Neurological Consultants of Alaska

PATIENT REGISTRATION FORM

PERSONAL INFO

Last Name: _____ **First Name:** _____
Date of Birth: _____ **Sex:** [ ] F [ ] M [ ] T
Address: _____ **City:** _____ **State:** ___ **Zip:**_____
Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Leave message? [ ] Home [ ] Cell [ ] Work **SSN:** _____

Marital Status : _____ **Employer:** _____ **Occupation:** _____

Responsible Party (If patient is under 18)
Last Name: _____ **First Name:** _____
Relation to the Patient: _____ **Sex:** [ ] F [ ] M [ ] T
[ ] Check here if same as above
Address: _____ **City:** _____ **State:** ___ **Zip:**_____
Home Phone (Primary): _____ **Cell Phone (Secondary):** _____

Date of Birth: _____ **Social Security:** _____

INSURANCE INFO

Primary Insurance :_____ **Secondary Insurance:** _____

ID # : _____ **ID #:**_____

Group #: _____ **Group #:** _____

Subscriber Name:_____ **Subscriber Name:** _____

Subscriber DOB:_____ **Subscriber DOB:** _____

**** SELF PAY, please check this box [ ]** **Injury Related? : [ ] Accident [ ] Job [ ] Motor Vehicle**

Workers Compensation Carrier _____ **Claim #** _____ **Adjuster** _____
Phone _____ **Address** _____ **City** _____ **ST** ___ **Zip** _____

EMERGENCY INFO

Name:_____ Relation:_____

Home Phone:_____ Work Phone:_____

[] Check here if same as above

Address:_____City:_____State:_____Zip_____

PATIENT PORTAL

A free & secure online portal: view medical records, request refills and new appointments.

Personal Email Address_____@_____

[You will receive online log in credentials via your email]

ADDITIONAL INFORMATION

STATISTICAL ANALYSIS

Race: [ ] Refuse [ ] Asian [ ] Islander [ ] African-American [ ] Caucasian [ ] Hispanic [ ] Other:

_____

Ethnicity: [ ] Refuse [ ] Hispanic/Latino [ ] Non-Hispanic/Latino

Language: [ ] English [ ] Spanish [ ] Other: _____

Interpreter Needed: [ ] Yes [ ] No

PHARMACIES

Pharmacy #1 Name:_____City:_____
Pharmacy #2 Name:_____City:_____
Pharmacy #3 Name:_____City:_____

Is there anyone else we can speak to regarding your account?

Name: _____ City: _____

Name: _____ City: _____

Name: _____ City: _____

Patient Name:_____ Date of Birth_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, **[name of patient]** _____, acknowledge and agree that I have received a copy of **Neurological Consultants of Alaska**'s Notice of Privacy Practices.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Relationship to patient

FOR CLINIC USE ONLY:

Neurological Consultants of Alaska made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy Practices.

[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]

Neurological Consultants of Alaska

Consent Authorization

Patient Name: _____

Patient DOB: _____

RX Consent

By signing this consent I grant permission to Dr. Downs to view my prescription history from external sources.

Patient/Guardian Signature:_____ Date:_____

Insurance Billing

Patients with insurance must sign stating the provider may release medical data to other organizations in order to adjudicate the claim.

Patient/Guardian Signature: _____ Date: _____

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Financial Policies and Procedures

Insurance: As a courtesy we bill most insurance companies. If there is no response within 30 days, the balance becomes due in full. Deductible and co-pay amounts are due at the time of service. It is your responsibility to inform us of any changes in your coverage. Please read and understand your policy prior to your office visit and/or procedure appointments. Each plan is different and may not pay for every service. Non-covered services are due at the time of your visit. Patients without insurance are required to pay at the time of service.

Primary Insurance/In-Network: If your primary insurance changes to Medicare, or one that we are not in-network with we will no longer be able to provide your neurological care. You will need to establish a patient doctor relationship with a different Neurologist.

Payment Options: We accept cash, checks, Visa, and MasterCard. There will be a $30 charge for checks returned for non-sufficient funds, stop payment, or closed accounts.

Referrals: Some plans require a referral prior to obtaining the services of a specialist in order to be covered. It is your responsibility to obtain a referral prior to treatment. By signing this policy, you are authorizing Neurological Consultants of Alaska, LLC to furnish information concerning your illness and treatments to the physician or agency that referred you to this practice and to any physician or agency to whom you are subsequently referred.

Unpaid Balances: Please do not hesitate to contact us for assistance with your account. Unpaid balances may be referred to a collection agency if other arrangements have not been made. An additional administrative fee will be added to accounts sent to collections.

Cancellation/Missed Appointments: Please cancel your appointment with at least 24 hours' notice. If less than a 24-hour cancellation is given this will be documented as a "No-Show/Missed" appointment. We reserve the right to charge $100.00 for a new patient "No-Show/Missed" appointment and, $50.00 for a follow up "No-Show/Missed" appointment. If you have 3 "No-Show/Missed" appointments within a one-year time period, dismissal from the practice will be considered. Please be advised that patients who arrive more than 10 minutes late for their appointment may need to be rescheduled.

Prescription Refills: Please contact your pharmacy for refill requests. Refills can take 24 to 48 hours to be processed. **Please call before you are out of your medication.**

Patient Consent/Assignment: I hereby authorize Neurological Consultants of Alaska to release any information acquired in the course of my treatment to/from my insurance company, physician's office, hospital or any other treatment facility. I agree to be fully responsible for all expenses incurred for treatment rendered to myself or my dependants regardless of insurance coverage. I understand fees are due at the time of service. I assign to Neurological Consultants of Alaska, LLC any and all insurance benefits due for myself or my dependants. I further state and give permission that a photocopy of this authorization and signature is to be deemed valid as the original.

I have read, understand and agree to the provisions of this Policy.

Patient/Guardian Signature: _____Date:_____

Relationship to Patient :_____

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Medical History

Print full name: _____ Age: _____ Date of Birth:_____
Date of appointment: _____Date form completed: _____
What are you here for? _____
_____

Past medical history – circle yes or no, and describe condition if applicable

Heart disease	yes	no	
High blood pressure	yes	no	
Diabetes / Other endocrine disorder	yes	no	
Stroke / TIA / Other neurological disorder	yes	no	
Lung disease	yes	no	
Gastrointestinal disorders	yes	no	
Kidney disease	yes	no	
Liver disease	yes	no	
Skin disorder	yes	no	
Other			

Surgeries – please list type and date:

Current medications and dosages:

Medication	Dose	Medication	Dose

Drug allergies:

Medication	Reaction	Medication	Reaction

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Social History

Name: _____ Date of Birth:_____ Where were you born: _____

Tobacco:

Please choose –

____Never smoked
____Previous smoker
What is the most you smoked routinely?
____Current smoker
How much do you smoke now?
What is the most you smoked routinely?

Alcohol:

Please choose –

____Don't drink alcohol
____< 1 alcoholic beverage per month
____Several alcoholic beverages per month
____Several alcoholic beverages per week
____Drink alcohol daily

Have you ever consumed alcohol on a daily basis for more than a few months? Y N
Have you ever had a problem with drinking too much on a routine basis? Y N

Recreational drugs:

Have you ever used recreational drugs within the last twelve months? Y N
If yes, what drugs? _____
Have you ever used cocaine (in any form)? Y N
Have you ever used IV drugs? Y N

For female patients:

Are you pregnant? Y N
Are you breast feeding now? Y N
Is there a chance you might become pregnant? Y N
What form of birth control do you use? _____

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Family History

L = living, D = deceased

Signature: _____ Date: _____

		Present age, or age at time of death	Cause of death	Medical problems
Father	L D			
Mother	L D			
Siblings				
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
Children				
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			
	L D			

Other pertinent family history: _____

_____

_____

_____