

Thanks for choosing Texas Neurology for your neurological Care. Your appointment information is below.

Appointment Date:	Appointment Time:
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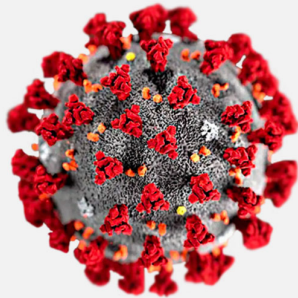
Please arrive 20 minutes prior to your appointment to complete the registration process. When you arrive for your appointment, please check in with the first-floor concierge desk.

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

Have Questions?

Feel free to contact our scheduling department at (214) 827-3610 (Option 2) with any questions relating to the information contained within this packet.



IMPORTANT COVID-19 POLICY

As mandated by Dallas County, we require that a mask or some form of covering over your nose and mouth, such as a homemade mask, scarf, bandana or handkerchief be worn when entering our building and through the entirety of your visit.

Upon entering, we will ask you a few screening questions about any symptoms you may be experiencing and if you have been in recent contact with someone who has COVID-19. Then, we will take your temperature with a contactless forehead thermometer.

We ask that patients attend their appointments alone and have additional friends and/or family members wait in the car. Our team is committed to doing our part to minimize the spread of the coronavirus (COVID-19). The safety of our patients and staff is of the utmost importance.

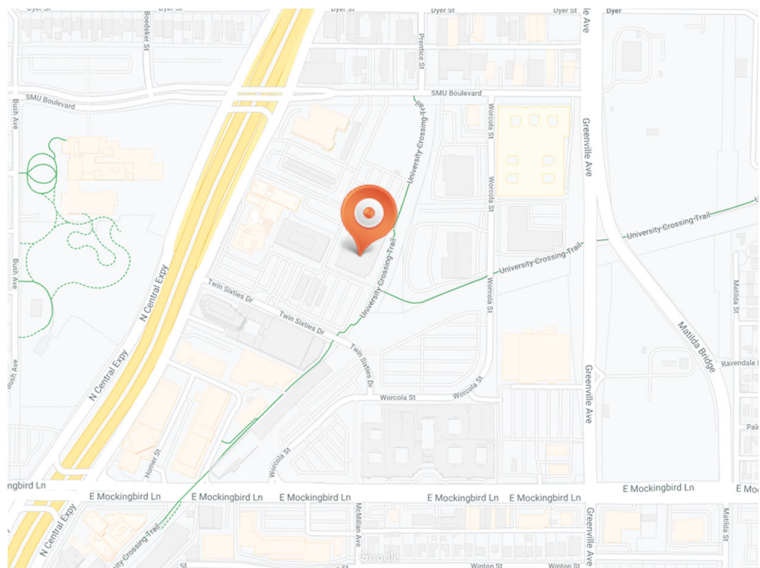
Location & Parking

6080 N Central Expy Ste 100
Dallas, TX 75206-5202

Self-parking is available on the 4th level in the parking garage above our building in the spots with a blue wheel stop with white "NEURO PATIENT" letters.

Utilize the elevator on the north side of the building. After exiting, proceed through the door on the left into our main lobby where you'll be greeted by a staff member and receive additional guidance on checking in.

A short-term patient drop off lane is available in the front of the building for patients with mobility issues.





Patient Information

FIRST NAME	MI	LAST NAME	DATE OF BIRTH
ADDRESS			
CITY	STATE	ZIP	
RESIDENCE TYPE <input type="checkbox"/> Private Residence <input type="checkbox"/> Nursing Home (Not a SNF) <input type="checkbox"/> Skilled Nursing Facility or Hospice			
SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender		SSN #	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Other			
ETHNICITY <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Asian/Pacific-Islander <input type="checkbox"/> Hispanic <input type="checkbox"/> Other			
EMPLOYMENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Full-Time Student			
EMPLOYER (IF APPLICABLE)		OCCUPATION	
HOME PHONE	CELL PHONE ¹	WORK PHONE	
PREFERRED PHONE NUMBER <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work			
WHAT PHONE NUMBER(S) MAY WE LEAVE PERSONAL/MEDICAL INFORMATION ON? <input type="checkbox"/> Home <input type="checkbox"/> Cell			
EMAIL			

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

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

Secondary

I do not have secondary coverage

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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Please Specify)	RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Please Specify)



Name: _____ Date of Birth: _____ Date 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	Secondary
NAME	NAME
HOME/CELL PHONE	HOME/CELL PHONE
WORK PHONE	WORK PHONE
RELATIONSHIP <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other (Please Specify)	RELATIONSHIP <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Sibling <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Friend <input type="checkbox"/> Other (Please Specify)
HIPAA AUTHORIZATION Do you authorize the disclosure of your protected health information (PHI) to the person listed above as your Primary Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No	HIPAA AUTHORIZATION Do you authorize the disclosure of your protected health information (PHI) to the person listed above as your Secondary Emergency Contact? <input type="checkbox"/> Yes <input type="checkbox"/> No

Primary Care Provider

NAME	PHONE
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Referring Provider

NAME	PHONE
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How did you hear about us?

<input type="checkbox"/> Physician/Provider Referral	<input type="checkbox"/> Family or Friend	<input type="checkbox"/> Website or Search Engine	<input type="checkbox"/> Other
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Pharmacies

Primary	Secondary
NAME	NAME
ADDRESS	ADDRESS
CITY ZIP	CITY ZIP
PHONE	PHONE
FAX	FAX
TYPE <input type="checkbox"/> Local <input type="checkbox"/> Mail-Order <input type="checkbox"/> Specialty	TYPE <input type="checkbox"/> Local <input type="checkbox"/> Mail-Order <input type="checkbox"/> Specialty



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 6080 N Central Expy Ste 100
City Dallas State TX Zip Code 75206-5202
Phone (214) 827-3610 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.

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

Physicians

Waleed H. El-Feky, MD
C. Fish Greenfield, MD
Daragh Heitzman, MD
Steven P. Herzog, MD
N. Bruce Jenevein, MD
Alan W. Martin, MD
Arun K. Nagaraj, MD
Frederic N. Nguyen, MD
Maria Philip, MD
Gincy Samuel, MD

Dallas Location

6080 N Central Expy
Ste 100
Dallas, TX 75206-5202
Phone: (214) 827-3610
Fax: (214) 821-4017

Richardson Location

2821 E President George Bush Hwy
Ste 303
Richardson, TX 75082-4280
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
 - Medical Appointment Cancellation /No Show Policy
- 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.com>

Texas Neurology Website Link

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



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

Within the past 6 months

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?		
Weight change	<input type="radio"/> Yes	<input type="radio"/> No
Hearing loss	<input type="radio"/> Yes	<input type="radio"/> No
Heart palpitations	<input type="radio"/> Yes	<input type="radio"/> No
Difficulty swallowing	<input type="radio"/> Yes	<input type="radio"/> No
Seizure	<input type="radio"/> Yes	<input type="radio"/> No
Loss of vision	<input type="radio"/> Yes	<input type="radio"/> No
Shooting arm pain	<input type="radio"/> Yes	<input type="radio"/> No
Shooting leg pain	<input type="radio"/> Yes	<input type="radio"/> No
Depression	<input type="radio"/> Yes	<input type="radio"/> No
Rash	<input type="radio"/> Yes	<input type="radio"/> No
Blood transfusion	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes	<input type="radio"/> Yes	<input type="radio"/> No
Nasal/seasonal allergies	<input type="radio"/> Yes	<input type="radio"/> No
Difficulty urinating	<input type="radio"/> Yes	<input type="radio"/> No
Sleep problems	<input type="radio"/> Yes	<input type="radio"/> No
Memory problems	<input type="radio"/> Yes	<input type="radio"/> No

General

WHICH HAND DO YOU WRITE WITH? <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both
WHAT IS YOUR SMOKING STATUS? <input type="radio"/> Nonsmoker <input type="radio"/> Current Smoker <input type="radio"/> Former Smoker
HAVE YOU EVER BEEN EXPOSED TO HIV? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown

Within the past 2 weeks

HOW OFTEN HAVE YOU EXPERIENCED LITTLE INTEREST OR PLEASURE IN DOING THINGS? <input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half the days <input type="radio"/> Nearly every day <input type="radio"/> Declined to specify
HOW OFTEN HAVE YOU EXPERIENCED FEELING DOWN, DEPRESSED, OR HOPELESS? <input type="radio"/> Not at all <input type="radio"/> Several days <input type="radio"/> More than half the days <input type="radio"/> Nearly every day <input type="radio"/> Declined to specify

Within the past year

HAVE YOU HAD A DRINK CONTAINING ALCOHOL? <input type="radio"/> Yes <input type="radio"/> No
HAVE YOU FALLEN WITHIN THE PAST 12 MONTHS? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A

If you are 65 years of age or older

DO YOU HAVE AN ADVANCE CARE PLAN/SURROGATE DECISION MAKER? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A
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Name: _____ Date of Birth: _____ Date Completed: _____

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 lists tests and where this was performed.

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
