THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Medical History

PHARMACY INFORMATION			
Pharmacy Name:	**Phone #:**	**Address:**	**City:**

List Drug Allergies and Nature of Allergic Reaction:

List Past and Current Medical Conditions:

List Past Surgeries:

List Medications: Drug / Dosage / Frequency

Tobacco user: ☐ Yes ☐ No	**If yes, how often, how long?** ☐ Former Smoker ☐ Current Someday Smoker ☐ Current Everyday Smoker How long? ___ yrs ___ mths	**Packs per day?** ☐ <1 ☐ 1 ☐ 2 ☐ >2
Current Alcohol user: ☐ Yes ☐ No	**If yes, which type?** ☐ Beer ☐ Liquor ☐ Wine	**Drinks per week?** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ >5
Current Drug user: ☐ Yes ☐ No	**If yes, which drugs?** ☐ amphetamines ☐ cocaine ☐ marijuana ☐ opiates ☐ PCP ☐ prescription drugs	**Past drug user:** ☐ Yes ☐ No

Family History:

	Primary Care Physician or Gynecologist
	Referring Physician

Current Occupation: **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Seperated ☐ Widowed

Highest Level of Education:

Please add any information you feel might be important for the physician to know prior to your visit.

Printed First Name _____ Printed Last Name _____

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Review of Systems (ROS)

	Please Check below to indicate whether you have experienced:	Explanation
☐	Headache	
☐	Neck Pain	
☐	Low back pain	
☐	Pain in a particular arm or leg	
☐	Sensory loss or tingling in an arm or leg	
☐	Blurred or double vision; blindness	
☐	Ringing in the ears	
☐	Dizziness or vertigo	
☐	Impaired speech	
☐	Difficulty swallowing	
☐	Memory loss	
☐	Trouble walking	
☐	Falling down	
☐	Weakness all over	
☐	Passing out	
☐	Spells of altered awareness	
☐	Seizures	
☐	Hallucinations	
☐	Depression	
☐	Trouble speaking	
☐	Loss of appetite	
☐	Unexplained weight loss	
☐	Nausea or vomiting	
☐	Persistent diarrhea or constipation	
☐	Blood in stool or urine	
☐	Abdominal pain	
☐	Incontinence of urine in stool	
☐	Pain or burring on urination	
☐	Sexual dysfunction	
☐	Chest pain	
☐	Shortness of breath	
☐	Palpitations or rapid heart rate	
☐	Recent cold or flu	
☐	Congestion or sinus problems	
☐	Prolonged or frequent fevers	
☐	Night sweats	
☐	Persistent cough	
☐	Skin rashes	
☐	Ulcers in mouth or on skin	
☐	Changes in skin moles	
☐	Loud snoring	
☐	Trouble sleeping	
☐	Day time sleepiness	

Printed First Name _____ Printed Last Name _____

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Aimee Garza MD • Robert Ulrich DO
Mary Concepcion NP • Gabrielle Tucker NP • Adrianne Bailey • PA Josh Florez PA
7000 Parkwood Blvd, Suite F100, Frisco, Texas 75034
Phone: (214) 494-4424 Fax: (214) 494-4423

Office Policy

Welcome to the Center for Neurology and Neurophysiology, P.A. Enclosed you will find a patient history, medical information form, a consent form, and privacy notice. These forms should be completed prior to your appointment. Please arrive at least **TWENTY MINUTES BEFORE** your first appointment so we may scan your information.

Our clinic hours are from 7:00 a.m. to 3:00 p.m. Monday through Thursday. During and after business hours, calls are handled by a voicemail system. All non-emergency calls should be left in the appropriate voicemail. In most cases a voicemail left before 2 pm will be returned the same day. The doctor's line is for emergency calls only which will notify the practitioner on-call 24 hours a day. **All non-emergency calls to the doctor's line will be assessed a $65.00 fee.** Our office is not equipped to manage life-threatening emergencies. You should call 911 or report to the nearest emergency room for all life-threatening emergencies.

HMO plans require a referral from your primary care physician for a visit to a specialist. A referral must be in place prior to your visit, or you will be financially responsible for any and all charges incurred prior to your visit.

Your co-payment, co-insurance, deductible, or balance will be collected prior to your visit. If you have a secondary insurance we will file it for you. However, any balance remains the responsibility of the patient. Payment in full is expected if your primary or secondary carrier has not paid in sixty (60) days. In order to prevent any misunderstanding about insurance we advise you speak with your insurance company prior to your visit. If you have no health insurance, payment is expected in full prior to your appointment, in the form of cash or credit card. We no longer accept checks and a 5% surcharge is assessed for American Express. The following is a brief, non-comprehensive listing of fees:

Family Medical Leave Application Form	$35.00
Short Term Disability Forms	$35.00+ fee for records if needed
Medical Records Requests	$25.00 for the 1st 25 pages; $0.50 for every page after
Financial Records	$25.00 for the 1st 25 pages
Certified Mail	$15.00
Returned Checks (NSF)	$35.00
Written Correspondence	$30.00
Prescription or prescription refill request after hours	$65.00
Appointment No Show/Same Day Cancellation	$35.00
EMG/NCVS Cancellation less than 24 hours	$75.00
Routine EEG Cancellation less than 24 hours	$75.00
Non-emergency call on the doctor's line	$65.00
Botox cancellation/rescheduling within 1 week of your appt	$250.00

Medical records are property of the clinic however a physician may request your records at no cost to you or their office with a signed medical release. A medical records request will not be processed without a signed release. Individuals will be assessed a fee for a copy of lab results, diagnostic testing, or an imaging report.

Our office does not participate in the completion of long term disability claim forms. In addition, if your injuries are the result of an automobile accident as a driver, passenger or pedestrian or from a work related accident you will be asked to pay for your office visit and all testing relating to the accident through your health insurance. You may request a HCFA-1500 form to assist you in your reimbursement from your insurance.

Printed First Name _____ Printed Last Name _____

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Office Policy

We make reminder calls the day before your appointment as a courtesy. However, if you do not call to cancel or reschedule your appointment the prior day your appointment will be documented as a no call/no show appointment on the day of your appointment. We reserve the right to charge you $35 before scheduling your next appointment after your second no call/no show. We reserve the right to dismiss you for non-compliance for excessive missed and cancelled appointments.

On the day of your appointment if you are more than ten minutes late we will attempt to accommodate you the same day but your appointment will be subject to cancellation.

We ask that you utilize our patient portal for questions. Patient Portal messages are only monitored during our normal business hours. In the event of an urgent issue, call our office at 214-494-4424.

Normal imaging or labs results will only be delivered through the patient portal. Results may take up to 72 hours to review before you are contacted. If results are emergent you will be contacted immediately by phone. If you have not received your results after 72 hours from the date your study was completed please notify us through the patient portal.

Please do not wait until you have exhausted your supply of medication before requesting refills. If your request is appropriate and received prior to 2:00 p.m. on a regular business day we will attempt to refill your prescription the same day but some requests make take 24 hours. To expedite refill requests use the patient portal or you may contact your pharmacy and ask them to fax a refill request to our office. You may be asked to schedule a follow-up appointment prior to refilling your request. If you have not been seen in the last 60 days you will be asked to be seen in the office. Patients receiving narcotics or ADD medications must keep their scheduled appointments. In the event of lost, stolen or missing prescriptions prior to your refill date a police report must be filed and submitted to our office prior to refilling your prescription at the discretion of the provider. **Please note that medications refilled after hours, on weekends, or office holidays are subject to a $65 refill request**. So please be responsible and plan ahead.

Most follow up appointments are with our Nurse Practitioners and Physician Assistants under the direction, and in collaboration, with your neurologist to ensure you receive the best possible care for your health.

Thank you for allowing us to participate in your healthcare.

Sincerely,

Aimee Garza MD, Robert Ulrich DO,

Mary Concepcion NP, Gabrielle Tucker NP, Adrianne Bailey PA and Josh Florez PA.

I have read and understand the above office policy.

_____ _____

Signature Date

_____ _____

Printed First Name Printed Last Name

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Patient Demographic Form

Today's Date				
PATIENT INFORMATION				
Patient's First Name	**Patient's Middle Name**	**Patient's Last Name**		
Street Address	**City**	**State**	**Zip**	
Social Security	**Date of Birth**	**Gender** ☐ **M** ☐ **F**	**Marital Status** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Seperated** ☐ **Widowed**	
Cell Phone # **Secondary Phone #**	**Ethnicity** ☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino** ☐ **Unknown**	**Race** ☐ **White** ☐ **Black or African American** ☐ **Asian** ☐ **Other Race** ☐ **Native Hawaiian or Other Pacific Islander** ☐ **American Indian or Alskan Native**		
Employer	**Email Address**	**Emergency Contact**	**Phone #:**	
INSURANCE INFORMATION				
Name of Primary Insurance	**Policy Holder:**	**Date of Birth:**	**Policy #:**	**Group #:**
Primary Social Security Number:				
Name of Secondary Insurance	**Policy Holder:**	**Date of Birth:**	**Policy #:**	**Group #:**
Secondary Social Security Number:				

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize The Center for Neurology and Neurophysiology, P.A. to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services.
I authorize payment of medical benefits to The Center for Neurology and Neurophysiology, P.A.
I understand I am ultimately responsible for all service whether covered by the insurance or not. I also authorize my physician, based on her discretion to access my chart for utilization management review.

_____ _____

Signature **Date**

_____ _____

Printed First Name Printed Last Name

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Notice of Privacy Practice

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

Medical information:
The Center for Neurology and Neurophysiology, P.A., understands that your medical information is personal and we are committed to protecting your information. A record is created for you at your first visit; this record describes the services you receive during your visits. You have the right to limit the disclosure of your information, although in some instances the information must be disclosed to insure proper treatment and payment.

Disclosures of medical information:
The following are descriptions of different ways we may disclose your information. Not every disclosure is listed; however we are permitted to use information that falls in one of these categories.

Treatment. We may disclose medical information about you to provide medical treatment and services. This information may be disclosed to other physicians, nurses, technicians, or other personnel involved in your treatment. This information will also be used for referrals to other physicians and services.

Payment. We may disclose medical information about you to an insurance company so we may bill and collect on the services.

Health Care Operations. We may disclose information to ensure that we are providing quality care. For example; we may use your medical information to evaluate performance of the staff. We may also use your medical information to determine if additional services need to be offered.

Treatment Alternatives. We may disclose medical information about you to recommend possible treatment options or alternatives that may interest you.

Individuals Involved in Your Care. We may release medical information about you to a friend or family member who is involved in your care.

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

To Avert Serious Threat to Safety or Health. We may disclose medical information about you when necessary to prevent serious threat to your health and safety or the health and safety of the public or another person.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle tissue transplantation, or as necessary to facilitate organ or tissue transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Printed First Name _____ Printed Last Name _____

Public Health Risks. We may disclose medical information about you for public health use. This is generally for these following reasons:
-To prevent or control disease, injury or disability
-To report births or deaths
-To report child abuse or neglect
-To report reactions to medications or problems with products
-To notify people of product recalls
-To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
-To notify the appropriate authorities, if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.

Healthcare Audits. We may disclose this information to an audit agency for activities authorized by law. These audits include investigations, inspections, and licensure. This is necessary for the government to monitor the health care system.

Lawsuits. If you are involved in a lawsuit we may disclose medical information about you in response to a court or administrative order. We may also disclose information about you to a subpoena, discovery request, or other lawful process by someone else involved, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcements. We may release medical information if asked to do so by a law enforcement official. This may be due to the following:
-Response to a court order
-Identify or locate a suspect, fugitive, material witness, or missing persons
-About a victim of crime
-About a death we believe may be the result of criminal conduct
-Emergency circumstances to report a crime

Coroners, Medical Examiners, and Funeral Directors. We may release medical information to a coroner or medical examiner. It may be necessary to identify a deceased person, or determine cause of death.

National Security. We may release medical information about you to authorized federal officials for national security activities authorized by law.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state.

Inmates. If you are an inmate of a correctional facility or under the custody of law enforcement officials, we may release medical information about you to the correctional facility or official. This release is necessary for the correctional facility to provide you with the proper health care, to protect your health and safety or the health and safety of others, for the safety and security of the correctional facility.

Printed First Name _____ Printed Last Name _____

Your Rights Regarding Your Medical Information.
You have the following rights with your medical information:

The Right to Inspect and Copy. You have a right to inspect your medical information. This can be done by calling the office and requesting to see your records. An appointment will be set for you to come in and review them. You may also have copies of your records.

The Right to Amend. If you feel that your medical information is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as we are in possession of your records. You must make your request in writing and it will be subjected to review.

Disclosure Accounting. You have the right to request an accountability of Disclosure Log. This is a list of disclosures that have been made on your medical history.

Restriction Right. You have the right to restrict the disclosure of your medical information. You also have the right to limit the medical information we disclose about you to someone involved in your care such as family. **We are not required to agree to your request.** If we do agree with your request, we will comply unless the information is needed for emergency treatment. To request restrictions, you must make the request in writing and specifying what information you want limited and to whom you want the limits to apply to.

Right to Request Confidential Communication. You have the right to request that we communicate your medical information to you in a certain way or at a certain location.
To request confidential communications, you must make the request in writing and specify how and where to communicate to you. We will try to accommodate all reasonable requests.

Right to Have a Copy of the Privacy Notice. You have the right to have a copy of this notice. You may ask us for this copy at any time.

Changes to This Notice. We reserve the right to change this notice with or without prior notice. We will post a copy of the current notice in the waiting room. The effective date will always be on the first page top right side.

Complaints. If you believe that your privacy has been violated then you may file a complaint with the privacy officer or with the Secretary of the Department of Health and Human Services. To file a complaint with the privacy officer, please have the complaint in writing and submit it to the office manager to be reviewed.

Other Disclosures. Other disclosures of medical information not covered by this notice or the laws will be made only with your written permission. If you provide us with permission to use or disclose medical information about you, you may revoke it at any time. This must be by your written authorization. You understand that we are unable to reverse any disclosures that were already made with your permission, and we are required to retain our records.

Printed First Name _____ Printed Last Name _____

Notice of Privacy Practice Acknowledgement Form

The Center for Neurology and Neurophysiology has provided me with a copy of the Notice of Privacy Practice regarding the use and disclosure of my health information.

_____ _____

Signature **Date**

_____ _____

Printed First Name Printed Last Name

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Financial Liability Form

Most commercial insurance plans and the Medicare programs will only pay for testing and professional services that they determine to be "reasonable and necessary." Often, such a determination is made after given services or test has already been performed. If an insurance company or a governmental program deems that the test or professional service was not "reasonable and necessary," they will deny payment for these services or procedure.

Some reasons for denial of payment include the following:
1. They usually do not pay for "routine" examinations of lab work.
2. They do not pay for a certain service within given time period.
3. They do not pay for lab testing utilized as a screen to investigate for, or to "rule out," a particular condition.
4. Routine lab work is not covered at a particular frequency.
5. They do not pay for test pending FDA approval.
6. The patient, or physician referring the patient, did not secure a proper insurance referral.
7. Others that vary by insurance program.

Our office will attempt to pre-certify your tests through your insurance company. However, this is not a guarantee of payment from your insurance company. Please understand this office is not responsible for your share of the cost of testing. You will be responsible for your payment before any visit or immediately after we are notified by your insurance of your share.

We are committed to practicing medicine in a professional and fiscally responsible manner, but certain situations may arise in which payment is denied to the physician or an outside laboratory or testing facility. In that circumstance, the patient or his/her guardian will be liable for any and all charges incurred at the negotiated rate with the insurance. If you have any questions regarding your responsibility, please contact your insurance company.

Patients without insurance are expected to pay in full their balance before each visit.

In the event that your deductible has not met, your copay changes or your insurance pays only a portion you will be responsible for paying the balance before your next visit.

Please read and sign below. If you have any questions, please direct them to our office staff before your appointment.

I have read and understand the above statements. I acknowledge that I have been informed that payment by my insurance carrier or Medicare could be denied for a variety of reasons. If my insurance carrier or Medicare denies payment, I agree to be personally and fully responsible for payment.

_____ _____

Signature Date:

_____ _____

Printed First Name Printed Last Name

THE CENTER FOR NEUROLOGY AND NEUROPHYSIOLOGY, P.A.

Release of Medical Records

I hereby authorize The Center for Neurology and Neurophysiology, PA to send or obtain any medical information needed for my care.
I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease; this does include Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dated notice, except to the extent that disclosure of information had been made prior. You have a right to limit medical information we disclose to someone involved in your care, if you wish to do so please write down any persons or facilities that you do not want to receive information and the information that you want limited. Please note that the physician does not have to agree to your request.

Restrictions List

Please fill out below any persons that may get information on your behalf.

Authorization List

Name of Person	**Relationship**

I may be contacted for appointments in the following manner (check all that apply)		
	Message with detailed information	**Message with call back number only**
Home Phone #	☐	☐
Cell Phone #	☐	☐
Text Message #	☐	☐
Work Phone #	☐	☐
Email	☐	☐

Signature	Date
Date of Birth	Social Security

Printed First Name _____ Printed Last Name _____