Neurology Electromyography

NAZAR H. HAIDRI, M.D.

Diplomate American Board of Psychiatry & Neurology (Neurology)

Diplomate American Board of Electrodiagnostic Medicine

Subspecialty Certification Headache Medicine

Clinical Associate Professor of Neurosciences, N.J. Medical School

Ideal Professional Park, Suite C9

2333 Morris Avenue, Union, New Jersey 07083

Telephone #: (908) 687-0810

FAX #: (908) 964-6090

Down below please <u>CHECK OFF</u> all tests that you have done, and facility name if known:

- ◯ MRI
- ◯ CT Scan
- ◯ EEG
- ◯ Blood Work
- ◯ Other:_____

If applicable, were you hospitalized after the accident/injury: Yes / No

-If so, what hospital and what dates?

Patient's/Guardian(s) Name (PRINT): _____

***Signature*:** _____ ***<u>Date</u>*:**

[ ] Priv. Ins. [ ] Police Rpt. [ ] Driver's License [ ] Auto Ins. ID. Card

PATIENT INFORMATION SHEET

DATE_____ NAME_____ [ ] MALE [ ] FEMALE AGE_____

STREET ADDRESS_____]M [ ] S[ ] D[ ] W[ ] SEP DOB_____

CITY_____ STATE_____ ZIP CODE_____ HOME # ( ) _____

SS#_____ CELL # ( ) _____

IN CASE OF EMERGENCY, CONTACT NAME _____ TELEPHONE ( ) _____

RELATIONSHIP TO PATIENT _____

SPOUSE'S NAME _____ WORK TELEPHONE ( ) _____

ARE YOU REPRESENTED BY AN ATTORNEY FOR THIS INJURY? [ ] YES [ ] NO

ATTORNEY NAME _____

ATTORNEY ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ TELEPHONE ( ) _____

HAVE YOU EVER BEEN EXAMINED OR TREATED BY DR. HAIDRI? [ ] NO [ ] YES - WHEN? _____

Patient Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice you may obtain a revised copy by mail/email or in person. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment payment and health care operations. You have the right to revoke this consent in writing except where we have already made disclosures in reliance on your prior consent.

Signature:
I have reviewed this consent form and give my permission to OUR OFFICE to use and disclose my health information in accordance with it.

Name(Print Name)_____ Signature X _____

Date_____

ACCIDENT INFORMATION

Date & Time of Accident _____

Where did accident occur: _____

Were you: Passenger _____ Driver_____ Pedestrian _____

Whose Car: Own Car _____ Family Car _____ Friends Car _____

Name of Insurance Company at the time of you accident **(Must be your insurance company, not the person who hit you)** _____

Policy # _____ Claim # _____

Adjuster (Claim Representative) _____

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* If you have Medical Insurance and want to use it as your Secondary Insurance to help pay your copay/deductible; please include that information below

* If your Health Insurance is **PRIMARY** to your Auto Insurance, please also include that information below

Health Insurance

Name of Insurance: _____

Name of Insured: _____

Group # _____ ID# _____

Which is primary: Health _____ Auto Insurance _____

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Authorization To Disclose Health Information

To:_____
Patient Name:_____ Date Of Birth:_____
Social Security:_____

* I authorize the use or disclosure of the above named individual's health information as described below. The type and amount of information to be used or disclosed is as follows:

__Inpatient From_____to_____ __Outpatient from_____to_____

__Emergency Room from_____to_____ __ Laboratory Results from_____to_____

__X-Ray/Imaging from_____to_____ __Entire Record From_____to_____

* I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome(AIDS) or human immunodeficiency virus(HIV). It may also include information about behavioral or mental health services, and treatment for alcoholand drug abuse.

This information may be disclosed to: Nazar H. Haidri, MD, at the address above. For the purpose of continuing medical care.

* I understand that I have the a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition. If I fail to specify an expiration date, event or condition, this authorization will expire in six months of the date signed.

* I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

X_____ X_____
Signature of patient/guardian Date

New Jersey Application for Benefits
Personal Injury Protection

Claim Number: _____

Important:
1. To enable us to determine if you are entitled to benefits under the Personal Injury Protection Law you must complete and sign this form.
2. You must also sign the authorizations, Affidavit and Notice attached.
3. Return promptly with any medical bills you have received to date.

Please be advised that knowingly filing a statement of claim containing any false, inaccurate or misleading information, or intentionally omitting information material to the claim will result in the denial of benefits. Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Your Name (First, Middle, Last) | Gender: Male ☐ Female ☐ | Home Phone: ( ) -

List any aliases, maiden names or other names you use or have used in the past | Cell Phone: ( ) - | Work Phone: ( ) -

Your Address (No. & Street, City/Municipality, State, County & Zip Code | Date of Birth | Social Security No. (if none, enter

Your Previous Address (If you lived at the above address for less than 3 years from the accident date) | Email:

Date of Accident | Time of Accident AM ☐ PM ☐ | Place of Accident (Street, City/Town & State)

Brief Description of Accident

Do you or any member of your household own a vehicle? Yes ☐ No ☐
Name of Insurance Company _____

Do you have health insurance? Yes ☐ No ☐
Name of Insurance Company _____

	Yes	No
Were you the driver of the vehicle?	☐	☐
Were you a passenger in the vehicle?	☐	☐
Were you a pedestrian?	☐	☐
Were you a member of vehicle owner's household?	☐	☐

As a result of this accident were you injured? Yes ☐ No ☐ If your answer is "Yes", complete the remainder of this form.
If "No", sign here and return this form to us.

Signature: _____ Date: _____

Describe your injury: _____

Were you treated by a doctor? Yes ☐ No ☐ | Doctor's Name and Address

If you were treated in a hospital, were you an In-patient? ☐ Out-patient? ☐ | Hospital's Name and Address

Amount of Medical Bills to Date: $_____	Will you have more medical expenses? Yes ☐ No ☐	At the time of your accident, were you in the course of your employment? Yes ☐ No ☐	Did you lose wages or salary as a result of your injury? Yes ☐ No ☐ If yes, amount loss to date: $_____	What is your average weekly wage or salary? $_____

Your lost wages: Date disability from work began: Date you returned to work:

Have you received or are you eligible for benefits under:	Yes	No
(1) Any Workers' Compensation Law?	☐	☐
(2) Employees' Temporary Disability Benefit Statute?	☐	☐
(3) Medicare?	☐	☐

If yes, amount: $_____ Per week ☐ Per month ☐

If you are a Medicare beneficiary, enter your Health Insurance Claim Number (HICN) _____

List names and addresses of your employer and other employers for one year prior to accident date and give occupation and dates of employment:

Employer & Address	Occupation	Dates: From - To

As a result of your injury, have you had any other expenses? Yes ☐ No ☐ If your answer is "Yes", explain on reverse side.

Signature: _____ Date: _____

Do Not Detach
Authorization for Medical Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation or treatment, including the history obtained, X-ray and/or physical findings, diagnosis and prognosis related to this accident as well as any prior or subsequent treatment rendered by you or your facility. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____ Date: _____

Do Not Detach
Authorization for Wage Information

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my wage or salary while employed by you. You are authorized to provide this information in accordance with the Personal Injury Protection Benefits Law.

Signature: _____

Social Security No.: _____ Date: _____

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Agreement For Payment Of Outstanding Bill

Re:_____ _____
Patient's Name Date of Accident

In consideration of withholding immediate legal action against me for collection of my outstanding bill for medical services rendered, I hereby direct my attorney,_____, to pay any such outstanding medical bill due to Dr. Nazar Haidri from the proceeds of my share of the settlement or judgement in any case or claim pending in my behalf. I understand, however, that my obligation to pay this outstanding bill is in no way contingent upon the outcome of any pending litigation and that I remain primarily responsible for payment of this outstanding bill irrespective of the outcome of any such litigation.

Dated:_____ X _____
Patient's Signature

Witness:_____

****

I,_____, attorney for the above named patient of Dr. Nazar Haidri, hereby agree to make payment to Dr. Nazar Haidri, of the amount of his outstanding bill for medical treatment rendered from the proceeds of my client's share of the settlement.

In the event that this client's sole remedy is by way of worker's compensation, this office agrees to expend it's best efforts at having the Judge of Compensation order payment of said outstanding bills.

I further agree to promptly advise the office of Dr. Nazar Haidri in the event such claim is dismissed without recovery of a settlement or judgement. I am accepting in consideration of the above , Dr. Nazar Haidri's agreement to withhold immediate legal action against my client for immediate payment of his outstanding bill and to avoid interest payments assessed against my client.

_____
Attorney

Nazar H. Haidri, M.D.
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Diplomat American Board of Electro diagnostic Medicine
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To Whom It May Concern:

Re:_____

D/A:_____

I hereby agree that in the event my Personal Injury Protection carrier fails to honor any of the medical bills which I incur as a result of my above accident, any such unpaid medical provider shall have the right to commence, in my name and place, all proceedings necessary to obtain payment. In the alternative, I hereby authorize my attorneys herein to institute such proceedings in my name. I agree to cooperate in all such proceedings.

Very Truly Yours,

Nazar H. Haidri, M.D.

X

Date:_____

X

_____
Patient's Signature

Date:_____

_____
Witness

NAZAR H. HAIDRI, M.D.

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Medical Records Release Form

Date: _____

I, _____, authorize the release of my COMPLETE MEDICAL RECORDS to Nazar H. Haidri and in requesting insurance companies, attorneys, physicians, and employers as needed

Patients Signature: X _____

Patients Printed Name: _____

Patients Responsibility

If your health or auto insurance benefits are terminated/exhausted, it is your responsibility to contact your insurance company as well as our office in order for your matter to be resolved. Any unpaid balances are your responsibility. Please contact our office if you have any questions.

Patients Signature: X _____

Patients Printed Name: _____

Dr. Nazar H. Haidri, MD
2333 Morris Ave- STE C109
Union, NJ 07083
908-687-0810

No Show/Cancellation Policy

I understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call at least 24 hours in advance to cancel an appointment, you may be preventing another client from getting much needed treatment. Conversely, the situation may arise where another client fails to cancel and I an unable to schedule you for a visit, due to a seemingly "full" appointment calendar. A cancelled appointment also delays our work.

When you must cancel, please give me at least 24 hours notice. I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, you will be charged the a fee for your session unless I am able to fill it with another client.

The only time I will waive this fee is in the event of serious or contagious illness or emergency. I reserve the right to waive or modify these fees at my discretion.

No Show Fee (no call prior to appointment time)(full fee)	$60.00
Late cancellation fee (24 hours prior)	$50.00

Patient Name:_____

Patient Signature:_____

Date:_____

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Current List of Medication:

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

How long have you been on this medication

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Current Doctors you are seeing:
Please Provide Doctor's Name and/or Specialty

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____