Neurology Electromyography

NAZAR H. HAIDRI, M.D.

Diplomate American Board of Psychiatry & Neurology (Neurology)

Diplomate American Board of Electrodiagnostic Medicine

Subspecialty Certification Headache Medicine

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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>*:**

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 _____ CELL# ( )_____-_____

Health Insurance

Primary Health Insurance:

Name of Insurance: _____

Name of Insured: _____

Group # _____ I.D#_____

Second Health Insurance:

Name of Insurance: _____

Name of Insured: _____

Group #_____ I.D #_____

PATIENT CONSENT FORM

Our notice of Privacy Practice 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 _____

Date_____

Any patient under the age of 18 must have a parent or guardian sign for them. - Thank you

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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.

Patient's Signature: _____

Patient's Printed Name: _____

Patient's 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 as your responsibility. Please contact our office if you have any questions.

Patient's Signature: _____

Patient's Printed Name: _____

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Authorization To Disclose Health Information

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

I authorize the use of 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 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 mental health service, and treatment of alcoholand drug abuse.

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

* I understand that I have the 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 to not sign this for in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CPR164.524. I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of patient/guardian Date

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Insurance Payment Order

_____
Insurance Company

Address: _____

I hereby authorize you to pay directly to the below named doctor, benefits due me out of indemnity under the terms of my policy issued by your company.

Nazar H. Haidri, M.D.
2333 Morris Ave.
Suite C-109
Union, NJ 07083

Payment is authorized upon your receipt of his itemized statement for service rendered to me. This policy was in full and effect at the time that these services were rendered. Payment of this amount as herein directed, in whole or shall be considered the same as if paid by your company directly to me.

Insured: _____ Policy# _____
Address: _____

Legal Signature: _____ Date: _____
If patient is a minor parent/guardian must sign

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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 _____