal: Trouble Swallowing, Heartburn, vomiting blood, Nausea, Vomiting, Pain, Swelling of abdomen, Constipation, Diarrhea, blood in stool, Hemorrhoids, Fecal Incontinence, Jaundice, peptic ulcer **No symptoms**	**Allergy:** Reaction to Penicillin or other antibiotic, Morphine, Demerol or narcotics Novocaine or other anesthetics Aspirin or other pain remedies Tetanus or other vaccines NONE
Genitourinary: Frequent urination, Burning or pain with urination, blood in urine, change in force of stream, Dribbling, Incontinence, Incomplete Emptying, Night time urination, Sexual Dysfunction, testicular pain **No symptoms**	**Allergy:** Iodine, fish, shell fish Antiseptics Food allergies NONE
Gyn: # pregnancies ___, # miscarriages ___, Last Menstrual period ____, Excess Bleeding, Irregular Bleeding, Painful periods, Hot Flashes, Postmenopausal Bleeding **No symptoms**	**ANYTHING ELSE WE NEED TO KNOW ABOUT YOU:**

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Patient Name _____

INDIVIDUAL PATIENT'S AUTHORIZATION

1. **INVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION**

   I give my authorization to use or disclose my protected health information as described in Section 2 below. I give this authorization voluntarily:

   Individual Patient's Name: _____

   Your Address: _____

   Your Telephone number: _Home _____Cell_____Fax_____

   Your e-mail Address _____

2. **(Please initial) THE USE AND/OR DISCLOSURE AUTHORIZED**

   ____ The protected health information you are authorizing to be used and/or disclosed for billing and medical records purposes and coordination of medical care.

   _____You are authorizing Central Jersey Neurological Institute and Dr. Maria Choy to use and/or disclose the protected health information described above

   _____You are authorizing Central Jersey Neurological Institute and Dr. Maria Choy to leave messages on your answering machine, fax machine, or e-mail as above

   _____Name the people and/or organizations (or kinds of people and/or organizations) that you are authorizing to receive and use your protected health information (***please circle and initial, add names as needed***): _____**INSURANCE COMPANIES,** _____ **PRE-CERTIFICATIONS TO INSURANCE COMPANIES** _____**OTHER HEALTH CARE PROVIDERS INVOLVED IN YOUR CARE ,** _____ **SPOUSE,** _____**CHILDREN,** _____**PARENT**

   _____

   _____

   _____

   _____

   You are authorizing your protected health information to be used and/or disclosed for purposes of billing and medical records , coordination of medical care, and educating family and caretakers

   ___ This authorization is in effect for as long as patient remains under our care

3. **CHANGING YOUR MIND ABOUT THIS AUTHORIZATION**

   I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer in your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and if I revoke this authorization, the insurance company has the right to contest my claims under the insurance policy.

Central Jersey Neurological Institute, PA

Maria Choy, M.

Direc
Board Certified Neurolo
EMG, Acupuncture, Homepa

Patient Name _____

4. **SIGNING THE AUTHORIZATION IS NOT A CONDITION OF TREATMENT**

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing this authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the plan to make enrollment and eligibility determinations.

5. **INDIVIDUAL PATIENT'S SIGNATURE**

I have had the chance to read and think about the content of this authorization form and agree with all the statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature _____ Date _____

If this authorization is signed by a personal representative for the individual patient:

Personal Representative's Name _____
(Print name)

_____
(Signature)

Relationship to individual _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Full Name: _____ Date of birth _____

Patient Full Address:

_____

_____

Signature _____ Date Signed _____

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PRESCRIPTION AUTHORIZATION

I authorize Central Jersey Neurological Institute, LLC, Maria Choy MD, and their representatives to send electronic prescriptions and receive electronic pharmacy history:

Local Pharmacy Name, Address and Phone _____

_____

Mail Away Pharmacy Name, Address, Contact info and Phone Number:

_____

_____

Signature _____ Date Signed _____

Patient Full Name: _____ Date of birth _____

Patient Full Address:

_____

_____

AUTHORIZATION TO LEAVE MESSAGES ON TELEPHONE OR ELECTRONIC DEVICE:

Telephone(s) _____

E-mail address (s) _____

Other method of contact _____

Signature _____ Date Signed _____

Patient Full Name: _____

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EMG, Acupuncture, Homepath

Maria Choy, MD

Board Certified Neurologist

EMG, Qigong

Vice President of New Jersey
Academy of Acupuncture

Fellow of American Academy
College of Acupuncture

Integrative Nutrition,

Homeopathy

Award Winning Physician,
Honored for Compassion,
Innovation and Excellence

Focus on Healing,
Wellness and
Health for better Life

Out of Network Notice

This notice is to confirm that you have been advised that the **Physician** you are seeing for your appointment is a **non-participating provider** with your **insurance carrier.** As a courtesy, we will submit your claim to your carrier.

Payment is expected on day of service. You will be receiving checks from your insurance carrier with their usual and customary fees according to coverage policy for services rendered. They will include an **Explanation of Benefits (EOB)** which outlines the services that are covered and they are paying for. If for whatever reason you have not paid on day of service, payment becomes due for full amount of service regardless of amount of insurance payment upon your receipt of payment. Please send a ***check for full amount of service and a copy of EOB*** to the address below.

If you need assistance , please call 732-591-5888. Please print patient name and sign in acknowledgement of above.

Patient_____

Signature _____Date: _____

400 Belchase Drive #402 ☯ Matawan, NJ 07747-9759
☯ 732-591-5888

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Wellness and
Health for better Life

PAIN MEDICATION POLICY

In order to serve you better, the following guidelines for prescription medications **MUST** be adhered to. Violations may result in discharge from our care:

1. A photocopy of the prescription you were given will be placed in your chart.
2. If you require refills, you must notify our office between the hours of 9:00 am to 2 pm, MWF. It may take up to TWO working days to call in medications.
3. The doctor **WILL NOT** call in additional prescriptions or refills on weekends or after hours.
4. If prescription is lost or stolen, a refill will not be given until the renewal date, ***THERE WILL BE NO EXCEPTIONS***.
5. Use of medications more often than prescribed will not be refilled early.
6. It is your responsibility to inform our physician of any medications you are receiving from any other health practitioner.

I have read and understand the above Medication Policy with will be duly enforced, especially as it relates to Potentially Addictive Medications.

Patient_____

Signature _____Date: _____

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☯ 732-591-5888