Neurological Associates of Washington

13107 121st Way NE, Kirkland, WA 98034

~We would be grateful if you could please take a few moments to complete/correct this form~

I. Demographics / Patient Information

Name: _____ Birthdate: _____ Gender: ☐ Male ☐ Female
First M.I. Last

Address: _____ Presently Married? ☐ Yes ☐ No
Street Address City State Zip Code

Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Do you have children? *(if so, how many, including stepchildren)* ☐ No ☐ Yes, # _____

Emergency Contact Information

Name: _____ Relationship: _____
First M.I. Last

Home Phone: _____ Work Phone: _____ Cell Phone: _____

II. Referral Information

Who referred you to our office? _____ Phone Number: _____
Name (First, Last) *(if physician)*

What is the reason for your visit? _____

Your Primary Care Physician?: _____ Phone Number: _____

III. Insurance Information

Most recent occupation? _____

Is this a **work related injury**? ☐ No ☐ Yes, injury date = _____ Claim # = _____

If so, please choose: ☐ State Industrial ☐ Self-Insured

Employer at time of injury: _____

Claims Manager Name: _____

Phone # / Fax #: _____

Is injury due to **car accident**? ☐ No ☐ Yes, accident date = _____ PIP Claim # = _____

PIP Insurance Carrier _____

Claims Manager Name: _____

Phone # / Fax #: _____

Primary Insurance

Insurance Company: _____ Policy Number: _____

Address: _____ Group Name/#: _____ / _____

Are you the policy holder on this insurance card? ☐ Yes ☐ No, *please provide the policy information:*

Policy Holder Information

Name: _____ SSN# _____ Date of Birth: _____
First M.I. Last

Relationship: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Policy Number: _____

Address: _____ Group Name/#: _____

Are you the policy holder on this insurance card? ☐ Yes ☐ No, *please provide the policy information:*

Policy Holder Information

Name: _____ SSN# _____ Date of Birth: _____

First M.I. Last

Relationship: _____

Employer: _____

IV. Health History Information

Height: _____ Weight: _____

Which hand do you write with? ☐ RIGHT ☐ LEFT

Do you smoke? ☐ NO ☐ YES

- ☐ Cigarettes
- ☐ Cigars
- ☐ Chewing Tobacco

How often:
Packs per week: _____
Or # per week: _____

Do you drink alcoholic beverages? ☐ NO ☐ YES

- ☐ Rarely
- ☐ Occasionally
- ☐ Weekly
- ☐ Daily

Type of beverage? _____

ALLERGIES

Do you have any allergies to any food(s) or medication(s)? ☐ NO ☐ YES

(If yes, please list and indicate reaction, Please exclude hay fever or seasonal allergies and use back of this page if needed)

Drug	Reaction

CURRENT MEDICATIONS? ☐ NO ☐ YES

(Please include aspirin and other anti-inflammatory drugs such as ibuprofen, Motrin, Advil, etc…, but exclude vitamins and attach list, if necessary)

Medication	Dosage

YOUR PHARMACY:

Name: _____

Location: _____

Phone Number: _____

Prior Surgeries

Have you ever undergone any surgery? ☐ NO ☐ YES

(Please attach list, if necessary)

Type of Surgery	Year

V. Medical History (please check either "Yes" or "No" for each item-thank you!)

Yes	No		Yes	No	
☐	☐	Abdominal Pain	☐	☐	Limb Symptoms Caused by Neck Movement
☐	☐	Anemia	☐	☐	Limited Neck Range of Motion
☐	☐	Angina or Chest Pain	☐	☐	Liver Problems
☐	☐	Asthma	☐	☐	Metal Implants
☐	☐	Bladder Control Problems	☐	☐	Neck Pain
☐	☐	Bleeding Disorders	☐	☐	Osteoporosis
☐	☐	Blood Clots	☐	☐	Recent Constipation
☐	☐	Bowel Control Problems	☐	☐	Recent Fevers
☐	☐	Cancer	☐	☐	Seizures
☐	☐	Diabetes	☐	☐	Serious Infections
☐	☐	Double Vision	☐	☐	Shortness of Breath
☐	☐	Emphysema	☐	☐	Spine Surgery
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Hearing Disorder	☐	☐	Thyroid Problems
☐	☐	Heart Attack	☐	☐	Tuberculosis
☐	☐	Heart Disease	☐	☐	Ulcer Disease
☐	☐	Heart Murmur	☐	☐	Unexplained Nausea
☐	☐	Hepatitis	☐	☐	Unintended Weight Loss
☐	☐	High Blood Pressure	☐	☐	Unusual Headaches
☐	☐	Implanted Pacemaker	☐	☐	Urological Problems
☐	☐	Kidney Problems	☐	☐	Use of Blood Thinners
☐	☐	Lapse of Consciousness	☐	☐	Unusual Cough
☐	☐	Calf/Thigh Tenderness to Touch	☐	☐	Visual Blurring
			☐	☐	Other Not Listed: Please list below

Please elaborate regarding any items to which you answered "Yes"

Family Health History

Do you have any inherited, family or genetic illnesses? ☐ NO ☐ YES

(if yes, please list)

Comments

We would be grateful for any comments you may have regarding how this form can be improved.

I certify all the information in these forms is true to the best of my knowledge. I authorize appropriate insurance benefits to be paid directly to my physician and understand that I am financially responsible for any required balance. I also authorize Neurological Associate of Washington or the insurance company to transmit any information as required for the processing of my claims.

Signature

Date

Print Name

If not signed by Patient, Guardian Name

Relationship to Patient

If the patient is a minor or not legally competent, the parent or legal guardian should sign this document for the patient.

Thank you for taking the time to complete this form!

Notice of Privacy Practices

~In Accordance with Federal Regulations~

Neurological Associates of Washington keeps necessary records of your medical condition and care. We would be happy to provide you with a copy of these records upon request and will not disclose these records to others unless you direct us to do so or unless the law authorizes or requires us to do so. Please feel free to submit to us any comments or corrections regarding these records.

Our **Notice of Privacy Practices** (please see next 3 pages) describes in more detail how your health information may be used and disclosed and how you can access this information.

By signing below, you will be acknowledging that you understand the Notice of Privacy Practices of Neurological Associates of Washington. This signed form will also be retained in your medical record and will remain effective until revoked by you in writing.

Additionally:

1. *May we leave messages regarding your appointment on your answering machine or voicemail at your home?* ☐ No ☐ Yes

2. *May we discuss your medical care with anyone that answers the telephone at your home?* ☐ No ☐ Yes

3. *Are there any members of your family, household or those coming with you to this appointment with whom we should not discuss any of your health care issues?* ☐ No ☐ Yes _____

4. *Do you have any suggestions regarding how we may improve our Patient Privacy Program?* ☐ No ☐ Yes _____

_____ _____

Signature Date / Time

_____

Print Name

_____ _____

If not signed by Patient, Guardian Name Relationship to Patient

If the patient is a minor or not legally competent, the parent or legal guardian should sign this document for the patient.

Notice of Privacy Practices

~In Accordance with Federal Regulations~

The following document describes how your medical records may be used and how you can obtain access to this information:

Neurological Associates of Washington respects your privacy and understands that your personal health information is very sensitive. Accordingly, we will not disclose your information to others unless you ask us to do so, or unless the law authorizes or requires us to do so (please see below).

The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers and the billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to obtain your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment and Health Operations

For treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing health care to you. This will help them remain informed about your care.

For payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For health care operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - medical quality review by your health plan;
    - accounting, legal, risk management, and insurance services;
    - audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and receive a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.

- Request that we review a denial of access to your health information—except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
- Upon your request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

For help with these rights, please contact our medical records department (tel.: 425-658-3310) during our usual business hours

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this Notice;
- Follow the terms of this Notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it or by visiting one of our offices to pick one up.

To Ask for Help or Complain

If you have questions, want more information, or want to report a problem about the handling of your protected health information, please contact our medical records department (tel.: 425-658-3310).

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to our medical records department. We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of Family and Others

- Unless you object, we may 1-release health information about you to a friend or family member who is involved in your medical care, 2-give information to someone who helps pay for your care, 3-tell your family or friends your condition and that you are in a hospital and
- 4-disclose health information about you to assist in disaster relief efforts.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it.

Notice of Privacy Practices

~In Accordance with Federal Regulations~

We may use and disclose your protected health information without your authorization as follows:

- **With Medical Researchers**—if the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.
- **To Funeral Directors/Coroners** consistent with applicable law to allow them to carry out their duties.
- **To Organ Procurement Organizations (tissue donation and transplant)** or persons who obtain, store, or transplant organs.
- **To the Food and Drug Administration (FDA)** relating to problems with food, supplements, and products.
- **To Comply With Workers' Compensation Laws**—if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law:**
    - to prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
    - to public health or legal authorities
        - to protect public health and safety
        - to prevent or control disease, injury, or disability
        - to report vital statistics such as births or deaths.
- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.

Other Uses and Disclosures of Protected Health Information

- Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization.

Thank you for your time and attention! We encourage you to contact us with any suggestions or comments.

-The physicians and staff at Neurological Associates of Washington.