Neuroscience & Rehabilitation Associates
1133 College Ave, Bldg B, Site 224
Manhattan, KS, 66502
Phone: (785) 537-9349 Fax: (785) 537-9486 Visit our website at: www.neuroscienceks.com

6/2/2017

Patient Information

Patient Information			
First Name	**Last Name:**	**MI:**	**Date of Birth:**
Address	**City**	**State**	**Zip**
Primary Phone:	**Secondary Phone:**	**Work Phone:**	
Other Name(s) Used:		**Email Address:**	
Gender □ M □ F	**SSN**	**Preferred Language**	**Driver's License**
Martial Status □ Married □ Single □ Divorced □ Separated □ Widowed	**Preferred Contact** □ Mail □ Home Phone □ Day Phone □ Cell Phone	**Ethnicity** □ Declined □ Other □ Hispanic/Latino □ Non-Hispanic	**Race** □ Declined □ American/Indian or Alaskan Native □ Asian □ Black or African American □ Native Hawaiian/Other Pacific Islander □ White □ Other
Primary Care Provider		**Referring Provider**	

If Under 18- Responsible Party (Guarantor)			
First Name	**Last Name**	**MI**	**Date of Birth**
Address	**City**	**State**	**Zip**
SSN	**Home Phone**	**Relationship to patient**	**Driver's License**

Emergency Contact FRIEND OR RELATIVE NOT LIVING WITH YOU!!!			
First Name	**Last Name**	**MI**	**Date of Birth**
Address	**City**	**State**	**Zip**
Relationship:	**Home Phone**	**Work Phone**	**Cell Phone**

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Assignment of Insurance Benefits/Eligibility Certification

For Medicare Patients Only		
Health Insurance Claim Number	**Part A Effective Date**	**Part B Effective Date**

Primary Insurance Plan-MUST BRING CARD TO BE SEEN		
Patient Name	**Date of Birth**	
Insurance Plan	**Group #**	**Policy #**
Subscriber Name	**Relationship to Patient**	
Subscriber Social Security #	**Subscriber Date of Birth**	

Secondary Insurance Plan- MUST BRING CARD TO BE SEEN		
Patient Name	**Date of Birth**	
Insurance Plan	**Group #**	**Policy #**
Subscriber Name	**Relationship to Patient**	
Subscriber Social Security #	**Subscriber Date of Birth**	

I/We do hereby consent to and authorize the performance of all treatments, surgeries, and medical services deemed advisable by the physicians and staff of the Neuroscience and Rehabilitation affiliated medical groups to me or the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Neuroscience and Rehabilitation affiliated medical group to release information requested by the insurance company and/or representatives and permit such representatives to contact me on provided numbers above concerning and all aspects of my account. I fully understand this agreement and consent will continue until cancelled by me in writing.

I hereby authorize and request that payment of authorized Medicare/other insurance company benefits be made on my behalf, be paid directly to Neuroscience and Rehabilitation for any medical or surgical services rendered by its affiliated medical groups to me or a member of my family. I authorize any holder of medical or other information about me to release to the Social Security Administration, Health Care Financing Administration, its agents or carriers, or the insurance company any information needed for this or a related Medicare/other insurance claim to determine these benefits payable for related services. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Signature of Patient/Responsible Party (Please Print) Relationship to Patient

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Privacy Notice and Permission to Relay Information

As a condition of providing treatment to you, Neuroscience & Rehab Assoc. must obtain your consent to use and disclose Protected Health Information (PHI) about you to carry out treatment, payment, and the health care operations of this office. You may revoke this consent at any time by notifying Neuroscience & Rehab Associates in writing, except to the extent the office has taken action and reliance on your consent. Please refer to the Notice of Privacy Practices for Health Information for a more complete description of the uses and disclosures that office/staff may use of your PHI. You have the right to review the Privacy Notice prior to signing the consent. Neuroscience & Rehab Assoc. has reserved the right to change its privacy practices described in the Privacy Notice in accordance with law; the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person. You have the right to request Neuroscience & Rehab to restrict the manner in which your PHI is used or disclosed to carry out treatment, payment, or health care operations. Neuroscience & rehab is not required, however, to agree to such requested restrictions. If, however, Neuroscience & Rehab agrees to the requested restriction, the office will honor the request and it will be binding. I hereby consent to the use and disclosure by Neuroscience & Rehab and its work force, and its business associates of my PHI for purpose of treatment, payment, and health care operations.

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to require that communication concerning your personal health information be made through confidential channels. If you request to receive confidential communications of PHI by alternative means, you must give us an alternative address or other method of contacting you. Some method of contact must be provided. We will not ask why you are making your request, and will make efforts to accommodate all reasonable requests. This request supersedes any prior request for communication of information I may have made.

Extended Authorization

Please list any persons you would like to have access to your billing, appointment or health information (with the exclusion of information that is protected under State and Federal law), such as your spouse, caretaker, or other family member.

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

Restriction on Communication Methods

Our methods of communicating with you may be through mail and/or telephone, including leaving messages on your answering machine/voicemail. Please list ways in which you do **NOT** want to receive communications _____. I agree to permit Neuroscience and Rehabilitation Associates and their business associates to contact me and all other responsible parties on my account on our cell phone or other mobile devices concerning any and all aspects of my account.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Signature of Patient/Responsible Party (Please Print) Relationship to Patient

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Office Financial Policy

1. PAYMENT in full is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company.

2. OUTSTANDING BALANCES will be transferred to a collections agency after they are 121 days past due. We understand that people have financial difficulty, so please communicate with our billing and collection staff so they can assist you and prevent further collection actions. If your account is in collections, please contact KCI at 800-333-8335.

3. INSURANCE is filed by our office on your behalf. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

4. RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, money order, or pay by credit card to cover the amount of the check plus the $30.00 service charge to pay the balance prior to receiving services from our staff or the physician.

5. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $30 missed appointment fee. This fee is not covered by insurance and will be due before you are seen in our office again. We have an answering service that allows messages to be left 24 hours a day, 7 days a week.

6. SELF-PAY patients are given a discount when fees are paid at time of service. If you are unable to pay the entire amount due, a payment plan must be set up.

7. Please read your insurance policy carefully or check with your insurance agent or employer regarding your benefits. You will be responsible for payment of any claims which have not been resolved within **90 days.** Your health insurance is a contract between you and them and you should contact your carrier if you have any complains or a problem in a settlement of a claim.

I HAVE READ AND UNDERSTAND THE PRACTICE'S FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print the name of the patient

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Medical History

Pharmacy:

Name of Pharmacy _____

I authorize Neuroscience and Rehabilitation Associates to view and import my medication history from my pharmacies. Signature: _____ Date _____

Primary reason for seeing us today?

Medication and Food Allergies-List all allergies (drugs, food, animals, etc.)

□ No Known Allergies	

Medications-List all medications you take, prescription and on-prescription, and the dosage

□ I do not take any medications	
Medication Name	**Dosage/Frequency**

Review of Symptoms: Please circle below if you are experiencing these symptoms today

Constitutional
Weight Loss
Weight Gain
Fatigue
Night Sweats

Eyes
Visual Changes
Eye Pain
Double Vision

ENT
Ear Pain
Tinnitus
Vertigo
Jaw Pain
Taste Disturbance
Sore Throat
Runny Nose

Respiratory
Cough
Shortness of Breath
Difficulty Breathing

Cardiovascular
Chest Pain
Passing Out
Palpitations
Swelling of Extremities

Gastrointestinal
Abdominal Pain
Heartburn
Constipation
Diarrhea
Nausea
Vomiting

Genitourinary
Urinary Frequency
Urinary Incontinence
Painful Urination

Hema/Lymph
Anemia
Bruising Tendency
Bleeding Tendency

Endocrine
Excessive Thirst
Change in Hair Texture
Hyperglycemia
Hypoglycemia

Immunologic
Immunocompromised
Recurrent Infections
Recurrent Fever

Musculoskeletal
Back Pain
Neck Pain
Joint Pain
Stiffness
Muscle Spasm
Decreased Range of Motion

Integumentary(Skin)
Rash
Excessive Dryness
Skin Lesions

Neurologic
Abnormal Balance
Headache
Migraine
Dizziness
Numbness
Tingling
Seizure
Tremor
Confusion
Muscle Weakness
Poor Balance
Speech Difficulty
Memory Loss

Psychiatric
Depression
Anxiety
Sleeping Problems
Lack of Energy
Difficulty Concentrating

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Medical History

Medical History- Check if you have every experienced the following conditions, and year of onset

Condition	Year	Condition	Year	Condition	Year
□ None		□ Coronary Artery Disease		□ Migraine Headaches	
□ Allergies(seasonal)		□ COPD (Emphysema)		□ Myocardial Infarction	
□ Anemia		□ Crohn's Disease		□ Osteoarthritis	
□ Angina		□Depression		□ Osteoporosis	
□ Anxiety		□ Diabetes		□ Peptic Ulcer Disease	
□ Arthritis		□ Gallbladder disease		□ Renal Disease	
□ Asthma		□ GERD (Reflux)		□ Seizure Disorder	
□ Atrial Fibrillation		□ Hepatitis C		□ Thyroid Disease	
□ Benign Prostatic Hypertrophy		□ Hyperlipidemia		□ Weight loss	
□ Blood Clots		□ High Blood Pressure		□ Weight gain	
□ Cancer-Type		□ Kidney Stones		□ Other	
□ Cerebrovascular Accident		□ Liver Disease			

Surgical History-Check if you have received the following procedures and the year performed:

Surgical Procedure	Year	Surgical Procedure	Year	Surgical Procedures	Year
□ None		□ Hip Replacement		**Female Only:**	
□ Angioplasty		□ Knee Replacement		□ Augmentation Mammoplasty	
□ Appendectomy		□ LASIK		□ Bilateral Tubal Ligation	
□ Arthroscopy Knee		□ Pacemaker		□ Breast Biopsy	
□ Back Surgery (Type)		□ Small Bowel Resection		□ Cesarean Section	
□CABG (heart bypass)		□ Thyroidectomy		□ D and C	
□ Carpal Tunnel Release		□ Tonsillectomy		□ Hysterectomy	
□ Cataract Extraction				□ Mastectomy	
□ Gallbladder removal		**Male Only:**		□ Myomectomy	
□ Colectomy		□ Prostate Biopsy		□ Reduction Mammoplasty	
□ Colonoscopy		□ TURP (Trans-urethral resection of prostate)		□ TAH/BSO	
□ Gastric Bypass		□ Vasectomy		□ Vaginal Hysterectomy	
□ Hernia Repair		□ Other:		Other:	

Family History

Father: _____ Alive (Age ____) _____Deceased (Age____) _____ Unknown
Medical Problems/Cause of Death _____ Unknown

Mother: _____ Alive (Age ____) _____Deceased (Age____) _____ Unknown
Medical Problems/Cause of Death _____ Unknown

Other Family History:

Social History for Adult Patient:

Occupation:		Employer:	
Do you have any children? □ Yes □ No	How Many?	Female (s):	Male (s):
Tobacco Use: □ No	□ Daily □ Weekly □ Less □ Former/Year Quit	□ Chewing □ Pipe □ Cigar □ Cigarette □ Smokeless Brand	
Alcohol Use: □ No	□ Daily □ Weekly □ Less □ Former/Year Quit	□Beer □ Wine □ Liquor □ Other	
Exercise Activity:	□ Moderate □ Vigorous □ Sedentary Days/Week	Sleep Pattern □ Changes □ No Changes	