NEUROLOGICAL ASSOCIATES | ALPINE SLEEP DISORDERS CENTER

801-763-0901
American Fork ➽ 212 S 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 Number:_____ Sex: M F Student: Y N Marital Status:_____

Ethnicity: Non-Hispanic Hispanic Not Specified Preferred Language: _____

Race: African / African American Native American / Native Alaskan Caucasian / European American

Asian / Asian American Native Hawaiian / other Pacific Islander Other: _____

Patient Contact Information

Cell Phone Number: _____Home Phone Number: _____

Email Address: _____ Consent to receive email: Yes No

Preferred contact method: Phone Email Text Other: _____

Primary Care Physician: _____ Clinic/City: _____

Referring Physician: _____ Clinic/City: _____

Pharmacy: _____ City/Phone: _____

Emergency Contact Name & Phone:_____ Relationship_____

Guarantor/Responsible Party Information

Name: _____ Date of Birth _____ Age: _____

Social Security Number: _____ Gender: Male Female

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:_____

Patient History Form

Name: _____ Birth Date: _____/_____/_____ Age: _____

Problems you are seeing the 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 other allergies.

_____	_____	_____
_____	_____	_____
_____	_____	_____

Substance Use (mark all that apply):

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

Any past or current substance use? ☐ Yes ☐ No

NEUROLOGICAL ASSOCIATES

CONSENT TO MEDICAL CARE

I hereby authorize my physician, Christopher J. Reynolds, M.D., Mohammad E. Taher M.D., 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, unforeseen 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 procedures 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 know to follow the procedure to which I am consenting even when the utmost care, judgement, 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 result 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 serviced are provided, detailing the date-of-services provided, diagnosis, 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, services, 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. **30% of the delinquent amount will be added if my account goes to collections.**
    c. **Collections 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 cost.

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 15 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 Associate 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 my 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 Guarantor's 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.mybriandoctors.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 212 S 1100 E American Fork, Utah 84003.

With my consent, Neurological Associates may call my home to other designated location and leave a message on voicemail 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

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.
B. The term "Claim" means one or more Malpractice Actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3(15)). Each Party may use any legal process to resolve non-medical malpractice claims.
C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.
D. The Term "Patient" or "you" means:
    (1) You and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
    (2) Your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
    (1) working directly with each other to try and find a solution that resolves the Claim, OR
    (2) using non-binding mediation (each of us will bear one-half of the costs); OR
    (3) using binding arbitration as described in this Agreement.
    You may choose to use any or all of these methods to resolve your Claim.
B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
C. Arbitration - Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
    (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
    (2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Providers(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
D. Final and Binding Decision. A Majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term / Rescission / Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination.If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date.I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of singing it.

Article 10 Receipt Of Copy I have received a copy of this document.

_____ _____

Name of Physician, Group or Clinic Name of Patient (Print)

By:_____ _____

Signature of Physician or Authorized Agent Signature of Patient or Patient's Representative / Date