NEUROLOGICAL ASSOCIATES

EMG &
Nerve Conduction
Study Specialists

Phone: (801) 465-6911
MyBrainDoctors.com

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. Specialists Richard Nielsen and David Johnson have performed over 60,000 EMG/Nerve Conduction Studies combined, and our office staff is dedicated to assisting you before and after your visit. 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

(801) 763 - 0901
AMERICAN FORK • 52 N 1100 E
OREM • 498 E 800 N SUITE 3B
PAYSON • 41 N 400 W

Patient Information

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

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

Social Security No.: _____ Sex: ☐ M ☐ F Student: ☐ Y ☐ N Marital 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: _____ Home Phone Number: _____

Email Address: _____ Consent to receive email: ☐ Y ☐ N

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

Primary Care Physician: _____ Clinic/city: _____

Referring Physician: _____ Clinic/city: _____

Pharmacy: _____ City/Phone: _____

Emergency Contact Name & Phone Number: _____

Guarantor/Responsible Party Information

Name: _____ Date of Birth: _____ Age: _____

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

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

Employer: _____ Employer Phone: _____

Insurance Information

Primary	Secondary
Policy Holder's Name: _____	Policy Holder's Name: _____
Insurance Company: _____	Insurance Company: _____
Policy ID Number: _____	Policy ID Number: _____
Group Number: _____	Group Number: _____
Date of Birth (policy holder): ___/___/___	Date of Birth (policy holder): ___/___/___

NEUROLOGICAL ASSOCIATES

Patient History Form

Name: _____ Birth date: _____ Age: _____

Problems you are seeing doctor for:

_____

When did this problem start? _____

How often does it occur? _____

How long does it last? _____

Is it changing? _____

Medications: List all you are taking (including over the counter drugs)

Name	Strength	Dose

Allergies: List all medications you are allergic to

and other allergies

_____ _____ _____

_____ _____ _____

_____ _____ _____

Substance Use (mark all that apply)

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

Any past or current substance use? ☐ Yes ☐ No

Christopher J. Reynolds, MD
Mohammad E. Taher, MD
Richard P. Nielsen, PT, DHSc, ECS
David N. Johnson, MPT, ECS

NEUROLOGICAL ASSOCIATES

Consent to Medical Care

I hereby authorize my physician, Christopher J. Reynolds, M.D., Mohammad E. Taher, M.D., Richard P. Nielsen, PT, DHSc, or David N. Johnson, MPT, to perform upon me electromyography and nerve conduction study for diagnostic purposes. I recognize that, during the course of the procedure, unforseen conditions may necessitate additional or different procedures than those explained. I, therefore, further authorize and request that my physician and any associates or assistants of his choice perform such procuedures as are, in their professional judgment, necessary and desirable for my well-being.

I understand that the proposed care may involve risks and possibilities of complications and that certain complications have been known to follow the procedure to which I am consenting even when the utmost care, judgment and skill are used. I acknowledge that no guarantees have been made to me as to the results of this procedure, nor are there any guarantees against unfavorable results.

I accept the risk of substantial and serious harm, if any, in hopes of obtaining the desired beneficial reuslt of such care and acknowledge that the physicians involved have explained my condition and the proposed health care and alternative form of treatment in a satisfactory manner and that all questions asked about the health care and its attendant risks have been answered in a manner satisfactory to me.

I have read and understand this document and authorize and accept the proposed care regardless of risk.

Dated this the _____ day of _____ _____
month year

Patient Signature _____ Witness _____

Parent or Guardian _____ Relationship _____

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 _____

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