



(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 Caucasian 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: _____

Primary	Insurance Information	Secondary
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Policy Holder's Name: _____		Policy Holder's Name: _____
Insurance Company: _____		Insurance Company: _____
Policy ID Number: _____		Policy ID Number: _____
Group Number: _____		Group Number: _____

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 than 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 _____

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.

<input type="checkbox"/> Numbness or tingling in hand or feet	<input type="checkbox"/> Social difficulties _____
<input type="checkbox"/> Weakness or fatigues	<input type="checkbox"/> Suicidal thoughts _____
<input type="checkbox"/> Difficulty making decisions	<input type="checkbox"/> Sought psychiatric help _____
<input type="checkbox"/> Depression Nervousness	<input type="checkbox"/> Recent major life crisis _____
<input type="checkbox"/> Major neighborhood conflicts	<input type="checkbox"/> Problematic sleep patterns _____
<input type="checkbox"/> Great deal of worry	<input type="checkbox"/> Difficulty falling/staying asleep _____
<input type="checkbox"/> Lose temper often	<input type="checkbox"/> Snoring <input type="checkbox"/> Restless legs at night _____
<input type="checkbox"/> Major job problems	<input type="checkbox"/> 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.

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

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

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