Tri-State Neurological & Sleep Disorder Center

PATIENT INFORMATION

Name:_____DOB:_____Age:_____

Mailing Address:_____

Physical Address:_____

Home Phone:_____ Cell Phone:_____ Gender M F

Marital Status M S W D S DL#_____ Social Security #_____

Spouse: _____DOB:_____ SS#_____

Responsible Party (if other than the patient)_____
Mailing Address:_____
Phone:_____ Relationship to Patient:_____

EMPLOYMENT
Employer:_____Work Phone:_____
Occupation:_____ Email address:_____

REFERRAL INFORMATION
Referring Physician:_____PCP_____
Reason for todays visit:_____

INSURANCE INFORMATION
Primary
Policy #_____Group#_____Subscriber:_____
Secondary
Policy#_____Group#_____Subscriber:_____

We bill your insurance company as a courtesy. Payment of services is overall the patient's responsibility

INSURANCE AUTHORIZATION &ASSISGNMENT

I authorize payment of benefits to include major medical benefits to which I am entitled to be made on my behalf to M.A. Nayer,M.D.,P.C dbs Tri-State Neurological and Sleep Disorder Center, for any services rendered to me in this office. I authorize any holders of my medical billing information pertaining to me to be released to M.A. Nayer, M.D.,P.C. This assignment is to be considered as valid as the original. I am financially responsible for any and all co-payments, deductibles and non covered services. I accept responsibility for any services not allowed by my insurance company and agree to make payment myself. I hereby authorize M.A. Nayer, M.D.,P.C dba Tri-State Neurological and Sleep Disorder Center to release all medical information necessary including medical records to to secure payment of benefits. Information may be released to any provider in my medical care by fax or mail. I authorize use of this signature on all insurance billing. I understand it is my responsibility to obtain authorization for diagnostic testing and to obtain these thru contracted facilities. I understand the office will submit PA on my behalf as a courtesy.

Patient Signature (if a minor, parent or guardian signature) Date

I understand it is the policy of TSNSC to charge cancellation fees for appointments missed without sufficient notice. I have been informed:_____
I acknowledge that I received Tri-State Neurology's privacy notice _____ This office does not discriminate against any race, age, sex or ethnicity.

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

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

Henderson
Phone: 702-433-7999
178 N. Pecos Rd, # 200
Henderson, NV 89074

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MEDICAL HISTORY

Name:_____ DOB_____ Age:_____

In case of an emergency, whom should we notify?

Name:_____ Phone Number:_____

Mailing address:_____Relationship:_____

Medication Allergies:_____

Please list any current medical condition(s):_____

List any surgeries you have had:_____

SOCIAL HISTORY

Tobacco user _____yes_____no If yes, how many years?_____How many packs per day_____

Alcohol use _____yes_____no If yes how much ____daily _____weel _____Month _____Rarely

Marital Status _____Married _____Single _____Divorced _____Widow _____Widower

Occupation:_____ If retired what did you do?_____

FAMILY HISTORY-if a family member is deceased please note and list cause of death

Father_____

Mother_____

Sister_____

Brother(s)_____

Son(s)_____

Daughter(s)_____

_____ _____

Patient Signature Date

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INSURANCE AUTH & 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 services rendered to myself of dependent at the time of service.

_____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

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PERMISSION TO RELEASE YOUR MEDICATION INFORMATION (VERBAL)

I, the undersigned, give my permission for the persons listed below (family members, significant others, friends, others) to be given information regarding my medical care. This includes all medical records and other diagnostic test results. This authorization is for the release of verbal information only, and does not apply to the release of medical records. A request for copy and/or release of medical records can only be released with a written signature from the patient.

This form /authorization Is not valid unless signed:

Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number
Print Name	Relationship	Phone Number

Patient Name (Print)	Signature	Date

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M.A. NAYER, MD,PC

Physician Aassistant (PA) / Nurse Practitioner (NP) Consent Form

This facility has on his staff a PA/NP to assist in the delivery of medical care. A PA/NP is not a doctor. A PA/NP is a graduate of his certified training program and is license by the State Board. Under the supervision of a physician, a PA/NP can diagnose, or treat, and monitor acute and chronic diseases as well as provide health maintenance care. Supervision does not require the constant physical present of the supervising physician, rather overseeing of activities and accepting responsibility for the medical services provided. A PA/NP may provide such medical services that are within his/her education, training, and experienced. These services may include 1. Obtaining history and performing physical exams 2. Ordering and or performing diagnostic and therapeutic procedures 3. Formulating a working diagnosis 4. Developing and implementing a treatment plan 5. Monitoring the effectiveness of therapeutic intervention 6. Offering counseling and education 7. Supplying sample medication and writing prescription 8. Making appropriate referrals.

I -_____-have read the above, and hereby consent to the services of a PA/NP for my health care needs. I understand that at any time I can refuse to see a PA/NP and request to see a physician.

_____ _____

Patient's(guardian) signature Date

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MEDICATION LIST

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

MEDICATION	STRENGTH	DOSAGE

Patient Signature _____ Date _____

My Pain Management Physician is: _____

My preferred pharmacy is _____

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PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner: (check all that apply)

___Home phone_____

___Okay to leave detailed message

___Leave message with call back number only

___Work telephone_____

___okay to leave detailed massage

___Leave message with call back # only

_____ Written communication

_____okay to mail to my home address

_____okay to fax to _____

_____Other_____

_____ _____ _____

Signature Print Name Date

The privacy rule requires that we keep an accounting of all no TPO disclosures of your protected health information (PHI). This accounting does not apply to disclosures made pursuant to authorization or used for TPO(treatment, payment, operation).

Date	Request by	Disclosed to	Approved	Description of PHI

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EPWORTH SLEEPINESS SCALE

Name:_____ Date:_____

Age:_____ Gender: Male Female

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired:

This refers to your usual way of life in recent times.

Even if you haven't done some of these thing recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation. It is important that you answer each question as best you can.

0=would never doze
1=slight chance of dozing
2=moderate chance of dozing
3=high chance of dozing

SITUATION

Sitting and reading	
Watching TV	
Sitting inactive in a public place –like a theatre or a meeting	
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 a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
total	

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. ___
- You will wash your hands or use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. ___
- You will wear a mask in all areas of the office (I [and my staff] will too). ___
- You will keep a distance of 6 feet and there will be no physical contact (e.g. no shaking hands) with me [or staff]. ___

- You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. ___
- If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you have a job that exposes you to other people who are infected, you will immediately let me [and my staff] know. ___
- If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let me [and my staff] know. ___
- If a resident of your home tests positive for the infection, you will immediately let me [and my staff] know and we will then [begin] resume treatment via telehealth.___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure

My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick

You understand that I am committed to keeping you, me, [my staff] and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection

If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent

This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____

Patient/Client Name Date

_____

Signature