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 MI

Address: _____ Sex: ___ Male ___ Female

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

Employer: _____ Occupation: _____ Student? Yes No

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

Pharmacy Name: _____ Phone Number: (_____) _____

PHONE MESSAGES MAY BE LEFT FOR ME ON: Please circle Preferred communication:		
Home Voice Mail	Cellular Voice Mail	Email Address
( ) -	( ) -	@
HOME NUMBER	CELL NUMBER	EMAIL ADDRESS

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: _____	SECONDARY INS: _____
ID # _____	ID # _____
GROUP# _____	GROUP# _____
EFFECTIVE DATE _____	EFFECTIVE DATE: _____
ARE YOU THE POLICY HOLDER? ____ Yes ____ No	ARE YOU THE POLICY HOLDER? ____ Yes ____ No
* IF NO, PLEASE PROVIDE THE POLICY HOLDER'S:	* IF NO, PLEASE PROVIDE THE POLICY HOLDER'S:
NAME: _____	NAME: _____
DOB: _____	DOB: _____
RELATIONSHIP TO YOU: _____	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 $35 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 WA
SCHEDULING COMMUNICATION PREFERENCE

In an effort to guard your privacy while allowing for efficient scheduling, please answer the following questions on how best to contact you regarding appointments.

____ Yes, it is ok to leave messages or voicemails at the following numbers
____ No, it is not ok to leave phone messages or voicemails

Phone #_____ Cell___ Home___

Phone #_____ Cell___ Home___

I would like to receive appointment reminders by:

____ Email: _____(email address)

____ Text: _____(cell phone number)

Name: _____

DOB: _____

Signature: _____

Date: _____

RELEASE OF INFORMATION GUIDE

A release of information form has been included in this packet. A release of information will give Neurological Associates of Wa and Dr. Plawner permission to obtain or release information with other providers providing care to your child, ie, pediatrician, primary care doctor, medical specialists, psychological, psychiatry, therapists, school districts.

There is room on this form for 3 providers. If you need additional forms or need help completing these forms, please ask for Linda, Dr. Plawner's assistant.

Authorization for Neurological Associates of Washington
To Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____ Social Security #: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition:
  _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:
Name (or title) and organization: _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify)
  _____
- ☐ check only if [practice/ facility]requests the authorization for marketing purposes
- ☐ check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

This authorization ends: *(no more than 90 days after the date it is signed.)*

- ☐ 90 days from the date signed
- ☐ on (date): _____
- ☐ when the following event occurs: _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

-Fill out a revocation form. A form is available from the [practice/health care facility]. Or
-Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized individual signature Date Time

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

Last Update. 09/05/03

Neurological Associates of Washington

Authorization for Verbal Disclosure of Protected Health Information

In compliance with Federal laws, we must have your signed approval before we discuss your personal health information with anyone not directly involved in your health care. This form enables to you designate those persons for us.

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#: _____

5. **Name of Person:** _____

   Relationship to you: _____ Phone#: _____

Your Signature: _____ Date: _____

Print Name: _____

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.**

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 requires 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 3 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 your 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.

Notice of Privacy Practices

~In Accordance with Federal Regulations~

The following document describes how your medical records may be used and how you can obtain access to this information:

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 (please 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 obtain 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 receive a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.

Notice of Privacy Practices

~In Accordance with Federal Regulations~

- Request that we 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.
- Upon your 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 medical records department (tel.: 425-658-3310) 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 one of our offices 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, please contact our medical records department (tel.: 425-658-3310).

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 medical records department. 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 1-release health information about you to a friend or family member who is involved in your medical care, 2-give information to someone who helps pay for your care, 3-tell your family or friends your condition and that you are in a hospital and
- 4-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.