MORTON I HYSON, M.D., P.C.
NEUROLOGY
701 Shadow Lane #170 • Las Vegas, Nevada 89106

Date _____

PATIENT INFORMATION

Last Name: _____ (Jr., Sr., etc.) Sex: M or F

First Name: _____ Middle Initial or Name: _____

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Driver's License Number: _____ State: _____ Marital Status: _____

Employer: _____ Occupation: _____

Employer Address: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____

Address: _____ City: _____ State: _____ Zip Code _____

Phone: _____ Employer: _____

REFERRED BY: _____ Date of Injury: _____

Your Primary Care Physician: _____ Phone _____

Part of the Body being Treated? _____

How were you Injured? _____

_____ ☐ Right-Handed OR ☐ Left-Handed?

On The Job Injury? ☐ Yes ☐ No X-Rays Taken? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No

Worker's Comp. Insur. Co. _____ Claim # _____

Do you have an Attorney pertaining to this injury? ☐ Yes ☐ No If yes, Attorney's Name: _____

NEXT OF KIN INFORMATION

Name: _____ Phone: _____

Address: _____

Employer: _____ Work Phone: _____

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
Name of Insurance Co.	Phone Number	Name of Insurance Co.	Phone Number
Insurance Company Claims Address		Insurance Company Claims Address	
Name of Insured	Relationship to Patient	Name of Insured	Relationship to Patient
Group No. or Name of Insured's Employer		Group No. or Name of Insured's Employer	
Insured's Social Security No.	Date of Birth of Insured	Insured's Social Security No.	Date of Birth of Insured

I hereby authorize payment of medical benefits to MORTON I. HYSON, M.D. for services furnished me. I also authorize the physician to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I hereby consent to and authorize medical treatment, tests, and procedures that my physician deems advisable and necessary based on his judgement.

_____ _____

Patient's Signature or Responsible Party Signature Date

WORKERS' COMPENSATION:

INSURANCE COMPANY			PHONE #:
ADDRESS	CITY / STATE		ZIP CODE
DATE OF INJURY	CLAIM NUMBER	CLAIMS ADJUSTER	
ATTORNEY			PHONE

MED PAY OR PIP:

DO YOU HAVE MED PAY OR PIP COVERAGE ON YOUR AUTO INSURANCE POLICY?	☐ YES	☐ NO	
HAVE YOU OPENED A CLAIM?	☐ YES	☐ NO	IF YES CLAIM # _____
INSURANCE COMPANY NAME			
ADJUSTER NAME			
ADJUSTER PHONE NUMBER		EXT.	
MAILING ADDRESS			
COVERAGE LIMIT $_____			

MOTOR VEHICLE ACCIDENT:

INSURANCE COMPANY (Vehicle Owner's Car Insurance)			PHONE #:
ADDRESS	CITY / STATE		ZIP CODE
DATE OF INJURY	CLAIM NUMBER	INSURED'S NAME (As it Appears on Policy)	
POLICY NUMBER	PLACE OF ACCIDENT	AGENT	
INSURANCE COMPANY (Other Driver)			PHONE #:
ADDRESS	CITY / STATE		ZIP CODE
INSURED'S NAME (As it Appears on Policy)	POLICY NUMBER	CLAIM NUMBER	
AGENT	ATTORNEY		PHONE #
ADDRESS	CITY / STATE		ZIP CODE

LIABILITY:

INSURANCE COMPANY (Vehicle Owner's Car Insurance)			PHONE #:
ADDRESS	CITY / STATE		ZIP CODE
DATE OF INJURY	PLACE WHERE ACCIDENT OCCURRED		
ADDRESS	CITY / STATE		ZIP CODE
CLAIM NUMBER	INSURED'S POLICY NUMBER		
ATTORNEY			PHONE
ADDRESS	CITY / STATE		ZIP CODE

ARE YOU ON MEDICARE? YES NO MEDICARE NUMBER: _____
ARE YOU ON MEDICAID (SAMI)? YES NO MEDICAID NUMBER: _____
IS THIS VISIT FOR WORK ACCIDENT RELATED PROBLEMS? YES NO
IS THIS VISIT FOR AUTOMOBILE ACCIDENT RELATED PROBLEMS? YES NO
IS THERE A LEGAL SUIT PENDING? YES NO
ATTORNEY'S NAME _____ PHONE # _____
ADDRESS _____ CITY _____ STATE ____ ZIP _____

OUTSTANDING BALANCES WILL BEAR INTEREST AT 1% PER MONTH. DELINQUENT ACCOUNTS WILL BE TURNED OVER TO AN ATTORNEY OR COLLECTION AGENCY WITHOUT NOTICE. ACCOUNTS WILL BE CONSIDERED DELINQUENT IF UNPAID AFTER 60 DAYS. IN THE EVENT MY ACCOUNT IS TURNED OVER FOR COLLECTION, I WILL PAY ALL REASONABLE COLLECTION AND COURT COSTS UP TO 50% OF THE OUTSTANDING BALANCE AT THE TIME THE ACCOUNT IS CONSIDERED DELINQUENT.

PATIENT'S SIGNATURE _____ DATE_____

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE PAYMENT TO MORTON I. HYSON, M.D. ALL BENEFITS DUE, IF ANY, BY REASON OF THE SERVICE DESCRIBED IN THIS STATEMENT. I WILL BE RESPONSIBLE FOR ANY BALANCE IN EXCESS OF WHATEVER SUMS MAY BE PAID BY THE INSURANCE COMPANY WHOSE POLICY IS IDENTIFIED BELOW.

I HEREBY AUTHORIZE MORTON I. HYSON, M.D. TO RELEASE ANY NECESSARY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION AND/OR TREATMENT, FOR THE PURPOSE OF THIRD PARTY REIMBURSEMENT.

I HEREBY AUTHORIZE PHOTOCOPIES OF THESE SIGNED AUTHORIZATIONS TO BE AS VALID AS THE ORIGINALS, AND I UNDERSTAND THAT ANY INSURANCE BENEFITS ARE DUE TO BE PAID DIRECTLY TO MORTON I. HYSON, M.D.

I UNDERSTAND THAT DR. HYSON IS A PARTICIPATING PHYSICIAN IN THE MEDICARE PROGRAM. I UNDERSTAND THAT MEDICARE PATIENTS ARE RESPONSIBLE FOR PAYMENT OF THE ANNUAL DEDUCTIBLE AMOUNT AND THE AMOUNT EQUAL TO 20% OF THE MEDICARE ALLOWABLE, WHICH IS THE PATIENT'S RESPONSIBILITY.

PATIENT'S SIGNATURE _____ DATE_____

Please Sign at "X" Only

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

X SIGNED _____ X DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

X SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1															NPI
2															NPI
3															NPI
4															NPI
5															NPI
6															NPI

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq, and 30 USC 901 et seq, 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Morton I. Hyson, M.D.
Neurology

Diplomate American Board of Psychiatry and Neurology

EEG, EMG, NCV, Evoked Potentials

MEDICAL RELEASE

TO: ANY DOCTOR, HOSPITAL, FEDERAL, STATE, COUNTY OR MUNICIPAL AUTHORITY OR ANY OTHER PERSON, FIRM, OR ORGANIZATION FROM WHOM INFORMATION MAY BE REQUESTED OR TO WHOM INFORMATION MAY BE TRANSMITTED.

I HEREBY AUTHORIZE YOU TO PERMIT MORTON I. HYSON, M.D. AND I AUTHORIZE MORTON I. HYSON, M.D. OF 701 SHADOW LANE #170, LAS VEGAS, NEVADA 89106, OR HIS AUTHORIZED AGENTS, TO INSPECT, TO TRANSMIT, AND TO OBTAIN COPIES OF THE COMPLETE AND ENTIRE MEDICAL RECORD, INCLUDING BUT NOT LIMITED TO MEDICAL REPORTS, HISTORY TAKEN, LABORATORY REPORTS, PHYSICIAN'S NOTES, ORDER AND PROGRESS RECORDS, NURSES, PSYCHIATRIC NOTES AND RECORDS, AND THE LIKE, PERTAINING TO THE CARE, TREATMENT AND CONSIDERATION OF: _____ _____ FOR ANY AND ALL TREATMENT PHYSICIANS AND HOSPITALS, WHICH YOU HAVE OR HE HAS IN YOUR OR HIS POSSESSION, CUSTODY OR CONTROL.

A PHOTOCOPY OR EXACT REPRODUCTION OF THIS MEDICAL RELEASE, AS DULY EXECUTED, SHALL HAVE THE SAME FORCE AND EFFECT AS THE ORIGINAL.

DATED THE _____ DAY OF _____ 20____

PATIENT'S SIGNATURE: **X** _____

WITNESS: _____

MORTON I HYSON, M.D., P.C.
N E U R O L O G Y

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Patient's Signature: _____ Date: _____

701 Shadow Lane #170, Las Vegas, Nevada 89106 • (702) 387-1757 • Fax (702) 387-2006

MORTON I HYSON, M.D., P.C.
N E U R O L O G Y
701 Shadow Lane #170 • Las Vegas, Nevada 89106

RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT

RELEASE OF INFORMATION, ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS:
My physician may disclose all or any part of the patient records to any person which is or may be liable for or responsible for payment of all or part of the charges, including, but not limited to, insurance companies, medical or hospital service companies, workmen's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a Medicare or Medicaid claim. In consideration of the physician's advancing or extending credit for services, the undersigned hereby assigns and transfers to **Morton I. Hyson, M.D., P.C.,** all benefits and payment now due and payable or to become due and payable to the patient under any insurance policy or policies, under any replacement policies thereof, under any self-insurance program, worker compensation policy or program, employers and state welfare funds, or under any other benefit plan. I request that payment of authorized benefits be made on behalf of the patient directly to the said physician.

RELEASE OF MEDICAL INFORMATION:
The undersigned agrees to release of medical information to referral sources to facilitate communications between facilities that have and may provide care.

FINANCIAL AGREEMENT:
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, the patient is hereby obligated to pay the account of the physician in accordance with the regular rates and terms of the physician. Should the account be referred to an attorney or collection agency for collection, the patient shall pay actual attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

INSURANCE POLICY:
I hereby authorize my insurance company to furnish all copies of my insurance policy to **Morton I. Hyson, M.D., P.C.**

_____ _____
Patient's Signature If Patient Unable to Sign, Patient Representative

_____ _____
Relation to Patient Date

_____ Time of Signing _____ / _____ / _____ _____(a.m.) (p.m.)
Insured Policyholder's Signature month day year

MORTON I HYSON, M.D., P.C.
N E U R O L O G Y
701 Shadow Lane #170 • Las Vegas, Nevada 89106

Date _____

PATIENT NAME _____

DATE OF BIRTH _____

SS# _____

I understand that all co-payments and deductibles that are collected at the time of service are strictly estimated figures. Once my insurance company has processed and paid for services rendered, I may in fact, have additional out of pocket expenses that will be my responsiblity.

The total amount due will be correlated with my insurance explanation of benefits, once my claim has been processed.

Patient Signature _____

Date _____

PERSONAL MEDICAL QUESTIONNAIRE

1)	Have you ever had a HEART ATTACK?	YES	NO
1A)	If yes, WHEN?	_____	
2)	Have you ever had a STROKE?	YES	NO
2A)	If yes, WHEN?	_____	
3)	Have you ever had a SEIZURE?	YES	NO
3A)	If yes, WHEN?	_____	
4)	Have you ever had cancer?	YES	NO
4A)	If yes, WHEN and what type?	_____	
5)	Have you ever had a SURGERY?	YES	NO
5A)	If yes, what type and when?_____		

_____

_____

6) What MEDICATIONS are you CURRENTLY taking?

_____ _____ _____

_____ _____ _____

_____ _____ _____

7) Do you have any METAL in your body, besides dental fillings? _____

8)	Are you ALLERGIC to any MEDICATIONS?	YES	NO
8A)	If yes, WHICH?		

_____ _____ _____

9)	Do you have HYPERTENSION (High Blood Pressure)?	YES	NO
10)	Are you PREGNANT?	YES	NO
11)	Do you have a PACEMAKER?	YES	NO
12)	Do you or did you ever SMOKE (Cigarettes/Cigars)?	YES	NO
12A)	If yes, how much DID/DO you smoke per day?	_____	
13)	Do you drink ALCOHOLIC BEVERAGES?	YES	NO
13A)	If yes, how much per day?	_____	
14)	Do you currently, or did you previously, use any ILLEGAL DRUGS (i.e., marijuana, cocaine, etc.)?	YES	NO
14A)	If yes, which drugs and how often?	_____	

_____ _____ _____

Signature _____ Date_____

*ALL ANSWERS ARE CONFIDENTIAL AND ARE FOR MEDICAL PURPOSES ONLY!

REVIEW OF SYMPTOMS

Please indicate whether or not you are CURRENTLY experiencing any of the following:

CARDIOVASCULAR:		
Chest pain	YES	NO
Fainting	YES	NO
Shortness of breath	YES	NO
Ankle swelling	YES	NO
RESPIRATORY:		
Coughing	YES	NO
Coughing up blood	YES	NO
Wheezing	YES	NO
GENITOURINARY:		
Pain on urination	YES	NO
Frequent urination	YES	NO
Blood in urine	YES	NO
Burning on urination	YES	NO
MUSCULOSKELETAL:		
Joint pain	YES	NO
Joint swelling	YES	NO
Decreased joint mobility	YES	NO
NEUROLOGICAL:		
Headaches	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Weakness	YES	NO
Loss of consciousness	YES	NO
ABDOMINAL:		
Nausea	YES	NO
Vomiting	YES	NO
Abdominal Pain	YES	NO
Diarrhea	YES	NO
Constipation	YES	NO

Signature _____ Date _____