Sandia Neurology Intake Form 2019

Please fill out completely and give to front desk staff when finished.

Name of patient _____ Gender M F Date of Birth ____/____/_____

Legal Name _____ Age _____

Primary provider _____ Referring provider _____

Billing address _____ Cell phone _____

City State Zip _____ Work phone _____

Email _____

Occupation _____ Employer _____

Social Security Number _____ Home phone _____

Spouse _____ Spouse phone_____

Emergency Contact _____ Emergency contact Phone _____

Insurance Company _____ Policy number _____ Group number _____

Name of subscriber _____ DOB _____ SS #_____ Phone _____

Employer of subscriber _____ Occupation of subscriber_____

Reason for this appointment _____

Medical History and Intake Form 2019

Date:_____

Name:_____Date of Birth_____
Referring Provider:_____Reason for Referral:_____
Primary Care Provider:_____
Name and relationship of person completing this from (if person is not patient) _____
Email _____
Owner of insurance plan _____ Date of Birth _____ Social Sec No _____

symptoms:

Fatigue	Eye pain	Bowel accidents	Need for cane/ walker/ wheelchair	Trouble with walking
Fever	Chest pain	Bladder accidents		Falling
Weight loss	Palpitations	Urgency of urine	Headache/Migraine	Other symptoms:
Weight gain	Fainting	Pregnancy	Memory loss	_____
Accidents	Heart Problems	Impotence	Numbness	_____
Smoking	Shortness of breath	Depression	Tingling	_____
Vision changes	Trouble with sleep	Anxiety	Tremor	_____
Double vision	Snoring	Hallucinations	Seizure	_____
Vision loss	Morning fatigue	Anemia	Weakness	_____

Past Medical Problems

Alzheimers	Dementia	Heart Disease	Operations_____	Other_____
Parkinsons	Migraine	High Blood Pressure	_____	_____
Multiple Sclerosis	Head injuries_____	Anemia	_____	_____
Epilepsy	Neck injuries_____	Osteoporosis	_____	_____
Neuropathy	Tremor	Sleep Apnea	_____	_____
Stroke/TIA	Cancer_____	Fibromyalgia		_____
Toticollis	Thyroid	Asthma		_____
Spasticity	Diabetes			

Social History:

Job:_____ Exercise:_____ Recreational Drugs Y N
Education:_____ Tobacco Y N Cannibus Y N how often_____
Marital Status:_____ date quit _____date started_____ packs per day _____ecig _____
Number of Children:_____ Alcohol Y N

Family Health: List known medical conditions for family members:

Mother:_____
Father:_____
Siblings:_____
Grandparents:_____
Other:_____

Drug Allergies:

_____

Current Medications and Supplements taken:

_____
_____
_____
_____
_____

Sandia Neurology PC Privacy and Payment Policy 2020

I consent to receive medical care and treatment as deemed necessary or advisable in the judgment of Dr. Sally Harris. This may include testing, outside consultation, treatment, and/or follow up exams. I understand I will be informed about my condition and recommendations to allow me to help make the best decisions for treatment. This consent allows Dr. Harris to perform or recommend reasonable and necessary medical examinations, testing, and treatment. This consent remains in effect until it is revoked in writing. I authorize SNP to share part or all of my medical record to outside medical providers, insurance companies, disability determination, legal representative, or workman's comp carriers unless I specifically indicate otherwise.

As long as Dr. Harris is IN my medical insurance network, I agree to provide accurate and complete insurance and personal id at every visit, and to pay either the expected copay and coinsurance or the standard fee at the time of my visit. It is my responsibility to understand the benefits provided by my insurance plan. If I use health insurance, I hereby assign all medical insurance benefits to which I am entitled to Sandia Neurology PC (SNP). I also authorize SNP to submit any and all appeals if my insurance denies benefits. I understand that after my insurance has paid their specified reimbursement to SNP, I will be contacted to inform me and given the options of payment (credit card, check, cash) because invoices are no longer mailed. I also agree to pay in full any balance not covered by my insurance which may include any no show fees, form fees, failed appeals, service fees if over 30 days, and collections fees detailed below. I understand that I may review the full privacy practice policy for a more complete description of my protected health information and the use thereof.

As long as Dr. Harris is OUT of my medical insurance network, I understand the fees that I am responsible for and agree to pay the posted amount at the time of my visit. After payment, I may choose to submit to my insurance plan the receipt for Out of Network reimbursement using the forms on the website.

I agree to pay a fee of $75 for missing a follow up appointment or giving less than 1 business day cancellation notice, or $150 for missing a procedure or new patient visit that I scheduled and did not cancel at least 2 business days in advance.

In the case of nonpayment, I agree to be charged a $20 service fee when my account is submitted to third party assistance. After 60 days of nonpayment, my account will be sent to collections, the fee will be updated to be either $35.00 or 35% or the amount due, whichever is greater. I will not be rescheduled, receive copies of records, or obtain refills from this office until my outstanding balance is paid in full. To avoid this, I may leave a valid credit or debit card on file to be automatically run in the case of balance due.

Printed Name _____ Signature _____

Date ____/____/_____ SNP Witness _____

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505-884-4406 and fax 505-884-1671
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Sandia Neurology Credit Card on File Policy 2019

Patient Name _____ Date _____

Thank you for choosing Sandia Neurology for your neurological consultation and care. We are honored to help you understand your neurological issues and help develop a treatment plan for you. Please complete and return to front desk with your card. You are welcome to contact your insurance company to get an estimate prior to the visit. Typical new patient or consult codes used can be obtained by asking the front desk.

___ I understand that my insurance usually does not cover my entire bill for my upcoming visit.

____I agree to leave my credit card in secure file in Sandia Neurology to be run automatically in case of charges determined by my insurance company which are my responsibility to pay. When my card is run, I will receive in the mail during the next week and a paid invoice from this clinic.

____Instead of leaving a card on file, I prefer to pay up front the SELF PAY discounted rate amount for the entire visit (refundable after insurance pays) instead of leaving the card information on file. (Skip to signature on bottom.)

____If my card is lost, stolen, declined, or changed, I agree to inform Sandia Neurology immediately with a replacement. Any account with a declined card will be notified, then sent to third party assistance. Service fee may be added.

___ If I miss an appointment with less than a business day notification (Monday morning appointments must be cancelled by Thursday noon) to the clinic, I agree to have my card run for the amount of the No Show fee of $75 for a follow up or $150 for a procedure, injection, or EMG. (No show fees are not charged for medical emergencies.)

My signature on this form is the same as the one I use to sign my credit card receipts with and may be used instead of a signature on the receipt.

Call me ___ or Text me ___ card is run at _____OR run and mail receipt.____

Name on card: _____

Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Address for card billing: _____

_____

Expiration date ___ ___ / ___ ___ Security code on back of card ___ ___ ___

Phone number to reach me if there is a problem _____

Email for receipt _____

Signature _____ Date ___ ___/___ ___/___ ___ __ ___

Show card to Dr. Harris or staff members _____ _____