FOUR PEAKS NEUROLOGY
REGISTRATION FORM

(Please Print)

Primary Care Physician:	Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home # ( ) Cell # ( )

City:	State and ZIP code	Occupation:	Employer:

Pharmacy Phone Number:	Pharmacy Name and Location	Employer phone no.: ( )

Referred to Practice by: ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

EMAIL :

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Name of Primary Insurance

Plan Address/City/State/ZIP

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize four peaks neurology or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

FOUR PEAKS NEUROLOGY
PATIENT FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing **Four Peaks Neurology [FPN]** as your care provider. Please read carefully each statement and sign. As you may be aware, the current medical environment has resulted in employers and individuals selecting health care insurance policies that have increasingly transferred costs and more responsibilities to you, the insured. Furthermore, most insurance plans require deductibles and copayments not known to you or us at the time of your visit. The financial policy is intended to eliminate financial confusion and misunderstanding between our patients and the practice. Your complete understanding of the financial policy is an essential element in your care and treatment.

INSURANCE: Due to the large number of insurance plans and policies, it is the patient's responsibility to know services covered by your plan. It is your responsibility to verify with your particular plan that **FPN** physicians are in network. **FPN** will verify insurance eligibility but we cannot verify that our physicians are in each individual's network. While we are happy to help you receive the maximum benefits allowed by your insurance carrier, bear in mind that it is your responsibility to pay any copay, deductible, coinsurance or non-covered amounts not paid by your insurance company, prior to receiving services. It is the patient's responsibility to clearly know and identify their primary insurance and their secondary insurance if this exists. Any confusion created by the patient with respect to multiple insurance plans resulting in non-payment of covered services immediately become the patient's responsibility. **FPN** will provide you with your itemized statement in order to bill your respective insurances. **FPN** as of 1/1/2016 does not accept or bill tertiary insurance policies. **FPN** will bill only once and when necessary will appeal once. Services during gaps in insurance coverage are your responsibility.

PRIVATE PAY/SELF-PAY PATIENTS: If you choose this option payment is due at the time of service.

NON-INSURANCE PAYMENT: If your insurance does not issue payment within 30 days of the date that services are provided, the entire balance will become your responsibility.

NON-COVERED SERVICES/ELECTIVE PROCEDURES DEEMED MEDICALLY UNNECESSARY: Please be aware that certain services you receive may not be covered and/or may be considered "unreasonable" or "unnecessary" by your insurer. If, your insurance plan determines that a particular service is not reasonable and necessary the insurance will deny payment for that service. The patient will be personally and fully responsible for payment of that service.

CHANGING INSURANCE CARRIER OR POLICY: Prior to your appointment it is your responsibility to notify **FPN** and provide new insurance information to ensure proper claim submission.

PAST DUE BALANCES: Any balance more than 2 weeks (15 days) old will be considered past due. Once a balance is past due payment will be required prior to your next appointment. Please pay your balance via the **FPN** Patient Portal, telephone or mail. Failure to make payment on a past due balance before your next scheduled appointment will result in the cancelation and rescheduling of your appointment. Your account balance must be *zero* prior to your next visit with the physician. If your account becomes past due we will take the necessary steps to collect this debt. A $25 dollar monthly statement fee will apply to any balance not payed within 30 days of the initial statement. If we have to refer your account to a collection agency a $50 collection agency fee will be added to your outstanding balance. If you have questions regarding outstanding balance you may contact billing office at **FPN** to set up a payment plan. Credit card *must* be on file for patient

payment plans. Default on payment plan will result in balance being immediately referred to collection agency.

CLAIM DENIALS: HMO/PPO claim denials due to cancelation of policy, lack of referral, lack of authorization, or reversals of authorizations are the patient's responsibility regardless if previously obtained. I understand that **FPN** office staff will try to obtain referral, precertification, and eligibility, however the final responsibility lies with the patient to comply with their specific insurance requirements. Referrals must be presented to **FPN** office before seeing the doctor.

NON-CONTRACTED INSURANCE CARRIERS: We strive to contract with many insurance carriers, but if we are not contracted with your insurance you are responsible for full payment at time of service. We will provide the itemized statement for you to file a claim with your insurance.

NO SHOW AND CANCELLATION: To further achieve our goal of providing each patient with utmost medical and neurologic attention, we kindly request that you make an effort to keep your scheduled appointment and arrive on time. Due to missed appointments or last minute cancelations, the blocked appointment time hinders the availability for other patients in need of our medical attention. As a result, a fee of $50.00 for no show or no notification of canceled appointments and $300.00 for procedures, such as an EMG, Botox, EEG, will be assessed. To avoid these fees please send **FPN** a notification through the Patient Portal or call the office at least *24 hours* in advance of your appointment.

FORM COMPLETION: Completion of forms such as applications, FMLA, disability, and forms requiring physician review and signature will be billed to the patient or representative that requested the completion of the form. It takes approximately 5-7 business days for the work to be completed or longer depending on the physician's schedule. Payment of $50 dollars per page is required before processing can begin.

MEDICAL RECORDS RELEASE: It takes approximately 5-7 business day to process a medical record request. Medical records will be released to physician's office upon written request and authorization as a courtesy. There is a fee for NON-TREATMENT MEDICAL RECORDS [medical records requested by your attorney, disability insurance, other nonmedical entities] release and payment is required before processing can begin. This is a service and not part of neurologic care. The fee is $50. Patients can view and access their individual medical record through the **FPN** Patient Portal.

INSUFFICIENT FUNDS: Checks written at the time of your visit or mailed as payment on an account balance that are returned by the bank will be assessed a $40 returned check charge. The original check amount plus the returned check charge must be paid within 30 days by cash or credit card.

ACCOUNT REFUNDS: Refunds will be returned when patient's balance for all rendered services is zero.

AFTER HOURS PRESCRIPTION REFILLS: After hour and weekend contact with covering physician to refill a prescription(s) will result in a $50 charge per prescription.

I have read and understand the Four Peaks Neurology Patient Financial Responsibility Policy and agree to abide by the terms of the policy.

_____ _____

Signature of Patient or Guardian **Date**

_____

Print Name of Patient

FOUR PEAKS NEUROLOGY CREDIT CARD ON FILE AGREEMENT

Starting 1/1/2016 **FPN** can maintain your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed ONLY after the claim has been filed and processed by your insurer, after all appeals have been exhausted and the insurance portion of the claim has paid and posted to the account.

I authorize Four Peaks Neurology to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

___ AmEx ___ Mastercard ___ Visa

Credit Card Number _____

3 Digit Sec. Code _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

PLEASE PRINT EXACTLY AS IT APPEARS ON YOUR CARD

Signature _____

Billing Address _____

City _____ State _____ Zip _____

I, the undersigned, authorize and request Four Peaks Neurology to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me by Four Peaks Neurology.
This authorization will remain in effect until I cancel this authorization. To cancel authorization I must give a 60 day notification to Four Peaks Neurology in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____ Date: _____/_____/_____

FOUR PEAKS NEUROLOGY
OFFICE POLICY AND PROCEDURE

Welcome to Four Peaks Neurology, for your neurologic care needs. Understanding our commitment to you and your financial responsibility to us is essential to establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our office policies.

Four Peaks Neurology Patient Portal Registration: The patient must register on the Patient Portal. The Patient Portal website is **www. FourPeaksNeurology.com** Once logged on it is a secure, HIPPA compliant website. Only you or people you select and your healthcare team can view your profile.

Patient Forms: To help us provide you with quality care, we ask that you complete a series of forms to ensure we have up to date demographic, insurance, medical history, and informed consent information on file.

Proof of Insurance and Identity: We must obtain a copy of your current Driver's License and a copy of your current, valid Insurance Card. If you fail to provide us with correct insurance information in a timely manner, you may be responsible for the balance of the claim. **FPN** reserves the right to reschedule your appointment if card(s) not available.

Copay, Coinsurance, Deductible: All copayments must be paid at the time of service. This arrangement is part of **your** contract with **your** insurance company. Failure to do so can be considered a breach of **your** contract with **your** insurance company.

Referrals: If you see a doctor that is out of network or if you have an insurance that requires a referral, you are responsible for obtaining the referral from your primary care clinic or referring physician.

Appointment Time: If you are 15 or more minutes late for your scheduled appointment, we reserve the right to reschedule you to another day and time. Our physicians strive to give quality care to each and every individual patient. Being a neurologic specialty practice we are often faced with unforeseen complicated patient/family scenarios that require extra time. When booking we cannot foresee which patient will need more time. Please forgive any delay. You may one day need more time for your problems and concerns. If you choose not to wait, please reschedule. Badgering staff may result in us rescheduling your appointment or discharge from our practice.

Prescriptions: To refill your prescription(s) please contact your pharmacy. Your pharmacy will then contact the office if authorization is needed. Your refill request will be handled by the practice within 24-48 hours after your pharmacy request is received. Refill requests may also be sent by the **FPN** Patient Portal. To ensure you do not run out of your medications please call at least one week in advance for any refills. Scheduled medications will not be filled after hours, weekends or by phone. **Please note, prescriptions will not be filled over the weekend or after hours.**

Tests and Procedures: Please allow 5-7 business days for our office to process any tests and procedures that your doctor may order for you. Once your test has been authorized the appropriate facility will contact you, unless otherwise specified.

Test and Procedure Results: Follow up appointments are required for all test results, including labs, unless otherwise specified. These appointments are generally scheduled 1-2 weeks after your test date to allow time to ensure that we have received the results.

Communication with Office: The fastest and most efficient means of communicating with the physician, advance practice provider (NP), medical assistant or other office staff is by the **FPN Patient Portal**. Take the time and save yourself time, register to log into the Patient Portal. Responses by **FPN** staff to Patient Portal communications occur ONLY during regular office hours. If you have left a phone message for the physician's assistants or any of the staff please allow 24-48 hours for the staff to return your phone call**. If you have an Emergency – call 911.**

Patient-Physician Relationship: Once you have established care with a particular physician you must continue care with that physician. You cannot switch providers within **FPN**.

Zero Tolerance Policy: FPN has a Zero Tolerance Policy to verbal, physical or psychological abuse of FPN Staff and/or Physicians. Any patient, patient's family members or guardian who engages in such activity will result in immediate discharge of patient from practice.

I have read and understand the Four Peaks Neurology Office Policy and Procedure and agree to abide by the terms of the policy.

_____ _____

Signature of Patient or Guardian **Date**

_____

Print Name of Patient

FOUR PEAKS NEUROLOGY PRIVACY PRACTICES AND INSTRUCTIONS FOR DISCUSSING PERSONAL HEALTH INFORMATION

Patient Name: _____Date of Birth: _____/_____/_____

___ (please check) I have received and read the noted of Privacy Practices (HIPPA) form.

Instructions for Discussing my Personal Health Information with Others: I give permission for the following individuals to receive and/or discuss my medical care with any and all providers and employees affiliated with Four Peaks Neurology.

1. _____
   Name and Relationship to Patient

2. _____
   Name and Relationship to Patient

3. _____
   Name and Relationship to Patient

Communication Request: I request that all communication with me by telephone, mail, or otherwise by Four Peaks Neurology and/or its staff be handled in the following manner: (please check all that apply)

___ You may leave a message on my answering machine.

___ You may leave a message with _____

___You may TEXT

___You may mail me.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Legal Representative **Relationship to Patient**

FOUR PEAKS NEUROLOGY
NEUROLOGICAL HEALTH HISTORY

Name:_____ Referred to us by:_____
Birthdate:_____ Primary Care Physician:_____
Age:_____ Race:_____ Other Physicians :_____

HANDED: ____Right ____Left

Reason(s) you are seeing us today_____
_____
_____
_____
_____
_____
_____

When did symptoms start _____ Location of symptoms _____
Severity of symptoms (1-10) _____ Worse at any time of day? _____
What make it better? _____ What makes it worse? _____
Does this problem affect your job? ___ Social Life? ___Family Life? ___ Exercise? _____

ALLERGIES to MEDICATION: _____
Over-the-Counter-Medications: _____

PAST MEDICAL HISTORY (circle)

Seizures	Angina	Asthma	Stomach Ulcers
Stroke	Arrhythmia	Arthritis	Drug Dependence
Depression	Heart Attack	Kidney Problems	Broken Bones
Anxiety	Hypertension	Kidney Stones	Sleep Problems
Panic Attack	Blood Clots	Hepatitis	Memory Difficulty
Headache	Thyroid Disease	Diabetes	Cancer: Type? ___
Spine Problems	High Cholesterol	Muscle Disease	_____

SURGICAL HISTORY: _____

Patient Name: _____
Date of Birth: _____

SOCIAL HISTORY:

Single _____ Married _____ Widowed _____ Partner _____
Whom do you live with? _____Occupation/Employment? _____

Tobacco Use: ____YES ___NO How many years? _____ Packs per day? ____ Quit? _____
Alcohol Use: _____YES _____NO ____Beer ____Wine ____Hard Liquor _____How Much
Medical Marijuana Use: ____YES ____NO Nonprescription drug use: ____YES ____NO
Servings per day of: _____Coffee _____Tea _____ Caffeinated Soda

FAMILY HISTORY:

___Similar type of illness that you have now
___Stoke
___Alzheimer's Dementia
___Seizures
___Muscle Disease
___Nerve Disease/Neuropathy
___Tremor
___Heart Disease
___High Blood Pressure
___Diabetes
___Cancer
___Blood Clotting Disorder
___Parkinson's
___Brain Aneurysms

SYSTEM REVIEW (Circle all that apply)

GENERAL: Fever, Chills, Sweats, Fatigue, Headaches EYES: Visual loss, Double vision
ENT: Hearing loss, Ringing in ear, Difficulty speaking, Difficulty swallowing
CARDIOVASCULAR: Passing out, Chest pain, Cyanosis (blue discoloration to skin), Leg swelling
RESPIRATORY: Shortness of breath, Exertional shortness of breath, Wheezing, Asthma
GI: Nausea, Vomiting, Diarrhea, Constipation, Blood in stool
URINARY: Painful urination, Urination at night, Symptoms of infection
MUSCULOSKELETAL: Muscle pain, Cramping, Spasm, Weakness, Swelling
ENDOCRINE: Intolerance to heat/cold, excessive thirst, excessive urination,
PSYCHIATRIC: Depression, Anxiety, Sleep problems, Psychotic thoughts or Hallucinations
HEME/LYMPH: Abnormal bleeding, Abnormal clotting
SKIN: Hives, Rash

MEDICATION LIST
(Either fill out form or provide list of medications to staff)

MEDICATION	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
12.		
13.		
14.		
15.		

FOUR PEAKS NEUROLOGY
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____DOB: _____

Address: _____City _____

State: _____ZIP code _____ Home Phone: _____

Work Phone: _____Cell Phone: _____

SSN: _____

I hereby authorize FOUR PEAKS NEUROLOGY to release medical record including but not limited to notes, lab results, diagnostic test results, etc. concerning the above mentioned patient to:

_____
(Name of the Authorized to Release Records)

_____
(Address)

_____ _____ _____
(City) (State) (ZIP code)

_____ _____
(Phone) (FAX)

HIV/AIDS. I consent to the release of any positive or negative test results for HIV/AIDS infections, antibodies to AIDS, or infection with any other causative agent of AIDS, with the rest of my medical records.
_____ Initial _____ Date

_____Copy of **FOUR PEAKS NEUROLOGY** generated medical records.
Date of Service: _____ to _____

I hereby release you, your physician and your employees from liability for fulfilling the authorization request for release of medical information. I have given my consent freely without coercion. I understand that any releases, which were made prior to my revocation, in compliance with this authorization, shat not constitute a breach of my right to confidentiality. I understand that a photocopy, facsimile of this authorization is considered acceptable in lieu of the original.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PRINT NAME IN BLOCK LETTERS DATE

_____ _____
PARENT/GUARDIAN/POA DATE