WELCOME

DR. MUNSHI WOULD LIKE TO INVITE YOU TO VISIT OUR WEBSITE SPECIFICALLY DESIGNED FOR HIS PATIENTS!

ILYAS MUNSHI, M.D.

NEUROLOGICAL SURGERY | BOARD CERTIFIED

BRAIN | SPINE | PERIPHERAL NERVE SURGERY

www.ilyasmunshimd.com

LIKE US ON FACEBOOK

PATIENT INFORMATION SHEET

Name: _____

Date of Birth: _____

Social Security Number: _____-_____-_____

Gender: Female Male

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

Mailing Address: _____

Race: _____

Ethnicity: Hispanic or Latino Non-Hispanic or Latino

Language: English Spanish French Italian Other: _____

Marital Status: Single Married Divorced Widowed Other: _____

Emergency Contact/Relationship: _____

Employer: _____ Phone number: _____

Email Address: _____

Primary Doctor: _____

Pharmacy Name/Phone Number: _____

Is this a result to an Auto Accident or Job Injury? _____
If so, give date and location of injury: _____

Authorized Representative Form

This form is used to confirm a patient's permission that we may discuss or disclose protected health information to a particular person(s) who act as their Authorized Representative.

Patient Name: _____

Date of Birth: _____ SSN: _____

HIPPA Representative Information – Please Print

Authorized Representative #1:

Name: _____

Date of Birth: _____ Phone Number: _____

Relationship to Patient: _____

Authorized Representative #2:

Name: _____

Date of Birth: _____ Phone Number: _____

Relationship to Patient: _____

Limitations on Disclosure: I understand that I have the right to limit information that you release under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations to disclose.

Limitations: _____

1. I understand that I may revoke this HIPPA Representative designation at any time by notifying the Physician in writing; however, if I do revoke the authorization, it will not have any effect on any actions taken by Dr. Munshi's office prior to their receipt of the revocation.
2. I understand that my treatment or payment for treatment cannot be conditioned on whether or not I sign this Authorization.
3. I understand that information disclosed pursuant to this form may be redisclosed by the recipient and no longer protected by HIPPA.
4. I understand that by voluntarily signing this form I am identifying, authorizing and granting permission to the HIPPA representative(s) named above to have authority to access to my protected health information (PHI) to assist in my care. .

Signature of Patient: _____ **Date:** _____

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

I hereby authorize Ilyas Munshi, M.D. to use or disclose the following protected health information listed below.

Disclose complete records for treatment dates _____ to _____.

Purpose for Disclosure: ____ Medical Care ____ Legal ____Insurance ____Other

Please initial on the blanks below after reading:

_____ I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

_____ I understand that the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee upon request and that I will receive a copy of this form after I sign it.

_____ I understand that I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

_____ I acknowledge, and hereby consent to such, that the release information may contain alcohol and/or drug abuse, psychiatric care, HIV/AIDS testing and/or treatment, or and/or other sensitive information.

_____ _____

Signature of Patient or Legal Representative Date

Pursuant to HIPPA Rule 45 CFR 164.508©, et. Seq

Ilyas Munshi, MD APMC Financial Policies

We would like to thank you for choosing Ilyas Munshi, MD as your medical provider. We have written this policy to keep you informed of our current financial policies.

No Insurance: Payment will be due at the time of the service. If you are unable to pay your balance in full, you will need to reschedule and make arrangements with our Accounts Manager.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician is in your plan. It is also your responsibility to know your insurance benefits.

As a courtesy to our patients we will file with your insurance company. In order to do this we need all of your demographic and insurance information prior to your appointment. We will also request an update on this information approximately every six months thereafter. We ask that at the time of your appointment you bring your insurance card and a photo ID.

At the time of service you will be responsible for all fees that are not covered by your insurance, including co-pays, co-insurance, deductibles and non-covered services or items received. The co-pay cannot be waived by our practice, as it is a requirement on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility but, with so many variations in policies and fee schedules, we are not always exact. You may receive a statement from our billing company for any balance due. If you think there is a problem with the bill you should first contact your insurance company. If you have any further questions about your bill, please call our billing department immediately. For your convenience we accept cash, checks, credit cards (Visa, MasterCard, American Express and Discover), and money orders. Payments are also accepted via phone.

Please note that any balance that is incurred must be paid in full within 6 months of the date your insurance company processes your claim. The same rule applies to all injection and surgery claims. You will have 6 months from the time your insurance carrier processes the claim unless otherwise agreed upon beforehand. We may refuse to see patients with an account balance and who are not making regular payments on their account balance. Failure to do so will result in your account being turned over to a collection agency. Once an account is in collections we will no longer be able to see you until the whole balance is cleared.

Auto Accident: If your injury is a result of an auto accident, you are required to go through either an attorney or be a self-pay patient. Our office does not go through any insurance carrier for MVA related claims. You will need to file your receipts through the insurance carrier to be reimbursed.

Worker's Compensation: If your injury is due to an accident in your work place, please inform the receptionist immediately. We are not authorized to treat you for this type of claim without prior approval from the carrier.

Return Checks: There will be a $25 NSF fee for all return checks plus any applicable fees incurred.

Disability Forms: Disability, insurance, work evaluations, or any other forms that require Dr. Munshi to fill out and sign will need a **PREPAYMENT OF $30 PER FORM** to be paid in cash or check only. Please allow **7-10 BUSINESS DAYS** for the form to be completed. It is your responsibility to make sure the forms are here in a timely manner with allowance for them to be completed. Please have specific directions as to where and how the forms need to be sent off.

Acknowledgment

I acknowledge that I have received and read a copy of the Ilyas Munshi, MD APMC financial policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Ilyas Munshi, MD APMC to extend credit.

_____ _____

Signature of Patient or Guardian Date

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and
treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form please let us know.

_____ _____

Patient's Signature Date

PATIENT HEALTH HISTORY FORM

Today's Date: _____

Patient Name: _____ Date of Birth: _____ Age: _____

Reason for today's visit (please list in detail):

_____

When did the problem first begin? _____

Do you have a history of the same problem? _____ Yes _____ No

If yes, please list previous treating physician and treatment:

_____

Current problem is the result of (please check all that apply):

____ Car Accident _____ Work Accident _____ Legal Case _____ Other

Date of injury if accident, work injury, or legal case: _____

Work History

Occupation: _____ Type of Work: _____

Does your work require lifting? _____ Yes _____ No

Are you currently working? _____ Yes _____ No Date last worked: _____

Have you been deemed disabled? _____ Yes _____ No

Social History

_____ Right Handed _____ Left Handed _____ Both

Do you have children? ____ Yes ____ No How many children? _____

Do you smoke? ____ No, I do not smoke _____Former Smoke; Quit (when)? _____

_____ Yes, I smoke _____ per day.

Cigarettes/Cigars/Pipe/Chewing Tobacco (circle one)

Do you drink alcohol? ____ No. Never. ____ No, but I used to. Quit (when)? _____

_____ Yes (circle) Daily/ Socially / Occasionally

Do you use any type of illegal drugs? _____ Yes ____ No

If yes, what type? _____

Family History

Family Member	Birth Date	Deceased (Date)	Age	Medical Problems
Grandmother (Mom)				
Grandfather (Mom)				
Grandmother (Dad)				
Grandfather (Dad)				
Mother				
Father				
Brother				
Sister				

Surgical History

List **ALL** previous surgeries and dates:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies

Do you have ALLERGIES to any MEDICATIONS? _____ Yes ____ No

List Drug Allergies: _____

_____

_____

Allergies to Iodine or Betadine? _____ Yes ____ No

Medications

List ALL current medications, strength and dosage (prescription and over-the-counter):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medical History

Do you have the following in your body? (Circle)

Pacemaker Stent Metal

Are you Claustrophobic? (Circle One) YES or NO

Review of Symptoms

(Please check next to ALL that apply)

Musculoskeletal		**Ear, Nose, Throat, Mouth**		**Gastrointestinal**	
Broken Bones		Wearing Hearing Aids		Indigestion When Eating	
Neck Pain		Ear Pain		Nausea	
Arm Weakness		Ear Infections (Right or Left)		Vomiting	
Arm Pain		Balance Disturbance (Vertigo)		Jaundice	
Back Pain		Nosebleeds		Colon Cancer	
Leg/Foot Pain		Nasal Drainage		**Genitourinary**	
Leg/Foot Weakness		Inability to Smell		Urinary Tract Infection	
Leg/Foot Tingling		Sinus Problems		Painful/Difficulty Urination	
Arthritis		Mouth Sores		Inability to Control Urine	
Neurological		**Integumentary**		Kidney Stones	
Fainting Spells		Skin Disease		Prostate Cancer	
Seizures		Skin Cancer		Endometriosis	
Loss of Memory		Breast Pain/Swelling		Uterine/Cervical Cancer	
Disorientation		Nipple Drainage		**Respiratory**	
Headaches		**Endocrine**		Asthma	
Numbing Sensations		Diabetes Type 1		Chronic Cough	
Difficulty with Speech		Diabetes Type 2		Emphysema/COPD	
Inability to Concentrate		Hyperthyroid (High)		Bloody Sputum	
Double or Blurred Vision		Hypothyroid (Low)		Shortness of Breath	
Face Weakness		Increased Appetite		Lung Cancer	
Cardiovascular		Excessive Thirst/Urination		Bronchitis	
Chest Pain/Angina		Hormone Problems		Pneumonia	
High Blood Pressure		**Eyes**		**Hematologic/Lymphatic**	
Low Blood Pressure		Wears Glasses		Anemia	
Irregular Pulse		Wears Contacts		Hemophilia	
Heart Murmur		Double Vision		**Diseases**	
High Cholesterol		Cataracts		HIV/AIDS	
Cardiac Disease		Glaucoma		Scabies	
Strokes		**Psychiatric**		Hepatitis	
Pacemaker		Anxiety		HPV	
Heart Attacks		Depression		Herpes	

To help us better understand your symptoms, please complete the following page to the best of your ability.

If you have any of the following symptoms, please mark (X) in the space provided and circle right, left, or both when applicable. Also, please rate your pain intensity on the scale that follows.

PAIN LOCATION	(X)	PAIN QUALITY	(X)
Head		Aching	
Neck		Cramping	
Shoulder right/ left/ both		Crushing	
Arm right/ left/ both		Dull	
Hand right/ left/ both		Heavy	
Upper Back		Numbness	
Between Shoulder Blades		Pressure	
Lower Back		Sharp	
Hip right/ left/ both		Shock-like	
Buttock right/ left/ both		Stabbing	
Groin right/ left/ both		Throbbing	
Thigh right/ left/ both		Tightness	
Knee right/ left/ both		Tingling	
Lower Leg right/ left/ both		Weak	
Foot right/ left/ both		Burning	

Pain Intensity

Rate your pain on a scale of "0-10"

(Circle One)

0 1 2 3 4 5 6 7 8 9 10

No pain Worst Pain

Please rate your current level of pain on the following scale (circle one)

Mild Mild-Moderate Moderate Moderate-Severe Severe

Ilyas Munshi, M.D. Office Policy
Treatment of Pain with Medications: Patient Agreement

I, _____, understand and voluntarily agree to the following:

- I will keep all my scheduled appointments with the doctor and other members of the treatment team. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.
- I will participate in all other types of treatment that I am asked to participate in.
- I will keep the medication safe, secure and out of the reach of children. If the medication is lost or stolen, I understand it will not be replaced until my next scheduled refill, and may not be replaced at all.
- I will not sell this medication or share it with others. I understand that if I do, my treatment will be stopped.
- My treatment team has the right to discuss my medication regimen, and may at any time refuse to refill prescriptions for any reason and/or refer me to pain management.
- I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (Klonopin, Xanax, valium) or stimulants (Ritalin, amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medication for an emergency at night or on weekends.
- I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.
- I will keep up to date with any bills from the office and tell the doctor or member of my treatment team immediately if I lose my insurance or cannot pay for treatment anymore.
- I understand that my provider will be verifying that I am receiving controlled substances from only one prescriber and only one pharmacy by checking the Prescription Monitoring Program web site with every refill, throughout my treatment period.
- I agree to only use _____ Pharmacy.

REFILLS

- I will not call at night or on the weekends for refills. I understand that prescriptions will be filled **ONLY** on **TUESDAYS** and **THURSDAYS**, 8 AM to 5 PM. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medication. Prescriptions will not be refilled until the prescription is due. **No exceptions.**
- I will not attempt to pick up my prescription refill until I am contacted by my treatment team.
- I agree to take this medication as prescribed, and not to change the amount or frequency of the medication without discussing it with my prescribing doctor. Running out early, needing early refills, escalating doses without permission, and losing prescriptions may be signs of misuse of the medications, and may be reasons for the doctor to discontinue prescribing to me.

RANDOM DRUG TESTING

- I understand that my doctor is under no obligation to provide these medications to me, and that he reserves the right to discontinue these medications at any time. At my doctor's discretion, I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medication will be stopped.
- Your insurance will be billed for random drug testing. I understand that if this testing is not covered by my insurance, I will be responsible for the billable amount before receiving my prescription.

RISKS ASSOCIATED WITH USE OF CONTROLLED SUBSTANCES

I, _____, understand that:

- If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
- There is a risk of psychological and/or physical dependence and addiction associated with chronic use of controlled substances.
- If I need to stop this medication, I must do it slowly or I may get very sick.

We here at Ilyas Munshi, M.D. are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

- We will make sure that this treatment is as safe as possible.
- We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.
- We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
- If you become addicted to these medications, we will help you get treatment.

All of my questions and concerns regarding treatment have been adequately answered. I fully understand all aspects of this agreement. A copy of this agreement has been given to me.

This agreement is entered into on this _____ day of _____, 202_.

Patient Signature: _____
Patient Name (printed): _____

Provider Signature: _____
Provider Name (printed): Ilyas Munshi, MD