PERSONAL INFORMATION

Today's Date: _____

NAME (LAST) _____ (FIRST):_____ (MIDDLE) _____

BIRTHDATE: _____ / _____ / _____ AGE: _____ SEX: _____ HEIGHT: _____

WEIGHT: _____ SOC.SEC #: _____ - ____ - _____ MARITAL STATUS: M S D W

ADDRESS: _____ CITY: _____ ST.:____ ZIP: _____

HOME PHONE (area code): _____**CELL PHONE: _____**

***** PHYSICIAN NAMES ARE REQUIRED FOR US TO SUPPLY YOUR CONSULTATION REPORT AND TEST RESULTS***.**

(1) REFERRING PHYSICIAN: (LAST) _____, (FIRST):_____
TELEPHONE #: (_____) _____ - _____

(2) PRIMARY PHYSICIAN: (LAST) _____, (FIRST):_____
TELEPHONE #: (_____) _____ - _____

OTHER CONSULTANTS (PHYSICIANS): _____

IF NOT A PHYSICIAN REFERRAL, WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? _____

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____**(CITY)**_____ **(STATE)**_____ **(ZIP)**_____

WORK NUMBER: (_____) _____ - _____

ARE YOU THE PRIMARY INSURED: Y / N (If no, please complete the section below.)

INSURED'S NAME: _____ BIRTHDATE: _____ / _____ / _____

SSN#: _____ - _____ - _____ RELATIONSHIP: _____

EMPLOYER: _____ADDRESS: _____

EMERGENCY CONTACT _____ RELATIONSHIP: _____

EMERGENCY PHONE NUMBER: (_____) _____ - _____

*******PLEASE PRESENT YOUR INSURANCE CARD AND DRIVER'S LICENSE FOR COPY.*******

CLINICAL INFORMATION

PLEASE COMPLETE IN DETAIL AND LEAVE NO BLANKS. MY STAFF WILL BE GLAD TO HELP YOU.

NAME: **(LAST):** _____ **(FIRST):**_____
AGE: _____ SEX: _____ ☐ RIGHT-HANDED ☐ LEFT-HANDED

WHAT DIFFICULTIES BRING YOU TO THE NEUROLOGIST: _____
_____
_____
_____
_____

WHEN DID THIS START? _____

REVIEW OF SYSTEM:

DO YOU HAVE ANY OF THE SYMPTOMS LISTED BELOW THAT ARE SIGNIFICANT AND FREQUENT? ☐ **YES** ☐ **NONE**

IF YES, PLEASE MARK THE APPROPRIATE CHOICES.

☐ Progressive Body Weight Loss ☐ Bowel/ bladder incontinence ☐ Severe incoordination
☐ Fever ☐ Chronic neck/ arm pain ☐ Progressive loss of balance
☐ Severe visual loss/blindness ☐ Chronic back/ leg pain ☐ Constant night leg jerks
☐ Double vision (not blurry) ☐ Skin rashes; Skin discoloration ☐ Marked depression
☐ Severe trouble hearing ☐ Severe dizziness ☐ Marked nervousness
☐ Slurred speech ☐ Headache ☐ Marked memory loss
☐ Irregular heart rate ☐ Numbness at extremity ☐ Severe trouble sleeping
☐ Heavy snoring ☐ Weakness at extremity ☐ Cold intolerance
☐ Sleep apnea (stop breathing) ☐ Trouble walking ☐ Marked daytime sleepiness
☐ Difficulty swallowing ☐ Tremor/ shaking ☐ Severe joint pain/ arthritis

PREVIOUS TESTS (done for your illnesses): ☐ NONE

☐ MRI: Head_____Neck _____ Back _____ Other _____
When _____Where _____ Per Dr.:_____
☐ CAT SCAN: Head ____ Neck _____ Back _____Other _____
When _____Where _____ per Dr.:_____
☐ X-RAYS: Head ____ Neck _____ Back _____ Other _____
When _____Where _____ per Dr.:_____

☐ BLOOD LAB TESTS: _____
When _____Where _____ Per Dr.:_____

CLINICAL INFORMATION (cont.)

MAJOR ILLNESSES: ? NONE

NEUROMUSCULAR DISORDERS
? Cervical Radiculopathy (pinched nerve: neck)
? Lumbosacral Radiculopathy (pinched nerve: back)
? Carpal Tunnel Syndrome
? Peripheral neuropathy
? Myopathy
? _____

STROKE
? Cerebral Infarct (blood clot in brain)
? Intracranial Hemorrhage (bleeding in the brain)
? Subdural Hemorrhage
? Subarachnoid Hemorrhage
? Cerebral Aneurysm
? _____

SEIZURE DISORDERS
? _____

INFECTION
? Meningitis ? Encephalitis
? Poliomyelitis (Polio)
? _____

TUMOR
? Brain Cancer ? _____
? Meningioma ? _____

AUTOIMMUNE DISORDER
? Multiple Sclerosis
? Optic Neuritis ? _____
? Bell's Palsy ? _____

OTHER NEUROLOGICAL DISORDERS
? PSYCHIATRIC Disorder _____
? Trigeminal Neuralgia
? Migraine
? Hearing Loss (Left / Right)
? VISUAL LOSS (LEFT / RIGHT)
? Others: _____
_____

DISORDERS IN OTHER SYSTEMS:

? Hypertension
? Coronary Artery Disease
? Myocardial Infarction(heart attack)
? High cholesterol
? Atrial Fibrillation
? Congestive Heart Failure
? Asthma
? COPD
? Ulcers – Where: _____
? GE Reflux
? Diabetes
? Hypothyroidism (low thyroid)
? Hyperthyroidism (high thyroid
? Gallstone
? Liver Cirrhosis
? Hepatitis
? Kidney Stone
? Lupus
? Rheumatoid Arthritis
? CANCER: Where: _____
Others: _____

CLINICAL INFORMATION (cont.)

OPERATIONS: ☐ NONE

1) _____ 2) _____
3) _____ 4) _____
Others: _____

FAMILY HISTORY (OTHER THAN YOU): ☐ NONE

explain who and what kind

☐ Stroke: _____ ☐ High Blood Pressure : _____
☐ Diabetes: _____ ☐ Heart Coronary Artery Disease: _____
☐ Psychiatric Disorder: _____ ☐ Inherited Family Disease: _____
☐ Seizure: _____ ☐ Dementia: _____
☐ Cancer/Tumor: Who and what type: _____
☐ Other Neurological Diseases: _____

SOCIAL HISTORY:

OCCUPATION: _____ MARITAL STATUS: _____
TOBACCO: ☐ **NEVER** ☐ **PRESENT USE** _____**/DAILY FOR** ____ **YRS; QUIT AT** _____
ALCOHOL: ☐ NEVER ☐ OCCASIONAL
☐ FREQUENT _____/DAILY FOR _____ YEARS

MEDICATIONS: (dose and frequency; give a list if needed)

1) _____ 2) _____
3) _____ 4) _____
5) _____ 6) _____
7) _____ 8) _____
9) _____ 10) _____

OTHERS: _____

DRUG ALLERGIES: ☐ NONE

_____

_____

FEMALE PATIENTS: ☐ PREGNANT or ☐ BREASTFEEDING

OFFICE POLICIES

OFFICE HOURS

Office hours are 8AM to 5PM, Monday through Thursday and 8AM to 4PM on Friday for appointments. Telephone hours begin each day at 8:30AM. The office hours for the satellite office in the Copperfield Medical Plaza are 8AM to noon on Tuesday mornings and 1PM until 4PM on Friday afternoons.

TELEPHONE CALLS

OUR STAFF MAKES EVERY EFFORT TO RETURN CALLS IN A TIMELY MANNER. MOST CALLS ARE RETURNED BETWEEN 12PM AND 1PM AND 4PM AND 5PM EACH DAY, EXCEPT FRIDAY AFTERNOON CALLS WILL BE BETWEEN 3PM AND 4PM.

AFTER-HOUR CALLS SHOULD BE FOR EMERGENCIES ONLY. PLEASE DO NOT CALL AFTER REGULAR OFFICE HOURS FOR REFILLS. IN CASE OF A TRUE MEDICAL EMERGENCY, PLEASE CALL 911 OR GO IMMEDIATELY TO THE NEAREST EMERGENCY ROOM.

TEST RESULTS

After you have completed all testing, please call the office for an appointment to review tests results. Tests results will not be reviewed over the telephone. Any urgent abnormal test result will be given immediate attention and you will be notified by phone for a more timely appointment.

REFILLS

IF YOU REQUIRE A REFILL OF A MEDICATION WITH NO DIRECTION CHANGES, PLEASE CONTACT YOUR PHARMACY DIRECTLY FOR THEM TO FAX THE REQUEST TO OUR OFFICE. ANY FAX RECEIVED BY 3PM WILL BE ANSWERED THAT DAY.

***Please note that a narcotic drug will not be refilled by telephone or fax or by the after-hour on-call neurologist. An appointment is needed for narcotic drug refills.**

REFERRALS

This practice does not require a physician referral unless you have a HMO policy that makes the referral from your chosen PCP a necessity. If you have a family member or friend with a neurological or sleep disorder, we will be happy to see that person with your referral. Our staff will be happy to furnish any helpful literature.

MEDICAL RECORDS

We adhere to The Health Insurance Portability and Accountability Act (HIPAA). You should have received a copy of this policy on your first visit.

In order for this office to complete your medical records, you must complete the condition(s) questionnaire(s) in full and give to the office staff prior to your examination.

Should you need forms, letters, or a copy of your records, please allow 1 week for processing and copying. There will be a $25.00 charge for such requests. Any written request for records by another physician will be furnished at no cost. Any records needed for an attorney will require pre-payment of $50.00 or $75.00 if requested by affidavit.

CANCELLATIONS

Any appointment not cancelled or rescheduled 24 hours prior to the appointment time is subject to a “NO SHOW” fee that is not covered by insurance: $25 for office visit, $30 for EEG, $50 for EMG, and $200 for Sleep Study.

BILLING

Please furnish current insurance information for our billing office. Please furnish the insured’s name, identification number and date of birth. If your coverage changes, please give new insurance card to the office staff to copy for your file.

*Please note that your payment is mostly determined by your insurance company for the service rendered and not by our actual charge. However, some policies do not pay 100% of the insurance company’s approved amount (deductible, co-pay, etc). In this instance, the balance is the patient’s responsibility and full payment is expected. If your policy has a pre-existing clause and your insurance company investigates your claim and determines that your service is non-covered due to a pre-existing condition, full payment is due within 30 days.

Signature:_____ Date_____

HN&SDC Financial policies

Welcome and thank you for choosing Houston Neurology and Sleep Diagnostic Center for your neurology and sleep care. We are committed to providing you with the highest quality medical care, in an efficient, timely and cost-effective manner. We hope that providing you with our policies in advance can prevent any misunderstanding or frustration at the time of your visit.

Initial ____ **Insurance:** When making an appointment with Dr. Chu. It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan. If your plan requires that you a have a referral prior to seeing a specialist, please contact your primary care physician so that you will have the referral ***In hand*** at the time of your appointment. If you do not have your referral prior to your appointment, we will need to reschedule your visit, unless you choose to be seen without using your insurance benefits and pay for your visit in full.

Initial ____ ***The patient is responsible for knowing their insurance benefit coverage and whether a referral is needed for specialist visits.*** We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/ or policy benefit criteria, i.e. deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or " reasonable and customary charges, etc. other than to provide factual information when necessary. You are responsible for the timely payment of your account.

Initial ____ **Check-In:** Please be prepared for the current visit as well as any past balances on your account. Please also bring your current insurance card with you to EACH VISIT. Without the insurance card, we will be unable to file your insurance claim, and you will be responsible for the charges for that day. On follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date.

Initial ____ **Check- Out:** ***Estimated patient responsibility for diagnostic procedures will be determined by insurance benefit coverage and collected at the time of service***. For your convenience we accept cash, check, MasterCard and Visa.

Initial ____ **Late arrivals**: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you may be rescheduled so that our patients are not inconvenienced, or be asked wait for an extended period.

Initial ____ **No Shows and late cancellations:** We require a 24-hour notice if you must cancel your appointment. For your convenience, our scheduler will call you 48 hours prior to your appointment and allow you to cancel at that time. If you cancel on the same day of your appointment, you will be considered a NO SHOW for that visit. Once you have a NO SHOW appointments in your file, you may be required to secure any subsequent appointments with a credit card and subsequent NO SHOW appointments may be charged as follows: **Office Visit $25.00, EEG: $30.00, EMG: $50.00, Sleep Lab $200.00, Please note that this charge will not be paid by insurance and will be patient's responsibility.**

Initial ____ **Minors:** The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have a written authorization for medical treatment signed by the parent or guardian before treatment can be rendered.

I authorize practitioners at HN&SDC to examine, diagnose and treat me, giving reasonable and proper medical care by today's standards.

I authorize release of any medical or other information necessary to process any medical claims. I authorize payment of government or medical benefits be paid to Houston Neurology and Sleep Diagnostic center or provider service, Dr. C. Allen Chu.

I have read, understand and agree to the above office policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name: _____ DOB: _____

Responsible Person's Signature:_____ Date:_____

HIPAA Notice of Privacy Practices

Allen Chu, MD, PhD
Board Certified in Neurology, Electrodiagnostic Medicine and Sleep Medicine
15655 Cypress Woods Medical Drive, Suite 400
Houston, Texas 77014-1488
Tel 281-537-0171 Fax 281-537-5144

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION. THESE SITUATIONS INCLUDE: AS REQUIRED BY LAW, PUBLIC HEALTH ISSUES AS REQUIRED BY LAW, COMMUNICABLE DISEASES: HEALTH OVERSIGHT: ABUSE OR NEGLECT: FOOD AND DRUG ADMINISTRATION REQUIREMENTS: LEGAL PROCEEDINGS: LAW ENFORCEMENT: CORONERS, FUNERAL DIRECTORS, AND ORGAN DONATION: RESEARCH: CRIMINAL ACTIVITY: MILITARY ACTIVITY AND NATIONAL SECURITY: WORKERS' COMPENSATION: INMATES: REQUIRED USES AND DISCLOSURES: UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOU AND WHEN REQUIRED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INVESTIGATE OR DETERMINE OUR COMPLIANCE WITH THE REQUIREMENTS OF SECTION 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW. WE WILL BE CALLING YOUR HOME TO CONFIRM APPOINTMENTS. NO INFORMATION WILL BE RELEASED TO ANYONE, INCLUDING FAMILY MEMBERS, WITHOUT A WRITTEN REQUEST FROM YOU.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

YOU MAY COMPLAIN TO US OR TO THE SECRETARY OF HEALTH AND HUMAN SERVICES (THE OFFICE OF CIVIL RIGHTS, DEPT. OF HEALTH AND HUMAN SERVICES, 1301 YOUNG STREET SUITE # 1169, DALLAS, TX 75202 TELEPHONE 214-767-4056, TDD 214-767-0432) IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY THIS OFFICE. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING OUR PRIVACY OFFICER OF YOUR COMPLAINT. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ **Signature**_____ **Date**_____

I herby give Dr. Allen Chu permission to discuss my medical condition, test results, treatment, medication and any other information pertaining to my health with:

_____.

I understand that I may withdraw this authorization in writing at any time.

_____ _____

Patient's signature **Date**

INSTRINSIC SLEEP DISORDER SURVEY

PATIENT'S NAME: _____DATE:_____

Briefly describe your sleep problem: _____

_____

_____

When did your sleep problems begin? _____

Overall sleep quality:

No Yes The quality of my sleep is poor (restless and disturbed).
No Yes I still feel groggy or tired upon awakening in the morning.
No Yes I feel groggy or tired most of the day.
No Yes **Have you had a prior sleep study?**
Diagnosis: _____

QUESTIONS FOR OBSTRUCTIVE SLEEP APNEA (OSA):

No Yes Have you had a recent weight gain? How much? _____
No Yes I snore in my sleep (or others told me).
No Yes I wake up feeling short of breath (or choking).
No Yes I hold my breath or stop breathing in sleep (or others said).

QUESTIONS FOR periodic limb movements in sleep (PLMS):

NO YES MY LEGS JERK OR KICK THROUGHOUT THE NIGHT.
NO YES MY LEG JERK OR KICKING WAKES ME UP.

QUESTIONS FOR Insomnia:

No Yes I do not have enough sleep. How many hours? _____
No Yes I have trouble getting to sleep or use sleep aids frequently.
NO YES I WOKE UP FREQUENTLY AND CAN NOT FALL BACK TO SLEEP EASILY.

please circle the following conditions if you have them:

Restless legs when falling asleep; Severe grinding teeth; chronic chest disease (bronchitis, asthma, emphysema) Depression; Anxiety disorder; Nose blocking up when trying to sleep (allergies, infections, nasal obstruction); Heart disease; Stroke; High blood pressure.