Lauren Plawner, MD
Pediatric Neurologist

New Patient Form

Patient Name: _____ **Date:** _____

Parent/Guardian Name(s): _____

Date of Birth: ____/____/_____ **Age:** ____ **Right**_ or **Left** _ **Handed** (check one) **Height** ____ **Weight** _____

How did you learn about our practice? Were you referred? (By Whom?) _____

_____

What is the reason you have come to see a Neurologist?_____

_____

Please list current medications (include supplements):

Name of Medication	Strength	Dosage/Directions

Pharmacy: _____ Phone #: (_____) _____

Does the patient have any allergies to medication? If yes, please list the medication and adverse reaction:

_____

Does the patient have any other significant medical problems? Surgeries? _____

_____

Is there anything else you think it is important that I know? _____

_____

_____

Please check if the patient has had any of the following to a significant degree:

- ☐ Unusually Tired
- ☐ Fever/Chills
- ☐ Trouble Sleeping
- ☐ Snoring
- ☐ Seizures
- ☐ Headache
- ☐ Ear/Throat Pain
- ☐ Trouble Swallowing/Chewing
- ☐ Runny Nose
- ☐ Trouble Hearing
- ☐ Trouble Seeing/Vision
- ☐ Hoarse Voice
- ☐ Trouble Breathing
- ☐ Wheeze
- ☐ Cough
- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Stomach Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Poor Eating
- ☐ Excess Eating
- ☐ Weight Loss/Gain
- ☐ Pain With Urination
- ☐ Increased Urination
- ☐ Irregular/Painful Periods
- ☐ Joint Pain
- ☐ Easy Bruising
- ☐ Rashes

NEUROLOGICAL ASSOCIATES OF WASHINGTON, P.L.L.C.

- PATIENT REGISTRATION -

Name: _____ **Date of Birth:** ____/____/_____
LAST FIRST M.I.

Address: _____ **Sex:** ___ Male ___ Female

City: _____ **State:** _____ Zip: _____ **Social Security Number:** _____-_____-_____

Employer: _____ **Occupation:** _____ **Student?** Yes No

Marital Status: S M W D **Emergency Contact:** _____ **Phone#** _____ **Relation**_____

Pharmacy Name: _____ **Phone Number:** (_____) _____

PHONE MESSAGES MAY BE LEFT FOR ME ON:		
__ Home Voice Mail	__ Cellular Voice Mail	__ Work Voice Mail
( ) -	( ) -	( ) -
HOME NUMBER	CELL NUMBER	WORK NUMBER

Which physician in our clinic are you seeing today? _____

- REFERRING PHYSCIANS -

Referred by: _____ Phone# _____
Last First

Primary Care Physician: _____ Phone# _____
Last First

- INSURANCE INFORMATION -

PLEASE BE SURE TO HAVE US COPY YOUR INSURANCE CARD (S) TODAY TO INSURE PROPER BILLING

Is this a work related condition? L&I? __Yes __No **Is this related to an auto accident?** __Yes __No

PRIMARY INS: _____
ID #: _____
GROUP# _____
EFFECTIVE DATE: _____
ARE YOU THE POLICY HOLDER? _____ Yes _____ No
* IF NO, PLEASE PROVIDE THE POLICY HOLDER'S:
NAME: _____
DOB: _____
RELATIONSHIP TO YOU: _____

SECONDARY INS: _____
ID #: _____
GROUP# _____
EFFECTIVE DATE: _____
ARE YOU THE POLICY HOLDER? _____ Yes _____ No
* IF NO, PLEASE PROVIDE THE POLICY HOLDER'S:
NAME: _____
DOB: _____
RELATIONSHIP TO YOU: _____

WORK/AUTO INJURY INFORMATION:

Date of injury: ____/_____/_____ Is this claim open & active? **Y N** Is PIP exhausted? **Y N** Claim #: _____

Claims Manager:_____ Phone Number: (_____) _____

Employer at time of injury: _____ Insurance Company: ___ Washington State L&I

___ Broadspire ___Sedgwick ___ Eberle Vivian ___ other: _____

PLEASE READ THE FOLLOWING STATEMENT BEFORE SIGNING:
I authorize treatment of the patient named above and agree to pay for all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I also authorize the healthcare provider or insurance company to release any information required to process the claim. In addition, I will not withhold or delay payment if my insurance company denies payment of any charges. I understand that there will be a $25 fee (per RCW 62A.3-515&520) on returned (NSF) checks. The undersigned agrees that whether he/she signs as an agent, that he/she is obligated to pay for the account. Past due balances will be charged 1% interest per month (per RCW 19.52) on the unpaid balance.

By my signature below, I acknowledge that the Notice of Privacy Practices has either been offered to me or received by me.

Signature: _____ Relationship: __ self __spouse __legal guardian __other_____

Date: __ /____/_____ Printed Name (if other than patient): _____

Neurological Associates of Washington

Notice of Privacy Practices:
Acknowledgement

Neurological Associates of Washington keeps a record of the health care services provided to you. In accordance with the law, you may ask to see and copy that record as well as ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so.

You are welcome to see your record or get more information about it by contacting our Bellevue office at 425-455-5440. Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By signing below, you will be acknowledging that you have read and understand the Notice of Privacy Practices of Neurological Associates of Washington.
(This signed form will also be retained in your medical record and will remain effective until revoked by you in writing).

Additionally:

1. *May we leave messages regarding your health information on your answering machine or voicemail at home?* ____*NO* *YES*____

2. *May we discuss your medical care with anyone that answers the telephone at your home?* ____*NO* *YES*____

3. *Are there any members of your family, household or those coming with you to this appointment with whom we should not discuss any of your health care issues?* ____*NO* *YES*_____
   _____
   _____

4. *Do you have any suggestions regarding how we may improve our Patient Privacy Program?* ___*NO* *YES*_____
   _____
   _____

_____
Patient or legally authorized individual signature Date Time

_____
Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

NEUROLOGICAL ASSOCIATES OF WASHINGTON, P.L.L.C.

BELLEVUE
1600 116th Ave NE, Suite 302
Bellevue, WA 98004
Phone: 425-455-5440
Fax: 425-455-1431

KIRKLAND
13107 121st Way NE, Suite A
Kirkland, WA 98034
Phone: 425-899-6200
Fax: 425-899-6220

Authorization of Verbal Disclosure and Protected Health Information

Due to the recent implementation of the new Federal guidelines known as HIPAA, we are required to have your signature to verbally discuss any protected health information with persons not directly involved in your health care. (i.e. family members, care givers) If you would like to designate a person (persons) to communicate with us regarding your healthcare, please list them below.

I hereby give my authorization for verbal disclosure of my protected health care information to be disclosed to:

1. **Name of Person:** _____

   Relationship to you: _____ Phone#: _____

2. **Name of Person:** _____

   Relationship to you: _____ Phone#: _____

3. **Name of Person:** _____

   Relationship to you: _____ Phone#: _____

4. **Name of Person:** _____

   Relationship to you: _____ Phone#: _____

Patient Name: (please print) _____

Signature: _____ **Date:** _____

***** NOTE: This authorization expires ONE YEAR form original date signed and must be updated on a yearly basis.**

Neurological Associates of Washington
Cancellation and/or No-Show Policy

Many doctors, especially Family Practice, stack patients (book them into overlapping time slots) to avoid having large holes in their schedules. We are very careful not to stack appointments and try to ensure that our patients get the very best care and our full attention. When our patients cancel with little or no notice or simply do not show up for their appointment, that time is wasted and there is no one to fill the hole. (If given proper notice, we are often able to fill it with someone from our lengthy cancellation list.)

Due to the increase of last-minute cancellations and no-shows in our appointment schedules, we have no choice but to implement the following:

Appointments that are cancelled without at least one business day's notice or where the patient does not show up or does not call to cancel until after the fact will be *billed directly to the patient as follows:*

• Office Visits	$75.00
• MRI	$300.00
• EEG	$100.00
• EMG/Nerve Conduction	$100.00

****

I have read the above policy, understand and agree to pay the penalty assigned to me if I should no-show or cancel my appointment without the required notice. When calling to cancel, please do not leave this message on voicemail. Please let the receptionist know that you need to cancel an appointment and ask to speak directly to the assistant.

_____
(signature of patient)

_____ _____
Patient Name (please print) Date

****Exceptions will be made for truly extenuating circumstances.**