LOS ANGELES NEUROSURGICAL INSTITUTE
MICHEL F. LEVESQUE, M.D.
Patient Registration

Please complete all pages entirely.

PATIENT NAME: _____
LAST FIRST MIDDLE

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Date of Birth: _____ **Age:** ____ **Sex:** ___ **SS#:** _____

Marital Status: ___

IF PATIENT IS A MINOR: Responsible Party: _____

EMPLOYER: _____

Employers Address: _____

City: _____ State: _____ Zip: _____

SPOUSE/GUARANTOR: _____

Date of Birth: _____ SS#: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

IN CASE OF EMERGENCY: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

ALLERGIES TO MEDICATION: _____

REFERRING PHYSICIAN: _____

Address: _____ City: _____ State: ____ Zip: _____

Pnone: _____ Fax: _____

PRIMARY CARE PHYSICIAN: _____

Address: _____ City: _____ State: ____ Zip: _____

Pnone: _____ Fax: _____

I certify that the above information is true and correct to the best of my knowledge.

SIGNED: _____ **DATE:** _____

Is your injury or condition the result of an accident ? (YES) or (NO)

If "Yes" is it related to: (Circle One) WORK AUTO ACCIDENT OTHER

If "Other", please explain: _____

Describe how the injury or condition occurred :_____

_____

If work related; employer at the time of the injury: _____

Address:_____City:_____State:____Zip:_____

Date of Injury:_____

PRIMARY INSURANCE CARRIER:

Insurance Company:_____

Address:_____City:_____State:____Zip:_____

Phone:_____ Fax: _____

Group Number:_____ ID Number: _____

Insured Name:_____ Effective Date of Coverage: _____

SECONDARY INSURANCE CARRIER:

Insurance Company:_____

Address:_____City:_____State:____Zip:_____

Phone:_____ Fax: _____

Group Number:_____ ID Number: _____

Insured Name:_____ Effective Date of Coverage: _____

INDUSTRIAL INFORMATION:

Carrier Name:_____ Claim Number: _____

Claims Representative: _____

Address:_____City:_____State:____Zip:_____

Phone:_____ Fax: _____

INFORMATION MUST BE COMPLETE IN ORDER TO BILL YOUR INSURANCE. IF YOU ARE UNABLE TO PROVIDE THIS INFORMATION YOU MUST PAY FOR ALL SERVICES AND BILL YOUR OWN INSURANCE. CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

ASSIGNMENT OF BENEFITS:

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO MAKE DIRECT PAYMENT TO: MICHEL LEVESQUE,M.D., I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR FULL PAYMENT TO DR. LEVESQUE INCLUDING PAYMENTS MADE TO ME BY INSURANCE AND ANY DEDUCTIBLES, CO-INSURANCE AND/OR CO-PAYMENT AMOUNTS.

SIGNED:_____ **DATE:** _____

LOS ANGELES NEUROSURGICAL INSTITUTE
8670 WILSHIRE BOULEVARD, SUITE 201
LOS ANGELES, CA 90211
Phone: 310- 659-6633 Fax: 310-659-6631

Note to patient: By providing your signature below and marking the appropriate boxes, you are authorizing us to: 1) Obtain films, test results and general information from other medical providers to assist us in evaluating your current condition. 2) Release information to your primary care or referring physicians (or other specifically designated person) or both of the above. 3) Request payment directly to Michel F. Levesque, M.D. for services rendered and accepting financial responsibility for any service provided. 4) Consenting to any and all medical treatments provided by Michel F. Levesque, M.D.

Patient Name **SS#** **Date of Birth**

AUTHORIZATION FOR RELEASE OF INFORMATION

I Authorize physician/staff associated with Michel F. Levesque, M.D:

- ❑ Release information to:
- ❑ Obtain information from:

PHYSICIAN OR OTHER PARTY NAME **PHONE** **FAX**

ADDRESS **CITY** **ZIP**

Information to be released from medical record includes:

- ❑ Complete Record
- ❑ Other: Please specify_____

_____

FINANCIAL AGREEMENT

The undersigned herby authorizes Michel F. Levesque, M.D. to receive insurance allowances otherwise payable to me for services rendered. I agree that I am ultimately financially responsible for payment of all services not covered by my insurance, as well as all copayments and deductibles.

CONSENT FOR TREATMENT

The undersigned hereby authorizes Michel F. Levesque, M.D. to perform and consents to any x-ray examination, laboratory procedure, and all treatments rendered to me and/or to my child/children named above (when a minor is being treated by Michel F. Levesque, M.D.).

PATIENT SIGNATURE **DATE**

SIGNATURE OF AUTHORIZED PERSON **DATE**

In the case of a patient who is physically unable to sign this authorization, he/she should place an "X" on the signature line and have his/her consent witnessed.

LOS ANGELES NEUROSURGICAL INSTITUTE
8670 WILSHIRE BLVD., SUITE 201
LOS ANGELES, CA 90211

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:

The following circumstances may require us to use or disclose your health information:

1. To the public health authorities and health oversight agencies that are authorized by the law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information only to certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to this office.
4. You may ask us to amend your health information of you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to this office. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

I hereby acknowledge that I have been presented with a copy of the Los Angeles Neurosurgical Institute's Notice of Privacy Practices.

Signature: _____

Date: _____

LOS ANGELES NEUROSURGICAL INSTITUTE

DIPLOMATE OF THE AMERICAN BOARD OF NEUROLOGICAL SURGERY

FELLOW AMERICAN COLLEGE OF SURGEONS

FELLOW ROYAL COLLEGE OF SURGEONS CANADA

MICHEL F. LEVESQUE, M.D.
DIRECTOR

8670 WILSHIRE BLVD., SUITE 201
BEVERLY HILLS, CA 90211

ASSOCIATE CLINICAL PROFESSOR
UCLA SCHOOL OF MEDICINE

Phone 310.659.6633
Fax 310.659.6631
www.LA-Neuro.org

Patient Name: _____

Dear Patient,

We are happy to provide copies of your records and assist you with completion of forms such as disability, family medical leave, motor vehicle division, etc. However, as medical insurance reimbursement for physician professional fees continues to be reduced and office overhead costs continue to rise, we are no longer able to provide these services without passing the cost on to you. Therefore, effective immediately we must require payment according to the following schedule:

Medical Records Request Fee

Your request will be processed and fulfilled within 5 working days. We will either mail or fax the records to the information you provide on the authorization form.

Listed below are charges for copying medical records:

Pages 1-20	$15.00
Pages 21-50	$25.00
Pages 51+	$40.00

Form and Letter Fee

This is to notify you that the office of Michel F. Levesque, M.D., will apply a fee of $20.00 for form and/or letters to be completed as requested by patient, employers, insurance carrier, etc. For forms over 3 pages, the charge may higher.

Forms include, but not limited to FMLA, disability, motor vehicle division, continuation of pay, payment of loans, payment of mortgages, industrial information, etc. Letters include, but are not limited to, insurance companies, employers, schools, airlines, travel agents, gyms, etc.

In order to comply with federal laws including HIPAA as well as California State and Federal statues, this office must have a signed authorization from the patient/ responsible party stating who we are authorized to release information to. You can contact our office and we can mail or fax the form to you. Unsigned requests cannot be processed.

_____ _____

Signature of patient or responsible party Date

LOS ANGELES NEUROSURGICAL INSTITUTE
Michel F. Levesque, M.D.
HEALTH HISTORY (Confidential)

Name:_____ Today's Date:_____

Age:_____ Birthdate:_____ Occupation:_____

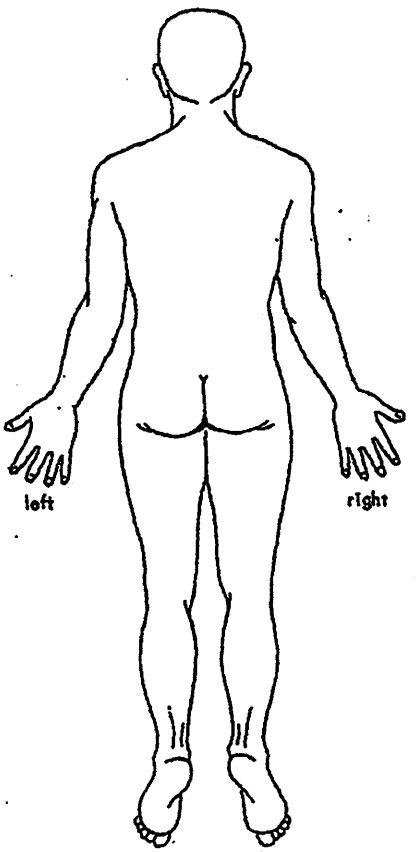
What is your reason for visit?_____

WHERE IS YOUR PAIN NOW:

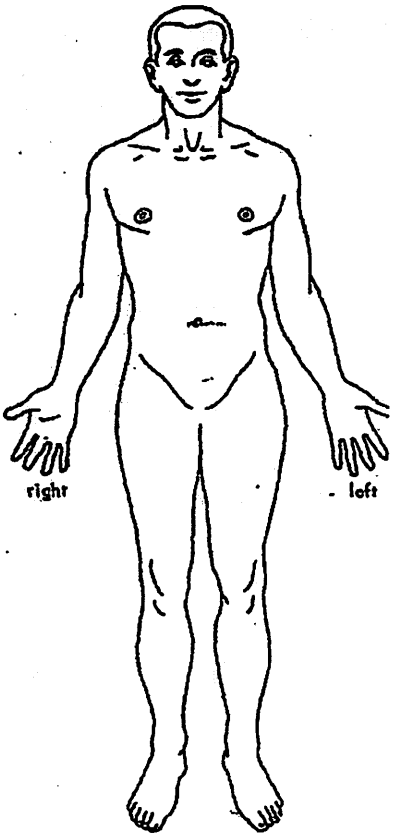
Mark the areas on your body where you feel the described sensations. Use the appropriate **symbol**. Mark the areas of **radiation**. Include all **affected areas**.

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
^^^^^^^^^^^^^^	= = = = = = =	OOOOOOOOOOOOOOO	xxxxxxxxxxxx	//////////////////////////

BACK



FRONT



No Pain **Worst Pain**

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

LOS ANGELES NEUROSURGICAL INSTITUTE
Patient Health History Page 2

1. When did symptoms first start? _____

Are they getting: Worse Better Stable

2. Please describe any other symptoms: _____

_____

3. What position and/or medication relieve your pain?

_____

_____

4. Do you have any pain, numbness, tingling or weakness in your arms or legs? Please describe:

_____

_____

5. Are presently working?

Full Time: _____ Part Time: _____ Not Presently Working: _____

On Disability: _____ Partial Disability: _____

If you are on disability/partial disability, when did it begin? _____

6. Have you had any treatment (including X-RAYS, tests, therapy, etc.) or seen any health provider for this injury? Please describe treatment & test results:

Test/Treatment:	**Date:**	**Result:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Please list previous diagnosis and treatments given or recommended:

_____

_____

8. Current Medical Status - Are you currently receiving treatment for any other medical conditions?

_____

_____

9. Review of Systems:

Symptoms Check (√) symptoms you currently have or have had in the past year.

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

EYE, EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double Vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nose bleeds
- ❑ Persistent cough
- ❑ Ringing in ear
- ❑ Sinus problems
- ❑ Vision- flashes

MEN ONLY
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN ONLY
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lumps
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple Discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

Date of last menstrual period_____

Have you had a mammogram? _____
Are you pregnant? _____
Number of children: _____

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

GENITO-URINARY
- ❑ Blood in Urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ High blood pressure
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

CONDITIONS Check (√) conditions you have or have had in the past.
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical dependency
- ❑ Chicken pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High cholesterol
- ❑ HIV positive
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Measles
- ❑ Migraine headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate problem
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Typhoid fever
- ❑ Ulcers
- ❑ Vaginal infections
- ❑ Venereal Disease

10. Have you had any prior surgeries? Yes:_____ No: _____

Year _____ Type: _____

Year _____ Type: _____

Year _____ Type: _____

11. List All Medications Currently Taking:

Medications:	Dosage:	Date:

12. Are you allergic to any medications/foods/others? Please list:

_____

_____

13. Family Medical History:
Is there family history of medical problems? Please list family member and medical problem:

_____

_____

_____

_____

14. Social History:

Age:_____Height:_____Weight:_____ LBS

Marital Status:_____ Children: _____ Left or Right Handed? _____

Do you smoke, if so how much? _____

Alcohol intake, if so how much? _____

Is there any history of alcohol or drug abuse? Yes:_____ No: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of this form.

_____ _____
Signature Date