Big Sky Neurology

Patient Registration

First Name:__________________________ Last Name: ____________________________ MI: ___
DOB: _________________________ Social Security number: ____________________________ Sex: Male Female Other

Mailing Address: _______________________________________ City: ___________________ State: ______ Zip Code: ________
Physical Address: _______________________________________ City: ____________________ State: ______ Zip Code: _______

Home Phone: __________________________ Cell Phone: _______________________
Email: ____
Preferred method of communication:
__Home Phone (Voicemail Ok) __ Mobile Phone (Voicemail Ok) __ Email

Marital Status: Single/ Married/ Divorced/ Life partnered/ Widowed
If married or domestic partnership, please provide:
Spouse/Partner Name: _______________________________________ DOB: _____________
Race: _African American/Black _American native/Alaskan native _Caucasian/White _Asian _Other
Primary Language: _____________________________

Employer name: __________________________________ Employer Phone: ________________
Occupation: _________________________________ Status: Part time/ Full time/ Retired/ Leave of Absence/ Unemployed

EMERGENCY CONTACT/NEXT OF KIN
Name: ____________________________________ Relationship: _________________________Phone: _______________

PRMARY CARE DOCTOR
Doctor's Name: ____ Phone number: ___________________________

PHARMACY
Pharmacy Name: _________________________________ Phone number: _______________________
Address: _______________________________________

MEDICAL POWER OF ATTORNEY (MPOA)
Do you have a Medical Power of Attorney (MPOA)? (Please Circle) Yes No
Name of MPOA: ____ Relationship: ___________________
If there is a MPOA, please provide a copy of the signed court document.

Medical History

Current Medical Conditions:

_______________________ _______________________ ____________________ ____________________
_______________________ _______________________ ____________________ ____________________
_______________________ _______________________ ____________________ ____________________

Past Medical Conditions:

_______________________ _______________________ ____________________ ____________________
_______________________ _______________________ ____________________ ____________________

Previous Surgeries:

_______________________ _______________________ ____________________ ____________________
_______________________ _______________________ ____________________ ____________________

Preventative Care:
Pelvic/PAP smear year and results: ________________
Mammogram year and results: ________________
Flexible Sigmoidoscopy/Colonoscopy Date: _________________

Family History:
____

Social History:
Do you drink? (Please Circle) Yes No If yes, how much and how often? _______
Do you smoke? (Please Circle) Yes No If yes, how much and how often? _______
Are you a former smoker? (Please circle one) Yes No

Medication List:

Medications:	Dose (mg)	Schedule
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________
________________________	________________________	____________________

Allergies:

________________________ ________________________ ____________________
________________________ ________________________ ____________________

Non-medication allergies including environmental and dietary:

________________________ ________________________ ___________________
________________________ ________________________ ___________________
________________________ ________________________ ___________________

Insurance/Billing Information:
Do you have insurance? (Please Circle) Yes No If yes, please complete insurance below:
Primary insurance Company: _________________________________ ID#: _________________ Group#: ________________
Insured Name: ________________________________ SSN: ______________________________ DOB: ___________________
Relationship to Patient: ________________________
Secondary Insurance Company: _________________________________ ID#: _________________ Group#: _______________
Insured Name: ________________________________ SSN: ______________________________ DOB: ___________________
Relationship to Patient: ________________________

Big Sky Neurology

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION MEDICAL RECORDS RELEASE

Patient Name: ______________________________________ DOB: ________________

I authorize release of my records
TO: ____

FROM: ____

For the following reason:
____Continued care with another physician ____Legal reasons
____Personal copy of my treatment records ____Other

Please note that there is a per page charge for printed personal copy of medical records. HIPAA compliant medical records request from doctors' offices/lawyers/insurance/other third party administrators do not have a charge to the patient.

I request my records to be provided in the following format (check one):

___Paper copy
___Faxed to #: ____
___Mailed to: ____

Signature of Patient/Legal Representative: ____

Date: _____________________

ID Verification: Document and number: ___________________________

This authorization will automatically expire in twelve (12) months from the date signed. I understand that I may revoke this consent any time and that revocation will not apply to information that has already been released as a result of this authorization. If I revoke this authorization, I must do so in writing and send it to the attention of the Privacy Officer. I understand that authorizing the disclosure of this health information is voluntary and that any disclosure of information carries with it the potential for unauthorized re-disclosure and may no longer be protected by federal confidentiality rules. Big Sky Neurology does not guarantee the completeness or accuracy of outside records; therefore, we will not be held responsible for the contents of the outside records that you receive.

Big Sky Neurology

AUTHORIZATION AND CONSENT TO TREATMENT

Assignment of Benefits and Authorization to Release Medical Information.
I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits of any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.
Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges. If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.
Consent to Treatment. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV), including, but not limited to, all medical/minor surgical procedures (including suturing) and vaccine administration. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.
Consent to Call, Email & Text. I understand and agree that my provider may contact me using phone calls, automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my provider's staff.
HIPAA. I understand that my provider's Privacy Notice is available to me and that I may request a paper copy at my provider's reception desk. I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information, and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with Big Sky Neurology.

Signature of Patient or Personal Representative: _________________________ Date: __________________

Name of Patient or Personal Representative: ____

Description of Personal Representative's Authority: ___________________________________

Big Sky Neurology

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients sign our Authorization and Consent To Treatment Form before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY
Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we request payment for your share when you schedule and/or when you present for your appointment.

INSURANCE
We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient responsibility. Keep in mind that our fees are for physician services only. You are responsible for understanding the limitations of your insurance policy, including: ● If a referral or authorization is necessary for office visits. (If it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient). Outstanding balances are the patient's responsibility. All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.
No-shows. If you miss your appointment without cancelling at least forty-eight (48) hours prior to your scheduled appointment, you will be charged a $50.00 fee for a missed appointment. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance. Thank you for choosing us as your healthcare provider!

Signature of Patient or Personal Representative: ____________________________________

Date: ___________________

Name of Patient or Personal Representative: _______________________________________

Description of Personal Representative's Authority: __________________________________

Big Sky Neurology

Notice of Privacy Practices

THIS NOTICE IS PROVIDED TO YOU PURSUANT TO THE PRIVACY REGULATIONS ENACTED AS A RESULT OF OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA). IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Big Sky Neurology ("CLINIC") collects protected health information ("PHI") about you and stores it in a chart and in an electronic health record. This is your medical record. The medical record is the property of this CLINIC, but the information in the medical record belongs to you. Except as described in this Notice of Privacy Practices, CLINIC will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. **Please note that the law permits us to use or disclose your health information for the following purposes:**

§ Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

§ Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

§ Health Care Operations. We may use and disclose your PHI to operate this CLINIC, or to get your health plan to authorize services or referrals. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of our business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your PHI.

§ Disclosure to Family Members or Third Parties Involved in Your Care: You have the right and choice to tell us to share your PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend, or in the event of a disaster relief effort. If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest.

§ Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

§ Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration ("FDA") problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

§ Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

§ Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

§ Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

§ Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

§ Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

§ Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

§ Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

§ Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

§ Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

§ Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

§ Change of Ownership. In the event that this CLINIC is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

§ Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach, but the email will not contain any PHI. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Patient Rights

You have the following rights concerning your PHI:

§ Right to Inspect and Copy. You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. To inspect and copy your medical record, you must make your request in writing detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We have up to 60 days to make your PHI available to you and we may charge you a fee per page and the actual cost of postage for the costs of copying, mailing or other supplies associated with your request. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable.

We will also send a copy to any other person you designate in writing If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

§ Right to Amend. If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the Privacy Officer. In most cases, we will respond within thirty (30) days. Please be aware, we are not required to agree to the requested amendment. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

§ Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Privacy Officer. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

§ Right to Request Special Privacy Restrictions You have the right to request restrictions on certain uses and disclosures of your PHI by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision within thirty (30) days.

§ Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to the Privacy Officer.

§ Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site. To obtain a paper copy of this notice, please contact the Front Desk or the Privacy Officer.

Changes To This Notice

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

Destruction of Medical Records

In accordance with law, CLINIC hereby advises all patients of its commitment to comply with Nevada law regarding the destruction of medical records as follows: the medical records of a person who is less than 23 years of age may not be destroyed; the medical records of a person who has attained the age of 23 years or older may be destroyed after 5 years.

Complaints

If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

This notice was published and is effective on December 1st 2023. If you have any questions about this notice, please contact our Privacy Officer.

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative: ____________________________________

Date: ___________________

Name of Patient or Personal Representative: _______________________________________

Description of Personal Representative's Authority: __________________________________

For Office Use Only

Notice of Privacy Practices sent/delivered on __________________________ Initials _______

Signed Acknowledgment of Receipt received on__________________________ Initials _____

Patient Refused or Failed to Acknowledge Receipt on _________