SHERIDAN NEUROLOGY, P.C.
CLOUD PEAK SLEEP SPECIALIST, LLC
1050 MYDLAND ROAD
SHERIDAN, WY 82801

PATIENT NAME: _____ _____ _____
LAST FIRST MI

DATE OF BIRTH: _____ **SSN:** _____

ADDRESS: _____
Include city, state, and zip code

CONTACT INFORMATION AND MESSAGE PREFERENCES

HOME PHONE: _____ CELL PHONE: _____
Voice call reminder ____ **(please circle one)** morning/afternoon-preferred number_____
Text reminder ____ **(please circle one)** morning/afternoon-preferred number_____
E-MAIL ADDRESS: _____
EMPLOYER NAME: _____ PHONE: _____
EMERGENCY CONTACT: _____
NAME PHONE NUMBER RELATIONSHIP

PHYSICIAN/PHARMACY PREFERENCES

REFERRING PHYSICIAN: _____
PRIMARY CARE PHYSICIAN: _____
PREFERRED PHARMACY: _____

OTHER DEMOGRAPHIC INFORMATION

ETHNICITY (please circle one) Non-Hispanic Hispanic Unreported/refuse to report
RACE (please circle one) Caucasian African American Native American/Alaskan
Native Hawaiian/Pacific Islander Unreported/Refuse to report
MARITAL STATUS (please circle one) Married Widowed Single Separated Divorced Partnered

PAYER INFORMATION (PLEASE CIRCLE ONE)

PRIVATE COMMERCIAL INSURANCE **MEDICARE** **MEDICAID**

IF SELECTING ANY OF THE ABOVE, COPIES OF THE CARDS ARE REQUIRED PRIOR TO SERVICES BEING RENDERED.

Policy holder name: _____ Date of Birth: _____

SELF PAY/AUTO OR PERSONAL LIABILITY INSURANCE-A REQUIRED $200 PAYMENT ON ACCOUNT MUST BE RECEIVED AT LEAST 24 HOURS PRIOR TO APPOINTMENT OR THE APPOINTMENT WILL BE CANCELLED. PAYMENT ARRANGEMENTS ARE AVAILABLE FOR ANY REMAINDER BALANCE.

WORKERS COMPENSATION:

Case number _____ STATE OR FEDERAL CLAIM? _____
If state WC claim, please specify state
Date of Injury_____ Body Part(s) covered_____
Case worker name _____ Case worker phone number_____
Claim mailing address: _____

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WRITTEN AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorized Dr. Thomas Mayer and his staff to discuss my Protected Health Information (PHI) with the following person(s):

Name_____ Relationship_____

Name_____ Relationship_____

Should I wish to revoke this authorization I understand I must do so in WRITING.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that a Notice of Privacy Practices from Sheridan Neurology, P.C. and Cloud Peak Sleep Specialist, LLC is available to me should I request a copy. I understand that my Protected Health information (PHI) may be used and disclosed for the purpose of TREATMENT, PAYMENT, AND HEALTHCARE OPERATION of the practice.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

I hereby acknowledge that I have read and understand the terms set forth in the financial policy of Sheridan Neurology, P.C. and Cloud Peak Sleep Specialist, LLC. I understand a copy of the policy is available to me upon request.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

ACKNOWLEDGEMENT OF NOTICE OF MEDICATION REFILLS, RECORDS AND MISCELLANEOUS FORMS POLICY

I hereby acknowledge I have read and understand the terms set forth in the Notice of Medication Refills, Records and Miscellaneous Forms policy. I understand a copy of the policy is available to me upon request.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____