Northwest Houston Neurology, PA

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THIS SECTION REFERS TO THE PATIENT ONLY

Last Name _____ First Name _____ Middle _____

Sex ___ D.O.B. _____ Marital Status _____ SS# _____ DL# _____

Street Address _____ City _____ State ___ Zip _____

Home Ph# _____Work Ph# _____ Cell Ph# _____

Email address _____ Preferred method of contact _____

Patient's Employer _____ Employer Ph# _____

Race _____ Ethnicity _____ Language _____

Emergency Contact _____ Relation to patient _____ Ph# _____

If a MINOR, complete with PARENT'S info – If MARRIED, complete with SPOUSE'S info

Mother's/Spouse's Name _____ D.O.B. _____

SS# _____ DL# _____ Email Address _____

Address (if different than above) _____ Ph# _____

Employer Name _____ Employer Ph# _____

Father's Name _____ D.O.B. _____

SS# _____ DL# _____Email Address _____

Address (if different than above) _____ Ph# _____

Employer Name _____ Employer Ph# _____

INSURANCE INFORMATION

Primary Insurance Company _____ Customer Service # _____

Subscriber Name _____ D.O.B. _____ Employer _____

Secondary Insurance Company_____ Subscriber Name _____ D.O.B. _____

ADDITIONAL INFORMATION

Name and Phone Number of Referring Provider _____

Preferred Pharmacy _____ Pharmacy Ph# or Address _____

How did you hear about us? _____

Name of family members that are also patients here _____

I, the insured person for this account, do assign the collection of benefits to the Pediatric and Adolescent Center of NW Houston, PA, Northwest Houston Neurology, PA. I give my permission to release medical information needed to process medical claims. I understand that the Pediatric and Adolescent Center of NW Houston, PA and the Northwest Houston Neurology, PA will attempt to collect payment from my insurance company, yet I am ultimately responsible for the payments on this account. Any balance unpaid by my insurance company after 60 days of filing can be billed to me for payment. I have been provided a copy of the office policies.

Signature of Patient/Legal Guardian_____Date_____

Northwest Houston Neurology, PA
Office Policy

Our goal is to provide quality medical care and to maintain a positive patient-physician relationship. Providing you with our office policy in advance encourages the flow of communication and enables us to achieve our goal. Please review our policy carefully.

Appointments

- All patients must complete the patient information forms prior to seeing the physician. We will require copies of your insurance card and photo identification. You may be asked to update this information annually.

- If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule your appointment.

- We value the time we have set aside to spend with you. If you are unable to keep an appointment, please provide a 24 hour notice so that we may offer this time to another patient. If you do not provide notice, you will be charged a No Show Fee. Failure to comply with our cancellation policy can lead to dismissal from the practice.

Financial Policy

- Payment in full is due at the time services are rendered, including past due balances.
    - Any patient share estimates (copayments, deductibles, co-insurances) are due in full at the time of service. An estimate is only an estimate and never a guarantee of exact fees. Your final share will be determined once the insurance processes the claims.
        - Patient overpayments will be refunded within 30 days of the request.
    - Our office verifies insurance coverage as a courtesy; however, payment is not guaranteed claims are processed by the insurance company. It is the insured's responsibility to understand the benefit plan with regards to covered services and participating facilities. The patient will be billed directly for any services not covered by insurance.
    - If our office is unable to verify the insurance coverage, the patient is financially responsible for the visit.
    - It is your responsibility to update us with current insurance information. If the insurance company you designate is incorrect, you may be held responsible for charges due to timely filing requirements.
    - If the insurance company requires a referral and one is not on file, the patient is financially responsible for the visit.
    - We are happy to help assist with insurance questions. However, specific coverage issues or claims processing questions should be directed directly to your insurance company.

- We do not file claims to the following (see below). The patient is responsible for payment in full. We will provide receipts so that you may file claims for reimbursement.
    - Secondary Insurances (Medicare is an exception)
    - Worker's Compensation
    - Automobile Insurance

- Your insurance company may request that you supply information to them directly in order to process claims (i.e. coordination of benefits, pre-existing info.). It is your responsibility to comply in a timely manner.

- If the patient is a minor, in cases of divorce or separation, the person requesting services is responsible for the payment due at the time of service and for any past due balance.

- We accept cash, check, Visa, and MasterCard. A $30 fee will be assessed for returned checks. Checks returned due to stop payment may lead to dismissal from the practice.

- Statement are sent out monthly and payment is appreciated within 10 days upon receipt. Accounts with balances over 90 days with no activity can be turned over to collections and dismissed from our practice.

Authorizations / Prescriptions and Refills

- Some tests ordered by our physicians may require authorization from your insurance carrier. If this is the case, please allow 10 business days for our office to obtain the authorization.

- Prescriptions and Refills
  - **We do not dispense written prescriptions**. We will send prescriptions electronically or call in prescriptions directly to the pharmacy on file.
  - Controlled Substances
    - Controlled Substance prescriptions cannot be sent electronically to pharmacy; we will call in to pharmacy on file when applicable
    - Some Controlled Substances cannot be called in to the pharmacy and must be picked up by an authorized person over the age of 18.
    - These prescriptions require monthly or quarterly visits with the physician.

Forms

- Forms will be completed during an appointment. Please bring forms to the visit and complete everything other than the section required by the physician. We reserve the right to decline completion of these types of forms.

- There is a $25 fee for medical letters written by physicians.

Transfer of Records

A $25 fee will be assessed for a copy of your medical records. A release of information must be signed. If you transfer to another physician or we refer you to another physician, we will send that physician a copy of your last visit and pertinent records free of charge. Please allow 10 business days for transfer of records.

Non Compliance with our office policy and violation of physician/patient relationship can lead to dismissal from the practice. Examples of this include noncompliance with physician orders, appointments, disruptive behavior, etc.

Signature of Understanding: I have read and understand the above stated office and financial policy.

Patient Name _____ Patient Date of Birth _____

Name of Parent / Guardian if Patient under 18 _____ Relationship _____

Patient or Parent / Guardian Signature _____ Date _____

Assignment of Benefits

I, the undersigned, authorize payment of medical benefits to Northwest Houston Neurology, PA, for any services furnished to the patient by the practice. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment, or supplies provided. This information will be used for the purpose of evaluating and administering claims benefits.

Patient or Parent / Guardian Signature _____ Date _____

NW Houston Neurology PA

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure of his/her individually identifiable health information (protected health information) by NW Houston Neurology PA in order to carry out treatment, payment, or health care operations. The patient should review NW Houston Neurology PA Notice of Privacy Practices for Protected Health information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

NW Houston Neurology PA reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If NW Houston Neurology PA does change the terms of its Notice of Privacy Practices, the patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. NW Houston Neurology PA is not required to agree to such requested restrictions; however, if NW Houston Neurology PA does agree to Patient requested restriction(s), such restrictions are then binding on NW Houston Neurology PA.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to NW Houston Neurology PA in writing. The revocations shall be effective except to the extent that NW Houston Neurology PA has already taken action in reliance on the Consent.

NW Houston Neurology PA may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that NW Houston Neurology PA is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, NW Houston Neurology PA has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that NW Houston Neurology PA is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT, OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name of Patient/Guardian Relationship to Patient

_____

Signature of Witness

_____

Print Witness Name

NW Houston Neurology, PA

Patient Privacy Questionnaire (HIPAA)

_____ _____
Patient Name Date of Birth

_____ _____
Parent/Guardian Name DL Number

This signed Privacy Form will remain in your file and considered current. If there are any changes, you must notify our office and complete another form.

1. Please list other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations):

Name: Phone:

_____ _____

_____ _____

_____ _____

2. Please list other persons, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name: Phone:

_____ _____

_____ _____

You may be contacted by your office to remind you of any appointments, healthcare treatment options or other health services. We will limit the amount of information left in the message to just the information necessary to confirm the appointment or to request a return call.

3. Can confidential messages (i.e. appointment reminders, messages) be left on your voicemail?

YES _____ NO _____

4. Please provide an email address we could send correspondence to. _____

_____ _____
Signature of Patient/Guardian Date

_____ _____
Print Name of Patient/Guardian Relationship to Patient

Northwest Houston Neurology, P.A.

Patient Name: _____ **DOB:** _____ **Today's Date:** _____
Drug Allergies: _____ **Assistive Devices:** _____

PAST MEDICAL HISTORY

□ Headache □ Migraine □ Stroke/ Mini Stroke □ Seizure □ Alzheimer's Disease □ Tremor
□ Parkinson's Disease □ Depression □ Anxiety □High Blood Pressure □ Diabetes □ Heart Disease
Other _____

_____

PAST SURGICAL HISTORY *List ALL Surgeries* _____

_____

_____

FAMILY HISTORY

□ Headache □ Migraine □ Stroke/ Mini Stroke □ Seizure □ Alzheimer's Disease □ Tremor
□ Parkinson's Disease □ Depression □ Anxiety □High Blood Pressure □ Diabetes □ Heart Disease
Other _____

_____

SOCIAL HISTORY

Occupation: _____ **Marital Status**: □ Single □ Married □Divorced □ Widowed
Tobacco Use? □ Yes □ No, How Much _____ **Drink Alcohol?** □ Yes □ No, How Much _____

This section is for CHILDREN ONLY. Only complete for patients under 18 years of age.
Pregnancy: □ Normal □ Problems _____
Delivery □ Normal □ C Section □ Problems _____
Development: □ Sitting _____ Months, □ Walking _____ Months, □ Started Speaking _____ Months

REVIEW OF SYMPTOMS *Please check ALL that apply*

GENERAL
- □ Neck Pain
- □ Back Pain
- □ Weight Gain
- □ Weight Loss
- □ Fever

HEAD/NECK
- □ Head Injury
- □ Vision Problems
- □ Sore Throat
- □ Trouble Swallowing
- □ Hearing Problems

CARDIOVASCULAR
- □ Chest Pain
- □ Skipped/Irregular Heartbeat

NEUROLOGIC
- □ Dizziness
- □ Numbness / Tingling
- □ Weakness
- □ Headaches
- □ Seizure
- □ Passing out Spells
- □ Tremors

RESPIRATORY
- □ Shortness of Breath
- □ Sleep Apnea
- □ Cough
- □ Wheezing

GASTROINTESTINAL
- □ Abdominal Pain
- □ Vomiting / Diarrhea

GENITOURINARY
- □ Pain with Urination
- □ Unable to Urinate
- □ Involuntary Urination

MUSCULOSKELETAL
- □ Joint Swelling
- □ Joint Pain

SKIN
- □ Rash

ALLERGIES
- □ Nasal Allergies

PSYCHIATRY
- □ Anxiety
- □ Depression

SLEEP
- □ Awake with Dry Mouth
- □ Difficulty Concentrating
- □ Excessive Daytime Sleepiness
- □ Frequent Awakenings
- □ Loud Snoring
- □ Memory Loss
- □ Morning Headaches
- □ Need to move legs
- □ Nervous / Anxious
- □ Nocturia
- □ Poor School Performance
- □ Racing Thoughts
- □ Reflux at night
- □ Sleep Talking
- □ Sleep Walking
- □ Teeth Grinding
- □ Unrefreshing Sleep
- □ Witnessed Apnea

Northwest Houston Neurology, PA

Phone: 281-357-5678

Seizure History Form

Please Complete ALL Information carefully as your treatment depends on this information

Today's Date: _____

Name: _____ **Age:** _____ **DOB:** _____

Referring Doctor Name: _____ Ref. Dr. Phone No.: _____

Seizure History (If you need more space, please use the back of the page)

When was the first seizure (date or how long ago) _____

Seizure frequency in the past _____ / day, or _____ / week, or _____ / month

Seizure frequency – current _____ / day, or _____ / week, or _____ / month

Do you get a warning (aura) before seizure? Yes / No. If yes, describe the aura:

_____

How many types of seizures do you have: _____

Describe seizure from the beginning to the end: _____

_____

_____

_____

_____

How long does seizure last? _____ Do you have seizures only when you have fever? _____

How do you feel after the seizure? _____ Do you lose consciousness during seizure? Y / N

Do you have spells in which you stare off into space and do not respond to questions? Yes / No

What specific SEIZURE medications have you used so far? List dosages and known side effects.

_____

_____

_____

What current medications are you taking (list dosages)? _____

_____

_____

What tests have been done so far?

CT Scan- Y / N. Results _____ MRI - Y / N Results _____ EEG– Y / N Results: _____

Allergies: *List all drug allergies:* _____

The Epworth Sleepiness Scale

Patient Name: _____ D.O.B.: _____ Date: _____

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?
How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	**Chance of Dozing** Indicate 0, 1, 2, or 3
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (e.g., a theater)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Total Score: _____

Northwest Houston Neurology, PA

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Tomball, TX 77375
Phone 281-357-5678 Fax 281-357-8765

Authorization to Release Protected Health Information

I hereby authorize the use or disclosure of information from the medical record of:

Patient Name _____ Date of Birth _____

Social Security# _____ Date(s) of service. If all dates of service, write "all" _____

_____ I authorize the above named organization to RELEASE my medical records to:

_____ I authorize the above named organization to RECEIVE records from:

_____
Person or Organization

_____
Address

_____
Phone Fax (if applicable)

This information is being released for the following purposes:
( ) Continued Care ( ) Attorney / Litigation ( ) Insurance ( ) Disability ( ) Other _____

INFORMATION TO BE RELEASED:

_____ Progress Note	_____ Billing Records	_____ Radiology Reports
_____ Diagnostics / Labs	_____ Sleep Study Reports	_____ EEG or Video EEG
_____ EMG Report	_____ Other _____	

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV; behavioral or mental health services, and treatment for alcohol and drug abuse.
- I understand that I have a right to revoke this authorization at any time in writing and will present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. This authorization expires 180 days from the date of my signature unless specified in writing here: _____
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- **To the party receiving this information**: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

_____ _____ _____
Signature of Patient or Legal Representative **Print Name** **Date**

_____ _____
Relationship to Patient (If Legal Representative) **Patient or Legally Authorized Rep. Driver's License / ID#**

_____
Witness – Printed Name and Signature