John J. Panagotacos, M.D.
1030 Sir Francis Drake Blvd., Suite 130, Kentfield, CA 94904
Tel: 415-578-3110 Fax: 888-578-2544

PATIENT INFORMATION:

Last Name:_____First:_____MI:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Cell:_(_____)_____-_____ Other Telephone (specify):__(_____)_____-_____

Birthdate:_____/_____/_____ Email _____

Occupation:_____ Employer_____

Martial Status: Single Married Divorced Separated Widowed Name of Spouse:_____

EMERGENCY CONTACT:_____Tel:_____

Relationship to Patient:_____

REFERRED BY: Doctor:_____Attorney:_____Self/Friend:_____

PRIMARY DOCTOR: Name:_____

PHARMACY INFORMATION:

LOCAL: Name_____Street Address:_____City:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS:
I hereby authorize John J. Panagotacos M.D. to furnish the above insurance company(s) all information which said insurance company(s) may request. I hereby assign John J. Panagotacos M.D. all money to which I am entitled for medical expense relative to the service rendered by him. I understand that total payment for medical services is my responsibility and not that of the insurance company.

_____ _____ _____
Patient Signature DPOA/Guardian Signature Date

John J. Panagotacos, M.D.
1030 Sir Francis Drake Blvd., Suite 130, Kentfield, CA 94904
Tel: 415-578-3110 Fax: 888-578-2544

Notice of Privacy Practices (Brief Summary)

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.

Uses and disclosures: We will use and disclose elements of your protected health information ("PHI") in the following ways, only if absolutely necessary:

Without your signed authorization

- Treatment information to share with other health professionals (lab tests, MRI, CT scan results, etc.)
- Payment
- Health care operations
- When release is required by law, including in judicial settings and to health oversight regulatory agencies and law enforcement.
- In emergency situations or to avert serious health/safety situations.
- To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.
- To organ, tissue and other donations organization, upon or proximate your death, if you have no indication on hand about your donation preferences (or a positive indication).
- To contact you about appointment reminders, treatment alternatives and other health related benefits and services.
- To the sponsor of your health plan
- All other uses and disclosure by us will require us to obtain from you a written authorization in addition to any other permission you will provide us.

Your rights: You have the following rights concerning your PHI:
Restrictions: To request restricted access to all or part of your PHI. To do this, contact the office staff; however, pending review, we are not required to grant your request.
Confidential communications: To receive correspondence of confidential information by alternate means or locations. To do this, contact the office staff.
Access: To inspect or receive copies of your protected health information. To do this, contact the office staff.
Amendments: To request changes made to your PHI, provide a written request through the office staff. We are not required to grant your request.
Accounting: To receive an accounting of the disclosure by us of your PHI in the six years prior to your request. To do this, provide a written request to our billing department.
This Notice of Privacy Practices: To get updates or re-issue of this notice, contact the office staff.
Complaints: To complain to us or to the U.S. Dept. of Health & Human Services if you feel your privacy rights have been violated. To register a complaint with us, contact the office staff. The law forbids us from taking retaliatory action against you if you complain.
Our duties: We are required by law to maintain the privacy of you PHI. We must abide by the terms of this notice or any update of this notice.

I acknowledge receipt of this notice,

Signature: _____ Date: _____

Print Your Name: _____

If you are signing as the patient's representative, sign below:

Signature: _____ Date: _____

Print Your Name: _____

Your relationship to patient: _____

John J. Panagotacos, M.D.

General Neurology and Stroke Specialist
1030 Sir Francis Drake Blvd., Suite 130, Kentfield, CA 94904
Ph: 415-578-3110 Fax: 888-578-2544

Appointment Cancellation & Fees Policy

Our goal is to provide excellent medical care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for patient appointments and we have implemented an *Appointment Cancellation & Fees Policy*.

We understand that there are times when you must miss an appointment due to personal emergencies. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much a needed appointment.

Cancellation/No Show Policy for Doctor Appointment

1. If you need to cancel your appointment, please try do so at least 48 hours prior to the scheduled time. To cancel an appointment, please call our office 8:30 am through 4:30 pm at (415) 578-3110 to speak with a receptionist or you may leave a message detailing your request.
2. For any appointment cancelled less than 24 hours prior to the scheduled appointment time, there will be a $75 charge to the patient.
3. A "no show" is someone who misses an appointment without canceling it within 24 hours of his or her actual appointment time. No show fee is $75 to the patient.
4. A patient is considered "late" if they arrive 15 minutes or more after their scheduled appointment time. If a patient is late we may have to reschedule the appointment. If they are late two times, they will be charged $75 on the second occurrence and again any occurrence thereafter.

Other fees/charges:

1. Medical Records Fee – No charge for electronic sending of records. For printed records: $.50 cents per page up to 50 pages, then $.25 cents a page over 50 pages thereafter for copies plus postage and shipping costs.
2. Returned Check Fee- $25
3. DMV / Disability / FMLA or any forms to be completed by Doctor: $25 per form.

These fees will be billed to you directly and are not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected within 30 days and if not, may be subject to collections.

We thank you for trusting Dr. Panagotacos with your medical care.

By signing below, you are indicating that you have read and understand the *Appointment Cancellation & Fees Policy* and agree to the terms of this policy and that you authorize your credit card to be charged by our office as per policy of fees detailed above.

_____ _____ _____/_____/_____

Print Patient Name Signature/Parent/Guardian/DPOA Date

John J. Panagotacos, M.D.

General Neurology and Stroke Specialist
1030 Sir Francis Drake Blvd., Suite 130, Kentfield, CA 94904
Tel: 415-578-3110 Fax: 888-578-2544

Credit Card Authorization Form

I authorize the office of John J. Panagotacos M.D. to charge any fees and outstanding balances that are not covered by my insurance.

This includes any fees for late cancellation, printed medical records, lost prescription and returned checks per the *Appointment Cancellation and Fees Policy*. Also, any forms to be completed by the Dr. Panagotacos, co-pays and other outstanding balances.

Please provide the information requested below, including your credit card information to secure your appointment.

_____	_____	_____
Credit Card Number	Exp Date	CCV

_____	_____	_____
Print Patient Name	Signature/Parent/Guardian/DPOA	Date

John J. Panagotacos, M.D.
1030 Sir Francis Drake Blvd., Suite 130, Kentfield, CA 94904
Tel: 415-578-3110 Fax: 888-578-2544

PAST MEDICAL HISTORY

Name_____Date_____

Age_____ Date of Birth_____

Height_____ Weight_____ Are you: RIGHT___ or LEFT___ handed?

What symptoms and problems are you seeing the doctor for today?

When did your symptoms begin?

Have your symptoms changed or progressed?

What types of tests and treatments have you had for the problems?

Past Medical History:

Do you have any of these medical conditions?

	Date/details:
Y__N__Seizures	_____
Y__N__Stroke	_____
Y__N__Dementia	_____
Y__N__Multiple Sclerosis	_____
Y__N__Parkinson's disease	_____
Y__N__Migraine headache	_____
Y__N__Aneurysm/Head bleed	_____
Y__N__Brain tumor	_____
Y__N__Head/neck injury	_____
Y__N__Neck/back surgery	_____

Please list additional medical conditions:

_____ _____

_____ _____

_____ _____

_____ _____

Past Surgical History:

Type of surgery	Date (Year)

Have you been exposed to any significant radiation, dangerous chemicals, or toxins?

Have you ever had treatment by a psychologist or psychiatrist?

What is the highest level of education you have attained? _____

Medication list:

Name	Dosage (mg, etc)	Frequency

ALLERGIES: _____

Personal Habits

Smoking history: Currently? No___ Yes?___ Packs/day?_____

Past history of smoking? Packs/day?_____Ages?____-____

Alcohol history: Currently? No___ Yes?___ Drinks/day?_____

Past history of alchohol? Drinks/day?_____Ages?____-____

Family History

Conditon	Relation to self
Y__N__Seizures	
Y__N__Stroke	
Y__N__Dementia	
Y__N__Multiple Sclerosis	
Y__N__Parkinson's disease	
Y__N__Migraine headache	
Y__N__Heart disease	

Review of Systems:

Please circle any symptoms that you have recently experienced:

General: weight gain / loss, weakness, fatigue, fever, nausea, vomiting, diarrhea or chills.

Skin: rashes, itching, dryness, bruising, changes in hair or nails, skin cancer.

Head: headache, head injury, sinus problems or dizziness.

Eyes: change in vision, pain, redness, double vision, glaucoma, cataracts.

Ear: problems hearing, tinnitus, vertigo, or earaches.

Nose and sinuses: frequent colds, nasal congestion, hay fever or nosebleeds.

Mouth and throat: gum disease, problems with chewing or swallowing, change in voice.

Respiratory: cough, bronchitis, pneumonia, asthma, or emphysema.

Cardiac: chest pain, shortness of breath, high blood pressure or palpitations.

Gastrointestinal: heartburn, change in appetite, black/bloody stool, change in bowel habits.

Urinary: incontinence, pain with urination, urinary tract infections, kidney stones.

Genito-reproductive: venereal disease, hernia, bleeding, or abnormal menstrual cycles.

Musculoskeletal: arthritis, joint stiffness, gout, neck or backaches, sciatica.

Peripheral vascular: leg pain with walking, muscle cramping, phlebitis or leg swelling.

Neurological: fainting, blackouts, seizures, focal weakness, or loss of sensation.

Psychiatric: depression, anxiety, nervousness, change in mood, or insomnia.

Endocrine: thyroid problems, intolerance of heat / cold, excessive sweating, diabetes.