CHARLES T. CRINNIAN, M.D., P.C.
NORTH MEDICAL PLAZA 1
10250 N. 92nd STREET, SUITE #304 SCOTTSDALE, AZ 85258
PHONE: 480-451-7676

CONSENT FOR TREATMENT/INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

1. My representative, recognizing the need for care, or I consent to be treated under the specific instructions of Charles T. Crinnian, M.D., P.C., I understand that it is my responsibility to arrange all follow up appointments relating to subsequent care and medical testing recommended.

2. I hereby assign to Charles T. Crinnian, M.D., P.C. all payments for medical services rendered to my dependents or myself. **I understand that I am responsible for any amount not covered by my insurance, I am responsible for any unpaid balance if I am outside my insurance provider network for these services, and it is my responsibility to obtain all referrals related to my care prior to the date of service.** If your insurance company does not respond within 60 days from the date we file your claim, it will then be your responsibility to pay for the services in full and seek reimbursement from your insurance company.

3. I hereby authorize Charles T. Crinnian, M.D., P.C. to bill and furnish information for services to insurance carriers concerning my medical status and treatment.

4. As you know, appointment times are valuable. Therefore, we ask that you notify our office in the event you need to cancel, (24 hrs is appreciated). **I understand there is a $50.00 "no-show" fee** in the event I do not notify the office prior to my appointment time and this "no-show" fee must be paid prior to my next office visit.

5. We accept Visa, MasterCard and have a financial plan available for those who have need of it. A fee of $25.00 will be charged for returned checks. I agree to pay any amount and all costs and expenses incurred in collecting any unpaid balance owed. Balances 60 days past due will be subject to a 1.5-% interest charge per month. If your account falls into a collection status, the Physician/Patient relationship is terminated and no further medical care will be provided.

6. I hereby authorize the release of any and all information required for the purpose of a credit transaction. This includes obtaining a personal credit report. I also agree that a photocopy or fax copy of this document shall be as valid as the original and will suffice as an authorized signature to release information on all my financial accounts.

By signing below I acknowledge that I have read, understand and agree to all of the above.

SIGNATURE OF PATIENT DATE

SIGNATURE OF GUARANTOR DATE

FRONTIER NEUROLOGY

Charles T. Crinnian, M.D., P.C.

MEDICAL DATA FORM

TODAY'S DATE________________ AGE:__________ SEX: M F DATE OF BIRTH:____________

RIGHT OR LEFT HANDED:________________

REFERRING PHYSICIAN:________________________________

PATIENT'S FULL NAME:____

BRIEFLY DESCRIBE YOUR MEDICAL PROBLEM:____

____

____

PAST MEDICAL, SURGICAL, ACCIDENT HISTORY (DATE & NATURE OF PROBLEM):____

____

____

____

____

____

ALLERGIES:____

DO YOU SMOKE:__________ IF SO, HOW MUCH_________________ HOW LONG __________

DO YOU CONSUME ALCOHOL: IF SO, HOW MUCH_______________ HOW LONG __________

ANY FAMILY HISTORY OF MEDICAL, GENETIC, NEUROLOGIC DISORDERS ___________________

____

WHAT TYPE OF WORK DO YOU DO CURRENTLY AND IN THE PAST:_______________________

____

IS THIS A WORK RELATED ACCIDENT_______________ DATE OF ACCIDENT_________________

IS THIS AN AUTO RELATED ACCIDENT_______________ DATE OF ACCIDENT_________________

IS THERE A LEGAL CASE PENDING THIS ISSUE_________________

Corporate Office
10250 N. 92nd Street, Suite 304
Scottsdale, Arizona 85258
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480-451-0971 FAX

FRONTIER NEUROLOGY

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Medical Systems Review

Do you have any of the following symptoms: (Circle items that apply)

Constitutional: chills, fatigue, fever, malaise, night sweats, insomnia, weight gain, weight loss.
HEENT: headaches, vision loss, burning eyes, dry eyes, itching eyes, eye redness, tearing, double vision, hearing loss, ear pain, vertigo, ringing ears, nasal congestion, nosebleeds, sore throat, decreased smell.
Respiratory: Cough, shortness of breath, chest pain, frequent infections, wheezing.
Cardiovascular: Chest pain, irregular heart rate, loss of consciousness.
Vascular: Leg pain, edema, cool extremities, ulcers.
GI: nausea, diarrhea, constipation, altered bowel habits, abdominal pain, reflux, gastritis, jaundice.
Genitourinary: increased frequency, hesitancy, urgency, bloody urine, stones, changes in urine, incontinence.
Metabolic: Voice change, intolerance to heat/cold, hair loss, overweight, frequent urination, thirst.
Dermatologic: contact allergy, rash, skin lesions, hair loss, nail changes.
Psychiatric: Depression, anxiety, hallucinations, suicidal tendencies, emotional problems.
Musculoskeletal: Joint pain, bone pain, back pain, muscle pain.
Hematologic: Easy bruising, easy bleeding, blood clots, tender/swollen lymph nodes.
Allergy: hay fever, dermatitis, food allergy, environmental allergy.

Detail any of the above issues: ______________________________

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____

Signature ____________________ Date __________

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FRONTIER NEUROLOGY

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MEDICATION LIST

PATIENT NAME____________________ DATE_____________

Please list all medications, vitamins and herbal supplements you are currently taking along with their strength and how they are taken.

MEDICATION NAME	STRENGTH	DOSING
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		

____
Patient Signature

____
Date

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Acknowledgment of Receipt of Privacy Notice
Original to be maintained in Patient's permanent electronic medical record.
Frontier Neurology

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

______________________________	______________________________
Patient or legally authorized individual signature	Date
______________________________	______________________________
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)