Advanced Neurological

Evaluation and Treatment Center, PC

Alexander Feldman, MD Jared Yarnell, MD
1601 E 19th Ave #4400 Denver, CO 80218
P: 303-863-0501 F: 303-863-0497

Patient Registration

Patient Name (Last, First Middle) _____

Street Address _____

City/State/Zip_____ Home Phone _____

Date of Birth _____ Cell Phone _____

Soc Sec # _____-_____-_____ Work Phone _____

Gender: M__ F__

Email Address _____

Referring Physician _____ Phone _____ Fax _____

Primary Care Physician _____ Phone _____ Fax _____

Pharmacy Name _____ Phone _____ Fax _____

Pharmacy Address _____

Emergency Contact _____ Phone _____

I authorize to have access to protected information regarding my medical care to:

Name _____ Phone _____ Relationship _____

Primary Insurance Company: _____

Address: _____ City, State, Zip: _____

Subscribers SSN: _____ - _____ - _____ Subscribers DOB: _____

Policy/ID #: _____ Group #: _____ Phone #: _____

Secondary Insurance Company: _____

Address: _____ City, State, Zip: _____

Policy/ID #: _____ Group #: _____ Phone #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize ANETC to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient identified above. I understand that insurance may not pay for ail charges, and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency. CO PAYMENT IS DUE AT THE TIME OF SERVICE.

I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims.

Patient/Patient Representative Signature: _____ Date: _____

Advanced Neurological
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Patient History

Patient Name: _____ DOB: _____

Age: _____ Right Handed: ____ Left Handed: ____ Height_____ Weight: _____

Reason for today's visit: _____

_____

When did the problem begin (Date): _____

Potential Reason: Injury:_____ Illness: _____ Stress: _____ Other: _____ (explain): _____

Disease Progression: Slowly: _____ Suddenly: _____ Attacks: _____

What makes your symptoms better: _____

What makes your symptoms worse: _____

Past Treatments:

Hospitalizations dates and reasons: _____

Name of Previous Neurologist: _____

Other MD (specialist name): _____

Physical Therapist: _____

Previous medications: _____

Medication Allergies: _____

Medications (including over-the-counter, Prescriptions, Birth Control Pills. Supplements):

Name:	Dosage:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prior Surgeries and Dates:

_____

_____

_____

_____

_____

Past Diagnostic Testing

	Date:	Result:
__ Blood work	_____	_____
__ MRI/ CT	_____	_____
__ EEG	_____	_____
__ EMG	_____	_____
__ Other: _____	_____	_____

Review of Systems

___ Fever/chills
___ Fatigue
___ Night Sweats
___ Irregular heartbeat
___ Weight change
___ High blood pressure
___ Headaches
___ High cholesterol
___ Clenching teeth
___ Heart attacks
___ Loss of vision
___ Nausea/vomiting
___ Light sensitivity
___ Shortness of Breath
___ Snoring
___ Diarrhea/constipation
___ Double vision Joint pain
___ Blurry vision
___ Radiating pain down legs/arms
___ Dizziness
___ Neck pain
___ Hearing loss
___ Back pain
___ Ringing in ears
___ Depression
___ Trouble swallowing
___ Anxiety
___ Sensitivity to noise
___ Memory loss
___ PTSD
___ Attention deficit
___ Numbness/Tingling
___ Muscles weakness
___ Migraines
___ Shaking/tremor
___ Seizures
___ Stroke
___ Fainting
___ Balance problems
___ Difficulties speaking
___ Blood clots
___ Anemia
___ High/low blood sugar
___ Cold/heat intolerance

Social History

Place of Birth: _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Long-term relationship ___

Number of Children: _____

Highest Level of Education: GED ___ High School ___ Associate's ___ Bachelor's ___ Doctoral ___

Occupation: _____

Do you smoke? Yes / No If yes, how much per day? _____

Do you drink alcohol? Yes / No If yes, how much per week? _____

Do you use street drugs? Yes / No If yes, what? _____

Family History (list close members with):

__Multiple Sclerosis __Diabetes __Heart Disease __Stroke __Migraines

__Parkinson's __Seizures __Dementia __Cancer __Aneurysms

Anything else you feel is important for us to know? _____

_____

_____

Patient/Patient Representative Signature: _____ Date: _____

Advanced Neurological
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name (Last, First, Middle): _____
Street Address: _____
City/State/Zip _____ DOB: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

I authorize the release of the following protected health information to:

To:
Advanced Neurological and Treatment Center
Address: 1601 19th Ave, Suite 4400, Denver, Co 80218
Phone: 303-863-0501 Fax:303-863-0497

From: _____
Address: _____
_____
Phone: _____
Fax: _____

I request the release of the specific categories of information that I have initialed below:

Acquired immunodeficiency syndrome (AIDS)/human immunodeficiency virus (HIV) infection

Diagnosis and/or treatment relating to drug or alcohol abuse

Diagnosis and/or treatment relating to mental health conditions confidential details of:

__Psychotherapy Notes (Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist)

__Social Work Counseling/Therapy __Discharge Summary __Lab Reports

__Operative Reports __Pathology Reports _Imaging Reports __Orders/Progress Notes

__H&P and Consultation(s) __Other: _____

The purpose of this disclosure is:

__ Medical Care __ Legal Matter __ Insurance __ Personal __Other(please specify): _____

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- lf the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Advanced Neurological Evaluation and Treatment Center shall not be held liable for any consequences resulting from re-disclosure.
- This Authorization expires on __/__/__ {if date not completed / one year after signed}

Patient/Patient Representative Signature: _____ Date: _____

Advanced Neurological
Evaluation and Treatment Center, PC

NO SHOW/LATE CANCELLATION POLICY

Welcome to Advanced Neurological Evaluation and Treatment Center, PC. It is our philosophy and commitment to deliver high quality care to our patients. Our staff will do all that they can to give you the best treatment available. In order for you to obtain optimal benefit from your treatment program, it is essential for you to promptly attend each scheduled appointment.

This policy has been established to help us serve you better.

A "no show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office visit and/or a procedure. Please communicate cancellations during our business hours, 8 AM to 5 PM, for emergencies we do have an answering service.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

A charge of $50.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

A charge of $150.00 will be assessed for each no show or late cancellation test and / or procedure appointment if less than 24 hours notice is given.

If you are more than 15 minutes late, you will be asked to reschedule.

If your appointment is not confirmed by 12 PM the day before you will be seem only if the providers are available.

After 2 "NO SHOWS" appointments, you will be dismissed from our practice by certified letter.

Please understand that insurance companies consider this charge to be entirely the patients responsibility.

I certify that I have read and understood the above policy.

Patient/Patient Representative Signature: _____ Date: _____

Patient/Patient Representative Printed Name: _____

Advanced Neurological
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NOTICE AND ACKNOWLEDGMENT OF PRIVACY POLICIES AND PROCEDURES

Patient Name: _____ Date Of Birth: _____

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA), The ADVANCED NEUROLOGICAL (Practice) may not use or disclose your personal health information without your authorization. The Practice has policies and procedures to comply with HIPAA Law. Every attempt has been made to keep the process for patients and staff as efficient as possible. However, the requirements are extensive and take time, effort and cooperation to process required tasks.

Notice of Privacy Practices: This notice describes how medical information about you may be used and disclosed and how you can get access this information.

Authorization for Use or Disclosure of Protected Health Information: The Practice may not use or disclose your health information for purposes other than treatment, payment or health care operations, without your authorization. Your signature on this form indicates that you are giving permission to the people listed on the form, for the use and disclosure of the health information listed on the form, for the purpose listed on the form, to the people/organizations listed on the form. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to this office.

Complaint: You have the right to complain about the Practice's privacy policies, procedures or actions. The Practice will not engage in any discriminatory or other retaliatory behavior against you because of a complaint. Request to Amend Protected Health Information: You have a right to request that health information that pertains to you be amended if you believe that it is incorrect or incomplete. The Practice will review your request and either grant your request or explain the reason why it will not be granted. In the event that your request is not granted, you have the right to submit a statement of disagreement that will accompany the information in question for all future disclosures.

Request for Inspection of Protected Health Information: You have a right to request the opportunity to inspect and copy health information that pertains to you. The Practice will evaluate your request and will either grant it or explain why the request will not be granted. In the event your inspection is not granted, you may request that the decision be reviewed by someone other than the person who originally denied the request.

Request for Accounting of Disclosure of Protected Health Information: You have a right to request an accounting of disclosure of health information that pertains to you.

Confidential Channel Communication Request: You have a right to request that communications concerning your personal health information be made through confidential channels. The Practice will do its best to accommodate all reasonable requests.

Designation of Personal Representative: You have a right to nominate one or more persons to act on our behalf with respect to the protection of health information that pertains to you. By making this request, you are informing the Practice of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Acknowledgment of Receipt of Notice of Privacy Practices: I acknowledge that I have received and read the above Notice of Privacy Policy and Procedures and that I have had any questions regarding this notice answered to my satisfaction.

Patient/Patient Representative Signature: _____ Date: _____

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Advance Beneficiary Notice (ABN)

Patient Name: _____ Date Of Birth: _____

We expect that your insurance company may not pay for the item(s) or service(s) that are described below. Your Insurance Company does not pay for all of your healthcare costs. Your Insurance Company only pays for covered items and services when your insurance company's rules are met. The fact that your insurance company may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, your
Insurance Company may not pay for:

Item or Service: _____

Why your Insurance may not pay: _____

Estimated Cost: _____

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Please not that this notice give our opinion, not an official insurance decision. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you do not understand why your insurance company may not pay.
- Ask us how much these items or services will cost you and why.

By signing below, I agree to receive these items or services and would like the claim submitted to my Insurance Company. I understand that my Insurance Company will be billed and will not decide whether to pay unless I receive these items or services. If my insurance company denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal my Insurance Company's decision and if my Insurance is not billed, I cannot appeal my Insurance Company's decision.

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to your insurance company, your health information on this form may be shared with your insurance company. Your insurance company will keep your health information confidential.

Patient/Patient Representative Signature: _____ Date: _____

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FINANCIAL POLICY

Thank you for choosing us as your Neurology provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and Insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. I f your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you must pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to an outside collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guide

Patient/Patient Representative Signature: _____ Date: _____