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 CHECK OFF 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*:** _____ ***Date*:**

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:_____

[ ] 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: _____

What occurred (in detail): _____

_____

_____

Health Insurance

Primary Health Insurance:

Name of Insurance: _____

Name of Insured: _____

Group # _____ ID# _____

Second Health Insurance:

Name of Insurance: _____

Name of Insured: _____

Group # _____ ID# _____

Do you have a Letter of Protection (LOP) from your lawyer? Yes _____ No _____

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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: _____

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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:_____
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

Nszar H. Haidri, M.D.
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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_____ _____
Signature of patient/guardian 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 _____