Ahmad Saeed Ata, M.D.
Greenville Phone: (903) 450-8122 Fax: (903) 454-2785
Frisco Phone: (214) 618-0808 Fax: (469) 731-1060

NAME: _____ DOB: ____ / ____ / _____ AGE: _____ SS#: _____ - _____ - _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

PRIMARY PHONE: _____ SECONDARY: _____ WORK: _____

OKAY TO LEAVE DETAILED MESSAGE? YES _____ NO _____ EMAIL: _____

MALE / FEMALE MARITAL STATUS: MARRIED _____ DIVORCED _____ WIDOWED _____ SINGLE_____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

REFERRING DOCTOR: _____ PHONE: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____

CARDIOLOGIST: _____ PHONE: _____

PAIN MANAGEMENT: _____ PHONE: _____

STATE BELOW ANY PHYSICIAN, FAMILY MEMBER, OR PERSON YOU ARE ALLOWING TO ACCESS YOUR MEDICAL RECORDS

IS ILLNESS OR INJURY WORK OR ACCIDENT RELATED? YES _____ NO _____

PRIMARY INSURANCE: _____ PHONE: _____

ID#: _____ GROUP: _____

SECONDARY INSURANCE: _____ PHONE: _____

ID#: _____ GROUP: _____

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NAME: _____ DOB: ____ / ____ / _____ DATE: _____

MAIN REASON FOR TODAYS VISIT: _____

ARE YOU CLAUSTROPHOBIC? YES _____ NO _____ DO YOU HAVE A HISTORY OF KIDNEY DISEASE? YES _____ NO _____

ARE YOU PREGNANT OR COULD YOU BE? YES _____ NO _____ IF YES, DUE DATE: ____ / ____ / _____

SOCIAL HISTORY (please check all that apply to you): □ TOBACCO USE □ ALCOHOL □ ILLICIT DRUG USE □CAFFEINE

BELOW IS A SERIES OF SYMPTOMS, IF YOU HAVE EXPERIENCED ANY OF THESE IN THE PAST 2 WEEKS (EVEN IF IT IS MILDLY) THEN PLEASE CHECK THE APPROPRIATE BOX

□ HEADACHES	□ BLACK OUT SPELLS	□ CHEST PAIN	□ FEVER
□ BACK PAIN	□ DOUBLE VISION	□ STROKE	□ WEIGHT LOSS (10lbs+)
□ NECK PAIN □	□ BLURRED VISION	□ IRREGULAR HEARTBEAT	□ WEIGHT GAIN (10lbs+)
□ NUMBNESS (where: _____)	□ DIFFICULTY BREATHING	□ LEG PAIN/SWELLING	□ SINUS PAIN
□ WEAKNESS (where: _____)	□ SNORING	□ RASH	□ COUGH
□ SEIZURES	□ ABDOMINAL PAIN	□ ITCHING	□ HOARSENESS
□ DIZZINESS	□ NAUSEA	□ HAIR LOSS	□ RINGING IN EARS
□ VERTIGO	□ DIARRHEA	□ DEPRESSION	□ HEARING LOSS
□ CONFUSION	□ ABNORMAL BLEEDING	□ MOOD DEPRESSION	□ FATIGUE
□ MEMORY LOSS	□ ANEMIA	□ ANXIETY	□ JOINT PAIN
□ TREMORS	□ BRUSING	□ LACK OF CONCENTRATION	□ MUSCLE CRAMPS
□ INVOLUNTARY MOVEMENT	□ SHORTNESS OF BREATH @ REST	□ EXCESSIVE DAYTIME SLEEPINESS	□ IRRITABILITY

PLEASE CHECK ALL MEDICAL CONDITIONS THAT APPLY TO YOU

□ DIABETES	□ HIGH BLOOD PRESSURE	□ HIGH CHOLESTEROL	□ HEART DISEASE
□ ARTHRITIS	□ THYROID	□ HEADACHES/MIGRAINES	□ SEIZURES
□ KIDNEY DISEASE	□ SLEEP APNEA	□ STROKE	□ VASCULAR DISEASE
□ HISTORY OF CANCER _____			

PLEASE LIST ALL OTHER MEDICAL CONDITIONS NOT LISTED: _____

SURGICAL HISTORY

□ SPINE SURGERY: LEVELS: _____ □HYSTERECTOMY □ PACE MAKER □ DEFIBRILLATOR
□ BRAIN SURGERY: TYPE _____ □ PAIN PUMP _____
□ STIMULATOR _____

OTHER NOT LISTED: _____

_____

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NAME: _____ DOB: ____ / ____ / _____ DATE: _____

LOCAL PHARMACY: _____ LOCATION: _____ PHONE: _____

MAIL ORDER: _____ LOCATION: _____ PHONE: _____

Please be aware that all medications are sent electronically & 90-day narcotics will NOT be sent by mail order

MEDICATION ALLERGIES - PLEASE LIST ALL MEDICATIONS THAT APPLY: _____

IF NO KNOWN DRUG ALLERGIES PLEASE CHECK THE BOX NKDA ☐

PLEASE LIST ALL CURRENT MEDICATIONS, INCLUDING OVER-THE-COUNTER, SUPPLEMENTS, AND AS NEEDED MEDICATIONS

Medication Name:	Dosage:	Frequency:

A LIST OF CURRENT MEDICATIONS IS REQUIRED AT EVERY VISIT, EVEN IF THERE ARE NO CHANGES. FAILURE TO PROVIDE A COMPLETE LIST AT THE TIME OF YOUR VISIT CAN RESULT IN YOUR APPOINTMENT BEING RESCHEDULED. _____ (Initial Required)

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Financial Policies and Agreement

Cash Patients: All fees for services rendered are due at the time of service. If there is an outstanding balance and payments are not made within 90 days of the visit date, the account will be turned over to the collection agency and collection fees will be added to the account balance; collection fees can be up to 35% of the charge amounts sent to collections. It is the patient's responsibility to call and update their mailing address and insurance information.

Commercial Insurance Patients: It is the patient's responsibility to know their insurance benefits and to know in/out of network status for our providers; patients can check this by calling their insurance company. We will bill the insurance company as a courtesy to the patient and any service or procedure not covered by the policy will be patient responsibility. Any copay, deductible, or co-insurance is due at the time of the service. Any balance left on the account by the insurance company is patient responsibility and is due when the patient receives the first statement. Any refunds due to the patient will not be credited back until the insurance has paid on all claims in full. If we do not receive a payment within 90 days of the visit date, the account will be turned over to the collection agency and collection fees will be added to the account balance; collection fees can be up to 35% of the charge amounts sent to collections. If there is a secondary insurance we will bill accordingly before sending out a patient statement. **Please be aware we do not accept Medicaid primary or secondary to any insurance other than Medicare. The patient will be responsible for any balance remaining from their insurance company.**

You will receive a separate bill from the Radiologist for the reading of any MRI/MRA's.

We do not accept Worker Compensation Carriers.

Please be advised that our office does not take LOP's (Letter of Protection), under any circumstances. It will be your responsibility and you are held accountable for any unpaid charges that you may have from NeuroCare of Texas. If any charges are processed through your insurance then refunded back to them at any time, you will be liable for the unpaid charges. We are sorry for any inconvenience this may cause.

If for any reason you cannot keep your appointment with our office, you must call to cancel or reschedule within 24 hours prior to your scheduled appointment; if you do not, there will be a $25.00 no show charge billed to your account and this must be paid before your next appointment.

_____	_____	_____
Name	Signature	Date

Ahmad Saeed Ata, M.D.

4501 Joe Ramsey Blvd, Suite 200
Greenville, TX 75401
Phone: (903) 450-8122
Fax: 9903) 454-2785

5550 Warren Parkway, Suite 100
Frisco, TX 75034
Phone: (214) 818-0808
Fax: (469) 731-1060

Office Policies and Procedures

Payments and Fees:

(1) There is a $25.00 charge for the doctor or medical assistant to fill out any paperwork. This needs to be paid in advance. We will need at least two weeks to complete the paperwork. **We cannot complete any paperwork on the same day that it was submitted as the doctor/medical assistants may be busy and in clinic on that particular day.**
(2) We will not refile claims if the patient has not updated their information in a timely manner and the patient will be responsible for the balance.
(3) There is a $30.00 NSF fee for returned checks; this amount may increase if the bank charges increase.
(4) Our office accepts Master Card, VISA, and Discover credit cards only. We do not allow business checks for personal injuries. No checks over $200.00 will be accepted.
(5) There will be a one-time fee of $25.00 for printed medical records.

_____ (initial, indicating you have read the above policies on *payments and fees*)

Medications:

(1) Medication may be denied for multiple reason including but not limited to: multiple missed appointments and non-compliance.
(2) Medication refill requests must be faxed by the pharmacy and may take up to 3 days for a response.
(3) Narcotic medications will not be written as a 90-day supply.
(4) For refills on all medications, please contact your pharmacy.
(5) Medications are sent electronically to the pharmacy.
(6) Some prescriptions do requires a Prior Authorization through your insurance, if your medication requires this it can take up to 2 weeks for the approval. Samples (if available) will be provided during this process.

_____ (initial, indicating you have read the above policies on *medications*)

General:

(1) Please allow 24 hours for returned phone calls from the nurses. ALL URGENT HEALTH CONCERNS, PLEASE CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM.
(2) Calls after 3:00 pm on Thursday, may not be returned until the following business day.

_____ (initial, indicating you have read the above policies on *general*)

_____ _____ _____
Name Signature Date

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Physician Assistant / Nurse Practitioner Consent

NeuroCare of Texas would like you to know that we employ a Physician Assistant / Nurse Practitioner to assist us in a team approach to deliver a high quality of medical care. A Physician Assistant / Nurse Practitioner is a mid-level practitioner who has received advanced education and training in the provision of health care, A Physician Assistant / Nurse Practitioner is not a doctor. They can however, diagnose, treat, and monitor routine and complex neurological disorders. If you are seen by a Physician Assistant / Nurse Practitioner, your doctor will review your care with the Physician Assistant / Nurse Practitioner as part of the care plan.

I have read the above and understand that in this practice a team approach is used, with my unique needs presented and discussed with one or more physician in the development of my care plan. I also understand that typically one physician will direct my overall care, but that from time to time I may be seen by either of the practitioners in this practice, this is including the Physician Assistant / Nurse Practitioner.
_____ (initial)

I hereby consent to the services of a Physician Assistant / Nurse Practitioner for my healthcare needs. _____ (initial)

I understand that I will be required to have follow-ups scheduled with the Physician Assistant / Nurse Practitioner. _____ (initial)

I understand that I can refuse to see the Physician Assistant / Nurse Practitioner and request to see a Physician. I understand that this may require my appointment to be rescheduled. _____ (initial)

_____	_____	_____
Name	Signature	Date

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Notice of Privacy Practices Acknowledgement

I understand that, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA),* 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.

I have received, read, and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization, at the address above, at any time 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.

_____	_____	_____
Name	Signature	Date

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>Please put your name, DOB and SIGN ONLY<

Authorization to Release Protected Health Information

Patient Name: _____ **DOB:** _____

I authorize: _____ **To Release To:** _____

Address: _____ **Address:** _____

_____ _____

Phone#: _____ **Phone #:** _____

Fax #: _____ **Fax#:** _____

This information is needed for the purpose of: at the request of the individual for:

Medical Care _____ **Insurance** _____ **Litigation** _____ **Other** _____

Date information needed: _____ **Information is to be sent via fax to:** _____

Treatment Dates to be Included: Most Recent OR _____ **to** _____

All marked needs to be included in the sent records:

History & Physical _____**Discharge Summary** _____ **ER Reports** _____**Lab Reports**_____

Consult Reports _____ **Progress Notes** _____ **ECHO/Carotid** _____ **CT/MRI/MRA** _____

EEG/EMG/VNG Reports _____ **Other:** _____

I understand that the information to be released may include information regarding a medical condition which is protected by Federal Law. Unless you indicate otherwise, this information will not be released (if present) to the organization, agency, or individual named on this request.

I, _____**, authorize the release of information regarding:**

Drug Abuse/Dependence _____ **HIV Test Results** _____ **Psychiatric Conditions** _____

Alcohol Abuse/Dependence _____ **HEP/HIV/AIDS/ARC Infection** _____

I request and authorize the above-named health care provider to release the information specified to the organization, agency, or individual name on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expired 180 days from the date signed. The facility to which this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that the information that is being released is subject to re-disclosure by the recipient and is no longer protected.

_____ _____ _____

Name Signature Date