The Neurology Group

Neurologists - EEG, EMG, NCV

Mukhtair S Kundi M.D

New Patient Packet

FULL NAME:		
DATE OF BIRTH:	**SEX:**	**SOCIAL SECURITY NUYMBER:**
HEIGHT:	**MARITAL STATUS:**	**PREFERRED LANGUAGE:**
ADDRESS:		
CITY:	**STATE:**	**ZIP:**
HOME PHONE:	**CELL PHONE:**	**EMAIL:**

PREFERRED CONTACT METHOD:

HOME ☐ **CELL** ☐ **EMAIL** ☐

CAN COFIDENTIAL MESSAGES (IE APPOINTMENT REMINDERS, NORMAL RESULTS) BE LEFT ON YOUR VOICEMAIL?

YES ☐ **NO** ☐

PLEASE INDICATE IF YOU WOULD LIKE ALL CORRESPONDANCE FROM OUR OFFICE MARKED CONFIDENTIAL?

YES ☐ **NO** ☐

EMERGENCY CONTACT: **PHONE:** **RELATIONSHIP:**

HIPPA RELEASE OF AUTHORIZATION

PLEASE LIST WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION, DIAGNOSIS, TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS:

NAME	PHONE	RELATIONSHIP

PRIMARY CARE DOCTOR:

REFERRING DOCTOR:

PHARMACY NAME AND ADDRESS:

SIGNATURE PRINT DATE

IF NOT SIGNED BY THE PATIENT INDICATE RELATIONSHIP

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HIPPA

I consent to the use or disclosure of my protected health information by MS Kundi, M.D., Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of MS Kundi, M.D., Inc. I understand that diagnosis or treatment of me by MS Kundi, M.D., Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of this practice. MS Kundi, M.D., Inc. is not required to agree to the restrictions that I may request.

However, if MS Kundi, M.D., Inc. agrees to a restriction that I request, the restriction is binding on MS Kundi, M.D., Inc. I have the right to revoke this consent, in writing, at any time, except to the extent that MS Kundi, M.D., Inc. or MS Kundi, M.D., Inc. has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is reasonable basis to believe the information may identify me.

I understand I have a right to review MS Kundi, M.D., Inc. Notice of Privacy Practices prior to signing this document. The MS Kundi, M.D., Inc. Notice of Privacy Practices has been provided for me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of MS Kundi, M.D., Inc. The Notice of Privacy Practices for MS Kundi, M.D., Inc. is also provided in the front office. The Notice of Privacy Practices also describes my rights and the MS Kundi, M.D., Inc. duties with respect to my protected health information.

MS Kundi, M.D., Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy sent in the mail or asking for one at the time of my next appointment.

SIGNATURE PRINT DATE

IF NOT SIGNED BY THE PATIENT INDICATE RELATIONSHIP

M.S. KUNDI MD

NEUROLOGY

EMG EEG EVOKED POTENTIALS

DIPLOMATE AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

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WEST COVINA, CA 91790
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P: 909-484-3400 F: 909-484-2079

130 W ROUTE 66 STE 216
GLENDORA, CA 91740
F: 626-337-7651

PATIENT NAME:_____ DOB: ___/___/_____

MEDICATION NAME	DOSEAGE	DIRECTIONS