ANDERSON
Neurological
Pain Solutions
LLC

Dear New Patient:

Thank you for choosing our clinic for your Neurology and pain management needs. We welcome you and would like to take this opportunity to provide you with some new patient forms to complete PRIOR to your appointment.

In order for us to better serve you, please complete the enclosed new patient questionnaire packet and bring it to your upcoming appointment. Please arrive 20 minutes early to your appointment and bring your insurance card. If you are unable to make this appointment please contact our office to reschedule as soon as possible. Please see separate Cancellation and No-Show Policy document.

Co-payments will be collected at the time of your appointment and for your convenience we accept cash, check, and credit cards.

2211 NW Professional Dr. #203 Corvallis, OR 97330

Phone: 541.286.4720 Fax: 541.205.4860

Website: www.neuropaindoc.com

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OFFICE POLICIES & PATIENT RESPONSIBILITIES

FINANCIAL RESPONSIBILITY

I agree to pay all charges for medical or other services not covered by my insurance company. I agree to pay my annual deductible, co-payment, and charges not covered by my insurance (which may include any office visits, treatments, or procedures performed), along with any cosmetic services. I further understand that I am responsible for all collection and/or attorney fees necessary to collect any outstanding or uncollected charges. Our contract with your insurance states that if you are responsible for any charges, we must accept those charges and cannot accept discounted payments. Our staff does their best to verify insurance eligibility and benefits, and inform you, before you are seen. But ultimately you, as the patient, are responsible for understanding your contract with your insurance and verify if you need a referral to be seen by us. There is a $35 charge for all returned checks and a rebilling fee of $10 per month on any and all unpaid balances aged over 60 days. We do not refund or bill patients for balances under $10.00.

SELF-PAY/UNINSURED

Patients without insurance are expected to pay in full at the time of each visit. If this is not possible, we require a deposit of 50% for each visit/procedure. This deposit will be applied towards the visit/procedure. Any remainder will be due at the time of service. We offer a discount to patients who pay in full at the time of service. Please ask our staff about this discount.

STATEMENTS/BILLING

Statements are mailed monthly. If you are unable to pay your balance in full, please contact our billing department for arrangements. Please keep in mind that our Biller is part time, and is one of the best in the country. Accounts with balances remaining after receiving two (2) statements will receive a reminder and be assessed a fee of $5 per month until your balance is paid. If you do not make contact with our Billing department within 30 days of this reminder you will receive a second reminder. If a balance remains unpaid, we may refer your account to a collection agency.

Authorizations & Referrals

We make efforts to obtain appropriate insurance referrals and authorizations prior to your appointment or procedure. However, it is ultimately your responsibility to verify that these referrals/authorizations are in place before services/tests are performed. If services or tests are performed without proper authorization, you may be financially responsible for the entire bill. We may refer you for tests/or services according to our standard referral patterns and your clinical need. The providers of those tests and/or services are generally contracted with a wide range of insurance plans. Again, it Is your responsibility to ensure that these providers are in network with your plan and that any services are authorized. Failure to do so may result in high out of pocket expenses.

Co-Payments and Past Due Balances

All co-payments and past due balances are due at the time of service. Your co-payment is a contract with your insurance. company. Co-payments will be collected at time of check-in. Failure to pay co-pays can be considered a breach of contract. We may have to reschedule your appointment which can be considered a missed appointment. Any balance more than 60 days old is considered past due. Once a balance is past due, payment will be required before your next visit. We ask that you make a payment over the phone when scheduling your appointment or in the office before your visit. Failure to make a payment on a past due balance before your next scheduled appointment may result in that appointment being rescheduled.

MISSED APPOINTMENT POLICY

A missed appointment is when you fail to show up for your appointment without a phone call to cancel or reschedule without **AT LEAST 2 business days notice and 5 business days notice for procedures/injections**. These procedures/injections include, but are not limited to: Botox/Xeomin, PRP, Trigger Point Injections, Joint Injections, and/or Nerve Blocks.

We understand that there are unforeseen circumstances and emergencies that warrant the cancellation of an appointment. However, if you don't show to your appointment or procedure/injection you are actually delaying other people who need an appointment or procedure/injection. Due to the abusive number of "missed appointments" and the difficulty to schedule procedure/injection appointments, we are obligated to charge a fee for all missed appointments. A physician/patient relationship is built on mutual trust and respect. As such, we ask that you give us the courtesy of a timely call when you are unable to keep any scheduled appointment**. Patients may be subject to a $50.00 fee per missed appointment ($100.00 for NEW patients) and $100.00 fee per procedure/injection appointment.**

Please note: There is a **$250.00** fee for each individual missed appointment on Botox/Xeomin procedure/injection appointments. Each Botox/Xeomin vial is ordered in advance and reserved for each patient's scheduled procedure/injection. The cost and overhead to obtain Botox/Xeomin is significant.

The missed appointment fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Repeated cancellations or missed appointments also may result in loss of future appointment privileges.

Please sign that you have read, understand and agree to these policies.

_____ Date of Birth _____

Patient Name (Please Print) (mm/dd/year)

_____ _____

Signature of Patient or Patient Representative Date (mm/dd/year)

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PATIENT INFORMATION

PATIENT (LAST): _____ (FIRST): _____ (MI): _____ DOB:_____

ADDRESS: _____ SEX: MALE FEMALE

CITY: _____ STATE: _____ ZIP CODE: _____ SSN: _____

HOME PHONE: (____)_____ CELL: (_____)_____ WORK: (_____)_____

REFERRING PHYSICIAN: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

PHARMACY: _____ CITY: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE:(____)_____

EMAIL: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE NAME: _____

SUBSCRIBER NAME: _____

SUBSCRIBER ID: _____

DOB: _____ SSN: _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE

SECONDARY INSURANCE:

INSURANCE NAME: _____

SUBSCRIBER NAME: _____

SUBSCRIBER ID: _____

DOB: _____ SSN: _____

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE

I certify that the above information is correct and true to the best of my knowledge. I consent to treatment and I authorize Anderson Neurological Pain Solutions, LLC to release to my insurance company any and all information necessary to process this claim. I authorize my insurance benefits be paid directly to the physicians or party who accepts assignment of this claim. I understand that charges not covered by my insurance carrier are my responsibility. I permit a copy of this authorization to be used in place of the original.

Patient / Guardian Signature: _____ Date: _____

CURRENT AND PAST MEDICAL HISTORY

CURRENT MEDICATIONS: ○ NONE ○ SEE ATTACHED

NAME	DOSE	HOW OFTEN	PHYSICIAN

DRUG ALLERGIES: ○ NONE ○ SEE ATTACHED

OTHER ALLERGIES: ○ NONE ○ LATEX ○ IODINE ○ LIDOCAINE ○ ADHESIVE ○ BUPIVICAINE ○ STEROIDS

PLEASE INDICATE IF YOU HAVE CURRENTLY USE OR TRIED THE FOLLOWING MEDICATIONS:

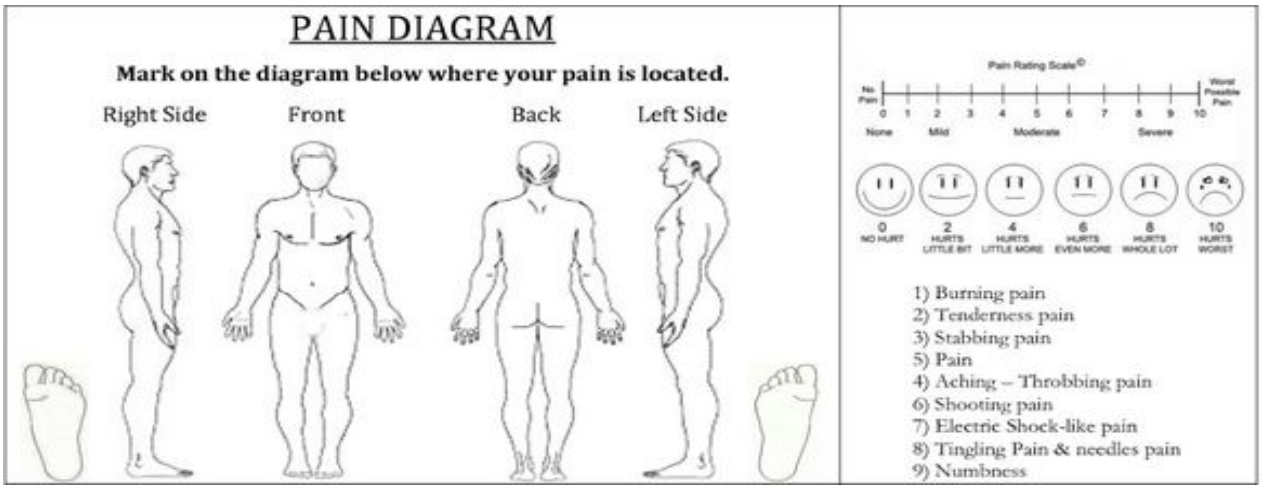
__Oxycodone
__ Oxycontin
__ Percocet
__ Vicodin/Norco
__ Butrans
__ Fentanyl
__ Methadone
__ Nucynta
__ Baclofen
__ Flexeril (Cyclobenzaprine)
__ Soma (Carisoprodol)
__ Robaxin (Methocarbamol)
__ Zanaflex (Tizanidine)
__ Zofran (Ondansetron)
__ Phenergan (Promethazine)
__ Abilify (Aripiprazole)
__ Risperdal (Risperidone)
__ Seroquel (Quetiapine)
__ Haldol (Haloperidol)
__ Geodon (Ziprasidone)
__ Prozac (Fluoxetine)
__ Paxil (Paroxetine)
__ Zoloft (Sertraline)
__ Lamictal (Lamotrigine)
__ Depakote(Divalproex-Sodium)
__ Tegretol (Carbamazeprine)
__ Trileptal (Oxcarbazeprine)
__ Neurontin (Gabapentin)
__ Topamax (Topiramate)
__ Keppra (Levetiracetam)
__ Vimpat (Lacosamide)
__ Imitrex (Sumatriptan)
__ Lyrica (Pregabalin)
__ Lidocaine Gel/Patches
__ Wellbutrin (Bupropion Hydrochloride)
__ Lexapro (Escitalopram)
__ Cymbalta (Duloxetine)

PLEASE INDICATE IF YOU TAKE ANY OF THE FOLLOWING OVER THE COUNTER MEDICATIONS:

○ Ibuprofen ○ Tylenol ○ Excedrin ○ Bayer Asprin How often taken? _____

PAIN LOCATION: (Please describe the location of your pain)

_____



PLEASE INDICATE IF YOU HAVE HAD THE FOLLOWING PAST MEDICAL HISTORY:

Cardiovascular:

- ○ **Coronary Artery Disease**
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Heart Attacks
- ○ Arrhythmia/Pacemaker
- ○ Bypass Surgery

Gastrointestinal:

- ○ **GERD/Ulcers**
- ○ Crohn's Disease
- ○ Irritable Bowel Disease
- ○ Gallbladder Disease
- ○ Hepatitis A/B/C
- ○ Pancreatitis

Neurological:

- ○ **Multiple Sclerosis**
- ○ Stroke
- ○ Migraine Headache
- ○ Tension Headache
- ○ Seizures
- ○ Polio/Gullain-Barre
- ○ Parkisons Disease
- ○ Dementia/Alzheimers
- ○ ALS
- ○ Cerebral Palsy
- ○ Myasthenia Gravis

Renal:

- ○ **Kidney Failure**
- ○ Kidney Stones
- ○ Incontinence
- ○ Urinary Tract Infection

Pulmonary:

- ○ **Asthma**
- ○ COPD
- ○ Sleep Apnea
- ○ Bronchitis
- ○ Pneumonia
- ○ Emphysema

Endocrine:

- ○ **Diabetes I**
- ○ Diabetes II
- ○ Hypothyroidism
- ○ Hyperthyroidism
- ○ Adrenal Insufficiency

Ear/Nose/Throat:

- ○ **Seasonal Allergies**
- ○ Sinus Infection
- ○ Ear Infection
- ○ Dental Problems
- ○ Other:_____

Hematological:

- ○ **Bleeding**
- ○ Anemia
- ○ Leukemia
- ○ Hypercoaguable Disorder

Musculoskeletal:

- ○ **Fibromyalgia**
- ○ Chronic Fatigue
- ○ Osteoarthritis
- ○ Rheumatoid Arthritis
- ○ Lupus
- ○ Raynaud's Disease
- ○ Back Pain
- ○ Muscle Weakness

Mental Health:

- ○ Depression
- ○ Anxiety
- ○ Bipolar Disorder
- ○ Schizophrenia
- ○ ADHD/ADD
- ○ Suicide Attempts

MEDICAL HISTORY:

CONDITION/DIAGNOSIS	IS THIS AN ACTIVE PROBLEM?	WHEN DID SYMPTOMS BEGIN?	WHEN WAS THIS DIAGNOSED?

PAST SURGICAL HISTORY:

DATE	TYPE OF SURGERY	FACILITY

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR PROCEDURES DONE:

TEST	BODY PART	DATE	WHAT FACILITY
Nerve or Muscle Biopsy			
EMG/Nerve Conduction Study			
CAT Scan or MRI			
X-Ray			
Botox Injections			
Lidocaine or Steroid Injections			
Nerve Block Injections			

PLEASE LIST ANY HERBAL OR SUPPLEMENTS CURRENTLY TAKING:

__ Petadolax
__ Boswella
__ Feverfew
__ Milk Thustle
__ Kava Kava
__ St. Johns Wart
__ Valerian
__ Riboflavin
__ Tumeric Curcumin
__ Ginger
__ Magnesium
__ Coenzyme Q10
__ Zinc
__ Vitamin E
__ Vitamin B12
__ Fish Oil
__ B6
__ Protein
__ Creatine
__ Vitamin D
__ Vitamin C
__ Thiamin
__ Glucosamine
__ Chondroitin
__ OTHER: _____
_____

DIETARY:

○ Gluten Free
○ Diabetic
○ Vegetarian
○ Vegan
○ Atkins Diet
○ Mediterranean Diet

FAMILY HISTORY:

If family history is not available please indicate here: ○ Unknown

Has any family member been diagnosed with Neurological Disease? ○ Yes (please describe below) ○ No

Does any family member have migraine headaches? ○ Yes (please describe below) ○ No

Does any family member have a tremor? ○ Yes (please describe below) ○ No

FAMILY MEMBER	MEDICAL DIAGNOSIS	STILL LIVING OR DECEASED	IF DECEASED AGE AND CAUSE OF DEATH
MOTHER:			
FATHER:			
SIBLINGS:			
CHILDREN:			

SOCIAL HISTORY:

(Social history questions are **OPTIONAL** only answer questions you are comfortable answering)

Do you have an Advanced Directive (Living Will) or POLST (Physician Orders for Life Sustaining Treatment) in place? ○ Yes ○ No ○ Not Applicable

Do you have a Financial Power of Attorney? ○ Yes ○ No

Are you: ○ Right handed ○ Left handed ○ Ambidextrous

Optional: ○ Single ○ Married ○ Separated ○ Divorced

○ Widowed ○ Domestic Partnership

Do you have children? ○ Yes ○ No If so, what are their ages:_____

Smoking: ○ Never ○ Past (when did you quit?_____) ○ Current (how much?_____ packs/day)

Do you use or have you used the following: ○ THC ○ Cocaine ○ Methamphetamine ○ Heroin

○ Ecstasy ○ PCP ○ Other: _____ If yes please explain: _____

Do you drink Alcohol? ○ Yes ○ No ○ Quit ○ When? _____

Are you under more than normal stress? ○ Yes ○ No If yes please explain: _____

CONSENT OF TREATMENT

Patient's Name:_____ **DOB:**_____ Date:_____

Medical Consent: I wish to receive examination and treatment for my medical condition or injury. I understand that my practitioner will inform me of recommendations related to my treatment and that, unless I object, this consent includes any routine tests or examinations. If a special procedure or surgery is needed, I understand that my practitioner will discuss them with me and an additional consent may be required. I reserve the right to refuse any particular medical treatment or health care procedure that is proposed by my health care practitioner.

Release of Information: I authorize **Anderson Neurological Pain Solutions** to release information from my medical records to any insurance carrier or government agency for the purpose of processing my claims for medical benefits. I understand that if any insurance company or government agency is paying for my claims for medical benefits they may have access to sensitive information about my diagnosis and treatment. Additionally, there may be quality improvement employees, utilization review employees, or my physician who may look at my medical record. **If I choose not to release my medical record information, I understand and agree that I will pay for all charges in the event that payment is denied.**

Authorization of Protected Information: A separate authorization will be required for release of the following information: HIV positive diagnosis, drug/alcohol addiction program records, psychotherapy notes and/or mental health program records.

Financial Agreement: I understand that I am responsible for determining my personal insurance requirements including eligibility, referrals and authorization. I am financially responsible for charges not covered by insurance. I also understand that I am responsible for paying deductibles, coinsurance, and co-pays. I agree to make payment according to Anderson Neurological Pain Solutions. In order to avoid a finance charge, all charges accrued must be paid in full within 90 days of the first statement's closing date. I understand that a service charge of $25 will be assessed for all checks returned for non-sufficient funds or written on a closed account.

Insurance Assignment: I certify that the information I have supplied is true and accurate to the best of my ability. I assign to Anderson Neurological Pain Solutions any insurance benefits payable to me for services rendered. I direct all insurance companies, health care service plans, and other third party payers to make payment directly to Anderson Neurological Pain Solutions.

Prescription Refills: Everything Important Takes Time. Please understand medication refills may take up to 48 hours to process after the request is made. You are part of our team. Please request medication refills at least two days before you may run out.

Patient Signature:_____ **Date**:_____

I acknowledge that the Notice of Privacy Practices has been made available to me: (Initials) _____

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VOLUNTARY INFORMATION DISCLOSURE

As part of health care reform, medical providers using Electronic Health Records are being asked to collect information about their patients related to the following. The information is used to benchmark trends in public health data. Your answers to the following questions are voluntary and confidential as protected by HIPPA laws.

Please take a few minutes to answer the following questions:

Print Patient's Name: _____ Date of Birth: _____

Race:

- ❑ Native American or Native Alaskan
- ❑ Asian or Asian American
- ❑ African or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Caucasian or White
- ❑ Patient Refused

Language:

- ❑ English
- ❑ Spanish
- ❑ Russian
- ❑ Chinese
- ❑ Arabic
- ❑ Other: _____

Ethnicity:

- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Patient Refused

AUTHORIZATION TO VERBALLY RELEASE
PROTECTED HEALTH INFORMATION

I,_____ hereby authorize ANDERSON NEUROLOGICAL PAIN SOLUTIONS LLC to verbally share confidential information to the following individuals:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____Relationship to Patient:_____

To include any or all of the following: (Check One)

○ Appointment Dates / Times Only

○ All matters relating to my health care including mental health, alcohol, drug treatment, and communicable diseases.

OR

○ Only specific health care problems and treatment relating to:

_____

(Describe the conditions for which information may be released)

This authorization may be revoked at any time by notifying **ANDERSON NEUROLOGICAL PAIN SOLUTIONS LLC** in writing, but the revocation will not affect any actions which have been taken prior to the receipt of the revocation. I understand that this authorization will expire upon my written request for change or revocation, directed to **ANDERSON NEUROLOGICAL PAIN SOLUTIONS LLC**.

I understand and acknowledge that the confidential healthcare information disclosed to the above named individuals may be subject to re-disclosure by those individuals and may no longer be protected by federal privacy regulations.

_____ _____ _____

Patient's Signature Date of Birth Today's Date