26800 Crown Valley Pkwy, Suite 455
Mission Viejo, CA 92691
Phone: (949) 365-9128
Fax: (949) 429-8073
www.ocneurologyinc.com

Orange County Neurology

A Elahi, MD
Director & Founder
Orange County Neurology, Inc
Diplomate, American Board of
Psychiatry & Neurology (ABPN)

Registration Form (Please Print)

Today's date: **Primary Care Physician**:

PATIENT INFORMATION

Patient's Last name: First: M:					Email:
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F
Street address:		Social Security no.:			Home No.:
City:		State:	ZIP Code:		Cell No.:
Occupation:	Employer:				Employer phone no.:
Referring Physician:		Tel. no.			Fax no.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: ☐ Blue Cross ☐ Blue Shield ☐ Medicare ☐ Aetna ☐ Cigna
☐ Greatwest ☐ Tricare ☐ Pacificare ☐ United Healthcare ☐ Other -

Please indicate insurance plan: ☐ PPO ☐ EPO ☐ HMO – Bristol Park Medical Group ☐ HMO – Mission Hospital Affiliated Physicians

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Member ID no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other -

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Member ID no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other -

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Orange County Neurology, Inc. to release any information required to process my claims.

Patient/Guardian Signature ***Date***

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NOTICE TO CONSUMERS

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Please Note: You are responsible for informing our office of any changes made to your information below including but not limited to your home address, telephone number, insurance policy, email address...etc.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB**:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam**:
Race: **Ethnicity:** **Language:**	
Are your symptoms related to an accident? ☐ **Yes** ☐ **What type of accident?** ☐ **AUTO** ☐ **PERSONAL INJURY** ☐ **WORK**	

PERSONAL HEALTH HISTORY

Please explain the chief complaint for which you are consulting the doctor
Describe symptoms associated with the chief complaint

Other Medical Problems

Year	Reason	Treating Physician

Surgeries/ Hospitalizations

Year	Reason	Hospital

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List your prescribed drugs

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

REVIEW OF SYSTEMS

Please indicate if you currently have any of the following symptoms. Disregard the bold heading in quotes on the left. They are for administrative purposes only.

1. "Constitutional"	Fever	Weight loss	Fatigue
2. "Eyes problem"	Blurred vision	Double vision	Loss of vision
	Eye pain	Eye redness	Eye dryness
3. "Ear/nose/throat"	Trouble hearing	Ringing in ear	Dizziness
	Loss of balance	Ear pain	Ear discharge
	Hoarseness	Trouble swallowing	Slurred speech
4. "Cardiovascular"	Chest pain	Irregular heart beat	Fast heart beat
5. "Respiratory"	Trouble breathing	Chronic cough	Coughing blood
6. "Gastrointestinal"	Indigestion	Heart burn	Abdominal pain
	Nausea	Vomiting	Regurgitation
	Diarrhea	Constipation	Bloody stool
7. "Genitourinary"	Incontinence	Pain on urination	Blood in urine
8. "Musculoskeletal"	Muscle pain	Muscle cramp	Muscle twitches
	Loss of muscle	Neck pain	Back pain
	Joint pain	Joint stiffness	Joint swelling
9. "Skin & breast"	Numbness	Tingling	Discoloration
	Hair loss	Nail changes	Sweating changes
10. "Neurologic"	Headache	Face pain	Face numbness
	Weakness	Tremors	Clumsiness
	Blackout	Memory trouble	Trouble concentrating
11. "Psychiatric"	Hallucinations	Feeling depressed	Trouble sleeping
	Suicidal thoughts	Inappropriate crying	
12. "Hematologic/lymphatic"	Abnormal bleeding	Nose bleeds	Lumps or swellings
13. "Allergic/immunologic"	Skin rash	Joint pain	Dry eyes or mouth
14. "Endocrine"	Excessive thirst	Excessive urination	

Please turn to next page

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OTHER SYMPTOMS

Check if you have, or have had, any symptoms in the following areas to a significant degree.

Headache	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Blood in Stool or Urine	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Pain or Swelling of the Joints	☐ Yes	☐ No
Visual Loss	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	How many drinks per week?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day	☐ # of years	☐ Or year quit	
Pregnancy	Are you pregnant?			☐ Yes ☐ No
	If yes, are you trying for a pregnancy?			☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			***Children***	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F		***Grandmother*** *Maternal*		
	☐ M ☐ F		***Grandfather*** *Maternal*		

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PATIENT PREFERENCE FOR DISCLOSURE OF PERSONAL MEDICAL INFORMATION

The HIPAA privacy law gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means.

Please read and mark those forms of communications listed below that you personally approve for disclosure and discussion of protected health information. Please put a checkmark on all the contact boxes with your preferences.

Please note that it is your responsibility to inform office of any changes to the information below, including but not limited to you home address, telephone, insurance information, or any other changes.

_____ Home Telephone: _____

Check one for home telephone preferences:

[ ] It is ok to leave message on answering machine with detailed information

[ ] Leave message with call-back number only

_____ Work Telephone: _____

Check one for work telephone preferences:

[ ] It is ok to leave message with detailed information

[ ] Leave message with call-back number only

_____ Cell Phone: _____

Check one for cell phone preferences:

[ ] It is ok to leave message with detailed information

[ ] Leave message with call-back number only

_____ Email address _____

[ ] I have read and signed the '*Online Communication Consent Form*'

Check one for Email Preferences:

[ ] It is ok to email messages for non-medical information (i.e. appointment scheduling, billing questions ONLY)

[ ] Do not email any messages

_____ Social Media (i.e. Facebook, OCN website…etc.).

[ ] I have read and signed the *'Social Media Policy*'

[ ] I understand that absolutely no medical information is permitted to be discussed or shared on any social media sites or platforms. State and federal HIPAA laws strictly prohibit sharing or discussing specific personal health information (PHI) on social media. Our office and physicians will not share any health-related information on social media sites.

_____ Written Communication:

Check all that may apply:

[ ] It is ok to send mail to my home address

[ ] It is ok to send mail to my work/office address

[ ] It is okay to Fax this number:_____

Communication with person(s) other than the patient:

I grant permission to OCN to relay or leave message with detailed information regarding my personal health information with the person(s) listed below:

Full Name_____ Relationship to Patient _____

Phone Number_____

Full Name_____ Relationship to Patient_____

Phone Number_____

Patient Signature:_____ Date: _____

Print Name:_____

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NOTICE OF PRIVACY PRACTICES

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice.

- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications and Special Circumstance and the Law
  - Research and Marketing
- Your Written Permission
- Other Restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice is available to you, as required by law. If you wish to keep a copy of our Privacy Practices, the receptionist will be happy to provide you with it.

Your signature only acknowledges that we have presented for your review a paper copy of our Notice of Privacy Practices and have retained a copy of this acknowledgement as required by law.

I hereby acknowledge receipt of the Notice of Privacy Practices and understand it is my responsibility to notify OCN of any changes in the information below.

_____ _____ _____
Signature Printed Name Date

I hereby authorize the release of my patient health information to the following:

_____ _____ ☐ Appointment Info ☐ Treatment Info ☐ Billing Info
NAME RELATIONSHIP

_____ _____ ☐ Appointment Info ☐ Treatment Info ☐ Billing Info
NAME RELATIONSHIP

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PATIENT FINANCIAL LIABILITY AGREEMENT AND DISCLOSURE STATEMENT

Orange County Neurology, Inc. (OCN) is dedicated to providing the very highest level of medical care and services to our patients. The doctor and staff will make every effort to ensure that you receive quality medical care.

INSURANCE BILLING PROCEDURES:

Please be aware that when you use a Health Insurance plan or designated medical group for reimbursement of medical services, that third party makes the final determination with respect to approval and reimbursement of all of the medical care rendered to you.

As a courtesy service to our patients, Orange County Neurology, Inc (OCN) will bill your health insurance company for services that you receive in our office if we are contracted with them. The staff and physician as OCN would like to be a "partner" with patients in providing medical care and with the complex process of health care reimbursement in today's often extremely confusing and financially difficult environment. In order to best serve patients and at least try to clear some of the confusion with respect to billing your insurance or third party payer, please be aware and adhere to the following office policies:

- A current valid insurance card. (We must obtain copy to provide proof of insurance)
- Valid picture identification (we must obtain copy for HIPPA & Red Flag Law "identity theft" policies)
- OCN will file both primary and secondary insurance claims for medical services rendered. Claims for a third insurance contract will not be filed. Any balance not paid by primary and secondary insurance will be patient's responsibility.
- All co-pays, deductibles and co-insurances are due when checking into the office. Co-pays will not be billed. If you are not ready to pay your co-pays at time of checking in for your appointment, you will be re-scheduled.
- If your insurance determines that you still have a balance after your office visit (and upfront calculated out-of-pocket expenses paid) due to deductible, co-insurance, or other amounts, you will be billed fore that balance once your insurance has processed the claim.
- Failure to collect co-payments, co-insurance and deductibles from patients by our office is considered fraudulent as per insurance/payer contract terms.
- OCN does not assume responsibility for verification of insurance benefits or explanation of patient's coverage, co-payments, co-insurance, deductibles or pre-existing conditions. Verification of insurance coverage is not a guarantee of payment for all medical services recommended or performed by OCN. The patient's insurance coverage is a contract between the patient and their insurance carrier. It is the patient's responsibility to understand their

X Initials:_____

insurance coverage, all policy limitations and preferred providers under their policy. The patient is responsible for all denied or non-payment of charges from your insurance company or medical group. The final determination of your eligibility and benefits is done by your insurance company or medical group.

- Any disputes regarding the approval of payment by the insurance company or medical group are between the patient and their insurance company or medical group. Your insurance may deny payment if your insurance company or medical group (not your doctor or OCN) determines that:
  - The care provided is not medically necessary.
  - The care provided is a non-covered benefit.
  - The patient is ineligible to receive benefits under the plan.
  - The policy is terminated.
  - Services were provided by a non-participating or out of network provider.
  - A referral and/or preauthorization are necessary.
  - Pre-existing conditions applies.
  - Additional information from the patient is necessary.
  - Incorrect billing and demographic information was obtained from patient.

By signing this agreement, you give consent and acknowledge understanding that all services you consented to and provided by OCN may not be covered by your health insurance company for any one or all of the reasons listed above; and that you give your consent for OCN to collect from you any charges for services that were rendered to you (but not covered by your health insurance).

REFERRAL/ AUTHORIZATIONS:

If your insurance plan requires an authorization from your primary care physician (PCP) (usually only applicable if you are part of an HMO, IPA, or work-comp network) for a particular service, you will need to contact your PCP for the authorization. Receiving an authorization is the patient's responsibility and NOT the specialty office (and often cannot be initiated by our office per insurance contract obligations). Services that have already been rendered to patients without first obtaining the required authorization are deemed as patient's consent for the non-authorized service and will be payable upon receipt of invoice from our office.

NON- CONTRACTED INSURANCES:

If you have insurance coverage with a plan with which OCN does not have a contract, the charges for your care and treatment are due at the time of service. However, we still send bill to insurance carriers with whom we are not contracted for any out-of-network reimbursements. A superbill for all charges can be provided and you may, at your discretion, bill your health insurance carrier or medical group for reimbursement on your own as well.

MEDICARE:

OCN is a participating provider for Medicare. This means that we must accept Medicare's allowed charges for the service rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20% plus any out-of-pocket deductibles. We will adjust the difference between what we charge and what Medicare approves. If you have secondary or supplemental insurance, we will submit the claim for the remaining balance after Medicare has paid.

X Initials:_____

- Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance.

SELF-PAY ACCOUNTS

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate in, liens, personal injury cases, auto accident insurance, worker's compensation cases.

HMO PATIENTS (MHAP AND BRISTOL PARK):

At this time, OCN is affiliated with *Memorial Care Medical Group* (Formerly known as Bristol Park) and *St. Joseph's Health (a.k.a. Mission Hospital Affiliated Providers—MHAP*) ONLY.

- Your Primary Care Physician (PCP) or patient coordinator will need to initiate your authorization for any new patient services.
- New patients cannot be scheduled until hard copy of authorization is submitted to our office. We will contact all patients once an authorization is received by your IPA or PCP.
- Following your initial visit, OCN will request authorization for any follow-up visits and treatments requested by OCN physician(s). No follow-up visits or other treatments or tests will be scheduled until we receive authorization. We will contact you regarding follow-up visits and treatments and tests, once we receive the authorization from your IPA.
- Please allow ten-to-fourteen (10-14) business days following your visit for an approval. Per your HMO stipulation, we must submit supportive documentation along with our request to your PCP or patient coordinator for review prior to approving any visits, treatments, or tests.

THIRD PARTY CASES (LIENS, PERSONAL INJURY, WORKERS COMP., …etc.):

OCN does accept liens, personal injury cases, auto accident insurance, third party payments, and worker's compensation cases on an individual case-by-case basis only. An *'OCN LIABILITY POLICY'* and '*OCN LIEN AGREEMENT'* will need to be signed by the patient and attorney (if applicable). It is the patient's responsibility to provide all third party contact information, in order for OCN to send itemized statements directly to them.

Do you feel that your symptoms are related to an accident or injury caused by a third party AND you have an attorney representing you in this matter?

☐ YES ☐ NO ☐ NOT SURE

If you checked 'YES', please choose the closest box below as to what your injury is related to:

☐ Auto Accident ☐ Personal Injury ☐ Work/Job Injury

TREATMENT OF MINORS:

X Initials:_____

The parent(s) or legal guardian(s) must accompany all minors. Minors are all patients who are younger than age 18. No minors will be seen or treated unaccompanied. The parent(s) or legal guardian(s) is responsible for any payment and will receive the billing statements. Responsibility for payments for services rendered to the child/children of divorced or separated parents' rests with the parent who seeks treatment. Any court-ordered judgment must be between the individuals involved, and does not include our facility.

OUTSIDE DIAGNOSTIC TESTING (MRI, LAB TEST, SLEEP STUDIES, ETC.)

If you are ever referred for any outside (i.e. not financially affiliated with OCN) diagnostic testing, you will receive separate billing charges from the companies performing the services. Please understand that OCN is in no way responsible for the charges related to the testing or medical care outside of OCN.

REQUEST FOR MEDICAL RECORDS

Copies of your records must be requested in writing. Copying fee applies and must be paid prior to mailing or faxing records. In accordance to HIPPA regulations, we request that you complete an Authorization to Release Confidential Information form before copies are mailed or faxed.

- $35 for 1-50 pages
- $50 for 50-200 pages
- $75 for over 200 pages

REQUEST FOR COMPLETIONS OF FORMS & LETTERS

With a few exceptions, all forms and letters that require doctor's documentation such as those submitted to DMV, EDD (e.g. disability forms), FMLA (Family Medical Leave Act), work excuses, school excuses, jury duty excuses, paperwork required from your employer, letters to attorney…etc. require a fee at time of form submission. Form fees are determined by office and/or physician and vary from $35 to $150 depending on the complexity of the form. (DMV handicap placard forms will have a fee of $35).

The forms will be completed usually within 3 business days. These forms WILL NOT be faxed or submitted to the requesting party unless required by law or the recipient. It will be the patient's responsibility to pick-up the completed forms from our office or we can mail the forms to the PATIENT/ GUARDIAN/ CAREGIVER ONLY, with prior arrangements made with the office staff.

We understand if you experience frustration regarding form fees. However, all forms, simple or complex, require significant physician and staff to a) review all data on your chart, b)ensure that the

X Initials:_____

data written on your form are accurate, and c)ensure that all state and federal laws are properly followed. This process takes much time and effort even for what appears as a simple form.

The doctor and our office can be and are in fact often audited by and legally accountable to state, federal, and other agencies regarding the data placed on forms on your behalf and must have supporting documentation in your chart. Also, insurance carriers do not reimburse office for completing office forms. We want to make sure that the content of the form accurately represents your condition and medical records. Otherwise, the form may be rejected or inaccurate. We hope you understand. If you are unable to afford the form fee or disagree with our office policy, you are welcome to ask any other physicians caring for you to complete the form.

As per HIPAA regulation and for the protection of your health privacy, you must authorize release of your medical information before the form is completed.

CREDIT CARDS/DEBIT CARDS

We accept Visa, MasterCard, American Express, and Discover.

PERSONAL CHECKS

No personal checks accepted for amounts due greater than one hundred dollars ($100).

RETURNED CHECKS

If payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account closed (AC), or Refer to Maker (RTM), the patient or the patient's responsible party will be responsible for the original check amount in addition to a $25 service charge. Once notice is received of the returned check, OCN will notify you in writing via a letter to the Responsible Party of the returned check.

If a response is not made within 15 days from the letter date by the patient or the responsible party, the account may be turned over to our collection agency.

CANCELLATION POLICY

Our staff and physician try their best to keep on schedule and provide prompt service. Please help us keep services prompt. As a courtesy to your physician, staff and other patients, please give 24-hour notice to cancel or reschedule your appointment. In the event that you fail to cancel a scheduled appointment and/or are a no-show, i.e. do not show for scheduled appointment without 24-hour notice, you will be billed $25. This fee will be due upon receipt of a statement from our office.

Exceptions may be made for emergency situations such as hospitalization. Patients who repeatedly miss scheduled appointments may be discharged from the practice.

BALANCE AND STATEMENT

A statement of charges will be sent to the patient or responsible party showing the patient's due balance each month. Unless we approve other arrangements in writing, the balance on your statement is due

X Initials:____

upon receipt. Balances older than 60 days may be subject to a $15 late fee per month. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise arranged by our office. Unpaid accounts in bad standing are sent to collections which will result in further costs including late fees, $45 collection fees, any interest, attorney fees and legal fees or any other fees that are required in the collection of the delinquent balances. The patient or responsible party will be financially responsible for these fees. Unpaid accounts may also be reported as earned income to the IRS with a 1099 form. Once your account is referred to a collections agency, you will be discharged from this practice. You will be notified by regular and/or certified mail that you have 30 days to find another source of rendering medical services. During that 30-day period, our physician will only be able to treat you on an emergency basis.

CHANGE OF PATIENT DEMOGRAPHICS:

Any changes to your insurance coverage, name, address or contact phone number needs to be communicated to OCN front office staff at time of check-in to assure correct billing and contact information is maintained in our records for your appointment. Any denials or non-payments from insurance carrier based on incorrect and/or invalid information provided to OCN is patient's responsibility.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to abide by these terms.

In addition, you also authorize OCN to furnish your information concerning your medical treatment, tests, and evaluations to your insurance carriers or medical group.

I hereby assign all payments for services rendered. A photocopy of the agreement is to be considered valid. In the event a signed claim is not obtained, this document may be used in its place.

Patient Name (please print)_____

Patient Signature_____ Date_____

Responsible Party Name_____

Responsible Party Relationship to the patient_____

Responsible Party Signature_____

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Credit Card Authorization for balances due to out-of-pocket Expenses

Your health insurance plans may include '*out-of-pocket expenses*' which can include, but not limited to, copays, co-insurance, and deductible before any charges are reimbursed. Our office staff works diligently prior, during, and after your appointment to obtain all information from your health insurance plan via all resources your health insurance makes available and via all the electronic tools we can access. However, your health plan's data may not be accurate or available at the time of your appointment. To avoid billing you for 'out-of-pocket' expenses, we require a valid credit card on file.

By your signature below, you authorize Orange County Neurology, Inc. (OCN) to charge the credit card you have listed below for all allowed out-of-pocket or unpaid balances owed for medical services rendered. As per your health insurance agreement, allowed out-of-pocket expenses may include unpaid balances due to copays, co-insurance, deductibles, or any balance due to OCN for all medically-necessary services already rendered.

Please note: Your credit card data along with ALL information submitted to our office (or any other medical office) are **kept strictly confidential** as required by federal and state HIPAA laws. Your information including all financial data is entered into a highly secure electronic medical record (EMR) system and becomes part of your private health information (PHI). Our office uses Allscripts Professional EMR system which is a registered and approved system by both state and federal regulatory agencies.

As a courtesy, our billing staff will notify you via phone call if you have a balance when charging your card for the above expenses. In addition, you will receive detailed invoice with details of all charges in the mail to address on file. All remaining balance on your account are due at time of the notification and will be charged in full. Our office will reimburse any charges that may have accrued in error for any reason or if the charged balance is later paid by your health insurance.

Credit Card Type:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ Debit

Name: _____

Credit Card No:_____

Credit Card Security Code: _____

Expiration Date:_____ Billing Zip Code: _____

Sign:_____ Date: _____

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Consent for Virtual Office Visits via *"Skype"*

By signing below, I give permission for OCN, its staff and physicians to conduct follow-up visits via the face-to-face internet software called *"Skype."* I understand that *'Skype'* visits are associated with certain unavoidable and unexpected risks including risk of technical failure during the visit including but not limited to loss of connection with staff and/or physician, potential (although small) risk of hacking or access to video by unauthorized parties, lack of physical examination by physician and staff, and difficulty prescribing certain medications. For protection of your safety, OCN reserves the right to refuse *'Skype'* visits to patients for various reasons including but not limited to patients who 1) have not yet established an in-person first visit with the physician for consultation, 2) have new or urgent matters, symptoms, or signs. There may be certain circumstances in which the physician requires more detailed in-person evaluations. OCN reserves the right to require in-person office visits to be scheduled soon after the '*Skype'* visits as per the discretion of the physician when the *'Skype'* visit does not suffice in providing adequate medical care.

OCN's first and foremost priority is your health and safety.

I understand the above regarding *'Skype"* visits with OCN.

Name: _____

Sign: _____

Date: _____

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www.ocneurologyinc.com

Orange County Neurology

A Elahi, MD
Director & Founder
Orange County Neurology, Inc
Diplomate, American Board of
Psychiatry & Neurology (ABPN)

Social Media Policy

The staff at OCN are aware of the positive benefits of social media such as Facebook, YouTube, Twitter, etc. However, please be aware that your private health information (PHI) is protected by state and federal HIPAA laws which prohibit sharing or discussing specific health-related information on any social media site. In efforts to protect your privacy and comply with HIPAA laws, we ask that you refrain from discussing or asking any specific health-related information on social medial sites.

Our staff are prohibited from answering or discussing any specific health-related concern, question, or comment posted on social media sites. We are more than happy to discuss and answer your questions via private telephone calls made to office or at your scheduled appointments.

[ ] I have read and understand the above social media policy

[ ] I understand that sharing, questioning, or discussing any health-related issue on social medial sites is prohibited and can risk disclosure of my private health information (PHI) to the public domain.

Print name:_____

Sign:_____

Date:_____

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Online Communication Consent and Policy

Online communication (i.e. email) is an additional option for communication along with telephone, mail, and in-person. It is not meant to replace other forms of communication with the doctor.

Patient's Initials

_____I understand that online communication cannot be used for emergencies or time sensitive matters. **At this time, online communication is to be used for appointment scheduling and non-medical administrative issues ONLY.**

_____I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important.

_____I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent party or me.

_____I understand that online communication cannot be used to communicate highly sensitive medical information.

_____I understand that it is my responsibility to determine if an unanswered online communication was received.

Again, please note that email communication should only be used for billing or scheduling appointments only.

I certify that I have read and understand this agreement and that all the blanks were filled in prior to my signature.

_____ _____
(Patient's name) (Date)

_____ _____
Patient or Legal Representative Signature Relationship to patient

_____ _____
Print Patient or Legal Representative Name Witness Signature

I certify that I have explained the nature of this agreement to the patient/legal representative. I have answered all questions fully, and I believe that the *patient/legal representative* fully understands what this form explains.

_____
Office Staff Member Signature