

# TEXAS NEUROLOGY – FORT WORTH

## New Patient Packet

### WELCOME TO

### TEXAS NEUROLOGY – FORT WORTH

Thank you for choosing Texas Neurology – Fort Worth for your neurological care.

### LOCATION

800 8<sup>th</sup> Avenue  
Suite 632  
Fort Worth, TX 76104

<b>Appointment Date:</b>
<b>Appointment Time:</b>

*Please arrive 20 minutes prior to your appointment to complete the registration process.*

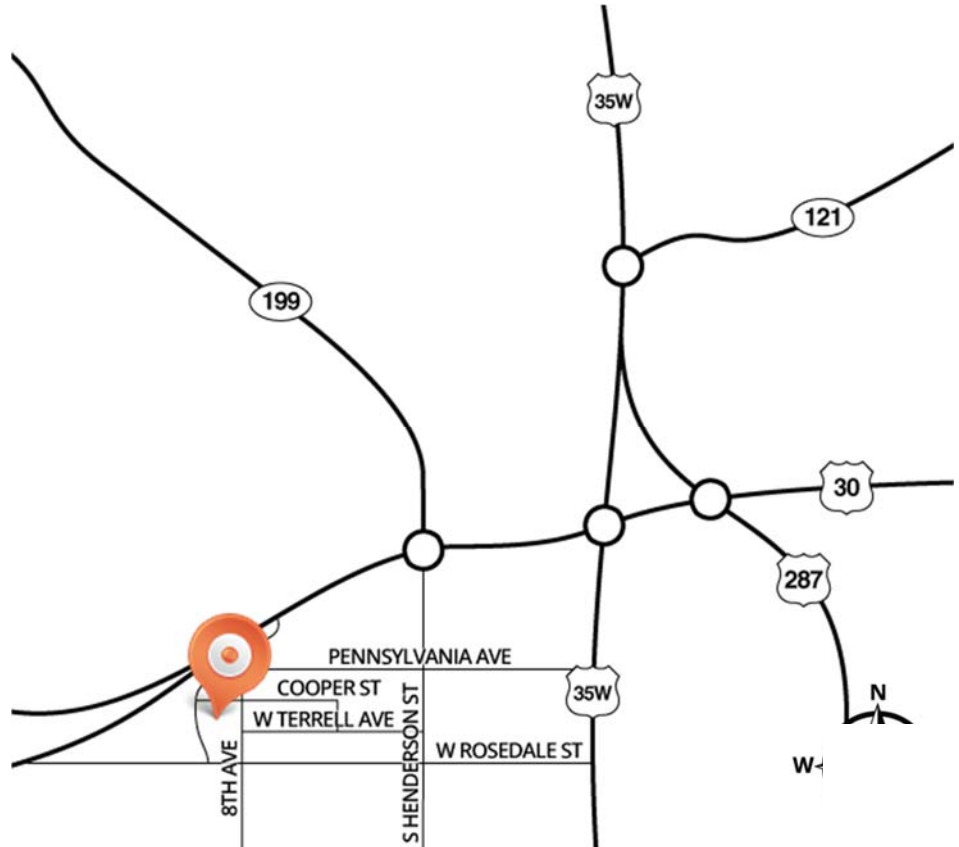
*When you arrive for your appointment, please sign in at the reception desk.*

Please bring the following items to your first appointment

- Completed New Patient Packet
- Photo identification card
- Insurance (card)s
- All medication bottles  
(Prescribed and/or over the counter/herbal supplements)
- Medical records & diagnostic studies

### CANCELLATION POLICY & FEE

If for any reason you cannot make your appointment, please call (817) 618-9355 (option 3) at least 24 hours in advance to cancel or reschedule. It is our policy that patients who do not provide 24 hours advanced notification of cancellation will be subject to a \$50.00 rescheduling fee.



### PARKING

Parking is available in the adjacent parking garage south of the building. Texas Neurology will validate your parking ticket, so please bring the ticket with you to your appointment.



### HAVE QUESTIONS?

Feel free to contact our scheduling department at (817) 618-9355 (option 3) with any questions relating to the information contained within this packet.



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date Packet Completed: \_\_\_\_\_

**EMERGENCY CONTACTS**

Please check a box below indicating whether or not you would like to have the selected contact(s) added as an authorized HIPAA contact.

Primary Emergency Contact

I authorize  I do **NOT** authorize the disclosure of my protected health information (PHI) to the person listed as my Primary Emergency Contact.

Name: \_\_\_\_\_

Home/Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Relationship:  Spouse  Partner  Sibling  
 Parent  Child  Friend  
 Other: \_\_\_\_\_

Secondary Emergency Contact

I authorize  I do **NOT** authorize the disclosure of my protected health information (PHI) to the person listed as my Secondary Emergency Contact.

Name: \_\_\_\_\_

Home/Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Relationship:  Spouse  Partner  Sibling  
 Parent  Child  Friend  
 Other: \_\_\_\_\_

**PRIMARY CARE PROVIDER**

Name: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**REFERRING PROVIDER**

Name: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?**

Physician/Provider Referral  Family or Friend  Website or Search Engine  Other

**REASON FOR VISIT TODAY**

\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL HISTORY** (e.g. diabetes, high blood pressure, cancer, TB)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SURGERY AND HOSPITALIZATION HISTORY**

Please list all surgeries, hospitalizations, and major injuries:	Date(s) (Month/Year)

**PREVIOUS TESTING**

Have you had any previous imaging or diagnostic tests including MRI, CT, EEG? Please list tests and where this was performed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





# AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)  
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

## NAME OF PATIENT OR INDIVIDUAL

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

OTHER NAME(S) USED \_\_\_\_\_

DATE OF BIRTH Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_ ALT. PHONE (\_\_\_\_) \_\_\_\_\_

EMAIL ADDRESS (Optional): \_\_\_\_\_

## I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

## REASON FOR DISCLOSURE (Choose only one option below)

- Treatment/Continuing Medical Care
- Personal Use
- Billing or Claims
- Insurance
- Legal Purposes
- Disability Determination
- School
- Employment
- Other \_\_\_\_\_

## WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: TEXAS NEUROLOGY  
Address: 800 8th Avenue, Suite 632  
City: FORT WORTH State: TEXAS Zip Code: 76104  
Phone: (817) 618-9355 Fax: (214) 821-4017

**WHAT INFORMATION CAN BE DISCLOSED?** Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> All health information | <input type="checkbox"/> History/Physical Exam | <input type="checkbox"/> Past/Present Medications   | <input type="checkbox"/> Lab Results            |
| <input type="checkbox"/> Physician's Orders     | <input type="checkbox"/> Patient Allergies     | <input type="checkbox"/> Operation Reports          | <input type="checkbox"/> Consultation Reports   |
| <input type="checkbox"/> Progress Notes         | <input type="checkbox"/> Discharge Summary     | <input type="checkbox"/> Diagnostic Test Reports    | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports      | <input type="checkbox"/> Billing Information   | <input type="checkbox"/> Radiology Reports & Images | <input type="checkbox"/> Other _____            |

## Your initials are required to release the following information:

\_\_\_\_\_ Mental Health Records (excluding psychotherapy notes) \_\_\_\_\_ Genetic Information (including Genetic Test Results)  
\_\_\_\_\_ Drug, Alcohol, or Substance Abuse Records \_\_\_\_\_ HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

**RIGHT TO REVOKE:** I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION:** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

**SIGNATURE X** \_\_\_\_\_  
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): \_\_\_\_\_  
If representative, specify relationship to the individual:  Parent of minor  Guardian  Other \_\_\_\_\_

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

**SIGNATURE X** \_\_\_\_\_  
Signature of Minor Individual DATE

# IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)  
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

**Definitions** - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

**Health Information to be Released** - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

**Note on Release of Health Records** - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

**Authorizations for Sale or Marketing Purposes** - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §§ 181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

**Limitations of this form** - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii)); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)).

**Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

**Charges** - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

**Right to Receive Copy** - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

# TEXAS NEUROLOGY

## INTAKE QUESTIONNAIRE

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### Within the past 2 weeks, have you experienced any of the following?

- Little interest or pleasure in doing things     Yes     No  
Feeling down, depressed, or hopeless     Yes     No

### Within the past 6 months, have you experienced any of the following?

- Weight change     Yes     No  
Hearing loss     Yes     No  
Heart palpitations     Yes     No  
Difficulty swallowing     Yes     No  
Seizure     Yes     No  
Loss of vision     Yes     No  
Shooting arm pain     Yes     No  
Shooting leg pain     Yes     No  
Depression     Yes     No  
Rash     Yes     No  
Blood transfusion     Yes     No  
Diabetes     Yes     No  
Nasal/seasonal allergies     Yes     No  
Difficulty urinating     Yes     No  
Sleep problems     Yes     No  
Memory problems     Yes     No

### Within the past 12 months, have you fallen?

- Yes     No

### Have you ever been exposed to HIV?

- Yes     No     Unknown

### Which hand do you write with?

- Right     Left     Both

# TEXAS NEUROLOGY

## HEADACHE QUESTIONNAIRE I

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

### Where do you generally experience your headache(s)?

- Left side       Right side       Either side       Orbital       Hatband  
 Frontal       Face/Jaw       Neck       Generalized       Moves around

### What type of headache do you experience?

- Achy       Lightning bolts       Pulsating       Throbbing       Pounding       Crushing  
 Piercing       Sharp       Deep pain       Squeezing       Dull       Pressure

### When do your headaches generally occur?

- Morning       Afternoon       Evening       Middle of the night       Menstrual       Constant

### How severe are your headaches?

- Mild       Moderate       Severe

### When did your headaches first start?

- Childhood       Teens       20s       30s       40s       50s       60s+

### How are your headaches relieved?

- Rest       Quiet and darkness       Cold compress       Ice  
 Heat       Massage       Pressure over area       Medications

### What worsens or triggers your headaches?

- Medications       Coughing       Sneezing       Heat/Sun       Missing meals  
 Smoke       Talking       Alcohol       Weather       Exercise  
 Sexual activity       Under sleeping       Bending       Lying down       Certain foods  
 Cold       Fatigue       Menstruation       Smells/Odors       Stress

### What are the associated symptoms?

- Light sensitivity       Joint pain       Sound sensitivity       Visual changes       Muscle spasm       Nasal congestion  
 Smell sensitivity       Neck pain       Difficulty speaking       Red teary eye       Queasiness       Limits activity  
 Dizziness, vertigo, lightheadedness       Nausea and/or vomiting  
 Numbness or tingling of body part       Weakness of body part

### Have you tried any of the following to treat your headaches?

- Biofeedback       Acupuncture       Physical therapy       Therapeutic massage  
 Chiropractic therapy       Nerve stimulator       Nerve blocks

### Have you had any previous head injury?

- Yes       No

### Do you have problems sleeping?

- Yes       No

### Have you had a recent eye exam within the past 3 months?

- Yes       No



# TEXAS NEUROLOGY

## HEADACHE QUESTIONNAIRE II

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**What is the number of headache days you experience, per month?**  
*(Any headache pain counts)*

**What is the number of headache free days you experience, per month?**  
*(100% free of pain or discomfort)*

**How many days a month do you experience nausea or queasiness with headache?**

**How many days a month do you experience sensitivity to light with headache?**

**How many days per month do you experience "dysfunction" due to a headache?**  
*(Not being able to function at your peak)*

**How many days a month do you use over the counter pain medications for headache attacks?**

**How many days a month do you use prescription pain medications for headache attacks?**

**Do you currently take a daily preventative prescription medication for headache management?**

Yes  No

# TEXAS NEUROLOGY

## ACKNOWLEDGEMENT FORM

### PHYSICIANS

Waleed H. El-Feky, M.D.  
C. Fish Greenfield, M.D.  
Daragh Heitzman, M.D.  
Steven P. Herzog, M.D.  
N. Bruce Jenevein, M.D.  
Alan W. Martin, M.D.  
Frederic N. Nguyen, M.D.  
Maria Philip, M.D.  
Gincy Samuel, M.D.  
Gary L. Tunell, M.D.

### DALLAS LOCATION

6301 Gaston Avenue  
Suite 100, West Tower  
Dallas, TX 75214  
Phone: (214) 827-3610  
Fax: (214) 821-4017

### FORT WORTH LOCATION

800 8th Avenue  
Suite 632  
Fort Worth, TX 76104  
Phone: (817) 618-9355  
Fax: (214) 821-4017

### RICHARDSON LOCATION

2821 E President George Bush Highway  
Suite 304  
Richardson, TX 75082  
Phone: (214) 540-1400  
Fax: (214) 821-4017

By signing my name below, I:

- Consent to receive the following documents electronically which are available through our Patient Portal or through our website unless I request a non-electronic paper copy of the documents disclosed herein.
  - [Texas Neurology's Notice of Privacy Practices](#)
  - [Texas Neurology's Financial Policy](#)
  - [Texas Neurology's Nurse Practitioner/Physician Assistant Information Guide](#)
- Authorize:
  - The release of any medical and/or other information necessary to process my claims.
  - Payment of medical benefits to my treating physician or supplier for services rendered by Texas Neurology.
- **Have read and agree to all of the above policies and understand that my failure to comply with any of these policies may result in discharge from Texas Neurology.**

X

\_\_\_\_\_  
*Patient/Guardian Signature*

\_\_\_\_\_  
*Date*

#### Patient Portal Link

<https://health.healow.com/texasneurology>

#### Texas Neurology Website Link

<https://www.texasneurology.com/forms>