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 offer the excellent care and service you deserve. The Neurological Associates medical team has the experience and knowledge to successfully help you, and 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,

All of us at Neurological Associates

We look forward to seeing you on _____ ***at*** _____
Day Date Time

in our office in: ☐ ***American Fork*** ☐ ***Orem*** ☐ ***Payson*** ☐ ***Evanston***

NEUROLOGICAL ASSOCIATES | ALPINE SLEEP DISORDERS CENTER

(801) 763-0901
52 N 1100 E · American Fork, UT
41 N 400 W · Payson, UT
700 W 800 N #330 · Orem, UT

Patient Information

Name: _____ Date of Birth: ____/____/____ Age: _____

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

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

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Not specified Preferred Language: _____

Race: ☐ African or African American ☐ Native American or Native Alaskan ☐ Caucasion or European American
☐ Asian or Asian American ☐ Native Hawaiian or other Pacific Islander ☐ Other _____

Patient Contact Information

[Cell] Phone Number: _____ Email Address: _____

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

Primary Care Physician: _____ Contact Info: _____

Referring Physician: _____ Contact Info: _____

Pharmacy: _____ Location/Phone: _____

Guarantor/Responsible Party Information

Name: _____ Date of Birth: _____ Age: _____

Social Security No.: _____ Gender: ☐ M ☐ F

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. Also include any developmental issues such as hereditary diseases and birth defects.

_____

_____

_____

_____

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

_____

Social History:

☐ Single ☐ Divorced ☐ Married ☐ Co-habitate ☐ Widowed

Substance Use (mark all that apply):

☐ Alcohol ☐ Tobacco ☐ Coffee ☐ Illicit Drugs (marijuana, etc.)

Any past or current substance use? ☐ Yes ☐ No

Personal Information

City of residence: _____

Occupation: _____

Highest completed education: _____

Number of children: _____

Women only:

Age of beginning periods: _____

Currently pregnant? ☐ Yes ☐ No

Do you have any menstrual problems? ☐ Yes ☐ No

At what age did menopause occur? ☐ Yes ☐ No

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

Headaches _____ Allergies _____ Arthritis/Gout _____

Strokes _____ Diabetes _____ Heart attack _____

Epilepsy/seizures _____ Cancer _____ Hearing problems _____

Mental retardation _____ High blood pressure _____ Multiple Sclerosis _____

Other Neuro. Diseases _____ Alcoholism _____ Neuropathy _____

Psychiatric illness _____ Ulcer _____ Sleep problems _____

Tremor _____ Other _____

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
☐ Marital problems
☐ 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:** _____

Receipt of Notice of Privacy Practices
Written Acknowledgment Form

NEUROLOGICAL ASSOCIATES

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