DFW NEUROLOGY, PLLC

PATIENT INFORMATION

LAST NAME_____ HOME PHONE # (_____)-_____-_____

FIRST NAME_____ M.I._____ WORK PHONE # (_____)-_____-_____

ADDRESS_____ DATE OF BIRTH _____ SEX: ☐ MALE ☐ FEMALE

CITY_____ STATE_____ ZIP_____ SOCIAL SECURITY #_____-_____-_____

REFERRING DOCTOR_____ MARITAL STATUS ☐-S ☐-M ☐-D ☐-W

EMPLOYER_____ EMERGENCY CONTACT_____

EMPLOYER ADDRESS_____ EMERGENCY PHONE #_____

CITY_____ STATE_____ ZIP_____ RELATIONSHIP OF CONTACT_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE COMPANY_____ INSURED ID #_____

ATTN_____ INSURED'S SSN_____

ADDRESS_____ INSURED PARTY_____

CITY_____ STATE_____ ZIP_____ INSURED'S DATE OF BIRTH_____

GROUP ID #_____ INSURED'S EMPLOYER_____

SECONDARY INSURANCE:

INSURANCE COMPANY_____ INSURED ID #_____

ATTN_____ INSURED'S SSN_____

ADDRESS_____ INSURED PARTY_____

CITY_____ STATE_____ ZIP_____ INSURED'S DATE OF BIRTH_____

GROUP ID #_____ INSURED'S EMPLOYER_____

- I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO OTHER PHYSICIANS PARTICIPATING IN MY CARE.
- I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE COMPANY LISTED ABOVE FOR THE PURPOSE OF PROCESSING MY INSURANCE CLAIMS.
- I AUTHORIZE THAT ANY BENEFITS DUE BE MADE PAYABLE TO DFW NEUROLOGY PLLC.

SIGNATURE_____ DATE_____

NEW PATIENT INFORMATION

Patient Name: _____ DOB: _____

Who referred you? _____ Who is your general physician (PCP)? _____

Please list the symptoms you are having and wish to bring to our attention:

_____

_____

_____

Are your symptoms due to an injury? ☐Yes ☐No

If yes, please specify date and type of injury: _____

Have you seen a neurologist before? ☐Yes ☐No

If yes, please specify date and who you saw: _____

MEDICATIONS (PLEASE ATTACH LIST IF NECESSARY)

MEDICATION	DOSE (MG)	HOW OFTEN

SOCIAL HISTORY

Occupation: _____ ☐Homemaker ☐Retired

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Widower

Education: ☐Grade School ☐High School ☐College ☐Post-Graduate

Do you smoke? ☐Yes ☐No If so, how many cigarettes/packs per day? _____

Did you smoke in the past? ☐Yes ☐No If so, for how long? _____

Do you drink Alcohol? ☐Yes ☐No If yes: ☐Beer ☐Wine ☐Liquor How much? _____

Have you used recreational drugs? ☐Yes ☐Nolf yes: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamines ☐MDMA/"X"

FAMILY HISTORY

☐Alcoholism	Who? _____	☐Migraine	Who? _____
☐Alzheimer's Disease	Who? _____	☐Multiple Sclerosis	Who? _____
☐Cancer	Who? _____	☐Muscle Disease	Who? _____
☐Depression	Who? _____	☐Neuropathy	Who? _____
☐Diabetes	Who? _____	☐Parkinson's Disease	Who? _____
☐Epilepsy	Who? _____	☐Schizophrenia	Who? _____
☐Heart Disease	Who? _____	☐Stroke	Who? _____
☐High Blood Pressure	Who? _____	☐Tremor	Who? _____
☐Lung Disease	Who? _____	☐_____	Who? _____

PATIENT SERIOUS ILLNESSES

☐Alzheimer's Disease	☐Diabetes	☐Hydrocephalus	☐Multiple Sclerosis	☐Seizures
☐Arthritis	☐Fibromyalgia	☐Kidney Problems	☐Muscle Disease	☐Sleep Apnea
☐Asthma	☐Head Injury	☐Liver Problems	☐Neck Problems	☐Thyroid Problems
☐Bipolar Disorder	☐Heart Problems	☐Lung Problems	☐Neuropathy	☐_____
☐Cancer	☐High Blood Pressure	☐Memory Loss	☐Parkinson's Disease	☐_____
☐Depression	☐High Cholesterol	☐Migraine	☐Passing Out/Syncope	☐_____

New Patient Information

Patient Name: _____ DOB: _____

Drug Allergies

- ☐ *No known drug allergies*
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Vicodin
- ☐ _____
- ☐ _____
- ☐ _____

Operations

- ☐ Appendectomy
- ☐ Back
- ☐ Brain Tumor
- ☐ Breast Augmentation
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Cervical Spine
- ☐ Gall Bladder
- ☐ Heart Bypass
- ☐ Heart Valve Replacement
- ☐ Hip
- ☐ Knee Replacement
- ☐ Hysterectomy
- ☐ Lumbar Spine
- ☐ Orthopedic
- ☐ PEG Tube
- ☐ Pituitary
- ☐ Shoulder
- ☐ Subdural Hematoma
- ☐ _____

Symptom Review

General
- ☐ Fever
- ☐ Weight Loss
- ☐ Weakness
- ☐ Fatigue
- ☐ Sweats

Ears/Nose/Mouth/Throat
- ☐ Hearing Impairment
- ☐ Ringing in ears
- ☐ Ear infections
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Sinus problems
- ☐ Difficulty Swallowing

Musculoskeletal
- ☐ Muscle weakness
- ☐ Muscle cramps
- ☐ Neck pain
- ☐ Back problems
- ☐ Joint pain/stiffness
- ☐ Arthritis
- ☐ Gout
- ☐ Deformities

Neurological
- ☐ Headaches
- ☐ Head injury
- ☐ Fainting
- ☐ Blackouts
- ☐ Seizures
- ☐ Stroke
- ☐ Dizziness
- ☐ Paralysis
- ☐ Numbness
- ☐ Pain
- ☐ Tingling
- ☐ Burning
- ☐ Tremors
- ☐ Speech problems
- ☐ Unsteadiness of gait
- ☐ Loss of memory
- ☐ Disorientation
- ☐ Behavior change

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mood swings
- ☐ Hallucinations
- ☐ Difficulty sleeping
- ☐ Drug abuse

Cardiovascular
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Shortness of breath (with exertion)
- ☐ Shortness of breath (lying flat)
- ☐ Heart attack (history)
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Leg Pain (walking)
- ☐ Swelling of legs
- ☐ Blood clots

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Blindness
- ☐ Eye pain/redness
- ☐ Cataracts

Chest
- ☐ Cough
- ☐ Tuberculosis
- ☐ Asthma/Wheezing
- ☐ Coughing up blood

Gastrointestinal
- ☐ Loss of appetite
- ☐ Excessive thirst
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Ulcers
- ☐ Abdominal pain
- ☐ Change in stools
- ☐ Vomiting blood
- ☐ Rectal bleeding
- ☐ Black, tarry stools
- ☐ Jaundice/Hepatitis
- ☐ Liver disease
- ☐ Gall Bladder disease

Genitourinary
- ☐ Bladder control loss
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Sexual problems

- ☐ Prostate problems
- ☐ Menstrual problems

Date of last menstrual period: _____

Endocrine
- ☐ Thyroid problems
- ☐ Goiter
- ☐ Diabetes/blood sugar
- ☐ Intolerance to heat or cold

Hematological/Lymphatic
- ☐ History of anemia
- ☐ Tendency to bleed
- ☐ Blood transfusions
- ☐ Swollen glands

Skin/Breasts
- ☐ Rashes/Easy bruising
- ☐ Changes in hair/nails
- ☐ Breast lumps
- ☐ Breast pain/discharge

Allergic/Immunological
- ☐ Eczema
- ☐ Hay fever
- ☐ Hives
- ☐ Allergic Reactions

Please sign and date below. This questionnaire will become part of your medical record.

Signature: _____ Date: _____

DFW NEUROLOGY, PLLC

6800 HARRIS PKWY, SUITE 100
FORT WORTH, TEXAS 76132
PHONE: (817) 292-0088 FAX: (817) 292-8288 OR (855) 285-0906

AUTHORIZATION TO OBTAIN MEDICAL RECORDS FROM THIRD PARTIES

By signing this authorization, I authorize the following third party to disclose certain protected health information (PHI) about me to DFW Neurology PLLC:

Name of third party (Doctor/Provider): _____

Street Address or PO Box: _____ Suite: _____

City/State: _____ Zip: _____

Phone: _____ Fax: _____

This authorization permits the above listed third party to disclose my PHI to DFW Neurology PLLC the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO THIRD PARTIES

By signing this authorization, I authorize DFW Neurology PLLC to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits DFW Neurology PLLC to use or disclose my PHI to:

_____

_____

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

_____

_____

This authorization will expire on: _____ (Expiration Date or Defined Event)
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that DFW Neurology PLLC has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer of DFW Neurology PLLC located at the address listed above.

Signed by: _____ _____
Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____
Patient's Name — Date

_____
Print Name of Patient or Legal Guardian

_____
Patient SSN & DOB

DFW Neurology PLLC -- Financial Policy

ALL PAYMENTS (INCLUDING ANY CO-PAY) ARE DUE AT THE TIME OF SERVICES ARE RENDERED unless payment arrangements have been approved in advance.
WE ACCEPT PAYMENT BY: Cash, Personal Check, Visa, MasterCard and Discover (*Per the new FTC regulations, we will check State Identification or Driver's License in processing credit card payments to prevent identity theft*).
NEW PATIENTS without valid insurance should be prepared to pay up to *$275 for the initial consultation.*
ESTABLISHED PATIENTS without valid insurance should be prepared to pay *$75 - $150 for each follow-up visit.*
ADDITIONAL SERVICES, such as diagnostic testing and labs, may be required during any visit. These additional services are not included and are rendered at an additional fee.
NO-SHOW POLICY: Patients that miss their appointments without calling and canceling or rescheduling at least twenty-four hours in advance of the appointment will be assessed a *$25 no-show fee.* Patients that show up for their appointment more than 15 minutes late may need to reschedule their appointment to a later time/date as the original appointment time may no longer be available.

EXCEPTIONS:
MEDICARE – We will accept assignment on all Medicare claims. We will also file Medicare Supplement claims. Patients covered by Medicare Part B must bring the Medicare card & Supplemental Policy card to the first visit. *PLEASE NOTE*: If you switch to a *Medicare HMO Plan*, you *must* inform us immediately.
HMO, PPO, EPO – Patients covered by a Managed Care or Participating Provider Plan of which the physician being seen is a participant, *must* bring the HMO/PPO/EPO card and be prepared to pay the *Co-Pay* amount at the time of service.
PLEASE NOTE: We want you to receive your maximum plan benefits. Our practice is not on every insurance plan and all of our physicians *do not* participate on the same plans. *It is your responsibility to verify that the physician you are seeing is on your plan.* If your plan requires a *Primary Care Physician Referral*, it is your responsibility to make sure you have a referral for every visit. It is your responsibility to inform us if the treatment or testing recommended to you requires insurance *Pre-Authorization.*
WORKER'S COMPENSATION – Injured workers covered under the Texas Workers Compensation Act will not be responsible for payment of medical services rendered *unless* the injury is finally adjudicated to not be compensated *or* the Texas Worker's Compensation Commission finds that the injured worker has violated Article 8303-4.62 or Article 8303-4.63 of the Texas Workers Compensation Act. *We do not accept out of state worker's compensation insurance.*
PRIVATE INSURANCE – We will file private insurance claims as a courtesy to our patients *only if* the day's charges *exceed $300.* Payment for the *Uninsured Portion* (Deductible & Co-Insurance) is *due at the time of service.*
PLEASE NOTE: Your Insurance Policy is a contract between you and your insurance carrier. We are not a party to that contract. As Medical Providers, our relationship is with *you – not your Insurance Carrier.* Not all services are a covered benefit of all policies. We recommend you inform yourself of any policy exclusions, as payment for non-covered services will be your responsibility.

I AGREE TO ABIDE BY THE FINANCIAL POLICY OF DFW NEUROLOGY, PLLC.

Signature of Patient or Guardian_____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice (displayed in the waiting room and also listed in our website **WWW.DFWNEUROLOGY.COM** under "Patient Informaition" tab).

Signature
I have reviewed this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I undersand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____
Name of Patient (Print or Type)

_____
Signature of Patient

_____
Date

_____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____
Relationship of Patient Representative to Patient