New patient Registration **Date**___/___/___

Patient Information

First Name _____ Last Name _____ DOB _____ Gender _____

Street Address _____ State _____ Zip _____

Social Security Number _____ Home Phone _____ May we leave a message? Yes / No

Cell Phone _____ May we leave a message? Yes / No Email _____ May we send email reminders? Yes / No

Patient's Employer _____ Work Phone _____ Ok to call work? Yes / No

Spouse or significant other _____ Contact No. _____

Emergency Contact

First Name _____ Last Name _____ Relationship _____ Phone _____

Name and relation of person we may speak with other than yourself regarding your medical care? _____ Phone _____

List of current/recent providers (Please include phone and fax if possible)

1) PCP: _____ _____ _____
2) _____ _____ _____
3) _____ _____ _____
4) _____ _____ _____

Please indicate which provider is the referring with a *

Preferred Pharmacy and Phone Number_____

Insurance information

Primary Insurance company _____ Name of subscriber _____ DOB of subscriber _____

SSN of policy holder _____ Group ID# _____ Policy/ID # _____

Relation to patient _____ Employer _____ Employer phone # _____

Secondary Insurance company _____ Name of subscriber _____ DOB of subscriber _____

SSN of subscriber _____ Group ID# _____ Policy/ID # _____

Relation to patient _____ Employer _____ Employer phone # _____

Medical Information

Allergies (Including reaction)

_____

_____

Medications (May attach sheet if needed). Include dosing and frequency

_____

_____

_____

_____

Health Concerns and Goals (Provide in rank order)

1) _____
2) _____
3) _____
4) _____

Past Medical History	**Past Surgical History**
Are you pregnant, planning or could be? Yes / No	

(Attach additional sheets if needed)

Family History	**Social History**
	Current Employment: Highest level of school performance: Tobacco: Drugs: Alcohol: Yes or No Freq: Occ, Daily Prior history of daily alcohol: Yes or No Marriage History: Children:

Review of Systems (Please check symptoms which are current)

General O poor appetite O weight gain O weight loss O poor sleeping O fever/chills O fatigue/generalized malaise O night-sweats O sudden energy drops O localized muscle weakness O bleeding/easy bruising O peculiar tastes/smells	**ENT** O dental/gum problems O temporal artery tenderness O jaw clicks/locks O teeth grinding O ringing in ears O poor hearing O earaches O facial pain O sinusitis O nasal congestion O nosebleeds O difficulty swallowing	**Eyes** O eye strain O corrective lenses O worsening/blurred vision O double vision O field of vision cut O color blindness O night blindness O cataracts O glaucoma O spots in front of eyes
Cardiovascular O Chest pressure or pain O difficulty breathing w/ exertion O irregular heartbeat O palpitations O fainting O spontaneous flushing/sweating O dizziness on standing O cold hands/feet O blood clots O varicose/spider veins	**Neurologic** O seizures O head trauma/concussion O vertigo/dizziness O areas of numbness O lack of coordination O poor memory O brain fogginess O tremor O gait instability O headaches	**Respiratory** O asthma/wheezing O cough/bronchitis O production of phlegm O pneumonia O coughing blood O history of +PPD O difficulty inhaling/exhaling O chest tightness O pain with deep inhalation O loud snoring O episodes of apnea
Skin O rashes O ulcerations O hives O itching O eczema/atopic dermatitis O psoriasis O loss of hair O change in skin/hair texture O weak or rigid nails O face flushing/rosacea	**GI** O nausea/vomiting O dyspepsia/indigestion O acid reflux/GERD O abdominal pain O constipation O diarrhea O black/bloody stools	**GU** O Blood in Urine O Urinary Frequency O Loss of Urine Control O Night Time Urination O Lack of Sex Drive O Unusual Urine color
Musculoskeletal O foot/ankle pain O knee pain O hip pain O low back pain O mid back pain O upper back pain O shoulder pain O neck pain O hand/wrist pain	**Endocrine** O Excess hunger (unusual) O Cold Intolerance O Heat Intolerance O Excess Urination O Excess Thirst	**Psychiatric** O attention deficit/distractibility O seasonal affective disorder O anxiety/panic attacks O temper/irritability O ADD/ADHD O Suicidal thoughts O Depression
Hematology O Weight Changes (Sudden) O Enlarged Lymph nodes O Bleeding (Unusual) O Abnormal Bruising	**Allergy/Immunology** O Persistent Infections O Hives/Rash O Seasonal Allergies	

_____ _____

Signature Date

Peak Neurology Financial Policy

Last Name	First	MI	Todays Date

DOB	SSN

Please carefully review this information and sign where indicated. We are committed to providing you the best possible medical care. If you have medical insurance, we would like to help you receive the maximum allowable benefits. In order to achieve this goal, we will need your assistance and understanding of our financial policies.

Please present current insurance cards at each visit. Any changes to personal information must be given to the office immediately.

Assignment: I request that payment of authorized insurance, medicare, and medicaid benefits be payable to Peak Neurology on my behalf for services furnished to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. In the event my account is turned over to a collection agency, I agree to pay all reasonable costs of collection and understand that I may no longer be a patient at this office.
_____ (Initial) I have read and agree to the above statement

Co-pay/coinsurance/deductible: I understand that my primary insurance will be billed; billing secondary insurance is a courtesy only and and I am ultimately responsible for assigned co-payments, co-insurance and deductible amounts by primary and/or secondary insurance. Tertiary insurance billing remains my responsibility.
_____ (Initial) I have read and agree to the above statement

Release of Information: I authorize the holder of medical information about me to release any and all information to Centers for Medicare and Medicaid Services, its agents, my insurance carrier(s), or other entities as needed to determine these benefits or the benefits for my dependents or myself. If I have health insurance coverage under an HMO, I authorize Peak Neurology to release information concerning my diagnosis and treatment to my primary care or referring physician after each visit.
_____ (Initial) I have read and agree to the above statement

Requests for Information: Should I receive any requests from my insurance company in regards to my services at this office, I must respond to that correspondence immediately in order to have the claim processed and paid.
_____ (Initial) I have read and agree to the above statement

Self-Pay: Self-pay and previous balance amounts are due and payable at the time of service. Insurance co-payments are mandated by your insurance company and MUST be paid at each visit. Patients with insurance claims pending will be sent statements for the full amount due until the account is satisfied. I agree that if the insurance company denies benefits for any reason, I am responsible for the full amount owed for services provided.
_____ (Initial) I have read and agree to the above statement

Workers' Compensation: I will provide approval/authorization by the Workers' Compensation carrier at the initial visit. If the claim is deferred, the private medical insurance will be billed. I understand if the claim is denied, I will be responsible for payment in full. If the claim is in litigation, a verification of this from an attorney and/or the Workers' Compensation carrier will be provided to this office.
_____ (Initial) I have read and agree to the above statement

Returned Checks: I understand and agree to pay a returned check charge of $35.00 for each check that is returned for any reason. I agree to pay the amount of the check plus the service charge within 30 days of receipt of notification.
_____ (Initial) I have read and agree to the above statement

Late Cancellation/No Show Policy: Late cancellations (<24 hours notice) or no show for a routine office visit (follow up or new patient appointment) will be charged $75. For late cancellation or no show for EMG/NCS studies a $150 dollar fee applies. This must be paid prior to scheduling any further appointments.

I have read and agree to the above information and I, the undersigned/patient, are ultimately responsible for the fees. By signing below, I consent be contacted by regular mail, by email or by telephone (including cell phone number) regarding any matter related to the above referenced account by the creditor, its successors or assigns. This consent includes any updated or additional contact information that I may provide and includes contact that employs auto dialer technology and/or pre recorded messages and text messaging. You may choose to discontinue your participation in our online communication system at any time simply by notifying the office by phone or email to stop further communication. Standard text messaging rates may apply.

Print Name_____

Signature_____ Date_____

5770 Flintridge drive Suite 100 Colorado Springs Colorado 80918
Phone: 719-445-9902 or 719-212-0770
Fax: 719-387-0312
Email: bpriebe@peakneurocos.com
www.peakneurocos.com

Acknowledgement of receiving Privacy Practices

I acknowledge that I have been offered to review and reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of the amended Notice of Privacy Practices will be available at each appointment if I request one.

Indicate relationship if not signed by patient.

O Guardian or conservator of an incompetent patient.
O Parent of guardian or minor.

_____
Patient Name

_____ _____
Signature Date

_____
Please complete below if refusing to sign the above acknowledgement

_____
Patient Name

_____ _____
Signature Date

Reason for refusal:
_____
_____
_____