TEXAS
NEUROLOGY
CONSULTANTS, PLLC

Shari Rosen-Schmidt, M.D., P.A.
Charisse H. Barta, M.D., P.A.
Joel D. Campbell, M.D., P.A

Dear Patient:

We look forward to meeting you at your new patient appointment with us.

We are located at 6124 W. Parker Road, Suite 432, Plano, TX 75093 - (Located 1 block west of the Dallas North Tollway, inside the Texas Health Plano Presbyterian Hospital, Building 3. Go through the main entrance, turn to your left and take the elevators behind the gift shop. We are on the fourth floor at the end of the hallway in Suite #432)

We are a fragrance-free clinic as perfumes, colognes, body sprays, etc. can be harmful to some of our patients.

PLEASE READ THE FOLLOWING INFORMATION

To make your visit more beneficial to you, please complete the forms online, print and bring all of them with you to your appointment. If you do not have access to a computer, please arrive 30 to 45 minutes prior to your appointment time to complete the packet.

We will also need the following information:

- Health insurance Card(s) and Pharmacy benefit card(s)
- Driver's License or other government issued photo ID
- Referrals: If you have an insurance carrier that requires a referral number, please obtain the referral prior to your appointment on all visits to our office by calling your primary care provider. If your referral has not been received in our office prior to your appointment, we will have to ask you to reschedule to another time.
- Medical Records:
  - ✓ Office notes, if you were referred by another doctor.
  - ✓ Any scans that you had done (e.g. X-rays, MRI, MRA, CT, etc.)
  - ✓ Any recent blood work results that you have had done prior to this appointment.
  - ✓ Medical Power of Attorney forms, if you are the legal guardian of the patient.

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PATIENT REGISTRATION FORM

Name: _____
LAST MIDDLE FIRST

Address: _____

Home: (_____) _____-_____ Cell: (_____) _____-_____ Work: (_____)_____-_____ ext._____

DOB: _____/_____/_____ Age: _____ Sex: ____ SSN: _____ DL#_____

Email address: _____

_____
Emergency Contact (Relationship) Telephone (Other than your home)

_____ Phone: (_____) _____
First and Last Name of Referring Physician

_____ Phone: (_____) _____
First and Last Name of Primary Care Physician

Local Pharmacy: _____ Phone: (_____) _____

Pharmacy Address: _____

Mail Order Pharmacy: _____ Phone: (_____) _____

Pharmacy Address: _____

Are you employed? ☐ Yes ☐ No Full-Time ☐ Part-Time ☐ Self ☐ Retired ☐

Are you a student? ☐ Yes ☐ No Full-Time ☐ Part-Time ☐

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other ☐

Ethnicity: _____ Race: _____ Language: _____

6124 W. Parker Rd, Suite 432, Plano TX 75093
(972) 403-3100 Phone (972) 403-3105 Fax

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PRIMARY INSURANCE COMPANY INFORMATION

PATIENT NAME: (please print) _____Date:_____

INSURANCE COMPANY NAME: _____

MAILING ADDRESS: _____

INSURANCE COMPANY PHONE #: _____

GROUP #: _____ POLICY OR ID #: _____

GROUP OR EMPLOYER NAME: _____

INSURED NAME: _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

MEDICARE #: (if applicable):_____

SECONDARY INSURANCE INFORMATION *(FOR MEDICARE PATIENTS ONLY)*

INSURANCE COMPANY NAME:_____

MAILING ADDRESS:_____

INSURANCE COMPANY PHONE #:_____

GROUP #:_____POLICY OR ID #:_____

INSURED: _____SOCIAL SECURITY #:_____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ **DATE** _____

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Patient Name: _____ DOB: _____

CONSENT TO TREAT

I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of Texas Neurology Consultants, PLLC.

Initial: _____

PAYMENT POLICY

I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance if benefits assigned. Texas Neurology Consultants, PLLC files claims for Medicare assignment and only the managed care plans, with which we are contracted. Claims will not be filed with other insurance carriers. If you plan to pay by check and it is dishonored a processing fee of $40.00 will be assessed.

Initial: _____

ASSIGNMENT OF BENEFITS

I assign to the treating physician of Texas Neurology Consultants, PLLC all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

Initial: _____

IS YOUR MEDICAL CONDITION RELATED TO ANY OF THE FOLLOWING?

Work injury? ☐ Yes ☐ No Auto Accident? ☐ Yes ☐ No Any pending/open lawsuit? ☐ Yes ☐ No **Initial:** _____

AUTHORIZATION TO MAIL, CALL, TEXT, AND EMAIL

I certify that I understand the privacy risks of the mail, phone calls, text messages and email. I hereby authorize Texas Neurology Consultants, PLLC to mail, call or email me with communications regarding my healthcare, such as appointment reminders and/or medical information regarding patient care. I understand that is my responsibility to update Texas Neurology Consultants, PLLC with any changes to my insurance, address, phones number(s) or email address. I understand that I have the right to revoke consent for any and all of the above initialed items at any time in writing. I authorize Texas Neurology Consultants, PLLC, its assignees, and third party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. This includes, but is not limited to, home telephone, cellular telephone, employment telephone, and any form of digital communications including, but not limited to, contact by manual calling methods, prerecorded or artificial voice messages, text messages, emails, and/or automatic telephone dialing systems. This consent includes any form of contact to a number for a cellular phone or other wireless device, regardless of whether I incur charges as a result. I hereby grant permission and consent to Texas Neurology Consultants, PLLC, its assignees, and third party collection agents to contact me on the numbers I have provided for any purpose related to my account, including debt collection, by a live person or automated dialing device. I understand that this consent may be revoked at any time, by informing Texas Neurology Consultants, PLLC, its assignees, and/or third party collection agents that I no longer consent to contact at the phone numbers I have provided, or by these forms of communication.

I have completed this form with accurate information. I have read and understand my obligations and responsibilities. I acknowledge that I am fully responsible for supplying correct insurance information, billing information and payment of any services not covered or approved by my insurance carrier.

_____ _____

Signature of Patient or Guardian **Date**

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APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Texas Neurology Consultants, PLLC. When you schedule an appointment with Texas Neurology Consultants, PLLC, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

Please note: your insurance company does not cover this charge. Repeated "no show" appointments could result in a dismissal from the practice and refer you back to the insurance company for reassignment to another specialist.

☐ Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $50.00 fee. The fee is $100.00 for established patients with EMG/NCS testing who No Show.

☐ Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a second time will be charged a $50.00 fee.

☐ If a third No Show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from Texas Neurology Consultants, PLLC.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Practice Manager, who may be able to waive the No Show fee. You may contact Texas Neurology Consultants, PLLC at the number below.

WE ARE A FRAGRANCE-FREE CLINIC

Perfumes, colognes, body sprays, etc. are not allowed as they can be harmful to our migraine headache patients. If you wear these to your appointment, you may be asked to wash them off prior to being seen by the doctor.

COMPLETION OF FORMS POLICY & PHONE CONSULTATIONS

There is a charge for completion of forms, which includes, but is not limited to FMLA, simple letters, such as jury duty or work/school excuses. Some disability forms may require an examination and there will not be a separate charge for these. These fees are not payable by insurance and therefore, it is the responsibility of the patient. Payment is expected at time of service.

FMLA Forms - $25.00 for the first 5 pages. $5.00 per page, thereafter
Disability Forms – $50.00 if not done at time of examination

Simple letters - $25.00
Phone Consultations - $35.00

_____ _____

Signature of Patient or Guardian **Date**

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HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Texas Neurology Consultants, PLLC to release any of my medical or incidental information, including billing information, that may be necessary for medical care or to process medical insurance claims.

I give permission to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

Name _____Relationship:_____Phone:_____

Name: _____ Relationship:_____Phone:_____

- OR -

I do not wish my information to be disclosed to any person other than myself.

Please note that you will be asked to sign a new HIPAA Authorization for Release form annually.

NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Texas Neurology Consultants, PLLC (TNC) is furnishing you with the attached notice, which provides information about how TNC and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of TNC's Notice of Health Information practices.

_____ DOB: _____ Date: _____
Signature of Patient or Guardian

TEXAS NEUROLOGY CONSULTANTS, PLLC
PATIENT HISTORY

Last Name **First** **Middle** **Date**

Age **Sex** **Right Handed / Left Handed?** **Birthdate**

Referring Physician (Name, Address, Phone, and Fax):_____

WHAT IS THE MAIN REASON YOU ARE SEEING A NEUROLOGIST? Describe onset, when did it start?, what makes worse or better?, etc)

MEDICAL HISTORY: list all medical conditions (e.g., diabetes, heart disease, high blood pressure, high cholesterol, arthritis, etc)

LIST ALL SURGERIES AND DATES: _____

Any major accidents or injuries:_____

Any recent hospitalizations? (If so give details)

Have you had any of the following problems? (If yes, explain)

Yes	No			Yes	No	
☐	☐	Neurologic (seizure, stroke, etc)		☐	☐	Kidney or urinary problems
☐	☐	Heart Disease		☐	☐	Sexual
☐	☐	Lung Problems		☐	☐	Psychological
☐	☐	Diabetes		☐	☐	Nervous breakdown
☐	☐	High Blood Pressure		☐	☐	Ears, nose, or throat problems
☐	☐	Abdominal, stomach/intestinal		☐	☐	Other: explain
☐	☐	Cancer (explain where, when, and how treated)				

ALLERGIES TO MEDICATIONS: (List medication and reaction)

MEDICATIONS (List all medications with dosage and frequency you are currently taking? If needed attach separate page.

Review of Systems: **Do you have any of the following conditions or complaints at present?**

	Yes	No	
Neurologic			**Headache**
			Fainting / Blacking out
			Seizures
			Dizziness
			Difficulty in Speech
			Memory problems more than age related peers
			Muscle weakness
			Numbness or tingling
			Difficulty walking
			Difficulty using hands
			Tremors
Constitutional			**Fever**
			Weight gain or loss
			Sleep problems
			Fatigue
Eyes			**Double vision**
			Blurred vision
			Eye pain
			Other
Ears, Nose, Throat			**Difficulty swallowing**
			Hearing loss
			Hearing aids?
			Ringing in ears
			Ear pain
Cardiac			**Chest pain**
			Palpitations
			Heart murmur
			Swelling in legs
Respiratory			**Shortness of breath**
			Cough
			Asthma
Gastrointestinal			**Reflux / heart burn**
			Nausea
			Vomiting
			Constipation
			Diarrhea
			Abdominal pain
			Bowel Incontinence
Urologic			**Urinary Incontinence**
			Urinary hesitancy / dribbling
			If male, prostate disorder
			Kidney stones
			Pain on urination

	Yes	No	
Musculoskeletal			**Muscle pain**
			Joint pain (if yes, where?)
			Pain in any part of body (where?)
Psychiatric			**Depression**
			Anxiety
			Bipolar disorder
Endocrine			**Diabetes**
			Thyroid disorder
Hematologic			**Anemia**
			Easy bruising
Infectious			**Sexually transmitted disease**
For women only			**Menstrual problems**
			Are you pregnant?
			Are you planning on having children within the next year?
			Do you take birth control pills?
			Have you had a hysterectomy?
Other (Please list)			

SOCIAL HISTORY: Mark Y (yes) or N (No)

Do you smoke regularly?_____ How long? _____

Cigarettes___ Pipe___ Cigars___ How many per day_____?

Do you drink alcohol? _____ Regularly?_____
Beer____ Wine____ Hard liquor?_____ How much per day?_____
How much per week?_____ How long?_____

Do you use any street drugs? _____

Are you or have you been addicted to any drugs or alcohol?
_____

Any blood transfusions? _____ tattoos?_____
Risky sexual activity for sexually transmitted diseases?_____

Are you single___ married___ divorced___ or widowed?___

What is your job?_____.

If retired, what did you do prior to retirement?_____

What is your highest level of education? _____

Any blood relative who has had the following? Mark yes or no and the relative who had (e.g. mother, father, paternal aunt or uncle, maternal grandfather, etc)?

_____ Similar type of illness that you have now
_____ Stroke
_____Alzheimer's or dementia
_____Migraines
_____Seizure disorder or epilepsy
_____Muscle disease
_____Nerve disease or neuropathy
_____Tremor
_____Parkinson's Disease

_____Heart Disease
_____High Blood Pressure
_____Diabetes
_____Cancer
_____Blood clotting disorder
_____Other

Are you adopted? Yes_____ No_____

Family History	If alive (good/fair/poor health) and illnesses	Age	Cause if deceased
Father			
Mother			
Brothers/Sisters (list individually)			
Children:			

For Doctor's use only: Reviewed by: _____ Date: _____

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Patient Name _____ **DOB** _____

Please fill out this form if you are being seen for headaches. Fill in the circle completely.

What is the number of days you experience headaches, per month?
☐ None ☐ 1-4 ☐ 5-10 ☐ 11-14 ☐ More than 15 ☐ Daily

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(s) do you experience?
☐ Achy ☐ Lightning bolts ☐ Pulsating ☐ Throbbing ☐ Pounding ☐ Crushing
☐ Piercing ☐ Sharp ☐ Deep pain ☐ Squeezing ☐ Dull ☐ Pressure

When does your headache(s) 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+

What are the associated symptoms?
☐ Light sensitivity ☐ Sound sensitivity ☐ Smell sensitivity ☐ Queasiness ☐ Nausea ☐ Vomiting ☐ Joint pain
☐ Limits activity ☐ Dizziness/lightheaded ☐ Visual changes ☐ Vertigo ☐ Nasal congestion ☐ Red, teary eye
☐ Neck pain ☐ Muscle spasm

How are your headaches relieved?
☐ Rest ☐ Quiet and darkness ☐ Cold compress ☐ Heat ☐ Massage ☐ 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

Do any of the following occur with your headaches?
☐ Changes in vision ☐ Difficulty speaking ☐ 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

Texas Neurology Consultants, PLLC
NOTICE OF PROTECTED HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

This notice describes the practices of Texas Neurology Consultants, PLLC (hereinafter "TNC" and that of its physicians with respect to your protected health information created while you are a patient. Physicians and personnel of TNC authorized to have access to your medical chart are subject to this notice. In addition, physicians of TNC may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at TNC. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at TNC.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of TNC the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction;
- Obtain a paper copy of this notice of protected health information practices;
- Inspect and request a copy of your health records provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law;
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests; and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken in reliance on your authorization.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of the notice to the Privacy Officer.

Our Responsibilities

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation: We do not accept new worker's compensation cases but we may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorized charges with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to recover reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

FOR MORE INFORMATION OR TO REPORT A PROBLEM:

If you have questions and would like additional information, you may contact:
Texas Neurology Consultants, PLLC, Privacy Officer at (972) 403-3100.

If you believe your privacy rights have been violated, you can file a complaint with Texas Neurology Consultants, PLLC or with the Secretary of Health and Human Services.
There will not be retaliation for filing a complaint**.**
Effective Date: 04/01/03
Version 1: HIPAA NOTICE