

Maria Cristina Ospina, M.D.

7500 North Dreamy Draw Drive, Suite 133

Phoenix, AZ 85020

Phone#: (602) 277-2228 Fax#: (602) 265-9494

Patient Name: _____ Responsible Party: _____

Permanent Address: _____ City, State, Zip: _____

Billing Address: _____ City, State, Zip: _____

Home Phone: _____ Business: _____ Cell: _____

Sex: Male _____ Female _____ Birthdate: _____ Age: _____

Patient's Social Security Number: _____

Responsible Party's Ins. Number: _____

Primary Ins: _____

Secondary Ins: _____

Patient is: Single _____ Married _____ Employer: _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

I hereby authorize my Insurance Company to pay this Physician directly for services rendered to myself and /or minor family member. I also understand that I am financially responsible for any charges not covered by my Insurance Company.

Name: _____ Date: _____

FROM THE OFFICE OF: **Maria Cristina Ospina, M.D.**

7500 North Dreamy Draw Drive, Suite 133
Phoenix, Arizona 85020

I am a Patient of: **Maria Cristina Ospina, M.D.**

I would like to request that my family member _____
be given access to my records and/ or medical condition, allowing the staff or physician to
discuss my care and any medical changes.

Patient: _____

Witness: _____

Date: _____

Please note: All records are kept confidential and are stored in a locked storage room.
No information will be transmitted by phone, fax, or mail with-out written consent
from the patient.

FROM THE OFFICE OF: **Maria Cristina Ospina, M.D**

7500 North Dreamy Draw Drive, Suite 133
Phoenix, AZ 85020

I understand I am responsible for providing my current health insurance plan information to the office. I agree to accept financial responsibility for payment on services rendered should my visit not be covered by my insurance plan.

Name: _____ Date: _____

Movement Disorders Specialists

7500 North Dream Draw Drive, Suite 133 Phoenix, AZ 85020

Phone: (602) 277-2228

Fax: (602) 265-9494

Maria Cristina Ospina, M.D., P.L.C.

Notice of Privacy Practices Patient Acknowledgement

Patient Name : _____ Date of Birth : _____

I have the option to receive or decline this practice's Notice of Privacy Practices written in
(please circle one)
plain language. The Notice provides in detail the uses and disclosures of my protected health
information that may be made by this practice, my individual rights and the practice's legal
duties with respect to my protected health information.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to
make new provisions effective for all protected health information that it maintains. I
understand that I can obtain this practice's Notice of Privacy Practices on request.

Signature : _____ Date : _____

Relationship to patient (if signed by a personal representative of patient): _____

Patient copy
Provider copy

Movement Disorder Specialist Fee Schedule

Patient Acknowledgement

My signature shall serve as my understanding that I have been informed of the office fee schedule. I understand I will be subject to the office fee's should I initiate a returned check, miss an appointment without 48 hour advanced notice to the office, require medical forms or a letter completed on my behalf without an office visit. Perception donated by third party entities shipped to me from the medical office would also be subject to a shipping fee.

(patient signature)

(Date)

Chart

Patient

Mailed

faxed

Movement Disorders Specialists

Central Neurology, LLC.

Office Fee Schedule

Return Check :

- Bank fee + \$ 35 Office Administrative fee

Appointment no show : (no show or did not contact office 48 hours prior to appointment)

- 1st occurrence (established patient) = call notification to patient with reschedule
- 2nd occurrence = \$ 50 no show fee
- 1st occurrence (new patient) = \$ 100 no show fee

Administrative paper work fee :

- Disability forms (single) or (multiple) same rate = \$ 50
- Life insurance = \$ 50
- FMLA = \$ 50
- Motor Vehicle = \$ 50
- Jury Duty = \$ 50
- Misc. = \$ 50

Medical records request :

- Patient request = no charge for first request, additional requests are \$0.25 per page plus postage fee.
- Patient's physicians office = no charge for first request, additional requests are \$0.25 per page plus postage fee.
- Non-patient request (ex: Legal guardian requesting extra copy) = \$ 25
- Department of Economic Security records request = \$ DES rate
- Attorney records request = \$ 40
- Life insurance records request = \$ 10
- Social Security Admin records request = no charge

Rx "samples" mailed :

- Shipping and packaging fee = \$ 10

Please take a moment to complete the following survey

Which doctor will you be seeing: Dr. J Samanta _____ Dr. M.C. Opsina _____

How did you hear about us? (Please check all that apply below)

Referred by a friend or family member: _____

Attended a support group or speaking event: _____

Discovered us on the internet: _____

Found us in the yellow pages: _____

Referred by your doctor: _____

Name of doctor: _____

Referred by hospital or facility

Name of hospital or facility: _____

Referred by your insurance: _____

Name of insurance plan: _____

Your response is greatly appreciated ☺

Your Name _____ Your Age _____

1) Why are you being seen today? _____

2) Please list current medications: Please attach a separate sheet if necessary.

Medication Name	Strength (mg)	How many times per day?
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3) Please list any medications taken for this problem in the past: CHECK IF NO CHANGE

4) Please List all ALLERGIES:

5) Please list any past medical history:

Medical Conditions	Past Surgeries
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6) Who do you live with? If you have a caregiver, please list their name and contact info: CHECK IF NO CHANGE

7) What is your occupation? Are you retired, (yes, no) If so, list their former occupation: CHECK IF NO CHANGE

8) Do you smoke? Yes or No CHECK IF NO CHANGE

If yes, how many packs per day? _____ For how many years? _____

If no, but you smoked in the past, how many packs per day and for how many years? _____

9) Do you drink alcohol? CHECK IF NO CHANGE

Yes or No If yes, how much per day or per week? _____

10) Have you experienced any of the following in the past (30) Thirty Days?

Tremor	Yes _____	No _____
Stiffness	Yes _____	No _____
Involuntary Movement	Yes _____	No _____
Difficulty w/ balance, walking	Yes _____	No _____
Memory Loss	Yes _____	No _____
Speech or Swallowing difficulty	Yes _____	No _____
Hearing Loss	Yes _____	No _____
Vision Trouble	Yes _____	No _____
Difficulty w/ daily activity	Yes _____	No _____
Weakness	Yes _____	No _____
Numbness	Yes _____	No _____
Heartburn	Yes _____	No _____
Nausea or Vomiting	Yes _____	No _____
Depression	Yes _____	No _____
Vivid Dreams/Hallucinations	Yes _____	No _____
Rash	Yes _____	No _____
Weight Loss	Yes _____	No _____
Fever	Yes _____	No _____
Chills, Sweats	Yes _____	No _____
Cough	Yes _____	No _____
Chest Pain	Yes _____	No _____
Swelling of Feet	Yes _____	No _____
Unexplained bruises, bleeding	Yes _____	No _____

List any other symptoms you are having: _____

11) Please List any medical conditions in your family, especially those possibly related to your symptoms:
 CHECK IF NO CHANGE (IF NO CHANGE THEN DO NOT FILL OUT BOTTOM)

Medical Problem or Diagnosis / Living? (Yes/No) Age(s)

Mother: _____

Father: _____

Brother (how many): _____

Sisters (how many): _____

Children (how many): _____

Patient's Signature: _____ Date: _____