PATIENT REGISTRATION (please print) Neurology Associates of Katy, PLLC

PATIENT'S LAST NAME FIRST NAME MI SEX: ☐ M ☐ F

MAILING ADDRESS CITY STATE ZIP

DATE OF BIRTH AGE SOCIAL SECURITY #

HOME PHONE CELL PHONE WORK PHONE

REFERRING DOCTOR OFFICE PHONE #

EMPLOYER NAME PHONE #

MARTIAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED

INCASE OF EMERGENCY NOTIFY: ______________________________

NAME PHONE #

INSURANCE INFORMATION- WE CANNOT FILE YOUR INSURANCE WITHOUT COMPLETE INFORMATION AND A COPY OF YOUR INSURANCE CARDS. PLEASE BRING YOUR INSURANCE CARD WITH YOU TO THE FRONT DESK WHEN YOU HAVE COMPLETED THIS FORM.

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY

ADDRESS CITY STATE ZIP

SUBSCRIBER'S NAME SUBSCRIBER'S DOB SEX: ☐ M ☐ F

SUBSCRIBER'S SOCIAL SECURITY # RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S ID # GROUP #

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY

ADDRESS CITY STATE ZIP

SUBSCRIBER'S NAME SUBSCRIBER'S DOB SEX: ☐ M ☐ F

SUBSCRIBER'S SOCIAL SECURITY # RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBER'S EMPLOYER

SUBSCRIBER'S ID # GROUP #

IS THIS RELATED TO: ☐ **WORKMENS COMP** ☐ **MOTOR VEHICLE ACCIDENT** ☐ **OTHER**

ASSIGNMENT AND RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO NEUROLOGY ASSOCIATES OF KATY, PLLC. AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. ALSO ALL PATIENTS WHO FAIL TO INFORM NAOMV THAT WORKMENS COMP OR MOTOR VEHICLE ACCIDENTS ARE ASSOCIATED WITH THEIR VISIT, OR CONDITION, OR SHOULD BE APPLICABLE WILL BE HELD RESPONSIBLE FOR THEIR BILLS IN FULL. I ALSO AUTHORIZE THE PHYSCIAN TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS. I HEREBY GRANT MY AUTHORIZATION AND CONSENT TO TREATMENT.

I HAVE READ THE ABOVE ACKNOWLEDGMENT AND AGREEMENT, AND FULLY UNDERSTAND.

SIGNATURE **DATE**

NEUROLOGY ASSOCIATES OF KATY, PLLC.
19255 Park Row Dr. Suite 101, Houston TX 77084
Tel: (281) 816-6455
Fax: (281) 914-4361

Atta Rehman, M.D.
Board Certified in Neurology
Board Certified in Vascular Neurology (Stroke)
Certified in Neuro-Imaging

RELEASE OF MEDICAL INFORMATION

Please list all persons you give permission to obtain any information regarding your health records at Neurology Associates of Katy, PLLC.

I hereby authorize:

____

Print Name Relationship

____

Print Name Relationship

____

Print Name Relationship

To obtain information on my behalf concerning my medical condition. I understand that only the people listed on this form are allowed access or to discuss any issues, concerns, treatment plans, etc. with the doctor or staff of Neurology Associates of Katy, PLLC. I understand this release includes all information in my medical records.

____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

____

Date of Birth

____

Signature of Patient or Personal Representative Date

***Please note if patient is unable to sign, a copy of 'Power of Attorney' must be on file giving permission of the guarantor to sign; otherwise this form is not valid.**

EMAIL ADDRESS: ______________________________________

NEUROLOGY ASSOCIATES OF KATY, PLLC.

ATTA REHAMAN, M.D.

MEDICAL INFORMATION

ALL PATIENT'S WHO FAIL TO INFORM **NAOK** THAT WORKMEN COMP / MOTOR VECHICLE ACCIDENTS ARE ASSOCOATED WITH THEIR VISIT, OR CONDITION, OR SHOULD BE APPLICABLE WILL BE HELD RESPONSIBLE FOR THEIR BILL IN FULL.

Is this Workmans Comp related? yes no

Is this Motor Vehicle Accident related? yes no

Reason for you visit and symptoms: ______________________________

____

____

Duration of symptoms: ______________________________

____

____

List all past surgeries: ______________________________

____

____

List all allergies to medication: ______________________________

____

____

Medical History

(Please circle)

High blood pressure: yes no

Diabetes: yes no

Sleep Apnea: yes no

Kidney disease: yes no

Do you smoke? yes no how much? ______________

Alcohol intake? yes no how much? ______________

Occupation? ______________________________

other: ______________________

other: ______________________

other: ______________________

other: ______________________

Family History

Heart disorder yes no

High blood pressure: yes no

Diabetes: yes no

Seizures: yes no

Headaches: yes no

other: ______________________

Print name: ______________________________ **Date:** ______________

Patient signature: ______________________________

revised 9/2013

REVIEW OF SYSTEM

(Circle all symptoms that apply)

GENERAL: (fever, wt. loss)______________________________

ENT: (hearing loss, dizziness, vertigo, dysarthria, dysphagia)______

RESPIRATORY: (cough, SOB, wheezing, hemoptosis)__________

GU: (polyuria, hematuria, incontinence, stones)_______________

SKIN: (prutitis, moles)_________________________________

ENDO: (goiter, impotence)_______________________________

ALLERGY/IMMUN: (hives, eczema) ____________________

EYES: (VISION, DIPLOPIA, PAIN)_________________________

CV: (chest pain, SOB)__________________________________

GI: (nausea, vomiting)__________________________________

MS: (myalgias, weakness, artralgias)_____________________

PSYCH: (memory loss, depression, mood, sleep)____________

LYMPH/HEMO: (adenopathy, bruising)_________________

NEURO: (HA, seizures, pain, numbness)

(cramps, ataxia, handwriting problems)___________

PLEASE LIST ALL MEDICINES YOU ARE TAKING: (including supplements and over counter medications)

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

MEDICATION:____ DOSE:______________________

DOB: ________/_______/_________

PATIENT'S NAME:____ **DATE:** ______________________

PHYSICIAN'S SIGNATURE:______________________________________ **DATE:** ______________________

Revised 09/2013

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use of disclosure of my protected health information by Neurology Associates of Katy, PLLC., for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Neurology Associates of Katy, PLLC. I understand that diagnosis or treatment of me by Dr. Iqbal or Dr. Rehman may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of this practice. Neurology Associates of Katy, PLLC., is not required to agree to the restrictions that I may request. However, if Neurology Associates of Katy, PLLC., agrees to that request, the restriction is binding on Neurology Associates of Katy, PLLC., and Drs. Iqbal and Rehman.

I have the right to revoke this consent, in writing, at any time, except to the extent that Neurology Associates of Katy, PLLC., has taken action in reliance to this consent.

My "protected health information" means health information, including my demographic information , collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and indentifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Neurology Associates of Katy, PLLC.'s Notice of Privacy Practices prior to signing this document. The Neurology Associates of Katy, PLLC.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my bills or the performances of health care operations of the Neurology Associates of Katy, PLLC. The Notice of Privacy Practices for Neurology Associates of Katy, PLLC., is also provided in the front office. This Notice of Privacy Practices also describes my rights and the Neurology Associates of Katy, PLLC.'s duties with respect to my protected health information.

Neurology Associates of Katy, PLLC. reserved the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

If you have any question regarding your privacy rights, please refer to the full version of this notice or contact our privacy officer at (281) 816-6455. You may also address questions of concerns to the privacy officer by writing to: **Privacy Officer, 19255 Park Row Dr Suite 101, Houston TX 77084.**

____

Signature of Patient or Personal Representative   Date

____

Print Name of Patient or Personal Representative   Description of Personal Representative's Authority

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Atta Rehman, M.D-
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Certified in Neuroimaging

NOTICE TO:

WORKMENS COMP / MOTOR VEHICLE ACCIDENTS

Neurology Associates of Katy, PLLC. will file your claim as a courtesy but please note that our policy is to require payment prior to any services rendered. It is the patient's responsibility to obtain reimbursement from the insurance company. All patients filing a Workmen's Comp claim or Motor Vehicle Accident claim will be responsible for all unpaid balances if the insurance company denies payment for any reason. All unpaid balances will be the responsibility of the patient and will be forwarded to a collection agency if no payment arrangements have been made once a claim should get denied.

By signing below, I agree to these terms and conditions and will not hold Neurology Associates of Katy, PLLC accountable if my claim should get denied.

____
Patient Name

____
Date