NEUROLOGICAL ASSOCIATES | CHRISTOPHER J. REYNOLDS, MD
MOHAMMAD E. TAHER, MD

Welcome to our Practice

Dear valued patient,

Welcome to Neurological Associates, Utah County's largest general neurology practice. Our practice has been operating since 1992, and has grown to include locations in American Fork, Orem, Payson, and Evanston, Wyoming. We have had the opportunity to serve many patients over these years, and have found great satisfaction in doing so. It is truly a privilege to assist in improving the health and quality of life of individuals and families.

If you are experiencing any uneasiness or anxiety in regards to your current medical condition, we hope you will find comfort in knowing that we are committed to understanding and serving your needs. To help you better understand this commitment, we share our mission statement with you:

> ***"We believe that individuals deserve to receive excellent medical services, while being treated with compassion, respect, and understanding. Our mission is to deliver this level of service by providing expert medical knowledge, innovative treatment options, personalized care, and dedicated support."***

The entire Neurological Associates team is committed to working together to accomplish this mission, and offering you the excellent care and service you deserve.

The Neurological Associates medical team has the experience and knowledge to successfully help you. Dr. Reynolds is double board certified by the American Board of Psychiatry and Neurology and American Board of Sleep Medicine. Dr. Taher is double board certified by the American Board of Electrodiagnostic Medicine and American Board of Neurology and Psychiatry. You can learn more about their experience and education, and other members of the medical team by visiting our homepage: **MyBrainDoctors.com**.

Our office staff is dedicated to assisting you before and after you are seen by our doctors. Please feel free to turn to them for help with any needs regarding scheduling, billing, records, and more.

We look forward to meeting you and helping you move forward to the regain the health and quality of life you deserve. If you have any questions or concerns at any time, our dedicated support staff is available to assist you.

Sincerely,

The entire Neurological Associates Team

NEUROLOGICAL ASSOCIATES | ALPINE SLEEP DISORDERS CENTER

52 North 1100 East
American Fork, UT 84003
801.763.0901 phone
801.763.0903 fax

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security No.: _____ Sex: ☐ M ☐ F Student: ☐ Y ☐ N Mairtal Status _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Home Phone: _____ Cell Phone: _____ Other Phone: _____

Email Address: _____ Authorize Neurological Associates to contact by text or email: ☐ Y ☐ N

Preferred contact method: ☐ Phone ☐ Email ☐ Text ☐ Other: _____

Primary Care Physician: _____ Contact Info: _____

Referring Physician: _____ Contact Info: _____

Pharmacy: _____ Location/Phone: _____

Emergency Contact

Name: _____ Relation to patient: _____

Phone: _____ Other Info: _____

Guarantor/Responsible Party Information

Name: _____ Date of Birth: _____ Age: _____

Social Security No.: _____

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

Employer: _____ Employer Phone: _____

Primary Insurance

Insurance Name: _____ Phone Number: _____

Claims Address: _____

Policy ID: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Name: _____ Phone Number: _____

Claims Address: _____

Policy ID: _____ Group Number: _____

Policy Holder: _____ Date of Birth: _____

Relationship to Patient: _____

Neurological Associates Financial and Service Agreement

I understand the office of Neurological Associates utilizes the following billing procedures:

1- An insurance claim will be sent to my HMO or other insurance soon after services are provided, detailing the date-of-services provided, diagnoses, and charges. In the event that I have not provided the adequate information to bill my insurance company, I can expect to receive a bill for the services provided. In the event that the information I have provided is incorrect, Neurological Associates may not back my claim. I will be responsible for the charges and can expect to receive a bill.

2- Neurological Associates should receive an Explanation of Benefits from the HMO and/or other insurance detailing my portion of the bill. After the Insurance company has responded to the claim from Neurological Associates I will receive a bill for my portion of the bill. If no amount is due, I may not receive a notice.

3- Neurological Associates collects co-payments at the time of service. Due to the high cost of statements, I agree to pay a $7 service fee if I fail to pay my co-payment at the time of service. I also agree to be fully responsible for the following charges, service, and action on any delinquent amount I am responsible for:

   a. Account must be paid within 90 days or a finance charge of $7 will be added to my account monthly.

   b. 33% of the delinquent amount will be added if my account goes to collections.

   c. Collection and legal fees of 50% of the total amount will be added if sent to collections.

   d. I will be terminated from the practice of Neurological Associates for failing to pay for services provided. Neurological Associates will notify me of this action with a letter in the mail and will assist as necessary until another provider can be located.

I understand that I am financially responsible for amounts that are designated as my responsibility by my HMO or other insurance member contract. Such amounts are computed on the Explanation of Benefits (EOB) and may include co-payments, co-insurance or deductible amounts. Any co-payments, co-insurance or deductible amounts are my responsibility under the insurance member contract and are due and payable to Neurological Associates at the time of service. I also understand that I am responsible to pay Neurological Associates the usual and customary, or otherwise reasonable fees (as determined by Neurological Associates) for any service rendered that is not defined by my insurance provider as being covered by Neurological Associates. In the case that my insurance provider deems me ineligible for services rendered by Neurological Associates, I understand that I am responsible for those charges. I understand that if at any time I do not have insurance coverage and receive services from Neurological Associates I am responsible to pay for the services provided. I also understand that in the course of my evaluation and treatment, medical treatment and neurological testing may be ordered and done. Such testing may be expensive and may not be covered or completely covered by my insurance. I understand that I am ultimately responsible for these costs.

Neurological Associates reserves the right to charge a reasonable fee determined by Neurological Associates for medical records, forms completion, letter writing, failing to appear at my appointment without proper notice and late cancellations. I authorize the release of my medical information by Neurological Associates as necessary for treatment, payment and operations and in compliance with HIPPA regulations.

Neurological Associates requires a 24-hour notification for cancellations of appointments. Neurological Associates requires 72 hours notice for prescription refills. Neurological Associates requires up to 30 days notice to provide medical records, completed forms and letters. I understand that I am responsible to follow up with the office to receive test results. Neurological Associates maintains a tight schedule in order to serve many patients while still allowing for adequate time to see them. I understand that if I show more that fifteen minutes late for my appointment I may be required to reschedule and be charged a late cancellation fee.

Appointments are scheduled and pre-authorization is obtained as a courtesy to me. Ultimately I understand that I am responsible to know which providers, service, and location I may or may not utilize, i.e. I am responsible to know which services are covered by my insurance, if my provider is contracted with my insurance and if the facilities in which I receive services are contracted.

Further, I understand that I am entering into a contractual relationship with Neurological Associates for professional care. I understand that meritless and frivolous claim for medical malpractice have an adverse upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Neurological Associates, I agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Neurological Associates. Should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use American Board of Medical Specialties ("ABMS") board-certified expert medical witness(es). I agree that these expert witnesses will adhere to the guidelines and/or code of conduct as defined for expert witnesses by the American Board of Neurology and Psychiatry, American Board of Electrodiagnostic Medicine, and the American Board of Sleep Medicine. In further consideration for this, Neurological Associates agrees to the same stipulations.

I have read and understand the above terms and conditions, and hereby agree to abide by all terms and conditions as outlined by this financial agreement.

Patient or Guarantors Signature _____

Date _____ Effective Date _____

NEUROLOGICAL ASSOCIATES
CHRISTOPHER J. REYNOLDS, MD
MOHAMMAD E. TAHER, MD

Patient History Form

Name: _____ Birth date: _____/_____/_____ Age: _____

Gender: Male Female Referring Physician (full name): _____

Height: _____ Weight: _____ Right Handed Left Handed

List problems you are seeing the doctor for:

_____

_____

Describe the chronological sequence of events of your main problems:

_____

_____

When did it start: _____ Is it changing: _____

How often does it occur: _____ How long does it last: _____

Describe typical symptoms: _____

What aggravates your symptoms: _____

What improves your symptoms: _____

What diagnostic test(s) have been performed to evaluate the condition:

_____

Where was this performed: _____

Epworth Sleepiness Scale

Rate the chance that you would fall asleep during different routine daytime situations.

0= No chance of dozing **1**= Slight chance of dozing
2= Moderate chance of dozing **3**= High chance of dozing

Situation	Score
Sitting and reading	
Watching television	
Sitting in a public place (meetings, theater, etc.)	
As a passenger in a car for an hour or more (no break)	
Lying down in the afternoon for a rest	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped in traffic	

Total _____

Any other comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Past Medical History

Medical- List main medical illnesses for which you are currently being treated and duration of each illness:

_____
_____
_____
_____

Developmental History- List any problems with birth, early childhood development, birth defects, or hereditary disorders:

_____
_____
_____

Social History:
Single _____ Divorced _____ Married _____
Co-habitate _____ Widowed _____

Substance Use (mark all that apply):
Alcohol _____ Tobacco _____ Coffee _____
Illicit Drugs (marijuana, cocaine, etc.) _____
Any past or current substance use? Yes No

Personal Information
City of residence: _____
Occupation: _____
Highest completed education: _____
Number of children: _____

Medication- List all medications you are currently taking (include over-the-counter medications)

Name	Strength	Dose

Allergies- List medications you are allergic to:

_____
_____
_____

Surgeries- List any surgeries:

_____
_____
_____

Trauma- List any accidents/loss of consciousness

_____
_____

Women only:
Age of beginning periods: _____
Are you currently pregnant? Yes No
Do you have any menstrual problems?
_____
At what age did menopause occur? _____

Write in the relationship of family member(s) for which history of following exists (ex. mom, dad, brother):

Headaches _____
Strokes _____
Epilepsy/seizures _____
Mental retardation _____
Other Neuro. Diseases _____
Psychiatric illness _____
Tremor _____
Allergies _____
Diabetes _____
Cancer _____
High blood pressure _____
Alcoholism _____
Ulcer _____
Other _____
Arthritis/Gout _____
Heart attack _____
Hearing problems _____
Multiple Sclerosis _____
Neuropathy _____
Sleep problems _____

Have you ever had any of the following illnesses?

___ Tuberculosis ___ Diabetes ___ Encephalitis ___ Rheumatic Fever ___ Gouts ___ Meningitis
___ Venereal Disease ___ Mononucleosis ___ Stroke ___ Malaria ___ Polio ___ Hepatitis/Yellow Jaundice

Have you ever experienced any of the following? Mark all that apply, and describe in space provided.

___ Numbness or tingling in hand or feet
___ Weakness or fatigues
___ Difficulty making decisions
___ Depression Nervousness
___ Major neighborhood conflicts
___ Great deal of worry
___ Lose temper often
___ Major job problems
___ Social difficulties
___ Suicidal thoughts
___ Sought psychiatric help
___ Recent major life crisis
___ Problematic sleep patterns
___ Difficulty falling/staying asleep
___ Snoring ___ Restless legs at night
___ Trouble staying awake during the day

_____
_____
_____
_____
_____

Have you experienced any of the following in the past 6 months? Mark all that apply and describe in space provided.

___ Trips out of this area
___ Contact with a sick person
___ Contact with a sick animal
___ Contact with a toxic chemical
___ Illness during foreign travel
___ Eye disease
___ Ear disease
___ Nose and/or sinus disease
___ Mouth or tooth disease
___ Thyroid disease
___ Hypoglycemia
___ Chest/breathing problems
___ Heart disease
___ Blood pressure problem
___ Mood changes
___ Swelling of feet
___ Breast disease
___ Stomach or intestinal disease
___ Liver disease
___ Kidney problems
___ Problems controlling urine/stools
___ Prostate problems
___ Bruise easily
___ Skin trouble
___ Recent change in weight
___ Tumors/cancer
___ Headaches
___ Muscle or joint problems
___ Memory problems
___ Nervousness

_____
_____
_____
_____
_____
_____
_____
_____
_____

Name (if different than patient): _____ **Relationship to patient:** _____

NEUROLOGICAL ASSOCIATES | CHRISTOPHER J. REYNOLDS, MD
MOHAMMAD E. TAHER, MD

Receipt of Notice of Privacy Practices Written Acknowledgment Form

I_____, have been given the opportunity to read, or have reviewed a copy of Neurological Associates Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Patient's Name

Patient Consent

With my consent, Neurological Associates may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Neurological Associates Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices *prior* to signing this consent. I may request a hard copy from the receptionist, or I may find this document at the Neurological Associates website (www.mybraindoctors.com/forms). Neurological Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Neurological Associates Privacy Officer at 52 North 1100 East American Fork, Utah 84003.

With my consent, Neurological Associates may call my home to other designated location and leave a message on voice mail or in person in reference to any item that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Neurological Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Neurological Associates restrict how it uses or discloses my PHI or carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Neurological Associates use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Neurological Associates may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Patient's Name

_____

Date