TEXAS NEUROLOGY

New Patient Packet

WELCOME TO TEXAS NEUROLOGY

Thank you for choosing Texas Neurology for your neurological care.

Appointment Date:
Appointment Time:

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

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

Please bring the following items to your first appointment

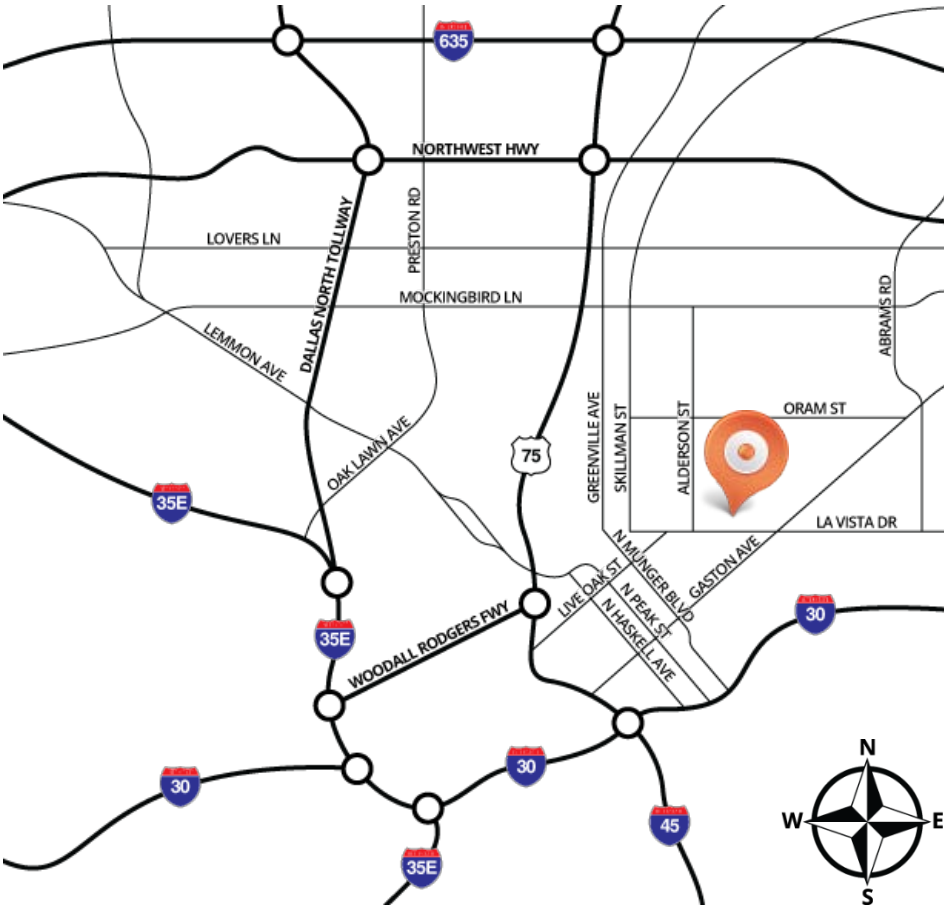
- ❑ Completed New Patient Packet
- ❑ Photo identification card
- ❑ Insurance (card)s
- ❑ All medication bottles *(Prescribed and/or over the counter/herbal supplements)*
- ❑ Medical records & diagnostic studies

CANCELLATION POLICY & FEE

If for any reason you cannot make your appointment, please call (214) 827-3610 (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.

LOCATION

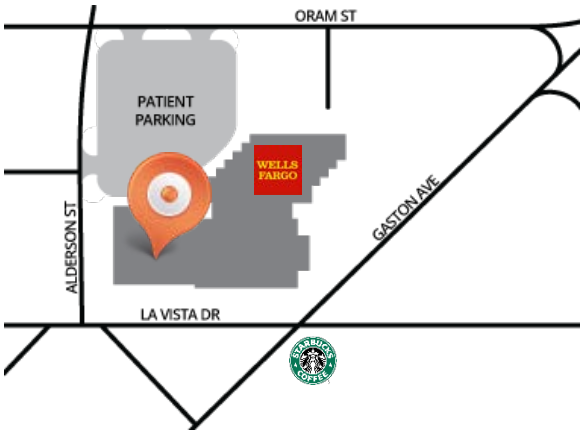
6301 Gaston Avenue
West Tower, Suite 100
Dallas, Texas 75214



PARKING

Our building is next to the 9-story Wells Fargo tower in the Lakewood Towers building at the corner of La Vista Drive and Gaston Avenue across from Starbucks.

The entrances to our parking lot are located off of Alderson Street and Oram Street.



HAVE QUESTIONS?

Feel free to contact our scheduling department at (214) 827-3610 (option 3) with any questions relating to the information contained within this packet.

PATIENT INFORMATION

Name: _____ Date of Birth: _____
First *MI* *Last*

Address: _____

City: _____ State: _____ Zip: _____

Residence Type: ❑ Private Residence ❑ Nursing Home (Not a SNF) ❑ Skilled Nursing Facility or Hospice

Sex: ❑ Male ❑ Female ❑ Transgender SSN #: ___ - ___ - ____

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Partnered ❑ Widowed ❑ Legally Separated ❑ Other

Ethnicity: ❑ Caucasian ❑ African-American ❑ Asian/Pacific-Islander ❑ Hispanic ❑ Other

Employment Status: ❑ Full-Time ❑ Part-Time ❑ Not Employed ❑ Full-Time Student

Employer (if applicable): _____

Occupation: _____

Home Phone:	Cell Phone[1]:	Work Phone:
(_____) _____ - _____	(_____) _____ - _____	(_____) _____ - _____
❑ This is my preferred number	❑ This is my preferred number	❑ This is my preferred number
May we leave personal/medical information on your voicemail? ❑ Yes ❑ No	May we leave personal/medical information on your voicemail? ❑ Yes ❑ No	

[1]I understand that a cellular phone is not a secure and private line.

Email: _____

INSURANCE COVERAGE

It is very important that you bring your photo identification card and insurance card(s) on the day of your appointment. Please remember that it is your responsibility to obtain a referral from your primary care physician (if your insurance requires it).

Primary Insurance	Secondary Insurance
	❑ I do not have a secondary insurance
Carrier: _____	Carrier: _____
ID#: _____	ID#: _____
Group#: _____	Group#: _____
Name of insured: _____	Name of insured: _____
Insured's date of birth: _____	Insured's date of birth: _____
Relationship to insured: ❑ Self ❑ Spouse ❑ Other: _____	Relationship to insured: ❑ Self ❑ Spouse ❑ Other: _____

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 Primary 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.

_____

_____

_____

_____

Name: _____ Date of Birth: _____ Date Packet Completed: _____

FAMILY HISTORY

List any major illnesses in your family, including parents, grandparents, siblings, or children, (e.g. diabetes, hypertension, multiple sclerosis, etc…)

_____

_____

_____

_____

ALLERGIES

List any allergies you have to medications

_____

_____

_____

PHARMACIES

Primary Pharmacy

Type: ❑ Local ❑ Mail-Order ❑ Specialty

Name: _____

Address: _____

City: _____ Zip: _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

Secondary Pharmacy

Type: ❑ Local ❑ Mail-Order ❑ Specialty

Name: _____

Address: _____

City: _____ Zip: _____

Phone: (_____) _____ - _____

Fax: (_____) _____ - _____

CURRENT MEDICATION LOG

List all medications (prescribed or over the counter/herbal supplements) that you are currently taking:

Medication	Start Date	Dose/Frequency	Prescribing Physician	Comments

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 (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: TEXAS NEUROLOGY
Address: 6301 GASTON AVENUE, SUITE 100, WEST TOWER
City: DALLAS State: TEXAS Zip Code: 75214
Phone: (214) 827-3610 Fax: (214) 821-4017

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 _____

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.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ 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 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 leg pain	❍ Yes	❍ No
Shooting arm 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

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

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