Blue Sky Neurology Patient Information

Last Name: _____ First Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Primary Care Physician: _____ Referring Provider: _____

Date of Birth: _____ Circle One: Male Female Marital Status: _____

Your Employer: _____

Name and Relationship to insurance policy holder: _____

Is this related to a work or auto accident injury? _____ If yes, date of injury: _____

Emergency Contact (Name, Phone, and Relation): _____

Name and Phone Number of nearest relative not living with you: _____

Do you have a living will, durable power of attorney, CPR Directive, Medical Orders for Scope of Treatment or other advance directive? (Circle one) YES NO If yes, please provide copies of each for the office. Please note, however, that as an outpatient physician office, it is Blue Sky Neurology's policy to initiate resuscitative measures and life-prolonging treatment if there is an adverse event during your patient visit at Blue Sky Neurology regardless of the contents of any advance directive you may have, or any instructions given by your legal representative. In the event of an adverse event, Blue Sky Neurology will contact emergency personnel or otherwise have you transported to an acute care hospital for further evaluation and treatment. If you do not wish to continue medical care and treatment at Blue Sky Neurology due to its policy to always initiate resuscitation and provide life-prolonging treatment, please so notify Blue Sky Neurology and we will be happy to transition your medical care and treatment to another medical provider of your choosing.

Do you wish to be added to our online patient portal?: _____

If yes, please provide your email address to be used for the patient portal: _____

Race: _____ Ethnicity: _____ Language: _____

Pharmacy Name and Phone Number: _____

Payment for services, including co-pays, are DUE AT THE TIME SERVICES are rendered unless payments arrangements have been approved and a signed Payment Agreement is on file with our billing department. A no-show fee of $45.00 will be charged to your account for each appointment that you fail to appear. A fee of $45.00 will be charged to your account for any appointment not canceled 24 hours prior to your appointment time.

Returned Checks: In the event a personal check is returned unpaid from the patient's bank, their account will be charged a returned check fee of $25 for each check, and their account may be placed on a "cash only" basis for one year.

Agreement and authorization for direct insurance payment signature: _____

Date: _____

I hereby certify that I have read, understand and agree to the information and policy advisements contained in this Patient Information form and I also hereby certify that the information I have provided is true, correct and complete. I understand and agree that it is my sole responsibility to update information I provided on this Patient Information Form as changes occur and that Blue Sky Neurology may rely upon the information I have provided on this Patient Information Form.

Patient or Responsible Party Signature: _____

Date: _____

Printed Name and Relationship if signed by a responsible party other than the Patient:

_____