North Texas Neurology & Neuropathy

Patient Name: _____ **Date of Service:** ____/____/____

Mailing Address: _____ **DOB:** ____/____/____

E-Mail Address: _____

Phone Number: (_____)_____ **Alt Number:** (_____)_____

Preferred Pharmacy: _____ **Number:** (_____)_____

Primary Care Physician: _____ **Referring Physician:** _____

Reason for today's visit: _____

Medication List

We would be happy to copy your medication list if you have it with you. If not please list all medications below.

Medication Name	Dosage	Directions

Past Medical History

Please check any boxes if you have been diagnosed with any of the following condition(s)

□ Diabetes	□ COPD	□ Kidney disease
□ Stroke	□ Erectile dysfunction	□ Seizures
□ Lupus	□ Osteoarthritis	□ Hypertension
□ Asthma	□ Fibromyalgia	□ Liver disease
□ GERD	□ Headache / Migraine	□ Bipolar disease
□ Irritable bowel syndrome	□ Thyroid problems	□ Heart disease
□ Cholesterol problems	□ Deep Vein Thrombosis	□ Depression
□ Sleep Apnea	□ Rheumatoid Arthritis	□ Neuropathy
□ Muscular Dystrophy	□ Huntington's disease	□ Multiple Sclerosis
□ Other (Please list)	□ Other (Please list)	□ Other (Please list)

Are you allergic to any medications? No Yes, please list _____

Past Surgical History

Month and Year	Type of Surgery

Family History

(If a family member has a history of any of the diagnoses below, please check box under appropriate box.)

Disease	Mother	Father	Maternal Grand Father	Paternal Grand Father	Maternal Grand Mother	Paternal Grand Mother	Siblings
Seizures							
Headache							
Stroke							
Heart Disease							
Cancer							
Parkinsons							
Alzheimers							
Diabetes							
Hypertension							
Other: (please list)							

Social History

Marital status	Work status	Have you had a drink containing alcohol in the past year?	Do you Smoke?	Have you ever been addicted to drugs?	Do you consume caffeine on a daily basis?
□ Single □ Married □ Divorced □ Widowed □ N/A	□ Yes □ No □ Student □ Disabled □ Retired	□ No □ Yes *Please answer questions below* □ N/A and/or Minor	□ Never smoked □ Current smoker □ Former smoker *Please answer questions below* □ N/A and/or Minor	□ Yes □ No □ N/A and/or Minor	□ No □ Yes, 1-2 cups/day □ Yes, 3-4 cups/day □ Yes, 5+ cups/day

If you answered Yes to "Have you consumed alcohol" please answer the following questions: (Circle what applies)

In the past year how often have you had a drink? Monthly or less 2-4 per mth 2-3 per wk 4+ per wk

How many did you have when you did drink in the past year? 1-2 3-4 5-6 7-9 10+

How often in the past year did you have 6 or more drinks at one time? Never Less than monthly Monthly
□ Weekly Daily

If you checked <u>CURRENT SMOKER</u> please answer the following questions:

How often do you smoke cigarettes? Daily Some days, not every day

How many cigarettes do you smoke per day? 5 or less 6-10 11-20 21-30 31 or more

How soon after waking do you smoke? within 5min 6-30min 31-60min after 60min

Are you interested in quitting? Ready to quit Thinking about quitting Not ready to quit

If you checked <u>FORMER SMOKER</u> please answer the following questions:

How long has it been since you last smoked: less than 1 mth 1-3 mths 3-6 mths 6-12 mths 1-5 yrs 5-10 yrs over 10yrs

North Texas Neurology & Neuropathy REGISTRATION FORM

(Please Print)

Primary Physician_____

Today's Date ____/____/____ **Referring Physician**_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐Mr. ☐Miss ☐Mrs. ☐Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐Yes ☐No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ☐M ☐F

Street Address	City	State	ZIP Code	Social Security	Home/Cell Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Referred to Clinic by:

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE SECRETARY)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home/Cell Phone No.
Is this person a patient here?	☐Yes ☐No		( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Please indicate primary insurance:

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber Self ☐Spouse ☐Child ☐Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home/Cell Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Tx Neurology & Neuropathy, or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date: _____/_____/_____

Consent for Treatment

I, the undersigned, hereby consent to the following: Administration and performance of general treatment use of prescribed medications, performance of diagnostic procedures/tests and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand this consent is given in advance of any specific diagnosis or treatment. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that this form may include consent at other satellite offices under common ownership. A photocopy of this consent shall be considered as valid as the original. I hereby authorize North Texas Neurology & Neuropathy to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations as described in the Notice of Privacy Practices. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare provider of North Texas Neurology & Neuropathy may refuse to treat me. I understand that these services are voluntary and that I have the right to refuse these services. The use of cell phones, tape recorders, and other portable listening / recording devices are prohibited while in this office you would have to ask Dr. Gupta permission.
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature (Parent/Legal Guardian):_____ **Date:**_____ **Patient Name (If Minor):** _____

I acknowledge that I have received or been given the opportunity to receive a copy of the HIPAA Privacy Policies and understand that if I have any questions or complaints, I should contact the Administrator. **Patient Initials:** _____

RELEASE OF MEDICAL INFORMATION

Please let us know how you would like us to communicate with you.
What information may we release: **(Check All That Apply)**

_____ All Personal Health Information
_____ Office Notes
_____ Lab/Diagnostic test results
_____ Appointment Information
_____ Billing Information
_____ Psychotherapy/mental health
_____ Prescription
_____ Other: _____

How may we release this information?

_____ Phone #:_____
_____ Fax #: _____
_____ Mail: Address: _____

Please let us know the name(s) with whom we may discuss health information or who may be allowed to enter the exam room during discussion regarding health information. I understand that I may request individual to leave the exam room at any time.

Name of Person(s) allowed in the examination room:

_____ _____

Name of Person(s) authorized to receive information:

_____ _____

Patient Signature: _____ **Date:** _____

Patient Name: _____ Patient DOB: _____

North Texas Neurology & Neuropathy
Financial Policy

Thank you for choosing North Texas Neurology & Neuropathy for all your neurology healthcare needs. Below is a brief explanation of our financial policy. We respectfully request that you adhere to this policy, as it enables us to provide you with the highest quality medical care possible. If you have any questions or need clarification, please ask one of our staff members or our management staff to assist you.

ABOUT YOUR INFORMATION

We require you to bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provide current and correct information will be due to payable by you. We require that you update your address, telephone information with us whenever there is a change. You are responsible to get all your medical records and anything that Dr. Gupta orders from your medical providers.

During the process of diagnosis and treatment., physician is likely to recommend scans, laboratory tests and procedures. Theses are typically covered by your insurance, but if in doubt, patient will be obliged to confirm this with insurance prior to performing the same and will be responsible for any cost incurred. Services not covered by your insurance including office visits, labs, diagnostic imaging, and procedures will be your responsibility to pay the bill.

PAYMENT DUE AT TIME OF SERVICE

As a courtesy, we will be happy to file your claim to your insurance. However, you will be asked to pay any portion not covered by your insurance due to co-payments, deductibles or coinsurance at the time of service, unless financial arrangements have been made in advance. If prior arrangements have not been made, you may be asked to reschedule your appointment. Please remember that your insurance is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, you are still responsible for payment of services regardless of the amount your insurance pays.

PATIENT BALANCE REMAINING

Payment in full is expected upon receipt of a statement from our billing office. Only two statements will be sent to patients with balances. If we receive no response to these statements, our office will make one final attempt to reach you to pay the balance or make payment arrangements. If we are unsuccessful at reaching you, your account may be referred to an outside collection agency and you may subsequently be discharged from our care.

PAYMENT AGREEMENTS

If you are unable to make payment in full for your remaining balance upon receipt of our statement, please contact our billing office immediately. We will make every effort to work with you and most likely, we can establish a mutually agreed-upon payment agreement.

REFERRAL FROM PCP

If your insurance requires you to have a referral to see a specialist, it is your responsibility to contact your primary care physician to obtain it prior to the day of your appointment. If this is not obtained prior to your appointment, you may be asked to reschedule or pay the total estimated charges for that day at the time of service.

MEDICARE PATIENTS

If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the 20 percent co-insurance at the time of service. However, if you have secondary insurance, we will be happy to file your claim. If payment is not received within 60 days after filing, the remaining balance will be transferred to the patient and due upon receipt of our statement.

MEDICARE LIFETIME AUTHORIZATION

I certify that the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorized any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payments of authorized benefits be paid on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare of applicable insurance carrier for payment.

MISSED APPOINTMENTS

Please kindly provide our office with at least 24 hours' notice if you need to cancel or reschedule your appointment. Missed appointments will be charged a NO-SHOW fee of **$50.00**.
After three no show appointments, you will be discharged from our care.

CONFIRMATION OF APPOINTMENTS

One of our scheduling coordinator's will attempt to contact you to confirm your appointment within 24-48 hours of your scheduled appointment. If you do not confirm your appointment within this time frame we will have to reschedule you for another time. Results of scans, tests and procedures are NOT discussed over the phone and patient will need to follow-up in the clinic to discuss results.

MEDICAL RECORDS

If you require a copy of your medical records, we will be happy to provide these records, upon your signature authorizing us to release the records. The fees for all subsequent copies are $30.00 for the first 20 pages and 50 cents per page thereafter. The above charges are in the standards of Texas Administrative Code Rules 165.2 and 165.3.

FORMS

If you require a form to be filled out by one of our physicians (i.e. FMLA, Disability, School, Camp, Handicap Placards, etc.) it is the policy of this practice to charge $100.00 per form for our physician's time and expertise. The fee must be paid prior to the form being filled out. Please allow up to 15 business days for completion of the form.

I have read the above financial policy and agree to abide by the terms.

Patient Signature: _____ **Date:** _____

North Texas Neurology and Neuropathy
Devanshi Gupta, M.D.

400 N Allen Drive Suite 105 Allen TX, 75013
Phone: 972-727-7070 Fax: 972-727-7080

AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM ANOTHER PHYSICIAN

Patient's Full Name: _____

Date of Birth: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Other #: _____

To Whom it May Concern: _____(List Physician name & city here)

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below) or otherwise release confidential information:

_____ Complete record
_____ Records of care from _____ to _____ only
_____ Records of care concerning the following condition(s)_____
_____Other- Specify: _____
_____ Confer with other person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial:_____ Date: _____

to the following person(s):

_____

The reasons or purposes for this release of information are as follows:

_____

I understand that you will provide this information within 21 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners).

Signed: _____ Date: _____
(Patient or person legally authorized to consent on patient's behalf)

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I desire this authorization to be in effect until _____(Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying this practice in writing at the address listed above. I also understand that the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.