

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 Driver'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

Tri-State Neurological and Sleep Center

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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 than 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.

<hr/>	<hr/>	<hr/>
Medication	Strength	Dosage
<hr/>	<hr/>	<hr/>
Medication	Strength	Dosage
<hr/>	<hr/>	<hr/>
Medication	Strength	Dosage
<hr/>	<hr/>	<hr/>
Medication	Strength	Dosage
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Medication	Strength	Dosage
<hr/>	<hr/>	<hr/>
Medication	Strength	Dosage
<hr/>	<hr/>	<hr/>
Medication	Strength	Dosage
<hr/>	<hr/>	<hr/>
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