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

I consent to receive medical care and treatment as deemed necessary or advisable in the judgement of Dr. Sally Harris which may include testing, outside consultation, treatments, and or follow up exams. I understand I will be informed about my condition and recommended diagnostic or medical procedures to allow me to help make the best decisions for treatment. This consent allows Dr. Harris to perform 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, and disability or legal representative unless I specifically indicate.

If my insurance is IN network for Dr. Harris (Presbyterian commercial or senior plan OR governmental Medicare primary) I agree to provide accurate and complete insurance and personal id at each and every visit , to understand my insurance coverage, and agree to pay in full my copay, coinsurance, and deductible as determined by my plan as soon as it is determined. 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. It is my responsibility to understand my insurance plan, deductibles, copays, and coverage. I understand that my insurance (s) may not cover my visit and I agree to pay the balance immediately. If I provide incorrect information I will be charged the self-pay rate for all visits. I may then submit for reimbursement myself. I understand that even if I have one, my secondary plan my not cover the visit. After one claim submission to my secondary, I am responsible for any nonpayment.

If my insurance is OUT of network for Dr. Harris (all others) I will pay the self-pay costs immediately.

I understand that I may leave a valid credit card on file. As long as SNP has permission to use the card, and the card is active, I will avoid all late fees and collections fees. I may choose to allow SNP to run the card when needed.

I agree to pay in full any balance not covered by my insurance which may include any no show fees, form fees, denials or failed appeals. 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.

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 I understand that after my insurance has paid their specified reimbursement to SNP, I will be called to inform me and given the options of payment (credit card, check, cash). I will ***have 30 days from the date of the visit to pay in full or set up a payment plan***. After 30 days of nonpayment a $20 fee will be added to my bill and sent 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, or obtain refills or records until my outstanding balance is paid or a payment plan has been initiated.

Printed Name _____ Signature _____

Date ____/____/_____

4600 Jefferson Lane NE, Suite D, Albuquerque NM 87109
505-884-4406 and 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 _____ _____