Alaska NEURO Associates, LLC
Comprehensive Evaluations. Relevant Recommendations.
4241 B Street, Suite 202 Anchorage, AK 99503
Phone: 907-277-0100Fax: 907-222-0566

PATIENT REGISTRATION FORM

PARENT/GUARDIAN/RESPONSIBLE PARTY: Who is responsible for the bill?

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

Marital Status: M / S / D SSN: _____ DOB: _____ Sex: M / F

Address: _____ City _____ State ____ Zip _____

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

Employer's Name & Address: _____

PATIENT INFORMATION

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

SSN: _____ Marital Status: M / S / D Sex: M / F DOB: _____

Address: _____City _____ State ____ Zip _____

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

Employer's Name & Address: _____

Emergency Contact:

Name: _____ Address: _____ Phone: _____

PRIMARY INSURANCE

Insurance Name & Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____ M_____F_____

Employer Name & Address: _____

SECONDARY INSURANCE

Insurance Name & Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Policy Holder: _____ Relationship to Patient: _____

SSN: _____ Date of Birth: _____ M_____F_____

Employer Name & Address: _____

_____ _____

Patient/Responsible Party Signature Date

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Consent for Cognitive Testing

I give permission for (name of child) _____, to have a post-concussion ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) evaluation at Alaska Neuro Associates. I understand that my child may need to be tested more than once, depending on his/her results and symptoms at the time of the initial evaluation and over time.

I understand that ImPACT test results do not diagnose learning disabilities (cognitive disorders), attention deficit disorder (ADD), or attention deficit hyperactivity disorder (ADHD). I also understand that ImPACT test results are not connected to creating or maintaining an Individualized Education Plan (IEP).

Child's Date of Birth:_____

Child's School:_____

Name of parent of guardian:_____

Signature of parent or guardian:_____ Date:_____

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CLINIC POLICIES

Alaska Neuro Associates is pleased to have been selected to provide your post-concussion assessment. The purpose of this sheet is to provide you with important information regarding confidentiality and responsibility for payment of services.

CONFIDENTIALITY: We respect your right to confidentiality and what you share with us will be kept in strict confidence. By law, we are required to report instances of child abuse or intent to harm yourself or others. We cannot speak with anyone about your health condition or care without your specific written permission. Please ask the front desk staff for a release of information if you want us to be able to speak with your family member or outside provider about your care. We will forward a copy of the report to the referral source.

Patient/Responsible Party initials _____

CHILDREN: A parent or guardian must accompany all children under the age of 13 years. No child is to be left in the waiting room without adult supervision.

CANCELLATIONS/NO SHOW: We will make a courtesy reminder call prior to each appointment, but the ultimate responsibility for keeping appointments is yours. For ImPACT evaluations, the appointment MUST be cancelled with at least 48 hours notice. If you cancel the appointment with less than 48 hours notice, you will be charged $25.00. Insurance will not be billed for late cancellations/no show fees.

Patient/Responsible Party initials _____

FINANCIAL: As a courtesy, we will bill your insurance for you if you provide an insurance card(s) and/or proof of coverage at the time of service. If you have a change of insurance, please notify us as soon as possible. Deductibles and co-pays are expected at the time of service. It remains your responsibility to pay in full any balance not covered by your insurance. You are ultimately responsible for payment of services. If you do not make a payment, or make financial arrangements to settle your account within thirty (30) days after receiving your statement, you may be sent to collections. We accept cash, check, Visa and Mastercard.

Patient/Responsible Party initials _____

GUARANTEE OF PAYMENT/ASSIGNMENT OF BENEFITS: In order to bill my insurance I understand they will have access to reports generated from services provided by ANA. I authorize the exchange of information necessary for payment of services. I authorize payment directly to ANA for services rendered to me regarding my illness and/or treatment. I also understand that I am responsible for any amount not covered or deemed over usual and customary by my insurance carrier or agency.

Self-paying patients: I understand that I am responsible for my bill and that payment is expected at the time of service unless prior arrangements have been made.

Patient/Responsible Party initials _____

QUESTIONS: If you have any questions concerning post-concussion assessment, please contact our office at (907) 277-0100 and we will be happy to assist you.

Alaska Neuro Associates, LLC - ANA clinic policies have been reviewed, understood and agreed to by me.

Patient Name: [print] _____

_____ _____

Patient/Responsible Party Signature Date

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PICTURE CONSENT

I authorize Alaska Neuro Associates (ANA) to take a picture for the purpose of the ImPACT evaluation process. I understand that this picture will be kept in my record for personal identification purposes.

_____
Signature of Acknowledgement

_____
Date

HIPAA ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

By my signature below I acknowledge I was offered a copy of the Alaska Neuro Associates Notice of Privacy Practices. Pursuant to **Ethical Standard 9.04** "**Release of Test Data"** the, "Psychologists may refrain from releasing test data to protect a client/patient or others from substantial harm or misuse or misrepresentation of the data or the test, recognizing that in many instances release of confidential information under these circumstances is regulated by law."

_____
Signature of Acknowledgement

_____
Date

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Authorization to Use and Disclose Health Information

Alaska Neuro Associates may exchange information regarding the ImPACT (Immediate Post-concussion Assessment and Cognitive Testing) results and recommendations with my (or my child's) relevant school personnel, primary care physician, coach, and/or athletic trainer for the purposes of evaluation and treatment. Neuropsychologist testing is protected under copywrite laws and we are not required to release it to any patient.

School/ProgramName:_____Phone:_____Fax:_____
Coach/Athletic Trainer: _____Phone:_____Fax:_____
Primary Care Physician:_____Phone:_____Fax:_____
(optional)

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Patient Identification:

Printed Name: _____ Date of Birth: _____
Address:_____ Social Security #:_____
_____ Phone: _____

Alaska Neuro Associates will release the Consultation Report, Permission to Return to Activity, and/or the ASD Medical Release to the referral source so long as the referral source is a licensed provider and not employed by the Anchorage School District (ASD).

Receive by: ___Mail ___Fax ___Pick-up ___Oral Exchange ___Email to:_____

Type of information to be released to patient's school if not referral source:
____Permission to Return to Activity ____ASD Medical Release ____All

Receive by: ___Mail ___Fax ___Pick-up ___Oral Exchange ___Email to:_____

Terms:
I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I understand that the referral source, if a licensed provider and not employed by ASD, will receive all information pertaining to this testing and that it may include psychiatric care or other sensitive information. I understand that raw test data will only be released to a trained ImPACT or Neuropsychologist professional. This request must be in writing.

Expiration and Right to Revoke Authorization:
Except to the extent that action has already been taken in reliance on this authorization, at any time I may revoke this authorization by submitting a notice in writing to the Health Information Services Department. Unless revoked earlier, this authorization will expire one year from the date on which it was signed, or upon the following **date:**_____.

Patient or Responsible Party Signature:_____ Date:_____

If signed by legal representative, relationship to patient:_____

Notice: This request is not valid unless all requested information is provided