



**General Medical Records Release and  
Authorization for Use or Disclosure of Protected Health Information**

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I authorize Neurological Associates of Nevada to release my records to:

- Dr. \_\_\_\_\_
- Dr. \_\_\_\_\_
- Relative : \_\_\_\_\_
- Relative : \_\_\_\_\_
- Other : \_\_\_\_\_

- I permit NAN to leave detailed messages on voicemail at the number(s) below (ie prescription directions, results of MRI, etc)
- I do not permit NAN to leave detailed messages on my voice mail. All information should be communicated to me directly.

Phone numbers where detailed voicemails can be left: \_\_\_\_\_

*\*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

I UNDERSTAND THAT AFTER THE CUSTODIAN OF RECORDS DISCLOSES MY HEALTH INFORMATION, IT MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY LAWS. I FURTHER UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT; RECEIVE PAYMENT; OR ELIGIBILITY FOR BENEFITS UNLESS ALLOWED BY LAW. BY SIGNING BELOW I REPRESENT AND WARRANT THAT I HAVE AUTHORITY TO SIGN THIS DOCUMENT AND AUTHORIZE THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AND THAT THERE ARE NO CLAIMS OR ORDERS PENDING OR IN EFFECT THAT WOULD PROHIBIT, LIMIT, OR OTHERWISE RESTRICT MY ABILITY TO AUTHORIZE THE USE OR DISCLOSURE OF THIS PROTECTED HEALTH INFORMATION.

\_\_\_\_\_  
Signature of patient (or patient's personal representative)      Date

\_\_\_\_\_  
Printed name of patient representative      Date  
Representative's authority to sign for patient,  
(i.e parent, guardian, power of attorney, executor)



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Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the custodian of records of: or other person/entity (specifically describe) to disclose/release the following information\* (check all applicable):

- |  |  |
|--|--|
| <input type="checkbox"/> All records                   | <input type="checkbox"/> Laboratory/pathology records  |
| <input type="checkbox"/> X-ray/radiology records       | <input type="checkbox"/> Billing records               |
| <input type="checkbox"/> Abstract/Summary              | <input type="checkbox"/> Pharmacy/prescription records |
| <input type="checkbox"/> Other (describe specifically) |  |

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**Please send the records listed above to:**

**Fax: (702) 946-5000 2121 E. Flamingo Rd. # 204 Las Vegas 89119**

The information may be used/disclosed for each of the following purposes:

- |  |  |
|--|--|
| <input type="checkbox"/> At my request         | <input type="checkbox"/> For my health care      |
| <input type="checkbox"/> For payment/insurance | <input type="checkbox"/> For employment purposes |
| <input type="checkbox"/> Other:                |  |

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\_\_\_\_\_  
Signature of patient (or patient's personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient representative  
Representative's authority to sign for patient,  
(i.e parent, guardian, power of attorney, executor)

\_\_\_\_\_  
Date

2121 E. Flamingo Road, Suite 204  
Las Vegas, NV 89119  
Phone (702) 990-3664 Fax (702) 946-5000  
www.neuro-associates.net

# Billing Policy

The following sets forth the general billing policy of Neurological Associates of Nevada. Please review this information and sign where indicated.

- ❖ I understand that it is my responsibility to provide the office of Neurological Associates of Nevada with current, accurate billing information at the time of check in and to notify NAN of any changes in this information.
- ❖ I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- ❖ I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a \$35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- ❖ I understand that there is a \$20 fee to complete disability paperwork associated with my care, for each packet completed. I also understand that any imaging films not picked up from NAN will result in a charge to me for the destruction of the films.
- ❖ I understand that the clinic will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any medical treatment that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my medical treatment. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on 1) anticipated procedures to be performed and 2) current information provided to clinic by my insurance carrier.
- ❖ I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- ❖ I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- ❖ I understand that the clinic may also take a verbal request to use my listed credit card for payment on my account or they may also use the same listed credit card on my account should my account become delinquent, or to cover an NSF check.
- ❖ I understand that any appointment cancelled with less than 24 hours notice (weekend cancellations are not acceptable) will result in a \$50 fee, which is not billed to my insurance carrier.
- ❖ I understand that any medical records requested, that are not sent to another physician, will require payment of 50 cents per page. I further understand that due to privacy practices reports will not be faxed to personal faxes or sent by email.

*My signature below confirms that I have read and understand these billing policies and my financial obligation, as well as the HIPPA policies and procedures notice I received, as it pertains to the office and physicians of Neurological Associates of Nevada.*

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**Legal Signature**

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**Date**

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**Relationship to Patient**



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**I am acknowledging that I have received a copy of the Neurological Associates of Nevada Notice of Privacy Practices.**

\_\_\_\_\_  
**Please Print Your Name Here**

\_\_\_\_\_  
**Please Sign Your Name Here**

\_\_\_\_\_  
**Date**

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**FOR OFFICE USE ONLY**

**We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:**

- The patient refused to sign**
- Due to an emergency situation it was not possible to obtain an acknowledgement**
- We were not able to communicate with the patient**

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**



# Neurological Associates

Phone: 702-951-7250

Fax: 702-946-5000

New patient  Established patient

Today's Date: \_\_\_\_\_

## PATIENT INFORMATION

PATIENT NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (M.I.) \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PATIENT'S EMPLOYER (Guarantor, if patient is a minor) \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ MAY WE CONFIRM YOUR APPOINTMENT BY E-MAIL?  YES  NO

WOULD YOU PREFER CONFIRMATIONS BY TEXT MESSAGE?  YES  NO IF YES, DO WE USE THE CELL PHONE ABOVE?  YES  NO

## GUARANTOR INFORMATION

IF GUARANTOR IS THE SAME AS PATIENT CHECK HERE AND DO NOT FILL OUT GUARANTOR INFORMATION BELOW

GUARANTOR NAME (LAST) \_\_\_\_\_ (FIRST) \_\_\_\_\_ (M.I.) \_\_\_\_\_

GUARANTOR ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

GUARANTOR EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_ WORK #: \_\_\_\_\_

GUARANTOR EMPLOYER ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

## REFERRAL INFORMATION

REASON FOR VISIT: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

## EMERGENCY CONTACTS

WHO DO WE NOTIFY IN CASE OF EMERGENCY? \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

## INSURANCE INFORMATION (please have receptionist copy your insurance cards)

PRIMARY INSURANCE CO: \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ POLICY HOLDER'S EMPLOYER: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

SECONDARY INSURANCE CO: \_\_\_\_\_ PHONE ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ POLICY HOLDER'S EMPLOYER: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP #: \_\_\_\_\_ EFFECTIVE DATE: \_\_\_\_\_

The above information is complete and correct. I authorize treatment of the above named patient. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits otherwise payable to me to the doctor indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due the doctor. A copy of the signature is as valid as the original.

\_\_\_\_\_  
\_\_\_\_\_



# Neurological Associates

*Phone:* 702-951-7250

*Fax:* 702-946-5000

PATIENT SIGNATURE

DATE

GUARANTOR SIGNATURE

DATE

REGISTERED BY INITIALS