Patient Demographics

Patient Full Name: _____ Gender: _____

First *M.I* *Last* **SS#**:_____

Date of Birth:_____ Marital Status: _____ Race: _____

Ethnicity: Non-Hispanic Hispanic Origin Unknown (please circle one) **Language: _____**

Mailing Address:_____

City: _____ State:_____ Zip code: _____

Primary Phone: _____ Secondary Phone: _____

Okay to leave messages at numbers listed: Yes No **(**Please circle one) **Email: _____**

Referring Provider:_____PCP:_____

Employer: _____ Employer phone: _____

Insurance Coverage

Primary Insurance: _____ **Group #**:_____ **ID: _____**

Primary Subscriber Name: _____ **Subscriber DOB: _____**

Secondary Insurance: _____ **Group #:_____ ID: _____**

2nd Subscriber Name: _____ 2nd subscriber DOB: _____

Worker's Compensation/Motor Vehicle Accident Claim #: _____Date of Injury: _____

Employer: _____Claims manager: _____ Phone: _____

Emergency Contact and Friends & Family Authorization

Emergency Contact: _____ Phone:_____

Relation to patient:_____

Below are listed individuals I wish to grant access to my healthcare information (including appointment scheduling, account information, medications and records). I will rely on the professional judgement of my provider and/or their designee to share such information, as they deem necessary. I understand that this information includes verbal discussion and/or paper copies of my medical records.

1. Name:_____Relationship:_____
2. Name:_____Relationship:_____
3. Name:_____Relationship:_____

Thank you for trusting Olympia Neurology PLLC to partner in your health care. We are committed to providing you with quality, personal health care and appreciate your commitment to adhere to this Financial Policy Agreement. We ask all

patients to review and sign this policy, asking questions as necessary. A copy will be provided to each patient upon request.

Insurance and claims**:** You must provide us a copy of your current valid insurance card. We accept assignment and participate in most insurance plans. Knowing your insurance benefits, copayment and deductibles are your responsibility. Please contact your insurer with any questions you may have regarding your coverage. If we do not participate with your plan, payment in full is required at the time of service. Your insurance company may need you to supply information directly to them prior to their payment of your claim, it is your responsibility to comply with their request. We will submit your insurance claims and assist you in any way reasonable to help get your claim paid. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company.

Patient payment: All copayments are to be paid at the time of service. This arrangement is part of your contract with your insurance company. Once payment is received from your insurance company we will mail out patient statements. Payment of this balance is due within 30 days. We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient balance in full, you must call our business office at (360) 413-8551. NSF checks will result in a $36.00 processing fee.

Credit and collection**:** Any balance over 30 days will be assessed a 1% Finance Charge. Accounts that are delinquent after 90 days may be subject to collection and all costs involved will be considered patient responsibility. Any legal action will be filed in the Thurston County Court system.

Pre-Collect: We ask for payment up front for patient share on procedures such as; Injections, MRI, Electroencephalogram and Nerve Conduction Velocity Studies. We will contact your insurance company for your estimated cost share and call you prior to your appointment date.

Forms**:** At the discretion of the Physician, letters and forms requiring medical review and Physician signature are subject to a fee.

Medicare, Medicaid and Commercial Payers: I request payment of authorized benefits be made on my behalf for any services furnished to me by Olympia Neurology, PLLC, for any professional services rendered.

I authorize treatment of the person named as patient and I have read, understand, and agree to comply with the terms of your Financial Policy Agreement

_____ _____

Signature of Patient/Guardian/Responsible Party Date

_____

Printed Name

Olympia Neurology, PLLC has a responsibility to protect the privacy of your healthcare information and to provide a Notice of Privacy Practices that describes how your healthcare information may be used and disclosed, how you can access your healthcare information, and whom to contact if you have questions, concerns or complaints.
We may change the Notice of Privacy Practices at any time, and you may contact Lisa Evans, HIPPA Compliance Officer at 360-413-8550 to obtain a current copy of Notice of Privacy Practices or to ask questions.
By my signature below, I agree that I have received the Notice of Privacy Practices of Olympia Neurology, PLLC.

Patient or legally authorized representative signature: _____