



Thank you for scheduling an appointment with Clinical Neurology Specialists West.

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

Patient Education / Physician and Provider Profile and Information

www.CNSnevada.com

Business hours

Monday – Friday 8:00 AM to 4:30 PM

Clinic Hours

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

Contacts

New Patient Scheduling /Rescheduling – Call (702) 804-4949

Established Patient Scheduling/Rescheduling – Call (702) 804-1212

Financial Payment Policy

It is our payment policy to collect the appropriate payment due from the patient at the time of service 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 most major credit cards.

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, then please call **(702) 804-1574**. Enclosed is the patient registration form and privacy acknowledgement form to be completed and brought to your appointment.

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

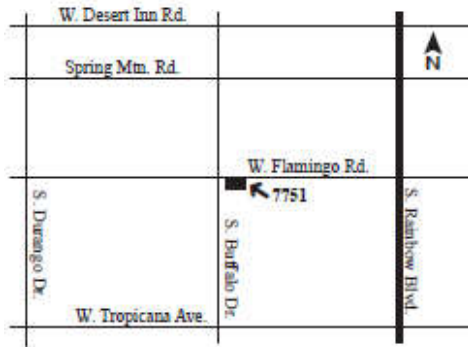
- Current Insurance card(s)
- Current Drivers license or other photo identification in absence of a Drivers License
- Completed Financial Payment Policy, Medical Records Authorization Form, Privacy Notice Acknowledgement, etc.

We appreciate you and your referring provider in selecting Clinical Neurology Specialists West for your neurological care.

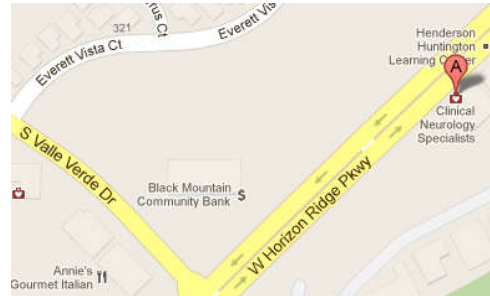
Sincerely,

Team CNS

Office Locations / Maps / Other Information



7751 W. Flamingo Rd.
Suite A100
Las Vegas, NV 89147
Phone: (702) 804-6555
Fax: (702) 804-1273



1691 W. Horizon Ridge Pkwy
Suite 100
Henderson, NV 89012
Phone: (702) 804-1212
Fax: (702) 804-1273

We look forward to seeing you at your appointment.

If you are unable to keep this appointment,
please call (702) 804-4949 for appointment changes and confirmations.

Get Connected with CNS!

www.cnsnevada.com



Office Policies Acknowledgement

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, 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/Co-insurance/Deductible/Balance

All Co-Payment, Co-Insurance, Deductible and Balance financial responsibilities are due in full at the time of service prior to being seen. Original Medicare and Medicare Advantage Plan members please see the front desk for payment responsibilities.

APPOINTMENT POLICY

We may contact you to provide you with appointment reminders by mail, phone, SMS message or email. At each visit, we will ask you to verify this information to assure that reminders are sent to the correct location. CNS understands that not all appointments may be kept due to family emergencies and changes in your personal schedule. CNS may allow for up to a combination of two missed appointments. After this, our staff will be unable to assist you in rescheduling your appointment. CNS will inform your PCP and your chart will be sent for Administrative review. Please note that scheduling outside testing/appointments and subsequent in-office follow up appointment is the responsibility of the patient and failure to do so is a violation of our appointment policy.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

(Skip this section if you do not have 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 West (CNS) and its divisions. I understand that if CNS is not a participating provider, or 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 consent to the procedures which may be performed during this visit or during an outpatient episode of care, including, but not limited to treatment or services, and which may include, diagnostic procedures, laboratory procedures, medical, nursing or other services rendered as ordered by the Provider. I consent to allowing medical students as part of their training in health care education to participate in the delivery of my medical care and treatment or be observers while I receive medical care and treatment at the office, and that these students will be supervised by instructors and/or provider staff. 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: _____

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 than the physician's office, the use of verbally abusive language, failure to follow plan of care or comply with an appropriate treatment regimen, patient going against medical advice, and appointment non-compliance.

I acknowledge and understand that in the event I do not pay for services rendered, CNS may place my account with a collection agency. I agree to pay reasonable collection fees, attorney fees and court cost incurred for 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

Full Name: _____ Recorded Gender Status: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____
Date of Birth: _____ SSN: _____ Relationship Status: _____
Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____
Spouse's Name: _____ DoB: _____
Authorized person to call in an emergency: _____ Relationship: _____ Phone: _____

SKIP SECTION 3A-3D IF PAYMENT IS BY CASH, VETERANS ADMINISTRATION, BUREAU OF DISABILITY, OR OTHER SOURCE NOT LISTED BELOW.

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

PRIMARY INSURANCE	SECONDARY INSURANCE	TERTIARY 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 carriers.

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 you 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 - ACKNOWLEDGEMENTS

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

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 Clinical Neurology Specialists.
Number 1 is for CNS to obtain your previous medical records from a specific medical facility or doctor.

Number 2.

I, _____ hereby authorize Clinical Neurology Specialists to
communicate my health care to the following family member/personal representative (PR):
a. _____
b. _____
c. _____
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
Clinical Neurology Specialists 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 Clinical Neurology Specialists 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 Clinical Neurology Specialists 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



Acknowledgement - Notice of Privacy Practices

You can view and print the CNS Privacy Notice online by going to www.cnsnevada.com or please request a copy at the front desk during registration.

I, _____ (print first name and last name) acknowledge that I have received the Notice of Privacy Practices or reviewed them in the office or online. 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