Jefferson Neurology LLC
Bear Creek Medical Plaza
1801 Hwy 99 N
Ashland, OR 97520
Ph: 541.482.5515
Fx: 541.482.2433
www.JeffersonNeurology.com

New Patient Information

Patient's Name (Please print) _____ S.S. # _____ Marital Status: □ S □ M □ W □ D □ Sep

Sex: □ Male □ Female Date of Birth _____ Age _____

Complete Mailing Address _____

Complete Residential Address (If different from above) _____

Home Phone _____ Cell Phone _____ Bus. Phone _____

Patient's or Parent's Employer _____ Occupation _____

Spouse or Parent's Name _____ Occupation _____ Phone _____

Primary Insurance _____ ID# _____ Group # _____

Secondary Insurance _____ ID# _____ Group# _____

I have reviewed, agree and consent to the below sections relating to policies, consent and authorization.

Name _____ Signature _____ Date _____

INSURANCE AUTHORIZATION & ASSIGNMENT

I request that payment of authorized insurance benefits be made to Jefferson Neurology LLC for any services furnished to me by Zakir Ali, M.D.. I authorize any holder of medical information about me to release to my insurance carrier and/or its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature above requests that payment be made to Jefferson Neurology LLC and authorizes release of medical information necessary to pay the claim. If Item 12 of 14 of the HCFA-1500 claim form is completed; my signature also authorizes releasing the information to the insurer or the agency shown.

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CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize Jefferson Neurology LLC to use and disclose the health and medical information for the purpose of Treatment, Payment and Health Care Operations.

Treatment includes activities performed by a physician, nurse, office staff and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any health care professionals that cover our practice by telephone as the on-call provider. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

Payment includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification, and pre-authorization.

Health Care Operations includes the necessary administrative and business functions of our office.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that Jefferson Neurology LLC has already used or disclosed the information in reliance on this CONSENT.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, correcting or amending that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and complaining if you think that your rights have been violated. We have available a detailed Notice of Privacy Practices which you have a right to obtain by upon request.

OFFICE POLICIES

Appointments: There are sometimes unpredictable last minute schedule changes. We recognize that emergencies do happen, so if you must cancel your appointment, please notify our office 24 hours before your scheduled appointment time or a 'no show' fee of $50 will be assessed. We may not make confirmation calls prior to your appointment. Please mark your calendars accordingly.

Living situation: Please notify us of any changes in your living arrangement, including: address, phone number, marital status, legal status, employment and major illnesses.

Prescriptions: Medication refills will be addressed at each visit. In the event that you need a prescription refill and do not have an upcoming appointment, you may contact your pharmacy. If there are no refills remaining, either you or your pharmacy should contact us.

FINANCIAL POLICIES

Fees: A list of services we offer and fees are available by contacting our billing services at (541) 512-0511.

Insurance: As a courtesy to you (our patients), we bill all primary insurance. It is your responsibility to pay any deductible amount, co-insurance or other balance unpaid by your insurance company.

Billing: To help cover the cost of billing we charge interest at 1.75 percent per month on all outstanding balances over 90 days. If you wish to avoid these charges, please pay in full at the time services are rendered.

Oregon Health Plan Patients: Our office requires that you provide us with a current recipient card each month. Patients who do not have this card with them at each visit might be denied services.

Motor Vehicle Insurance: As a courtesy, we will bill your Motor Vehicle Insurance. We request a copy of your private insurance information in the event that you claim is closed or your PIP (personal injury protection) has run out.

Worker's Compensation: If you are seeing us due to a work related injury, we will bill your Worker's Comp insurance. If you were injured at work but do not have a claim opened, please let our staff know immediately so we can make the proper arrangements. We will request a copy of your private insurance information in the event that your claim is closed or the provider treats you for something that is not included in your claim.

Notice of Privacy Practices: You have the right to receive a written description of our Notice of Privacy Practices. It describes the uses and disclosures of health information made, the information practices followed by our employees and health care providers, and your rights regarding your health information. A copy of the Notice of privacy Practices is available upon request.