Authorizations & Notice of Privacy Practices

Welcome NW Neurology & Electrodiagnostic Center. Our goal is to provide you the highest quality medical care in the most professional manner possible. The following authorization permits us to provide appropriate information to your insurance company, referring doctors, other physicians, and others who are legally entitled. **PLEASE READ CAREFULLY:**

I authorize reports of my evaluations, treatments and any follow-up evaluations to be sent to my referring doctor, my family physician, insurance company that is being billed, as well as any other health care providers that I have or will identify to you. I also authorize release of all pertinent medical information to any hospital or outpatient facility or clinic.

While I am here I permit the employees, doctor, and all other persons caring for me to treat me in ways that they judge are beneficial to me. I understand that the physician will explain to me the nature of my condition and his recommended treatment and any associated risk involved. I understand that this care may include diagnostic testing, examinations, medical treatments, and no guarantees have been made to me about the outcome of this case**.**

I understand that I am responsible for following up on the diagnostic tests and future appointments. I am aware there is a cancellation / no-show policy.

Please be aware that some of the services that we provide may be non-covered services by your insurance company, but have been deemed to be in the best interest by your physician.

I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to a party who accept assignment. I assign all benefits for unpaid services to which I am entitled to Ashish M. Trivedi, MD. This assignment will remain in effect until revoked by me in writing.

I acknowledge that I have received the **Notice of Privacy Practices (HIPAA)**. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the practice and myself or others. I am entitled to my chart summary within three business days.

Chronic care management services, cognitive care, telemedicine service, care coordination, and non face-to-face encounters.

By signing this Agreement, I agree to the following:

- I consent to the Provider providing chronic care management services to me.
- I authorize electronic communication of my medical information with other treating providers as part of coordination of my care.
- I acknowledge that only one practitioner can furnish CCM Services to me during a thirty (30) day period.
- I understand that cost-sharing will apply to CCM Services, so I may be billed for a portion of CCM Services.
- I understand I can be billed for services provided by office staff and the physician for coordination of my care.
- Our billing office will bill your insurance for these services. **This includes charges for phone visits, chronic care management, and virtual telemedicine visits**.

Cancellation and No-show Policy

Many doctors 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 less than 48 hours in advance will be billed directly to the patient as follows:

- Procedure = $150.00
- New Patient or 30 minute revisit = $100.00
- Follow up or revisit = $50.00

Workman's Comp / Labor & Industries claim or Motor Vehicle Accident claim

Our neurologists are only consulting physicians, and do not act as attending physicians for L&I / workman's comp claims. You will need to establish an attending physician for management of your claim.

This office will bill L&I (or worker's compensation) for your medical care that is directly related to this injury **ONLY.** It is your responsibility to discuss your appointment with your claims manager to confirm that today's visit is authorized in advance. If you discuss any other ailments with the provider while you are here, or have any routine medical care provided, this will be considered a regular medical visit and **cannot** be billed to L&I. This means that there may be two claims submitted for the same visit, with a portion being billed to L&I and a portion being billed to you or your medical insurance carrier.

If you would rather have your regular medical care managed separately from your L&I care, please make sure you discuss **only** the injury while you are here for your L&I visit. You will then need to make a separate appointment to address your other medical concerns.

If you choose to address your medical care and this injury at the same appointment, claims will be submitted to both L&I and your regular insurance carrier, and you will be responsible for whatever charges you would normally incur for an office visit (copayment, coinsurance, etc.). If your appointment is not authorized by your claim manager in advance, you will be billed for the total charges of the appointment.

General Credit Policy

The following is our policy regarding financial arrangements. The clinic will bill your insurance company. We ask, however, that you present your identification card and sign any necessary forms. The insurance co-pay is due and payable at the time of service. A service charge of $10 will be added if you cannot pay the co-pay at the time of service. Any balance, after the insurance payment has been made, is due upon receipt of your statement. If for any reason your insurance carrier rejects your claim, you will be responsible for full payment of your account. IF YOU ARE A MEMBER OF A MANAGED CARE PLAN THAT REQUIRES A REFERRAL FROM A PRIMARY CARE PHYSICIAN (PCP), YOU ARE RESPONSIBLE FOR PRESENTING THE REFERRAL AT THE TIME OF THE APPOINTMENT.

I understand that payment is due at the time of service, unless my insurance is being billed on my behalf. If I am paying out-of-pocket, I will need to pay 50% of the cost before services are rendered to me. I understand that I am fully and legally responsible for payment of the account, which includes all outstanding balances not covered by Medicare, Employer/Workman's Compensation and/or insurance companies. In event of collection, I agree to pay all outstanding charges including costs of collections. If my account is not paid by my insurance company within 60 days, the account becomes my responsibility. Balances over 60 days are subject to 1.5% service fee. Past due accounts over 90 days are referred to a collection agency as a last resort after effort of voluntary payment have been exhausted. I understand that this office does **NOT** bill third-party auto insurance companies or attorneys. We do not accept Care Credit.

If you have no insurance, a discount is offered when services are paid in full with either cash, check or by VISA/MASTERCARD at the time of service (3rd Party Reimbursement is not available for this discount). All professional services rendered are charged to the patient. The PATIENT is RESPONSIBLE for all fees, REGARDLESS of insurance coverage.

By signing below, I consent for medical treatment and/or diagnostic testing and that I acknowledge that I have read, understand, and agree to the above authorizations. I have received a copy of the Notice of Privacy Policies and Disclosure of Physician Financial Relationships, detailing my health information rights and health care services under Cascade Surgery Associates, PLLC dba NW Neurology & EDX Center. I authorize my insurance benefits to be paid directly to Ashish Trivedi, MD (dba Cascade Surgery Associates, PLLC, Auburn Neurological Institute, PC).

This form will be electronically signed during the check-in process in our clinic when you arrive for your appointment and retained in your medical record. To get copies of your records contact 253-333-1637. Please allow 48 hours for any records request.

Northwest Neurology & EDX Center Patient Financial Policy

(Please check each then sign. We are unable to provide services without signature)

☐ **INSURANCE COVERAGE AND FINANCIAL POLICY**

Our billing office will bill your insurance for your visit for a plan in which the practice participates**. This includes charges for phone visits, chronic care management, and virtual and telemedicine visits**. Please bring your insurance card(s) and identification with you to each appointment. The amount for which you are responsible (any deductibles, copays, percentages or **non-covered services**) is required at the time of service. **You are responsible for knowing the specific rules of your insurance carrier.** Northwest Neurology & EDX Center is contracted (in-network) with several insurance carriers, however, if we are not contracted with your insurance carrier, you may be required to pay a higher fee than if you were seen by a contracted (in-network) provider. Please check with your insurance carrier for your plan benefits.

☐ **MANAGED CARE REFERRAL PROCESS**

Your plan may require a referral from your primary care physician (PCP) to be on file with them before seeing a specialist. If a referral is required, it is your responsibility to work with your PCP to obtain this referral before your appointment.

☐ **PAYMENT OF POST VISIT BALANCES**

All post-visit balances must be paid within 30 days of when the balance becomes the patient's responsibility and a statement from our clinic is received. If you have any questions regarding your statement or outstanding balance you may contact our office at 253-333-1637.

☐ **CANCELLATION/RESCHEDULING**

Your appointment reserves a time especially for you. Because we make every effort to see patients on time, we do not overbook or double-book to accommodate patients who do not keep their appointments. Therefore, the practice charges **$50.00 for missed appointments that are not rescheduled or cancelled with at least two business day's notice**. After 2 missed or late changed appointments, you may not be rescheduled.

☐ **COMPLETION OF OUTSIDE PAPERWORK**

Northwest Neurology will charge a **Processing Fee of $30.00 (+) $5.00 per page to complete Outside Paperwork. We will bill your insurance if your insurance allows.** This includes Disability Forms and FMLA Paperwork. Payment is required in advance and paperwork will not be processed until payment is received. Please allow one week for paperwork to be completed.

I acknowledge and agree to the financial and office policies:

Patient Name: _____ _____ _____ _____

Signature of Patient or Representative | *Relationship to Patient | Date

*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the patient.

Date of Visit: _____ **Patient Health History** ***PLEASE COMPLETE BOTH SIDES OF THIS SHEET***

Patient's Name_____ Age _____ Sex _____ Date of Birth _____ Right or left handed_____

Referring Doctor Name and Specialty: _____

Please list all the physicians (with phone #), in addition to the referring physician, who should receive a copy of your evaluation.

_____

Preferred pharmacy Name _____ Pharmacy phone # _____

Briefly describe your symptoms or problems. _____

PERSONAL HISTORY

Have you ever had any of the following illnesses?

High blood Pressure	No	Yes	Glaucoma	No	Yes	**Date of last Flu Vaccine?** _____
Diabetes	No	Yes	AIDS/HIV	No	Yes	
Date of last diabetic eye/foot exam _____			Stroke	No	Yes	
Heart Disease	No	Yes	Anxiety	No	Yes	
Low Back Pain	No	Yes	Depression	No	Yes	
Seizures	No	Yes	Tuberculosis	No	Yes	
Head Injury	No	Yes	Meningitis	No	Yes	
Migraines	No	Yes	Polio	No	Yes	
High Cholesterol	No	Yes	Thyroid Disorder	No	Yes	
Rheumatic fever	No	Yes	Bladder Disease	No	Yes	
Arthritis	No	Yes	Bowel Disease	No	Yes	
Asthma	No	Yes	Heart Attack	No	Yes	
Lung Disease	No	Yes	Atrial Fibrillation	No	Yes	
Liver Disease	No	Yes	Reflux	No	Yes	
Kidney Disease	No	Yes	Cancer	No	Yes*	
			* _____			

Others:_____

_____

65 Years and Older:

Have you had a pneumonia vaccine? When? _____	Yes	No
Have you fallen in the last year?	Yes	No
Do you feel unsteady on your feet?	Yes	No
History of broken bones as an adult?	Yes	No
Fallen more than twice in the last year?	Yes	No
Sustained injuries from falling?	Yes	No
Take calcium or Vit D supplements?	Yes	No
Currently taking osteoporosis meds?	Yes	No

Have you ever had any of the following surgeries?

Heart Surgery	No	Yes	Brain Surgery	No	Yes
Back Surgery	No	Yes	Aneurysm repair	No	Yes

Any other type of operation:

Type _____ Year _____

Type_____ Year_____

Do you have any metal or surgical implants? (i.e. pacemaker)

No

Yes _____

Have you ever been hospitalized for any illness? No Yes _____

Have you had any of the following tests?

CT scan No Yes **MRI** No Yes **EMG** No Yes **EEG** No Yes **Lumbar Puncture** No Yes

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MEDICATIONS

Allergies: please list any allergies you have including any medication allergies **NONE**

_____

_____

Medications: Please list all medicines you are taking and how you actually take them. Please include all vitamins herbal supplements and birth control medications. (If you require more space, please attach additional sheets of paper or bring a list of medication with you)

	Drug Name	***Dosage***	***How many times a day?***
1			
2			
3			
4			
5			

Please turn over and complete the back. Thank you

SOCIAL HISTORY

Do you exercise? No Yes What kind of activity/how many times a week? _____
Do you smoke? No Yes How many packs per day?_____ Quit (When_____)
Do you drink alcohol? No Yes How much/ what type?_____ Quit (When_____)
Do you use street drugs? No Yes
Occupation (or former occupation if retired) _____
Education: Years in high school _____ Years in college _____ Years in post grad. _____
Marital Status: Single Married Divorced Widowed Separated Other _____

Who lives at home with you?_____

FAMILY HISTORY

Has any blood relative ever had: (circle yes or no)			**Who**
Stroke	No	Yes	_____
Epilepsy or Seizure	No	Yes	_____
Migraine	No	Yes	_____
Memory Loss	No	Yes	_____
Multiple Sclerosis	No	Yes	_____
Other Neurological Illness	No	Yes*	_____ *If yes, please explain _____
Psychiatric Illness	No	Yes	_____
Heart Attack at young age	No	Yes	_____
High Blood Pressure	No	Yes	_____
Diabetes	No	Yes	_____
Tuberculosis	No	Yes	_____

Others: _____

REVIEW OF SYSTEMS – Please circle and provide brief detail for the medical conditions below which apply to you currently or recently.

Constitutional - General
NONE
Weight loss
Weight gain
Change in appetite
Fever
Fatigue
Excessive Sleepiness
Unable to Sleep

Neurological
NONE
Headache
Concussion
Atrophy
Numbness
Tingling
Trouble walking
Poor balance
Trouble swallowing
Trouble chewing
Trouble talking
Falls
Vertigo
Memory loss
Loss of consciousness
Seizures
Tremor

Eyes
NONE
Blurred Vision
Double Vision
Loss of Vision
Cataracts
Glaucoma

Psychiatric
NONE
Anxiety
Mania
Depression
Psychosis

Musculoskeletal
NONE
Weakness
Neck pain
Back pain
Joint pain
Joint swelling

Cardiovascular
NONE
Chest pain
Angina
Fainting spells
Heart Murmur
Heart Failure
Leg Swelling
High/Low Blood Pressure

Respiratory
NONE
Shortness of Breath
Emphysema
Asthma
Bronchitis
Pneumonia
Chronic cough

Endocrine
NONE
Diabetes
Impotence
Thyroid disease

Skin
NONE
Rash
Moles
Tumors
Discoloration

Genitourinary
NONE
Frequent urination
Painful urination
Urinary urgency
Getting up at night to urinate (more than 2 times a night)
Blood in Urine
Urinary incontinence
Kidney Stones
Sexually Transmitted Disease _____
Impotence
Sexual Dysfunction

Gastrointestinal
NONE
Gastric ulcer
Gastric Bleeding
Abdominal pain
Diarrhea
Hepatitis
Pancreatitis
Rectal bleeding

Ear, Nose, Throat
NONE
Ringing in the ear
Hearing loss
Sinusitis
Dizziness

Hematological
NONE
Sickle cell disease
Other blood disorders
Enlarged lymph nodes

Patient Information* – *Please complete ENTIRE form

Today's Date _____

Date of Birth _____ Sex (circle one): Male Female ❒Single ❒Married ❒Widowed ❒Divorced

Name _____ Social Security # _____

REQUIRED FOR INSURANCE BILLING

Race (circle one)
American Indian/Alaska Native
Asian
Black/African American
Native Hawaiian/Other Pacific Islander
White
Undetermined

Ethnicity (circle one)
Hispanic/Latino
Non Hispanic/Latino
Undetermined

Patient E-mail address: _____

Address _____ **City** _____ **State** _____ **Zip** _____

Preferred method of contact:
❒Home ❒Work ❒Cell

Phone _____ _____ _____
Home *Work* *Cell*

Doctor who referred patient _____ **Doctor's phone #** _____

Patient employed by _____ **Patient occupation** _____

Emergency contact: Name _____ **Phone** _____ **Relationship** _____

Name _____ **Phone** _____ **Relationship** _____

Patient Insurance

CO-PAY $_____ ***Co-pay is due at time of service. There is an additional $10 charge if not collected.***

Primary Insurance _____ ID # _____ Group _____

Secondary Insurance_____ ID # _____ Group _____

Insured person's name _____ Relationship to patient _____

Insured person's date of birth _____ Insured person's SSN _____

➢ ***If the patient is a <u>MINOR</u> or has a <u>POA</u>, please complete the next two lines of information***

Parent/Guardian/POA Name _____ Relationship to patient _____

Parent/Guardian/POA date of birth _____ Parent/Guardian/POA SSN _____

➢ ***If your claim is to be billed to a worker's comp (L&I) or motor vehicle accident, please complete the following:***

Claim #: _____ Case manager Name/Phone #: _____

Please indicate which company we are billing this claim to:
- ❒ Labor and Industries
- ❒ Sedgwick
- ❒ Other self-insured _____
- ❒ Car accident insurer _____

Claim Mailing Address:
_____
_____

Date of injury: _____ Employer/Place of Injury: _____