Tri-State Neurological and Sleep Center

3015 HWY 95, Bullhead City, AZ, 86442 (928)763-50558
178 N. Pecos Rd # 200, Henderson, NV 89074 (702)433-7999

Thank you for scheduling an appointment with Tri-State Neurological and Sleep Center.
The following is some information that will help familiarize you with our practice.

Patient Education/ Physician and Provider Profile and Information
tsneurology.com

Business Hours

Monday-Thursday 8:00am-5:00pm and Friday 8:00am-2:00pm

Contact Us

For any questions please call our office-- (928)763-5055 Bullhead City
(702)433-7999 Henderson

Financial Payment Policy
It is our payment policy to collect the appropriate payment due from the patient at the time of service prior to being seen. This may be your co-payment, deductible and/or co-insurance, but we do ask for payment at the time of your visit. Tri-State Neurological and Sleep Center accepts most major credit cards.

Co-Payment—The part of the patient's medical bill that must be paid each time the patient visits the physician/provider. This is a pre-set fee determined by the health insurance policy

Deductible—The amount the patient must pay for medical treatment before their health insurance company starts to pay. In most cases, a new deductible must be satisfied each calendar year.

Co-Insurance—The part of the patient's medical bill, often in addition to a co-payment, that the patient must pay. Co-insurance is usually a percentage of the total medical bill allowable by insurance.

If you have any questions after reading this information, then please call (928)763-5055. Enclosed is the patient registration form and privacy acknowledgment for to be completed and brought to your appointment.

Please bring the following information if you have not already faxed or brought this information to the practice prior to your scheduled visit:

- Current Insurance Card(s)
- Current Driver's license or other photo identification in absence of a Diver's license
- Completed financial payment policy, medical authorization form, privacy notice acknowledgement, etc.

We appreciate you and your referring provider in selecting Tri-State Neurological and Sleep Center for your neurological and sleep care.

Sincerely,

Tri-State Staff

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REG SECTION 1- APPOINTMENT INFORMATION

Did a Physician, PA, NP refer you to TSNSC? __ Yes __No Did you make the appointment yourself: __ Yes __No

If yes, name of physician, PA, NP______________________ Specialty_________________ OR

Date of Accident/injury:___/___/____ OR Date Symptoms Began:___/___/____

Type of Accident: __At work __At Home __Auto __Other(Explain):______________________________

REG SECTION 2- PATIENT INFORMATION

Full Name:____ Gender:___________________________

Address:______________________ City:____________________ State:__________ Zip Code:__________

Employer:____Occupation:_____________________________

Date of Birth:_________________ SSN:____________________ Relationship Status:__________________

Home Phone: (___)____________ Cell Phone(___)___________ Email:_____________________________

Spouses Name:__________________________ Date of Birth________________________

Authorized person to call in an emergency:_______________________ Relationship_____________
Phone:_________________________________

REG SECTION 3- HEALTH INSURANCE INFORMATION

Primary Insurance:

Ins. Name:____________________________ Holder:_______________________ Policy ID:_____________
Group ID:_________________ Eff. Date:________________________ Co-Pay:______________
Deductible:________________ Employer:____

Secondary Insurance:

Ins. Name:____________________________ Holder:_______________________ Policy ID:_____________
Group ID:_________________ Eff. Date:________________________ Co-Pay:_______________________
Deductible:_________________ Employer:____

Tertiary Insurance:

Ins. Name:_____________________________ Holder:________________________ Policy ID:___________
Group ID:___________________ Eff. Date:________________________ Co-pay:_________________
Deductible:__________________ Employer:____

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REG SECTION 4 WORKER'S COMPENSATION INSURANCE INFORMATION

Complete only if your appointment is the result of a work related injury or worker's compensation claim. Your visit to our office must be authorized by the Worker's Compensation insurance carrier or your employer prior to your appointment or we may be required to reschedule your appointment.

Employer Name (when injured):___________________________________ Phone: (____)________________
Address:____ Contact Person:_____________________________
Worker's Compensation Insurance:_____________________________ Adjuster:_________________________
Claim Address:_____________________________________ Date of Injury:____/____/________
Phone: (____)_______________ Claim #:____________________ State Where Injured:_____________
Case Manager:__________________________________ Phone: (____)________________

REG SECTION 5- ACKNOWLEDGEMENT

I certify that the information I have provided above is complete, true and accurate. I have read the Office Policies Acknowledgement form and the TSNSC Financial Payment and Appointment Policy and all the questions have been asked and answered. Co-payments, co-insurance, deductibles, and balances are due at the time of service prior to being seen as described in the policy.

Signature:___________________________________ Initial:__________ Date:___________

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Office Policies Acknowledgment

Financial Payment Policy:

The following policies apply: Certain exemptions or additional policies may apply for Medicare Part B and Part C recipients, Medical Lien cases, Worker's Compensation cases, and other payer sources like (Veteran's Administration, Bureau of Disability, Accident Liability Insurance, etc.) If you have one of these Other Payors mentioned for your visit today then please see the front desk after completing this form and other registration paperwork for additional information,

Co-Payment/Co-Insurance/Deductible/Balance

All Co-Payment, Co-Insurance, Deductible and Balance financial responsibilities are due in full at the time of service prior to being seen. Original Medicare Advantage Plan members please see the front desk for payment responsibilities.

Appointment Policy:

We may contact you to provide you with appointment reminders by phone. At each visit, we will ask you to verify this information to assure that reminders are sent to the correct location. TSNSC Understands that not all appointments may be kept due to family emergencies and changes in your personal schedule. TSNSC may allow for up to a combination of three (3) missed appointments. After this, our staff will be unable to assist you in rescheduling your appointment. TSNSC will inform your PCP and your chart will be sent for administrative review. Please note that scheduling outside testing/appointments and subsequent in-office follow up appointments is the responsibility of the patient and failure to do so is a violation of our appointment policy.

Acceptance of Financial Responsibility and Assignment of Benefits:

I hereby authorize payment of benefits on my behalf under my insurance plan(s) and/or any government-sponsored plan(s) directly to Tri-State Neurological and Sleep Center (TSNSC) and its division. I understand that if TSNSC is not a participating provider, or special program participating provider with my insurance plan(s) that I am responsible to TSNSC for amounts determined ineligible by my insurance plan(s) due to their "maximum allowable", "usual customary and reasonable", or other payment policies. There are generally found in your insurance plan handbook and not known by TSNSC. I agree to pay any co-payments, co-insurance, and deductibles that are my responsibility under my insurance plan(s) at the time of service prior to being seen. I understand that I will be billed and held responsible for my account regardless of the status of any insurance claim(s) as allowable by my plan's patient responsibility rules.

Signature:________________________________Initial:______________Date:______________________

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Consent for Treatment:

I consent to the procedures which may be performed during this visit or during an outpatient episode of care, including, but not limited to treatment or services, and which may include, diagnostic procedures, laboratory procedures, medical, nursing or other services rendered as ordered by the provider. I acknowledge that no guarantees or promises have been made to me concerning the outcomes of any procedure or treatment I receive.

Signature:__________________________________Initial:____________Date:____________________

Discharge/Transfer of Neurological Care/Other Instructions:

You may terminate the patient-physician relationship by verbal/written request at any time. Your physician may terminate the physician-patient relationship within a 15-day written notice from the following, but not limited to: neurologic services are no longer needed, no longer contracted with your health insurance plan, you request services outside the physician's expertise/office hours/or at a location other then the physician's office, the use of verbally abusive language, failure to follow plan of care or comply with an appropriate treatment regimen, patient going against medical advice, and appointment non-compliance.

I acknowledge and understand that in the event I do not pay for services rendered, TSNSC may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court cost incurred for collection of my overdue account.

Print Name:____________________Patient Signature:______________________________Date:______________

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Permission To Release Your Medical Information

I, the undersigned, give my permission for the persons listed bellow (family members, significant others, friends) to be given any information regarding my medical care. This includes all medical reports (lab, pathology, x-ray, consultations and other diagnostic test results) and records of physical examinations. This permission is granted for in office and phone reports to any of the individuals listed below. This authorization is for the release of verbal information only and does not apply to the release of medical records can only be processed upon written authorization of the patient. This form allows Tri-State Neurology and Sleep Center to release your information (verbally) in case of an emergency to any of the listed below.

This form/authorization is not valid unless signed.

Name:______________________________ Relationship:__________________ Phone Number:__________________________

Name:______________________________ Relationship:__________________ Phone Number:__________________________

Name:______________________________ Relationship:__________________ Phone Number:__________________________

Name:______________________________ Relationship:__________________ Phone Number:__________________________

Print Patient Name:____

Signature:____ Date:_____________________

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Medication List

Please list ALL the medications you currently are taking. It is very important that we know everything you are taking. If you are under the care of a Pain Management Physician, please list below.

Medication	Strength	Dosage
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________
______________________	__________	____________________

Signature: ______________________________ Date:____________________

My Pain Management Physician is ____

Please use the back of this sheet is necessary to list your medication.

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Insurance Authorization & Assignment

We strongly feel that all patients deserve the very best medical care that we can provide. Everyone benefits when financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not your insurance company. Payment for treatment is your responsibility.

Financial Agreement:

________I have no insurance coverage. I understand that I am responsible for payment of service rendered to myself or dependent at the time of service.

________I understand if I fail to pay amount owed; the clinic has the right to secure an outside collection agency and/or attorney collect the unpaid debt including any additional charges or fees associated with collecting that debt, and reporting that paid debt to a credit reporting agency.

Insurance Authorization & Assignment:

________I hereby authorize the release of any information necessary to process insurance claims for payment of benefits to be made of service rendered to myself or any dependents.

________I understand I am responsible for paying co-payments and deductibles prior to services being rendered.

Medicare/Medigap:

For Medicare patients only. Medicare #:____

________I authorize medical records or any other information about me to be released to Social Security Administration, Health Care Finances Administration, or any of its intermediaries or carriers as needed for any related Medicare claim. I also authorize a copy of this authorization to be used in place of the original to request payment of medical insurance to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who might be responsible for paying for my treatment. (section 1128B of social Security Act and 31 U. S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also applies.

Medigap Authorization Statement: Policy #:______________________________

________I authorize medical records or any other information about me to be released to process Medigap claims. I also authorize to be used in place of the original to request payment of medical insurance to the party who accepts assignment.

There will be a $25.00 charge on all returned checks.

I have read and understand the payment policy and agree to abide by the policy.

Patient signature:____________________________________ Date:_________________________

I will pay by: Cash___________ Check__________ Visa, MC, Discover_____________

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Authorization to Release Medical Records & Information Form

Patient Name:________________________________ Date:________________ SSN:_______________________

Address:________________________________ City:________________ State:________ Zip:__________

Phone:_______________________

Number 1.

☐ I, ___________________________________ hereby authorize the following physician/clinic: __________________________
____ to release medical records and information to Tri-State Neurological and Sleep Center.

Number 2:

☐ I, ___________________________________ hereby request my medical records and authorize Tri-State Neurological and Sleep Center to release my medical records to myself and/or family member or personal representative listed:_____________
____

____

Please list any family members you **DO NOT** wish TSNSC to discuss your health condition with

A. ____
B. ____

In the event we have to contact you and you are not home, may we leave a message on your machine/voicemail box or leave a message with your contact person/family member?

_______Yes _______No _______Patient Initial

Name of Contact Person:____ *Please note that unless this authorization(s) are revoked by patient in writing, this authorization shall remain valid indefinitely.*

Print Name:___________________________Patient Signature:_______________________Date:__________

Acknowledgement- Notice of Privacy Practices

You can view and print the TSNSC Privacy notice by going to tsneurology.com or please request a copy at the front desk during registration.

I,____________________________ (print first name and last name) acknowledge that I have received the Notice of Privacy Practices or reviewed them in the office or online. I have 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 communities between the practice and myself or others.

____
Signature

____
Date

Tri-State Neurological & Sleep Disorder Center

INSURANCE AUTH & ASSIGNMENT

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FINANCIAL AGREEMENT

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_____I understand that if I fail to pay amounts owed,the clinic has the right to secure outside collection and/or attorney to unpaid debt including and additional fees with collection the debt and reporting the paid debt to a credit reporting agency.

INSURANCE AUTHORIZATION AND ASSIGNMENT

_____i hereby authorize the release of any information necessary to process insurance claims for payment of benefits to be made for services rendered to myself and/or dependents.

_____I understand I am responsible for paying co-payments and deductibles prior to services being rendered.

MEDICARE/MEDIGAP (for Medicare patients only) Medicare #________________________________

_____I authorize medical records or any other information about me to be released to Social Security Administration, Health Care Finance Administration, or any of its intermediaries or carriers as needed for any Medicare related claim. I also authorize a copy of this authorization to be used in place of the original to request payment of medical insurance to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who might be responsible for paying my treatment. (Section 11288 of the Social Security Act and 31U.S.C. 3801-3812 providers penalties for withholding this information) Regulations pertaining to Medicare assignment of benefits also applies.

MEDIGAP AUTHORIZATION STATEMENT Policy #____

_____I authorize medical records or any other information about me to be released to process Medigap claims.I also authorize a copy of this authorization to be used in place of the original to request payment of medical insurance to the party who accepts assignment.

There will be a $25.00 fee on all returned checks. I have read and understand the payment policy and agree to abide by the policy.

Patient Signature:____Date:____________________

I will pay by _____cash _____Visa _____Mastercard _____Check _____Discover _____American Express

Main Office
Phone: 928-763-4270
Fax: 928-763-5056
3015 Hwy. 95, Suite 109, BHC, AZ. 86442
Palo Verde Professional Plaza

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Phone: 928-763-5055
2020 Silver Creek Rd , A111
Bullhead City, AZ 86442

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