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

Emergency Contact: _____**Phone#** _____ **Relation to you:** _____

Marital Status: ☐S ☐M ☐W ☐D **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**

- REFERRING PHYSICIANS -

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:_____
Employer: _____
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:_____
Employer: _____
RELATIONSHIP TO YOU: _____

WORK INJURY INFORMATION:

Date of injury: _____ Is this claim open & active? **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
HEALTH HISTORY FORM: (Please complete both sides)

Name: _____ Date of birth: _____

Age: _____ Weight: _____ Height: _____ RIGHT or LEFT Handed Dominant

Present Complaint - Why are you being seen today?

_____

_____

_____

PATIENT MEDICAL HISTORY:

Please read each one and check all that apply to the person who is being seen

	YES	NO		YES	NO
ANEMIA (iron poor blood)			LOSS OF BALANCE		
ARTHRITIS			LOSS OF HEARING		
ASTHMA/Lung Disease			MEMORY LOSS		
BLEEDING PROBLEMS (unusual)			NECK or BACK PROBLEMS		
BOWEL PROBLEMS			PERSONALITY CHANGE		
CANCER			PNEUMONIA		
CONVULSIONS			PULMONARY CONDITION		
CHRONIC PAIN			STROKE		
CHEST PAIN			SEIZURES		
CIRCULATORY PROBLEMS			SPEECH PROBLEMS		
DEPRESSION			SLEEP DISORDER		
DIABETES			STOMACH PROBLEMS		
DIZZINESS			SWALLOWING DIFFICULTY		
FATIGUE/TIREDNESS (unusual)			TINGLING or NUMBNESS		
FRACTURES			ULCERS		
HEADACHE or MIGRAINE			URINARY PROBLEMS		
HEART DISEASE			VISUAL DISTURBANCE		
HIGH BLOOD PRESSURE			WEIGHT LOSS or GAIN (sudden)		
JOINT or RANGE OF MOTION			** HIV + or AIDS		
KIDNEY PROBLEMS			** HEPATITUS A,B,C ?		
LEG BLOOD CLOTS			OTHER:		

Please explain any of the above items marked “yes”: _____

_____

_____

_____

_____

_____ OVER PLEASE

Neurological Associates of Washington
HEALTH HISTORY FORM: (Please complete both sides)

ALLERGIES TO MEDICATIONS: please include allergies to shellfish, nuts, etc...

NAME OF MEDICATION	DESCRIBE REACTION

LIST ALL MEDICATIONS: prescription, herbal and over the counter

Name of Medication	Dosage	last dose	Reason for taking this

Pharmacy _____ Phone # _____

PLEASE LIST ANY ILLNESS, SURGERIES OR INJURIES:

DATE	ILLNESS-SURGERY- INJURY	LOCATION - HOSPITAL	DOCTOR

Do you drink alcohol? ___ NO ___ YES (If yes, how much and how often?)

_____

Do you smoke or chew tobacco? ___ NO ___ YES (If yes, how much daily?)

_____

Do you use “recreational drugs” of any kind? ___ NO ___ YES
(This information is valuable and knowing it may prevent harmful drug interactions):

_____

Please outline any family health history (i.e. – heart disease, diabetes, etc): _____

_____

_____

_____

_____

_____ _____

Signature of Patient Date

Notice of Privacy Practices

~In Accordance with Federal Regulations~

Neurological Associates of Washington keeps necessary records of your medical condition and care. We would be happy to provide you with a copy of these records upon request and will not disclose these records to others unless you direct us to do so or unless the law authorizes or compels us to do so. Please feel free to submit to us any comments or corrections regarding these records.

Our **Notice of Privacy Practices** (please see next 2 pages) describes in more detail how your health information may be used and disclosed and how you can access this information.

By signing below, you will be acknowledging that you 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 appointment 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 _____

_____ _____

Signature Date / Time

_____

Print Name

_____ _____

If not signed by Patient, Guardian Name Relationship to Patient

If the patient is a minor or not legally competent, the parent or legal guardian should sign this document for the patient.

This following describes how your medical records may be used and how you can obtain access to this information.

Notice of Privacy Practices

~In Accordance with Federal Regulations~

Neurological Associates of Washington respects your privacy and understands that your personal health information is very sensitive. Accordingly, we will not disclose your information to others unless you ask us to do so, or unless the law authorizes or requires us to do so (see below).

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers and the billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing health care to you. This will help them remain informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - medical quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.

- Have us review a denial of access to your health information—except in certain circumstances;

- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights, please contact our Kirkland Office (tel.: 425-899-6200) during our usual business hours

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting our Bellevue office to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, you may contact our Kirkland Office (tel.: 425-899-6200).

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our Kirkland Office. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may release health information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

Notice of Privacy Practices

~In Accordance with Federal Regulations~

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
        - to protect public health and safety
        - to prevent or control disease, injury, or disability
        - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Web Site

- For your benefit, this Notice is also listed on the Web site: **http://neuroassociates.us**

Thank you for your time and attention! We encourage you to contact us with any suggestions or comments.-

The physicians and staff at Neurological Associates of Washington.

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.**