

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 No If yes: Marijuana Cocaine Heroin Methamphetamines MDMA/"X"

FAMILY HISTORY

<input type="checkbox"/> Alcoholism	Who? _____	<input type="checkbox"/> Migraine	Who? _____
<input type="checkbox"/> Alzheimer's Disease	Who? _____	<input type="checkbox"/> Multiple Sclerosis	Who? _____
<input type="checkbox"/> Cancer	Who? _____	<input type="checkbox"/> Muscle Disease	Who? _____
<input type="checkbox"/> Depression	Who? _____	<input type="checkbox"/> Neuropathy	Who? _____
<input type="checkbox"/> Diabetes	Who? _____	<input type="checkbox"/> Parkinson's Disease	Who? _____
<input type="checkbox"/> Epilepsy	Who? _____	<input type="checkbox"/> Schizophrenia	Who? _____
<input type="checkbox"/> Heart Disease	Who? _____	<input type="checkbox"/> Stroke	Who? _____
<input type="checkbox"/> High Blood Pressure	Who? _____	<input type="checkbox"/> Tremor	Who? _____
<input type="checkbox"/> Lung Disease	Who? _____	<input type="checkbox"/> _____	Who? _____

PATIENT SERIOUS ILLNESSES

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

NEW PATIENT INFORMATION

Patient Name: _____ DOB: _____

DRUG ALLERGIES

- | | | | |
|--|-------------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> No known drug allergies | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Vicodin | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

OPERATIONS

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hip | <input type="checkbox"/> PEG Tube |
| <input type="checkbox"/> Back | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Pituitary |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Subdural Hematoma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> _____ |

SYMPTOM REVIEW

- | | | | | |
|---|---|---|---|--|
| GENERAL
<input type="checkbox"/> Fever
<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Weakness
<input type="checkbox"/> Fatigue
<input type="checkbox"/> Sweats

EARS/NOSE/MOUTH/THROAT
<input type="checkbox"/> Hearing Impairment
<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Ear infections
<input type="checkbox"/> Nosebleeds
<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Frequent sore throat
<input type="checkbox"/> Prolonged hoarseness
<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Difficulty Swallowing

MUSCULOSKELETAL
<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Neck pain
<input type="checkbox"/> Back problems
<input type="checkbox"/> Joint pain/stiffness
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Gout
<input type="checkbox"/> Deformities | NEUROLOGICAL
<input type="checkbox"/> Headaches
<input type="checkbox"/> Head injury
<input type="checkbox"/> Fainting
<input type="checkbox"/> Blackouts
<input type="checkbox"/> Seizures
<input type="checkbox"/> Stroke
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Numbness
<input type="checkbox"/> Pain
<input type="checkbox"/> Tingling
<input type="checkbox"/> Burning
<input type="checkbox"/> Tremors
<input type="checkbox"/> Speech problems
<input type="checkbox"/> Unsteadiness of gait
<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Disorientation
<input type="checkbox"/> Behavior change

PSYCHIATRIC
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Mood swings
<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Difficulty sleeping
<input type="checkbox"/> Drug abuse | CARDIOVASCULAR
<input type="checkbox"/> Chest pain
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Palpitations
<input type="checkbox"/> Shortness of breath
(with exertion)
<input type="checkbox"/> Shortness of breath
(lying flat)
<input type="checkbox"/> Heart attack (history)
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Leg Pain (walking)
<input type="checkbox"/> Swelling of legs
<input type="checkbox"/> Blood clots

EYES
<input type="checkbox"/> Blurry Vision
<input type="checkbox"/> Double Vision
<input type="checkbox"/> Blindness
<input type="checkbox"/> Eye pain/redness
<input type="checkbox"/> Cataracts

CHEST
<input type="checkbox"/> Cough
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma/Wheezing
<input type="checkbox"/> Coughing up blood | GASTROINTESTINAL
<input type="checkbox"/> Loss of appetite
<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Change in stools
<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Black, tarry stools
<input type="checkbox"/> Jaundice/Hepatitis
<input type="checkbox"/> Liver disease
<input type="checkbox"/> Gall Bladder disease

GENITOURINARY
<input type="checkbox"/> Bladder control loss
<input type="checkbox"/> Burning urination
<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Sexual problems

<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Menstrual problems
Date of last menstrual
period: _____ | ENDOCRINE
<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Goiter
<input type="checkbox"/> Diabetes/blood sugar
<input type="checkbox"/> Intolerance to heat
or cold

HEMATOLOGICAL/LYMPHATIC
<input type="checkbox"/> History of anemia
<input type="checkbox"/> Tendency to bleed
<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Swollen glands

SKIN/BREASTS
<input type="checkbox"/> Rashes/Easy bruising
<input type="checkbox"/> Changes in hair/nails
<input type="checkbox"/> Breast lumps
<input type="checkbox"/> Breast pain/discharge

ALLERGIC/IMMUNOLOGICAL
<input type="checkbox"/> Eczema
<input type="checkbox"/> Hay fever
<input type="checkbox"/> Hives
<input type="checkbox"/> 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) 285-0908

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 Information" tab).

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand 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