Johan Samanta, M.D.

7500 North Dreamy Draw Drive, suite 133
Phoenix, AZ 85020
Ph# (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: Johan Samanta, M.D.

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

I am a Patient of: Johan Samanta, 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: Johan Samanta, 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 Dreamy Draw Drive, Suite 133 Phoenix, AZ 85020
(602) 277-2228

Johan Samanta, M.D., P.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?

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

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:_____