Sandia Neurology Intake Form 2021

Please fill out completely and either email back OR give to front desk.

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 _____

Relationship of subscriber _____ Occupation of subscriber_____

Reason for this appointment _____

Medical History and Intake Form 2021

Today's Date:_____

Name:_____ Date of Birth_____

Referring Provider:_____ Reason for Referral:_____

Primary Care Provider:_____ Location or fax for referring _____

Email _____

Height _____ Weight _____ Recent blood pressure _____

Your current symptoms:

Fatigue	Eye pain	Bowel accidents	Need for cane/ walker/	Trouble with walking
Fever	Chest pain	Bladder accidents	wheelchair	Falling
Weight loss	Palpitations	Urgency of urine	Headache/Migraine	Others:
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

Alzheimer's	Dementia	Heart Disease	Operations_____	Others_____
Parkinson's	Migraine	High Blood Pressure	_____	_____
Multiple Sclerosis	Head injury	Anemia	_____	_____
Epilepsy	Neck injury	Osteoporosis	_____	_____
Neuropathy	Tremor	Sleep Apnea	_____	_____
Stroke/TIA	Cancer	Fibrillation		_____
Toticollis	Thyroid	Asthma		_____
Spasticity	Diabetes	Height _____	Weight _____	

Social History:

Job:_____ Exercise:_____ Recreational Drugs Y N

Education:_____ Tobacco Y N Cannabis Y N how often_____

Marital Status:_____ date started _____date quit_____ packs per day _____e-cig Y N

Number of Children:_____ Alcohol Y N

Family Health: List known medical conditions for family members:

Mother:_____

Father:_____

Siblings:_____

Grandparents:_____

Drug Allergies: _____

_____

Current Medications and Supplements taken:

_____

_____

_____

_____

_____

Sandia Neurology PC Privacy and Payment Policy Overview 2021 v 2

I consent to receive the medical care and treatment as deemed necessary of advisable in the judgment of Dr. Sally Harris which may include testing, outside consultation, treatments or follow up exams. I authorize Dr. Harris to advise me on reasonable and necessary medical examinations, testing,referrals, and treatment and to perform those we agree on. If Dr. Harris has a student in attendance, I understand that I may elect to accept or decline their participation.

I authorize Dr. Harris to share part or all of my medical record to outside medical providers, insurance companies, disability or legal representatives, or others unless I specifically indicate.

I agree to provide accurate and complete insurance information at each and every visit including evidence of current insurance cards and photo id. Co pays are due at the time of service.

I understand that my insurance does not cover all my costs and I agree to pay in full any balance that they do not cover including no show fees, form fees, out of network charges, denials, take backs, failed appeals, and service fees.

I understand that my primary insurance will pay only if they are in network for Sandia Neurology.

I understand the benefits provided by my insurance plan and assign all medical insurance benefits to Sandia Neurology PC.

I understand that I may leave a valid credit or debit card on file which will allow me to **avoid late fees**. If my card is invalid for whatever reason, late fees may apply.

I understand that if I miss an appointment or do not cancel 2 business days in advance (M-Th) that I will pay a NO SHOW FEE equal to the FULL COST of the visit listed on the fee schedule. I understand that I may cancel 2 business days (M-Th) prior to the visit without penalty.

I understand that, if I fail to pay the amount due, I may be charged a service fee of $20 for missing co pays or co insurance after 30 days. After 60 days I will have a service fee of $35 or 35% of the amount due whichever is greater. As long as I have an outstanding balance, I will not be rescheduled, receive refills, or have forms completed until that balance is paid.

Printed Name _____ Signature _____

Date ____/____/_____

4600 Jefferson Lane, NE, Suite D, Albuquerque NM 87109
Reception (505)884-4406, Fax (505)884-1671
www.sandianeurology.com

Sandia Neurology Credit Card on File Policy 2021

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. You are welcome to contact your insurance company to get an estimate prior to the visit if we are in network OR if they cover out of network reimbursement.

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

____I agree to leave my credit card in secure file in Sandia Neurology.

____I request to be CONTACTED before it is run. Phone _____ Text _____
Late fees are $20 after 30 days and 35% or $25 whichever is greater after 60 days.

____ I give permission to run my automatically in case of charges determined by my insurance company which are my responsibility to pay. As long as the card is active, I will receive no service charges or late fees this way.

____When my card is run, I will receive email notice that it was run. Email _____

____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 I miss an appointment with less than a business day notification (Monday morning appointments must be can celled 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.

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 _____ _____