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 ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ African American ☐ White
☐ Hispanic ☐ Other Pacific Islander ☐ Other ☐ Refused to Report

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino 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 Northwest Houston Neurology, PA. I give my permission to release medical information needed to process medical claims. I understand that 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 and Financial Policy

Thank you for choosing Northwest Houston Neurology! 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.

Financial Policy

- Payment in full is due at the time services are rendered, including past due balances.
    - 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 after the insurance pays and upon the patient's 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 workers' compensation or automobile insurance. The patient is responsible for payment in full. We will provide receipts so that you may file claims for reimbursement.
- 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, and most major credit cards. A $30 fee will be assessed for returned checks. Checks returned due to stop payment may lead to dismissal from the practice.
- Statements 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 fee for the completion of medical forms and for medical letters written by physicians.

Transfer of Records

A 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 and financial 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.

Summary of Notice of Privacy Practices

Purpose

This Notice gives you information required by law about the duties and privacy practices of Northwest Houston Neurology, PA (NWHN) to protect the privacy of your protected health information ("PHI"), as the term is defined under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), in providing for your medical treatment and needs. **It describes how medical information about you may be used and disclosed and how you can access this information.** This Notice of Privacy Practices is a summarized version of our Full Notice of Privacy Practices available in our office.

Northwest Houston Neurology Responsibility

We as the provider have the responsibility to make you aware of HIPAA and how it relates to you and your treatment. We are required to supply you with a written copy of the Summary of Notice of Privacy Practices and to make the full-length version of the Notice for Privacy Practices available to you. We also have the responsibility to accept formal complaints and may not retaliate against or attempt to dissuade you in that instance. We do, however, reserve the right to make changes or amendments to the Notice, but we will make any revisions known as soon as they are in place and provide you with a written copy of the revised notice.

Patient Rights Regarding Medical Information

HIPAA allows you, the patient, various rights in regards to your PHI. To exercise any of the following rights, you must submit a written request to the office:

- Inspect and copy. You have the right to inspect and copy your health information unless in a circumstance prohibited by law. You may be charged a fee by NWHN, in accordance with Texas Law.
- Request Amendment. If believe the PHI maintained is wrong, you may request an amendment. NWHN is not required to agree with this request.
- Request Restrictions. You may request limitations on how NWHN uses and/or discloses your PHI. NWHN does not have to agree to the request. If NWHN agrees, we will comply with your request unless there is an emergency or it is otherwise required by law.
- Receive confidential communications. You may request that NWHN communicate with you in a certain manner or a certain location. You must be specific, otherwise, any contact information provided by you will be utilized including addresses, phone numbers or email addresses.
- Accounting Disclosures. You may request a list of disclosures made by NWHN of your PHI to persons or entities other than for the purpose of treatment, payment of health care operations, or pursuant to your specific authorization.
- File a complaint with NWHN or the Secretary of Health and Human Services if you feel your rights have been violated.

Use and Disclosure of Your Protected Health Care Information

The following is a list of ways NWHN may use and disclose your PHI. Not every possible use or disclosure in any given section is listed. However, all of the ways NWHN is permitted to use and disclose your PHI will fall within one the categories:

Treatment NWHN may use your PHI to provide you with medical treatment or services. NWHN may disclose your PHI to doctors, nurses, technicians, pharmacists, medical students or other members of your health care team.

Payment NWHN may use and disclose your PHI to obtain payment from your insurance company or third party. NWHN may also disclose your PHI to other health care providers to assist those providers in obtaining payment from your insurance company or third party.

Health Care Operations NWHN may use and disclose your PHI for routine health care operations.

Appointments and Alternatives NWHN may use and disclose your PHI to contact you to provide appointment reminders, prescriptions refill reminders, and other communications regarding your case management or health care conditions.

Business Associates NWHN may disclose your PHI to NWHN business associates in order to carry out treatment, payment, or other healthcare operations. Under certain circumstances, we may use and disclose PHI for research purposes.

Health Oversight Activities NWHN may disclose your PHI to a health oversight agency or entity for activities authorized by law, such as audits, investigations, and licensure.

Public Health Activities As required by law, NWHN may disclose your PHI for public health activities.

You may revoke any prior authorization in writing. A written revocation will not apply to any previous use or disclosure of PHI made in good faith under a prior authorization.

Northwest Houston Neurology, PA

Patient Privacy Questionnaire (HIPAA)

_____ _____

Patient Name Date of Birth

_____ _____

Parent or Legal 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 the patient's general medical condition and diagnosis (including treatment, payment, and health care operations):

Name and Relationship: Phone:

_____ _____

_____ _____

2. Please list any persons that can consent to treatment and medical care for the patient when the legal guardian is not available to give consent:

Name and Relationship: Phone:

_____ _____

3. Please list any persons that are authorized to pick up paperwork or prescriptions for the patient:

Name and Relationship: Phone:

_____ _____

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

Name: Phone:

_____ _____

_____ _____

The patient may be contacted by our office with appointment reminders, healthcare treatment options or other health services. We will limit the amount of information left in messages to just the information necessary to confirm the appointment or to request a return call. We may contact you by mail, phone, voicemail, text or email, using any information that you provided. **You may request that NWHN communicate with you in a certain manner. You must be specific and provide this request in writing.**

_____ _____

Signature of Patient or Legal Guardian **Date**

Northwest Houston Neurology, PA
Patient Consent Form

Name of Patient_____D.O.B. _____ Date: _____
Name of Patient's Representative_____ Relation to patient: _____

Notice of Privacy Practices Acknowledgment

I hereby consent to the use or disclosure of individually identifiable or protected health information (PHI) by Northwest Houston Neurology (NWHN) in order to carry out treatment, payment, or health care operations. I acknowledge that NWHN has provided a copy of the Notice of Privacy Practices as required by law.

NWHN reserves the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time and must notify the patient. The patient retains the right that NWHN further restrict how the PHI is used or disclosed. NWHN is not required to agree to such requested restrictions; however, if NWHN does agree to Patient requested restriction(s), such restrictions are then binding on NWHN. The patient retains the right to revoke this Consent. Such revocation must be submitted to NWHN in writing. The revocations shall be effective immediately except to the extent that NWHN has already taken action in reliance on the Consent.

NWHN 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, NWHN 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).

General Consent to Treat

I authorize and consent to the medical care, treatment, and diagnostic tests that the providers at Northwest Houston Neurology and their designated associates believe are necessary. I understand that by signing this form, I am giving permission to the doctors or other health care providers in this medical office to provide treatment as long as a physician / patient relationship exists, or until I withdraw my consent in writing. **Treatment of Minor,** if applicable: I, as the parent/legal guardian of a minor receiving treatment, do hereby agree and understand that I have been advised to remain on the premise during any such treatment, and waive any claim I may have resulting from failure to do so.

Office Policy and Financial Policy

I acknowledge that I been provided a copy of NWHN's Office Policy and Financial Policy and I understand the terms.

Electronic Prescribing

I voluntarily authorize Northwest Houston Neurology to allow E-prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice and review medication history as long as a physician / patient relationship exists, or until I withdraw my consent in writing.

Voicemail, Texts, and Email Notifications

Northwest Houston Neurology provides courtesy appointment reminder calls/texts/emails and possibly other important calls or reminders that may be placed by a staff member or by using a prerecorded auto messaging system. This information may include PHI. I understand that by signing this form, I give consent to receive such calls/texts/emails at the number/email addresses I have provided unless specific restrictions have been provided in writing.

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.

I have read this form, had the opportunity to ask questions and accept the terms and conditions as stated.

Patient or Authorized Representative Signature _____Date: _____

Northwest Houston Neurology
Medical History Form

Patient Name: _____ DOB: _____Today's Date: _____

Were you recently seen by our physician in the hospital? Y or N If yes, when and where? _____

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 □ Depression □ Anxiety □High Blood Pressure □ Diabetes □ Heart Disease □ Other _____

Social History Occupation: _____Marital Status: _____ Assistive Devices (ex: cane) _____

Tobacco Use? □ Yes □ No, How Much _____ Drink Alcohol? □ Yes □ No, How Much _____

This section is for CHILDREN ONLY. <u>Only complete for patients under 18 years of age.</u>

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

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

Psychiatry
- □ Anxiety
- □ Depression

Northwest Houston Neurology, PA

Phone 281-357-5678 Fax 281-357-8765

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.: _____

HISTORY OF PRESENT ILLNESS

Briefly state the reason for your visit in the space provided:

_____

_____

MEDICATIONS

List all current medications including doses and directions

_____

_____

_____

_____

_____

_____

_____

PREVIOUS TESTS:

Have you had any tests done previously for this problem?

☐ CT Scan ☐ MRI ☐ EMG/NCV (nerve test) ☐ EEG ☐ Other test _____

What did the test show? ☐ Normal ☐ abnormal _____

ALLERGIES:

List all drug allergies and correlating reactions that have occurred:

_____

_____

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:

- Chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Dozing = to fall into a light sleep unintentionally

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

455 School Street Suite 20
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