ROBERT M. CAIN, MD, PA

Robert M. Cain, M.D.

Pediatric Medical History

Today's Date:_____

Patient's Name:_____ Date of Birth:_____

Your Name:_____

Relationship to Patient:_____

Child's Primary Care Doctor and phone number:

_____

Other doctors who should receive a copy of our report with phone numbers:

_____

_____

Child's Problem:

_____

_____

_____

_____

Current Medications:

Medication	Dosage	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List Any Allergies or Other Problems Caused By Medications

_____

_____

_____

Has your child had any of the following tests?

Test	Date	Where	Results	
MRI	_____	_____	Normal	Abnormal
CT	_____	_____	Normal	Abnormal
EEG	_____	_____	Normal	Abnormal

Other Tests:

_____

_____

Past Medical History

Birth History:

Was your child born early or after nine months of pregnancy? **Early**____ **Full Term**_____

If early, how many weeks gestation?_____ Birth Weight_____

Was a C-section performed? **Yes**_____ **No**_____

Were there complications during the pregnancy or at delivery? **Yes**_____ **No**_____

If so, what was the complication?_____

Did the baby come home with you from the hospital? **Yes**_____ **No**_____

If not, how long did the baby stay in the hospital?

_____

Has your child ever been hospitalized or had any surgeries?

Age_____ Reason_____

Age_____ Reason_____

Age_____ Reason_____

Has your child had all of his/her immunizations required for his age?

Yes_____ **No**_____ **Not Sure**_____

Has your child ever had any of the following? If so, when?

Seizure: With Fever_____ Without Fever_____

Head Injury_____ Loss of Consciousness_____

Severe Headache_____ Hearing Problems_____

Vision Problems_____ Frequent Day-dreaming_____

Problems Sleeping_____ Daytime Sleepiness_____

Unexplained Vomiting_____ Loss of Balance_____

Weakness of Extremities_____ Paralysis of Extremities_____

Numbness/ Tingling_____ Double Vision_____

Does your child have problems with any of the following?

Asthma_____ Other breathing Issues_____

Nose or Throat_____ Thyroid_____

Heart_____ Stomach Pain or Digestive_____

Changes in Bowel or Bladder Function_____

Weight Loss or Gain_____ Swollen Lymph Nodes_____

Rashes or Skin_____ Bruising or Bleeding_____

Motor coordination_____

Has your child ever been seen by a specialist (eye doctor, heart doctor, lung doctor, etc.)?

Yes No If yes, who?_____

Development

At what age did your child learn the following skills?

Rolling Over_____ Sitting_____ Crawling_____

Walking_____

First Words_____ Speaking in Sentences_____

Toilet Trained_____

Has your child ever received any physical therapy?_____

Has your child ever received any speech therapy?_____

If so, how often does he/she get therapy?_____

If so, where?_____

Grade level in school_____

Has he/she ever received educational support? Yes No

Has he/she received special education? Yes No

Are there any problems in school with the following:

Reading_____ Motivation_____

Attention_____ Behavior_____

Relationship with peers_____ Relationship with teachers_____

Family

Please list ages of all brothers and sisters:

_____

_____

Who in the family has had any of these problems? (Please include parents, brothers, sisters aunts, uncles, grandparents, and cousins.)

Seizures_____ Learning Disabilities_____

Migraines or Headaches_____ Genetic Diseases_____

Depression_____ Bipolar Disorder_____

Autism_____ Attention Problems_____

Brain Tumor_____ Substance Abuse_____

Mental Retardation_____ Movement Disorder/ Tics_____

Are there any other medical problems that run in the family?

_____

_____

_____

_____

Social

Who lives at home with your child?

_____

_____

Are the parents: Married Divorced Never Married Separated

Parent's occupation:

Father:_____ Mother:_____

Is there any additional information you would like the doctor to know?

_____

_____

_____

_____

Are there specific questions you would like to address at this visit?

_____

_____

_____

_____

Robert M. Cain, MD, PA

Phone (512) 458-2600
Fax (512) 454-2292

Check In:_____

Patient Room Time:_____

Room #:_____

Patient Name:_____Date of Birth:_____ Date:_____

Chief complaints. *Please circle all that apply:*

Multiple Sclerosis	Epilepsy/ Seizures	Headache
Attention Deficit Disorder	Dizziness/ Vertigo	Tremor
Numbness/ Tingling of hands or arms	Low Back Pain	Neck Pain
Numbness/Tingling of feet or legs	Memory Loss	Depression
Automobile Accident Injury		

Robert M. Cain, MD, PA

(512) 458-2600

Welcome. We thank you for choosing us as your healthcare partner.

PLEASE FILL IN AND COMPLETE ALL BLANKS WITH THE PROPER INFORMATION.

PLEASE PRINT

Patient Information

Name (Last, First, Middle Initial)		Date of Birth	Sex	SS Number	
Physical Address (no P.O. Boxes)	City	State	Zip Code	Home Phone	
Mailing Address (If Different)	City	State	Zip Code	Cell Phone	
Employer/ School or Retirement Date	Student Status: Full: Part time:	Marital Status	Work Phone/ Ext.		
Employer/ School Address		Occupation	Driver's License Number and State		
Emergency Contact Name and Phone Number:		Relation to Patient:			
Referring/ Consulting Doctor, full name, address and phone number:					
Family Doctor full name, address and phone number:					
Date of first symptom/ injury	If injury/ accident Please check:	Home	Work	Auto	Other
PATIENT E-MAIL ADDRESS:					

Policy Holder Information, if other than patient

Name of Insured:	Date of Birth	Sex	SS Number
Relation to Patient:	Address, if different than patient:		
Home Phone:	Business Phone:	Cell Phone:	Employer Name:

Please complete.

Primary Insurance Company	Plan Name		Policy #	Group #
Address for Claims	City	State	Zip	Phone
Secondary Insurance Company	Plan Name		Policy #	Group #
Address for Claims	City	State	Zip	Phone
Name of Policy Holder for Secondary Coverage:		DOB	Employer:	
Patient relationship to insured:	SELF	SPOUSE	CHILD	OTHER

Authorizations

I authorize payment of medical benefits directly to Robert M. Cain, MD, PA for services rendered by Robert M. Cain, MD

Signature of Patient or Guardian:	**Date of Signature:**

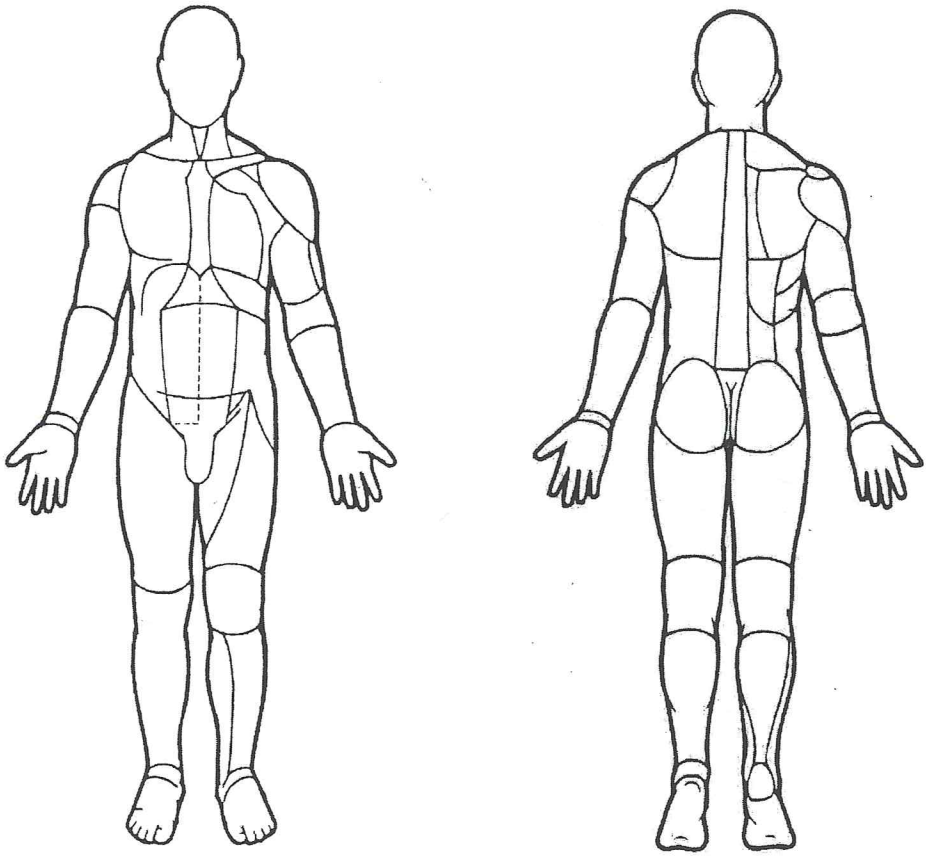
Robert M. Cain, MD, PA

Phone (512) 458-2600
Fax (512) 454-2292

PAIN DIAGRAM

Please mark the areas of your body where you feel the described sensations. Use the appropriate symbols to mark all the affected areas. Thank you.

Numbness: = = = = **Pins and needles: O O O O** **Aching Pain: ((((**
Burning: X X X X **Stabbing Pain: / / / /**



PLEASE SIGN AND DATE THIS FORM CLEARLY.

Patient Print Name _____ DOB _____

Signature of responsible party _____ Date _____

ROBERT M. CAIN, MD, PA

Robert M. Cain, MD

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

We require your written authorization prior to sending any protected health information per HIPAA regulations.

Name of Patient:_____ **DOB:**_____

I authorize the disclosure of medical records to the insurance company, and/ or representative of my insurance company listed below:

_____ Signature:_____

I authorize the disclosure of medical records to my attorney:_____Signature:_____
I authorize the disclosure of medical records to the following physicians and family members:

Name:_____ Signature:_____

Name:_____ Signature:_____

Name:_____ Signature:_____

For the purpose of:_____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Signature:_____ Date:_____

I understand that the information released is for the specific purpose stated above. Any other use of this information with the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and 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. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____
If I fail to specify an expiration date, event or condition, this authorization will remain on file until doctor/ patient relationship is terminated.

Please initial if you authorize us to speak with/ release information to the following:

Spouse_____ Mother_____ Father_____ Daughter_____ Son_____

CONSENT FOR TREATMENT

I hereby authorize evaluation and treatment by Robert M. Cain, MD.

_____ _____
Patient/ Guardian Signature *Date*

I authorize the release of my protected health information by Robert M. Cain, MD, PA from any physician, hospital or clinic to facilitate my treatment by Robert M. Cain, MD.
I also authorize Robert M. Cain, MD, PA to disclose my protected health information to any physician, hospital or clinic to which we refer you.

_____ _____
Patient/ Guardian Signature *Date*

Notice Concerning Complaints
(Aviso Sobre Quejas)

Complaints regarding physicians, as well as other licenses and registrants of the Texas State Board of Medical Examiner may be reported for investigation to the address below:
Se pueden presentar quejas acerca de medicos, asi tambien como de otras personas authorizadas y registradas pro la junta de Examinadores Medicos del Estrado de Tejas (Texas Boaed of Medical Examiner) para su investigacion en siguiente direccion:

Texas State Board of Medical Examiners
Attention: Investigations
1812 Centre Creek Drive, Suite #300
Austin, Texas 78714-9134
Phone: 1-800-201-9353

ROBERT M. CAIN, MD. PA
102 Westlake Drive, Suite 102

Patient Name:_____ **Date of Birth:**_____

Please…read, initial, and sign below.

(Initial)_____**FINANCIAL RESPONSIBILITY**: I understand that I am ultimately responsible for payment on my account. **Payment is expected at the time of service.**
I understand that **I am responsible for any Referral or Authorization that my insurance may require**.
I understand that I am responsible for any charges not covered by my insurance plan, including Co-payments, Co-insurance, and Deductibles.
Claims will be filed for PPO and HMO participants and Medicare. Payment of benefits will be made directly to Associated Neurological Specialties.

(Initial) _____**INSURANCE COVERAGE**: I understand that I am responsible for providing ANS with **any and all insurance coverages at each and every visit**. I will be responsible for any balances due as a result of not disclosing this information.

(Initial) _____**INSURANCE PROVIDER**: I certify that _____ is my primary insurance provider.

SECONDARY INSURANCE PROVIDER: **Please circle and initial one of the following:**

(Initial) _____ **I certify I do have a secondary insurance policy**. I also understand that ANS will not file my secondary insurance, except in the case of Medicare. **AND** Upon my request, they will provide me the paperwork necessary to obtain reimbursement directly from my insurance, unless prior arrangements have been made with our billing department.

-OR-

(Initial) _____I certify I do **NOT** have a secondary insurance policy.

(Initial)_____ **HIPPA**: I acknowledge that I have received a copy of ANS' Notice of Privacy Practices.

(Initial)_____**FEE FOR FORMS COMPLETION**: I understand there will be a charge for any forms I bring to be completed by ANS physicians or staff. (Example: Disability forms, FMLA forms, etc.). I will be required to schedule a re-visit with the doctor to discuss these forms and there will be a charge of $18.00 for their completion. I understand it is my financial responsibility, not my health plan's responsibility, to pay this. Forms will not be completed until this fee is paid.

(Initial)_____I understand that when I call this office, **I may or may not be able to speak with a live person right away**. I understand that if I am having a **medical emergency, I should not call this office, but should call 911.** When calling this office about a medical question, I am aware that the doctors are very limited by my report and are limited in what they can observe over the phone. **If I have new symptoms, worsening symptoms, and unexplained symptoms, I understand I should present to the emergency room immediately for an evaluation.** I will then need to schedule a visit with the doctor, so that he can review my questions and concerns thoroughly. **I understand not all of my calls can be answered, due to time and personal constraints.**

(Initial)_____I understand that a $25 "no show" fee will be assessed for appointments I do not keep and have not called within 24 hours of the appointment to cancel.

Patient signature:_____ **Date**:_____

*

Robert M. Cain, MD, PA

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), and the Texas House Bill 300 of 2012, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- We are required to notify patients that their protected health information is subject to electronic disclosure.

I have received, read, and understand your *Notice of Privacy Practices*, and Texas House Bill 300, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Addendum

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), and the Texas House Bill 300 of 2012, I have certain rights to privacy regarding my protected health information. I understand that my health information can and will be used for the following:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- We are required to notify patients that their protected health information is subject to electronic disclosure.
- As provided by the Texas Health and Safety Code, Section 181.102, as amended by HB 300 (CONSUMER ACCESS TO ELECTRONIC HEALTH RECORDS): if we are using an electronic health records system that is capable of creating an electronic health record, then Associated Neurological Specialties must provide you with an electronic copy of such record.
- The record will be available no later than 15 business days after we receive a written request from you asking for your record. The record must be in electronic form unless you agree to accept the record in another form.
- We are not required to provide access to a person's protected health information if it is exempted from access, or to which access may be denied under 45 C.F.R Section 164.524 of the Code of Federal Regulations.

WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, A NOTICE OF SUCH CHANGE WILL BE POSTED ON OUR WEB-SITE

We will not use or disclose your health information without your consent or authorization, except as described in this notice or otherwise required by law.

Authorization is required for uses/ disclosures of psychotherapy notes and for Private Health Information (PHI) for marketing purposes and for the sale of PHI.

Other uses and disclosures of PHI not described in the Notice of Privacy Practices will be made only with patient authorization.

Patients have the right to be notified following a breach of unsecured PHI.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____