Shari Rosen-Schmidt, M.D.
Charisse H. Barta, M.D.
Alla Al-Habib, M.D.
Yu Zhao, M.D.

TEXAS NEUROLOGY CONSULTANTS, PLLC

PATIENT REGISTRATION FORM

Name: _____
LAST MIDDLE FIRST

Address: _____City _____ST_____ Zip _____

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 Phannacy: _____ Phone: (_____) _____

Pharmacy Address: _____

Mail Order Pharmacy: _____ Phone: f____) _____

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.

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 are 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.

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.

IS YOUR MEDICAL CONDITION RELATED TO ANY OF THE FOLLOWING?

Work injury? Yes ____ No ____ Auto Accident? Yes ____ No ____ Any pending/open lawsuit? Yes ____ No ____

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**

TEXAS
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APPOINTMENT CANCELATION/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 ordering physician 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, EEG, or other testing who No Show.

 If additional No Show or cancellations/reschedules 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

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 - $50.00 for the first 3 pages. $10.00 per page, thereafter
Disability Forms – $100.00 if not done at time of examination
Simple letters - $25.00
Expediting Fee - $100.00 (24-48 hrs)

Signature of Patient or Guardian **Date**

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

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

X _____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____ X

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 Texas Neurology Consultants, PLLC
Address 6124 W Parker Road, Suite 432
City Plano State Texas Zip Code 75093
Phone (972) 403-3100 Fax (972) 972-403-3105

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

X 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 _____

X **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_____

X **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.

X **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.

PATIENT HISTORY FORMS

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)				

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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)			

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