Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

PATIENT REGISTRATION

Patient Name: _____ Social Security Number: _____

Patient Address: _____ Date of Birth: _____ Age: _____ Sex: _____

City, State, Zip: _____ Phone Number: (____) _____ Marital Status: _____

Email: _____

Employer: _____ Employer Phone Number: _____

Address, City, State, Zip: _____ Occupation: _____

Race: Caucasian _____ African American _____ Native American _____ Asian _____ Latino/Hispanic _____

How did you hear about our office: _____

Reason for Visit: _____ Referring Physician/PCP: _____

Guarantor (if other than patient) or Spouse Information
Name:_____ Social Security Number: _____
Address: _____ Relationship to Patient: _____
City, State, Zip: _____ Phone Number: (____) _____

Employer: _____ Employer Phone Number: _____
Address, City, State, Zip: _____ Occupation: _____

Primary Insurance:
Insured's Name: _____ Insured's D.O.B. _____/ _____/ _____
Insurance Company: _____ Policy/I.D. Number _____
Insurance Address: _____ Group Number:____ _____
City, State, Zip: _____ Relationship to Patient: _____

Secondary Insurance:
Insured's Name: _____ Insured's D.O.B. _____/ _____/ _____
Insurance Company: _____ Policy/I.D. Number_____
Insurance Address: _____ Group Number: _____
City, State, Zip: _____ Relationship to Patient: _____

Emergency Contact Information:
Name: _____ Relationship to Patient: _____

I declare that the above information is complete and accurate. I understand that I am financially responsible for all charges for services rendered. I further understand that it is my responsibility to make sure that my insurance will cover the services provided and that if they are not paid, I am fully responsible of the charges. I hereby authorize the release of information necessary to file a claim with my insurance company and I assign benefits payable to the physician or group who rendered services.

_____ _____
Patient Signature Date Guarantor Signature Date

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

Patient Name _____ Date of Birth _____

Treatment Authorization and Financial Agreement

As I have requested the care of Neurology Center of Nevada and I hereby authorize them to release any information to my insurance company necessary to facilitate treatment or secure payment of services rendered. Information may include but is not limited to the following: diagnosis, treatment plan, x-ray, laboratory, consultation and follow up documentation. I also authorize and request that my insurance payer or other third party administrator pay services directly to Neurology Center of Nevada.

I understand that I am financially responsible for all services rendered and that the eligibility agreement is between my insurance company and me. As a courtesy to me, Neurology Center of Nevada will make every effort to secure payment from my insurance company before turning to me for payment. I understand that I am responsible for all cost shares (copayments) and deductibles at the time of service. I can pay with cash; a check or credit card; however should my check be returned by the bank for insufficient funds there will be a $25 return item fee added to my account.

I understand that Neurology Center of Nevada is entitled to contact me directly for payment should my insurance company deny coverage or not pay for services rendered. Unpaid balances will be due monthly and I will make arrangements to pay the balance, otherwise the unpaid balance may be turned over to a collection agency. Should the use of a collection agency be necessary, I will also be responsible for the fee charged by the collection agency to collect any unpaid balance. I have been informed that the collection fee can be 35% of the unpaid balance amount, therefore increasing the balance originally owed. I also agree to keep the office up to date with my personal information relating to changes in insurance coverage, mailing address, medications, physician changes, and any other changes that may affect the treatment and care rendered to me. I understand that I am financially responsible for a ***$40 NO SHOW FEE*** if not given ***24 hour notice*** for follow up appointments.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature Date

Health Information Policy

I have received a copy of Neurology Center of Nevada Notice of Health Information Practices detailing how my information may be used and disclosed as permitted under federal and state law.

I understand that Neurology Center of Nevada may leave a message on my answering machine or with a third party regarding limited health information, pending appointments, and the time and place of scheduled appointments, or other healthcare related communications.

_____ _____

Patient Signature Date

_____ _____

Guarantor Signature Date

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

Patient Name: _____ Social Security #:_____

Date of Birth: _____ Phone Number: _____

STANDARD AUTHORIZATION OF USE, DISCLOSURE OF AND RECORDS RELEASE REQUEST OF PROTECTED HEALTH INFORMATION

Information to be Used or Disclosed: The information covered by this authorization includes all medical records in my file such as medical reports, consultations, history and physicals, x-rays, laboratory results, pathology results and any insurance information.

Records Release Request: This request includes any medical records from patient's **primary care physician, hospital, lab, diagnostic center or any other physician treating patient.**

NAME OF ORGANIZATION/ PHYSICIAN	ADDRESS	PHONE/ FAX NUMBER

Persons to Whom information may be Released/Disclosed to: The information listed above will be disclosed to the following **FAMILY member (s) or friends.**

NAME	RELATIONSHIP	PHONE NUMBER

Expiration Date of Authorization: This authorization is effective for one year unless revoked or terminated by the patient or the patient's authorized representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a **WRITTEN** revocation to **Neurology Center of Nevada.**

Potential for Re-disclosure (release): Information that is disclosed (released) under this authorization may be disclosed again by a person or organization to which it is sent or given to. The privacy of this information may not be protected under the federal privacy regulations.

PRINT NAME OF PATIENT	PATIENT SIGNATURE	DATE
Print Name of Authorized Representative/ Relationship	**Authorized Representative Signature**	**Date**

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

PHARMACY PHONE NUMBER: _____

MEDICATION LIST:

Medication Name	Dosage	Frequency	Start Date

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

THE EPWORTH SLEEPINESS SCALE

Name: _____ Today's Date: _____ Age: _____ Sex: _____

How likely are you to feel sleepy in the following situations: compared to just feeling tired. This refers to your usual way of life in recent time. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never feel sleepy
1 = slight chance to being sleepy
2 = moderate chance of being sleepy
3 = high chance of being sleepy

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (meeting, theater)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after eating lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
Total Points	_____

**** If your score is 10 or higher, you should discuss these results with your Doctor. ****

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

Name: _____ DOB: _____ Today's date: _____

Drug Allergies / Reactions to medication: Please list any medications to which you've got an allergy/bad reaction:
____***NO KNOWN ALLERGIES***

Name of Medication	What was the reaction?

SOCIAL HISTORY:
Which hand do you use most or dominantly?: ____Right ____Left ____Ambidextrous
Are you: ____single ____married ____partnered ____divorced ____widowed?
Do you have children? ___Yes ___No If Yes: Number of sons: _____ Number of daughters _____
Uses tobacco: ___ current ___former ___never ___unknown Type: chewing / cigar / cigarettes / pipe
Units/day _____ Ever tried to quit: ___Yes ___No Year quit: _____
Drinks alcohol: ____Yes ____No ____Formerly Type (circle): beer / wine / vodka / hard liquor /rum /gin / scotch
Frequency (circle): daily / weekly / monthly / yearly / occasionally / rarely / socially Amount of: beers/glass/drinks: ____
Caffeine consumed: ____Yes ____No Type: coffee / chocolate / energy drinks / soda / tea Amount of: cups / oz ____

PAST MEDICAL HISTORY: Please check if you've ever had any of these Neurological or Muscle illnesses:

___ADD/ADHD (attention deficit disorder)
___Alzheimer's Disease
___Angina (heart pain)
___Arrhythmia (heart rhythm disturbance)
___Arthritis
___Asthma
___Blood disease (blood cells diseases)
___Brain tumor
___CAD (disease of heart blood vessels)
___Cancer Type _____
___Carpal tunnel/peripheral nerve
___Congestive Heart Failure
___Hearing Impairment
___COPD (lung disorders)
___CVA (stroke)
___Depression
___Diabetes
___Fibromyalgia
___Fracture, upper limb
___Fracture, lower limb
___Fracture, spine
___Genitourinary disease
___Head injury
___Headache, migraine
___Headache, tension
___Heart Murmur
___Hepatitis
___HIV (AIDS)
___ Hyperlipidemia (high cholesterol)
___Hypertension (high blood pressure)
___Liver Disease
___Mumps
___Myocardial infarction
___ Obesity
___Osteoarthritis
___Osteoporosis (softening of bones)
___Parkinson's disease
___Peptic ulcer disease
___Peripheral nerve disease
___Peripheral vascular disease (legs/arms)
___Polio
___Rheumatic Fever
___Rheumatoid Arthritis
___Renal disease (kidney disease)
___Seizure disorder
___Spinal cord injury
___Spinal disease, Cervical
___Spinal disease, lumbar
___Thyroid disorder
___Tuberculosis
___Venereal disease
___OTHER _____
_____
___**Mental illnesses** :
(depression/anxiety/bipolar/schizophrenia)

PAST SURGICAL HISTORY:

___Angioplasty	Year _____	___Craniotomy	Year _____	___Spinal bone allograph	Year _____
___Angio w/ stent	Year _____	___Gastric bypass	Year _____	___Spinal fusion	Year _____
___Arthroscopy knee	Year _____	___Knee replacement	Year _____	___Thyroidectomy	Year _____
___Arthrodesis	Year _____	___Pacemaker	Year _____	___Prostate biopsy	Year _____
___CABG	Year _____	___Laminectomy	Year _____	___Tonsillectomy	Year _____
___Carpal tunnel release	Year _____	___LASIK	Year _____	___Vasectomy	Year _____
___Cataract extraction	Year _____	___Liver biopsy	Year _____		
___Cervical discectomy	Year _____	___Lumbar discectomy	Year _____	___OTHER	Year _____
___Colectomy	Year _____	___ORIF	Year _____	_____	
___Colostomy	Year _____	___Small bowel resection	Year _____	_____	

FAMILY HISTORY: Please fill in the health history of your blood relatives below:

Relation	Are they Alive?		Age	Health Problems
	Yes	No		
Mother				
Father				
Brother or Sister				
Brother or Sister				
Son or Daughter				
Son or Daughter				
Paternal Grandfather or Grandmother				
Maternal Grandfather or Grandmother				

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

Name: _____ Date:_____

REVIEW OF SYSTEMS
CHECK EACH ITEM AS THEY RELATE TO YOUR HEALTH

CONSTITUTIONAL

- ☐ Fevers
- ☐ Chills
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Cancer or tumors (specify)_____

HEENT

- ☐ Head tenderness
- ☐ Visual loss
- ☐ Double vision (diplopia)
- ☐ Blurry vision
- ☐ Hearing loss
- ☐ Facial pain
- ☐ Trouble swallowing (dysphagia)
- ☐ Snoring

RESPIRATORY

- ☐ Coughing
- ☐ Asthma

CARDIOVASCULAR

- ☐ Swelling of extremities (edema)

GASTROINTESTINAL

- ☐ Constipation
- ☐ Bloody urine (hematuria)
- ☐ Painful urination (dysuria)

METABOLIC/ENDOCRINE

- ☐ Changes in sleep/awake patterns
- ☐ Cold intolerance
- ☐ Heat intolerance

NEUROLOGICAL/ PSYCHIATRIC

- ☐ Trouble speaking (aphasia)
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Tremors
- ☐ Stroke
- ☐ Facial droop
- ☐ Seizures
- ☐ Speech changes
- ☐ Gait disturbance
- ☐ Headaches
- ☐ Incontinence: Urinary/ Bowel
  (Circle which applies)
- ☐ Depression
- ☐ Anxiety
- ☐ Thoughts of suicide
- ☐ Have you ever been treated by a psychiatrist?

MUSCLESKELETAL

- ☐ Muscle cramps
- ☐ Leg pain
- ☐ Joint pain

HEMATOLOGIC

- ☐ Easy bruising
- ☐ Thromboembolic events
  (DVT/pulmonary embolism/blood clots)

IMMUNOLOGICAL

- ☐ Food allergies (specify)_____

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

HIPAA NOTICE OF PRIVACY PRACTICES

Revised 1/15/2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NEUROLOGY CENTER OR NEVADA (NCN) is committed to complete compliance with all State and Federal Guidelines with HIPAA. We maintain the privacy and confidentiality of information entrusted to us beyond the legal and ethical standards. This notice discusses the uses and disclosures we will make of your protected health information.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit NCN, a record of your visit is made. NCN collects and maintains oral, written and electronic information to administer our business and to provide care to all patients. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. We maintain physical and electronic safeguards to protect against risk, destruction or misuse.

NOTICE OF RETENTION OF PATIENT HEALTH RECORD

State and Federal law requires the records of every patient be kept for a minimum length of time. To ensure there is no unauthorized access to the patient information; records shall be purged including but not limited to a period of 7 years, and if the patient is a minor, the record will be maintained for at least 5 years after age of majority, which is equivalent to 23 years.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of NCN, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon your request
- Inspect and obtain a copy of your health record
- Request an amendment of your health record
- Obtain an accounting of disclosures of your health information free of charge within a 12-month period
- Request confidential communications of your health information by alternative means or at alternative locations
- Request a restriction on certain uses and disclosures of your information. We are not required to agree to your request, however if you or someone on your behalf has paid out-of-pocket for services rendered in full, you have the right to restrict access to your health plan.
- To be notified when there is a breach of unsecured protected health information; and
- Revoke your authorization to use or disclose except to the extent that action has already been taken

If you would like to access or ament your records, the request must be submitted in writing. You may acquire the forms by coming into our facility. When submitting the completed form please provide a copy of a valid ID to ensure your privacy and identification. Your request will be forwarded to the Privacy Officer who will act on the request within 30 days.

OUR RESPONSIBILITIES

NCN is required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonably requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our policies and practices concerning the privacy of your medical information we already have about you as well as any information we received in the future. Should our information practices change, we will post a copy of the revised notice in our front lobby. The notice will contain on the first page, the current effective date.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received written revocation of authorization according to the procedures included in the authorization.

FOR MORE INFORMATION OR TO FILE A COMPLAINT

If you believe your privacy or security rights have been violated, you may contact the Practice Privacy Officer, Roseanne Trimble at (702) 247-9994. All complaints must be submitted in writing to Roseanne Trimble, c/o NCN, 2430 W Horizon Ridge Pkwy, Henderson, NV 89052.

USES AND DISCLOSURES WE MAY MAKE WITHOUT WRITTEN AUTHORIZATION

For Treatment: We may use medical information about you to provide you with treatment or services. We may disclose medical information about you to doctors, nurses, technicians, and other personnel who are involved in your care. We will also provide your physicians or a subsequent you.

For Payment: We may use and disclose medical information about you so that the treatment and services you received may be billed for a payment collected from you, an insurance company or a third party. For example: A bill may be sent to you or a third-party payer. The information that identifies you, as well as your diagnosis, procedures, and supplies used.

For Health Care Operations: We may use and disclose medical information about you for NCN operations. These uses and disclosures are necessary to run the clinic and make sure all of our patients receive quality care. For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes of your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Data Notification Purposes: We may use your contact information to provide a legally required notice of unauthorized acquisition, access or disclosure of your protected health information. We will send notice directly to you.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment. NCN may send you an email; leave a message on a answering machine or with a third party regarding limited protected health information.

Business Associates: There are some services provided in our organization through contracts with Business Associates. When these services are contracted, we may disclose your health information to our Business Associates so that it can perform the job we have asked it to do and bill you or your third-party payer for the services rendered. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

***Communication with Family*:** Health professional, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment to your care. We may use or disclose information to notify or assist in notifying a family member, representative, or another person responsible for your care, your location and general condition.

Research: Your access may be restricted for as the research is in progress, provided that you agreed to the temporary denial of access when consenting to participate. We may disclose information to researcher when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Coroners, Medical Examiners and Funeral Directors: We may disclose health information to such entities consistent with applicable law to carry out their duties.

Organ Procurement Organization: Consistent with applicable law, we may disclose health information to organ procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: We may contact you to provide information about NCN sponsored activities, including fundraising programs or events. We would only use your contact information you provided us. You may opt out of all fundraising contacts. NCN will **not** "sell" PHI without your authorization.

Public Health: NCN may disclose PHI as required by laws that mandate the reporting of certain types of wounds, preventing or controlling, disease, injury or disability. Injuries such as child abuse, neglect, or domestic violence will be reported to the appropriate public health authorities or social services agencies.

Health Oversight Agency: NCN may disclose PHI to a health oversight agency for oversight activities authorized by law, including, but not limited to audits, civil, administrative or criminal investigations; and licensure or disciplinary action.

Military & Veterans: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with regards to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Judicial Proceedings: NCN may disclose PHI to comply with a court order, a court ordered subpoena, or a grand jury subpoena. These disclosures will be limited to the minimum necessary standard. Correctional Institutions: Should you be an inmate of a correctional institution, we may disclose to the institution or agents there health information necessary for your health and the health and safety of others. Also obtaining a copy of your information may be restricted if it would jeopardize your health, safety, security, custody or rehabilitation or that of other inmates or the safety of any officer, employee, or person at the correctional institution or person transporting you.

Law Enforcement: NCN may disclose PHI about an individual when we reasonable believe the individual to be a victim of abuse, neglect or domestic violence and the provider of care, using his/her professional judgment, believes this disclosure is necessary to prevent serious harm to the individual or the other potential victims. NCN may also disclose PHI if the disclosure is required by law and the disclosure is limited to the minimum necessary standard or the individual consents to the disclosure. Such disclosures may be made to a government authority authorized by law to receive such reports (including a social service or protective services agency).

NCN may use or disclose PHI in response to a law enforcement official's request, for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, provided that the disclosed information is limited to: Name and address, date and place of birth, social security number, ABO blood type and RH factor, type of injury, date and time of treatment, date and time of death, if applicable, and a description of distinguishing characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair, scars and tattoos. Federal law makes a provision for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a work force or a business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

National Security and Intelligence Activities: We may release health information about you to authorized Federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

We are required by law to maintain for privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone number (702) 247-9994

Signature below is only acknowledging that you have received this HIPAA Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

Neurology Center of Nevada

2430 W. Horizon Ridge Pkwy • Henderson, NV 89052 • (702) 247-9994 • Fax (702) 651- 9995

PATIENT CONSENT TO HEALTH CARE TEXT MESSAGING

I consent to the Practice contacting me by text message for the purposes of health promotion and for appointment reminders.

I accept that the responsibility of attending appointments or cancelling them rests with me whether text messages are sent by the Practice or not. I am aware that I can cancel the text message facility at any time.

I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure; however I am aware that the Practice will not transmit any information which would enable me to be identified.

Patient Name _____ Date of Birth _____

Date_____ Cell Phone#_____