SILVER STATE NEUROLOGY

2575 Montessouri St., Suite 110
Las Vegas, NV 89117
Office: (702) 272-0694
Fax: (702) 272-0659
Contact@SilverStateNeurology.com
www.SilverStateNeurology.com

DATE_____

PATIENT INFORMATION - INFORMACION DE PACIENTE

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, M.I.) - NOMBRE DE PATIENTE (APELLIDO, NOMBRE, M.I.)					SSN - SEGURO SOCIAL
HOME TELEPHONE - TELEFONO	SEX - SEXO	DOB - FECHA DE NACIMIENTO		AGE - EDAD	MARITAL STATUS - ESTADO MATRIMONIAL
PATIENT ADDRESS - DIRECCION					APT / SPACE / UNIT #
CITY - CIUDAD			STATE - ESTADO		ZIP CODE - ZONA POSTAL
PATIENT'S GAURDIAN NAME - NOMBRE DEL PERSONA RESPONSIBLE			GUARDIAN'S OCCUPATION - OCUPACION		
GUARDIAN'S EMPLOYER'S ADDRESS - DIRECCION DEL EMPLEADOR					TELEPHONE - TELEFONO
CITY - CIUDAD			STATE - ESTADO		ZIP CODE - ZONA POSTAL

ER

NOTIFY IN CASE OF AN EMERGENCY - NOTIFICA EN CASO DE EMERGENCIA?	TELEPHONE - TELEFONO	RELATIONSHIP - RELACION	
EMERGENCY ADDRESS - DIRECCION	CITY - CIUDAD	STATE - ESTADO	ZIP CODE - ZONA POSTAL

RESPONSIBLE PARTY - REPRESENTABLE DE RESPONSIBLE

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, M.I.) - PERSONA RESPONSIBLE			SSN - SEGURO SOCIAL
GUARANTOR ADDRESS - DIRECCION			TELEPHONE - TELEFONO
CITY - CIUDAD	STATE - ESTADO		ZIP CODE - ZONA POSTAL
GUARANTOR EMPLOYER - EMPLEADOR	OCCUPATION - OCUPACION		
GUARANTOR EMPLOYER'S ADDRESS - DIRECCION DEL EMPLEADOR			TELEPHONE - TELEFONO
CITY - CIUDAD	STATE - ESTADO		ZIP CODE - ZONA POSTAL

MD

REASON FOR VISIT - RASON POR SU VISITA	REFERRING PHYSICIAN - DOCTOR DE FREFERENCIA	HOW DID YOU HEAR ABOUT OUR OFFICE?

INSURANCE INFORMATION - ASEGURANZA INFORMACION

PRIMARY INS

PRIMARY INSURANCE CO - PRIMARIA ASEGURANZA			TELEPHONE - TELEFONO
ADDRESS - DIRECCION	CITY - CIUDAD	STATE - ESTADO	ZIP CODE - ZONA POSTAL
POLICY HOLDER'S NAME - NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN - SEGURO SOCIAL
RELATIONSHIP TO PATIENT - RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER - NOMBRE DEL EMPLEADOR DEL ASEGURO		
POLICY NUMBER - NUMERO DE POLIZA	GROUP NUMBER - NUMERO DE GRUPO		EFFECTIVE DATE - FECHA DE EFECTO

SECONDARY INS

SECONDARY INSURANCE CO - ASEGURANZA SEGUNDARIA			TELEPHONE - TELEFONO
ADDRESS - DIRECCION	CITY - CIUDAD	STATE - ESTADO	ZIP - ZONA POSTAL
POLICY HOLDER'S NAME - NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN - SEGURO SOCIAL
RELATIONSHIP TO PATIENT - RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER - NOMBRE DEL EMPLEADOR DEL ASEGURO		
POLICY NUMBER - NUMERO DE POLIZA	GROUP NUMBER - NUMERO DE GRUPO		EFFECTIVE DATE - FECHA DE EFECTO

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the signature is as valid as the original. A 25.00 fee will be charged if I do not call 24hrs prior to canceling your appointment.

La information obtenida es completa y correcta. Por este medio usted autoriza el desclosamiento de informacion necesaria al hacer reclamos con mi aseguranza. Tambien asigno benefecios que de otra manera serian pagados a mi a que sean asignados a mi doctor o grupo indicado en el reclamo. Yo entiendo de que soy responsible por doctors los cargos relacionados a servicios medicos prestados independientemental tipo de aseguranza. 25.00 dollars vas a pagar si no llamas 24hr para cancelar su sita.

PATIENT SIGNATURE	DATE	GUARANTOR SIGNATURE	DATE

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Financial Policy

We are committed to providing you with the best possible care. **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract.** All charges are your responsibility from the date of service rendered. We realized that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse Silver State Neurology within 90 days or within the guidelines mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral from the primary care physician. **We will attempt to obtain these as a courtesy; however, the policy holder must be pro-active in assuring the requirements are met prior to the visit.**

If you have medical insurance, with whom we are contracted, we will bill your insurance company. All deductibles, co-payments and non-covered items are due at the time of check-in.

Collection Fees Policy

I, _____ (patient /guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

_____ _____
Signature of patient, parent / guardian Date

Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office. **INITALS:** ____

No Show Fees: There is a $25.00 no-show/late-cancellation fee for office visits and $75.00 fee for testing appointments. All appointments must be canceled by 3 p.m. of the previous day. Insurance will not cover charges for no-show/late-cancellation.
INITALS: ____

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Patient Communication Authorization

NAME: _____ **Date of Birth:** _____

PLEASE LIST CONTACT PHONE NUMBERS:

(Home) (_____) - _____-_____

(Other) (_____) - _____ - _____

IF YOU ARE NOT AVAILABLE MAY WE LEAVE A VOICE MESSAGE?

□ NO, DO NOT LEAVE A VOICE MESSAGE
□ YES, LEAVE A VOICE MESSAGE

IF YOU ARE NOT AVAILABLE - WHO MAY WE COMMUNICATE WITH ?

□ COMMUNICATE WITH SELF ONLY

Please check all that apply.

□**SPOUSE** (Name) _____ Phone: (_____) _____ - _____
□ ANY INFORMATION
□ APPOINTMENT INFORMATION

□**CHILD** (Name) _____ Phone:(_____) _____
□ANY INFORMATION
□ APPOINTMENT INFORMATION

□**OTHER** (Name) _____ Phone: (_____) _____

(Relationship to Patient) _____
□ANY INFORMATION
□APPOINTMENT INFORMATION

_____ _____
Patient Name or legal representative Date

_____ _____
Patient Signature or legal representative Witness

Please notify us of any changes

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I _____ give my authorization for Silver State Neurology to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries. The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at Silver State Neurology.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Requested by Law, Public Health issues as requested by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for Silver State Neurology to provide treatment. You will be provided with a copy of this signed authorization upon your request.

Signature: _____

Printed Name: _____

Date: _____

Witness: _____