LEO GERMIN, M.D.
&
NEUROLOGICAL
ASSOCIATES

SCHEDULING CONTACT:
PHONE: (702) 804-4949
FAX: (702) 577-0985

Dear Patient,

Thank you for scheduling an appointment with CNS. It is our pleasure to welcome you to Clinical Neurology Specialists in advance of your first visit.

Following is some information that will help familiarize you with our practice.

Patient Education / Physician and Provider Information
www.CNSnevada.com / www.cnsneurodx.com

Business hours
Monday – Friday 8:00 AM to 4:30 PM

Patient Scheduling Hours
Monday – Friday 7:00 AM – 4:30 PM (end times may vary); Select Saturdays (by appointment)

Contact person
New Patient Scheduling /Rescheduling – Call (702) 804-4949
Established Patient Scheduling/Rescheduling – Call (702) 804-1212
Note: Established patients not seen within 3 years will be scheduled as a new patient

Financial Payment policy
It is our payment policy to collect the appropriate payment due from the patient at the time the service is rendered prior to being seen. This may only be your co-payment, deductible and/or co-insurance, but we do ask for payment at the time of your visit. CNS accepts (Visa/MC/Discover) and (CareCredit/MyMedicalLoan.com). See our website at www.cnsnevada.com then click on "Our Practice" for more payment policy information.

Co-payment – The part of the patient's medical bill that must be paid each time the patient visits the physician/provider. This is a pre-set fee determined by the health insurance policy.

Deductible – The amount the patient must pay for medical treatment before their health insurance company starts to pay. In most cases, a new deductible must be satisfied each calendar year.

Co-insurance – The part of the patient's medical bill, often in addition to a co-payment, that the patient must pay. Co-insurance is usually a percentage of the total medical bill allowable by insurance.

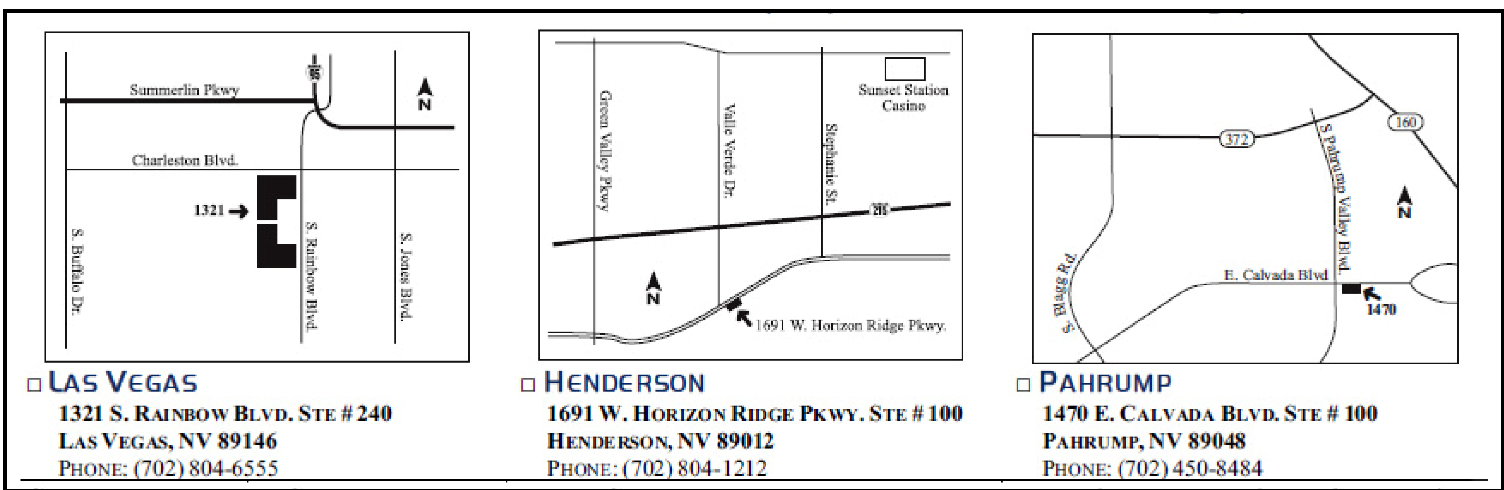
If you have any questions after reading this information, CNS will be happy to answer them for you prior to your visit by telephone at **(702) 804-1574**. Also enclosed is a patient registration form and privacy form to be completed prior to your scheduled visit. These forms may be faxed to **(702) 577-0985** or you can bring them to your appointment.

Please bring the following information to your visit, if you have not already faxed or brought this information to the practice prior to your scheduled visit:

- Current Insurance card(s)
- Current Drivers license or other photo identification in absence of a Drivers License
- Completed Financial Payment Policy, Medical Records Authorization Form, Privacy Notice, etc.

We appreciate you and your referring provider in selecting Clinical Neurology Specialists for your neurologic care.
Sincerely CNS

Office Locations / Maps / Other Information



We look forward to seeing you at your appointment. If you are unable to keep this appointment, please call (702) 804-4949 for appointment cancellations and confirmations.

www.CNSnevada.com

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&
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CONTACT:
Rainbow: (702) 804-6555
Fax: (702) 804-1998
Horizon: (702) 804-1212
Fax: (702) 804-1273

FINANCIAL PAYMENT POLICY

The following policies apply. *Certain exemptions or additional policies may apply for Medicare Part B and Part C recipients, Medical Lien cases, Worker's Compensation cases, and other payer sources like (Veteran's Administration, Bureau of Disability, Accident Liability Insurance; Victims of Crime, etc.) If you have one of these Other Payors mentioned for your visit today then please see the front desk after completing this form and other registration paperwork for additional information.*

Co-payment

All co-payment responsibilities for consultation and follow up appointments are due in full at the time service is rendered prior to being seen. Co-payments for in-office procedures are due in full if the financial responsibility for the day is less than or equal to $40.00. Medicare Advantage Plan members see the front desk for additional information regarding co-payment responsibilities for in-office procedures if applicable.

Co-insurance

All coinsurance responsibilities for consultation and follow up appointments are due in full at the time the service is rendered prior to being seen. If you are unable to pay the full amount or estimate amount then please see the front desk. Coinsurance for in-office procedures are due in full if the financial responsibility for the day is less than or equal to $40.00. If the coinsurance total is over $40.00, then the full amount is due at the time the service is rendered prior to being seen. If you are unable to pay this amount, then please see the front desk. Original Medicare Part B recipients please see the front desk.

Deductible

All deductible responsibilities are due in full at the time the service is rendered prior to being seen. Original Medicare Part B and Medicare Advantage Plan recipients please see the front desk.

Balance

All balance responsibilities equal to or less then $75.00 are due in full at the time service is rendered prior to being seen in addition to any appointment co-payment, co-insurance responsibilities, and/or deductible responsibilities.

All balance responsibilities greater then $75.00 are due in full at the time service is rendered prior to being seen in addition to any appointment co-payment and co-insurance responsibilities. If you are unable to pay your balance amount or are a Medicare Part B recipient then please see the front desk.

APPOINTMENT POLICY

CNS understands that not all appointments may be kept due to emergencies and changes in your personal schedule. CNS allows for up to a combination of two consecutive cancellations (or one cancellation and one no show) for the same appointment (or series of testing appointments) within 12 calendar months. After this, staff will be unable to assist you in rescheduling your appointment and your chart will be sent for Administrative and Clinical review. Please allow up to 15 business days for a response regarding your appointment. During this time you should seek care from your primary care physician.

DISCHARGE/TRANSFER OF NEUROLOGIC CARE/OTHER INSTRUCTIONS

You may terminate the patient-physician relationship by verbal/written request at any time. Your physician may terminate the physician-patient relationship with a 30-day written notice for the following, but not limited to: neurologic services are no longer needed, no longer contracted with your health insurance plan, you request services outside the physician's expertise/office hours/or at a location other then the physician's office, verbally abusive language, failure to follow plan of care or comply with an appropriate treatment regimen, patient going against medical advice, appointment non-compliance.

I further acknowledge and agree that all accounts past 30 days shall bear a compounding interest rate of 1.5% per month. I also acknowledge and agree that in the event I do not pay for services purchased, CNS may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court cost incurred in collection of my overdue account.

____

(Print Name) (Patient Signature) (Date)

REG SECTION 1 - APPOINTMENT INFORMATION

Did a physician, PA, NP refer you to CNS? ☐ Yes ☐ No If yes, name of physician, PA, NP: ______________

Specialty: ______________ OR Did you make this appointment yourself: ☐ Yes ☐ No

Date of Accident/Injury: ___/___/___ OR Date Symptoms began: ___/___/___

Type of Accident: ☐ at work ☐ at home ☐ auto ☐ Other (explain): ______________

REG SECTION 2 - PATIENT INFORMATION

Name: (Last) ______________ (First) ______________ (Middle) ______________ Sex: ☐ M ☐ F

Address: ______________ City: ______________ State: ______ Zip: ______

Date of Birth: ___/___/___ SSN: ___-___-___ Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Sep

Home Phone: (____) ______________ Cell Phone: (____) ______________ Email: ______________

Spouse's Name: ______________ DoB: ______________ Employer: ______________

Authorized person to call in an emergency: ______________ Relationship: ______________ Phone: ______________

☐ **SKIP SECTION 3A-3D** IF PAYMENT IS BY CASH, VA, BUREAU OF DISABILITY, OR OTHER SOURCE OF PAYMENT FOR SERVICES NOT LISTED BELOW.

REG SECTION 3A - HEALTH INSURANCE INFORMATION (SKIP **REG SECTION 3A** if not using health insurance)

PRIMARY INSURANCE	SECONDARY INSURANCE	3rd INSURANCE
Ins. Name: ______	Ins. Name: ______	Ins. Name: ______
Holder: ______	Holder: ______	Holder: ______
Policy ID: ______	Policy ID: ______	Policy ID: ______
Group ID: ______	Group ID: ______	Group ID: ______
Eff. Date: ______	Eff. Date: ______	Eff. Date: ______
CoPay: ______ Deduct.: ______	CoPay: ______ Deduct.: ______	CoPay: ______ Deduct.: ______
Employer: ______	Employer: ______	Employer: ______

REG SECTION 3B - MOTOR VEHICLE ACCIDENT (MVA) INSURANCE INFORMATION (COMPLETE only If your appointment is the result of an MVA and you are using Motor Vehicle Insurance) *CNS does not bill third party motor vehicle companies*

Motor Vehicle Insurance: ______________ Policy #: ______________ Claim#: ______________

Address: ______________ Phone: ______________ Contact: ______________

REG SECTION 3C - WORKER'S COMPENSATION INSURANCE INFORMATION COMPLETE only If your appointment is the result of a work related injury or worker's compensation claim. Your visit to our office must be authorized by the Worker's Compensation insurance carrier or your employer prior to your appointment or we may be required to reschedule your appointment.

Employer Name (when injured): ______________ Phone: (____) ______________

Address: ______________ Contact Person: ______________

Worker's Compensation Insurer: ______________ Adjuster: ______________

Claim Address: ______________ Date of Injury: ______________

Phone: (____) ______________ Claim#: ______________ State where injured: ______________

Case Manager: ______________ Phone: (____) ______________

REG SECTION 3D - ATTORNEY INFORMATION If your have retained the services of an attorney in connection with your injury or illness please give the attorney's name, law firm name, address, and phone number:

Attorney: ______________ Phone: (____) ______________

Address: ______________ Law firm: ______________

REG SECTION 4 - CERTIFICATIONS, AUTHORIZATIONS AND CONSENTS

I certify that the information I have provided above is complete, true and accurate. I have read the CNS Financial Payment Policy and all questions have been asked and answered. Co-payments, co-insurance, deductibles, and previous balances are due at time of service prior to being seen as described in the policy.

Signature: ______________ Initial: ______ Date: ______________

Acceptance of Financial Responsibility and Assignment of Benefits: Skip this section if you do not have personal/governmental health insurance. I hereby authorize payment of benefits on my behalf under my insurance plan(s) and/or any government-sponsored plan(s) directly to Clinical Neurology Specialists (CNS) and its divisions; Hyperbaric Institute of Nevada; CNS Neurodiagnostics. I understand that if CNS is not a participating provider, special program participating provider with my insurance plan(s) that I am responsible to CNS for amounts determined ineligible by my insurance plan(s) due to their "maximum allowable", "usual, customary and reasonable" or other payment policies. These are generally found in your insurance plan handbook and not known by CNS. I agree to pay any co-payments, co-insurance, and deductibles that are my responsibility under my insurance plan(s) at the time of service prior to being seen. I understand that I will be billed and held responsible for my account regardless of the status of any insurance claim(s) as allowable by my plan's patient responsibility rules.

Signature: ______________ Initial: ______ Date: ______________

Consent for Treatment: I hereby consent to medical treatment, including consultation evaluation, taking vital signs, diagnosis, treatment or care as ordered by my attending physician or other licensed healthcare provider for myself or for the patient I am the authorized representative. I acknowledge that no guarantees or promises have been made to me concerning the outcomes of any procedure or treatment I receive.

Signature: ______________ Initial: ______ Date: ______________

Authorization to Release Medical Records & Information Form

Patient Name: ______________________________ Date: ____________ SS# ____________
Address: ____________________ City: ________ State: ___ Zip: __________ Phone: __________

Number 1.
☐ I, ______________________________ hereby authorize the following physician/clinic:

____

to release medical records and information to **C**linical **N**eurology **S**pecialists.
Number 1 is for CNS to obtain your previous medical records from a specific medical facility or doctor.

Number 2.
☐ I, ______________________________ hereby authorize **C**linical **N**eurology **S**pecialists to communicate my health care to the following family member/personal representative (PR):

a. ____
b. ____
c. ____
d. ____

Number 2 is authorization for CNS to speak to your family or PR about scheduling and your health condition.

Number 3.
☐ I, ______________________________ hereby request my medical records and authorize **C**linical **N**eurology **S**pecialists to release my medical records to myself and/or family member or personal representative listed: ______________________________

Number 3 is authorization for CNS to release your medical records to yourself and/or designated person. Please allow up to 30 days from the date of your request to have your medical records sent to your address listed above.

Do you give permission to **C**linical **N**eurology **S**pecialists to obtain and/or discuss your medical condition, examination or diagnosis with your primary care provider (PCP) and referring licensed health care provider (at times these may be two different providers):

Primary Physician	☐ Yes ☐ No	Physician's Name:	______________________
Referring Provider	☐ Yes ☐ No	Referring Provider:	______________________

Please list any family members you **DO NOT** wish CNS to discuss your health condition with:

a. ____
b. ____

Do you give **C**linical **N**eurology **S**pecialists permission to send this information electronically by fax or carrier?
☐ YES ☐ NO ______Patient Initial

In the event we have to contact you and you are not home, may we leave a message on your machine/voicemail box or leave a message with your contact person/family member?
☐ YES ☐ NO ______Patient Initial

Name of Contact Person: ______________________________

Please note that unless this authorization(s) are revoked by patient in writing, this authorization release shall remain valid indefinitely.

____
Patient Name (print) Patient Name (signature) Date

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☎ Rainbow: (702) 804-6555
🖶 Fax: (702) 804-1998
☎ Horizon: (702) 804-1212
🖶 Fax: (702) 804-1273

Acknowledgement - Notice of Privacy Practices (www.cnsnevada.com/files/PrivacyPractices.pdf)

I, _________________________ (print first name and last) acknowledge that I have received the Notice of Privacy Practices or reviewed them online at the above website address. I have also been given the opportunity to ask questions about this notice and to request additional restrictions on the Practice's use and disclosure of my personal health information, or to request additional confidential treatment of communications between the Practice and myself or others.

____
Signature

____
Date