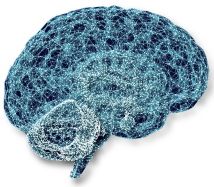

TNMD
TEXAS NEUROLOGY & MOVEMENT DISORDERS

Thank you for choosing Texas Neurology and Movement Disorders! In order to serve you properly, we need the following information. Please print out and **FILL OUT COMPLETELY**. All Information is confidential.

Patient Information

Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone: Contact Method: ☐ Home ☐ Mob ☐ E-mail ☐ Text	Mobile Phone:	Email: ☐ No Appointment Reminders	

Date of Birth:	Race: ☐ Asian/Pacific Islander ☐ African American ☐ Caucasian ☐ Hispanic ☐ Multiracial ☐ American Indian/Eskimo	SSN:	Sex: ☐ Male ☐ Female	Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer Information

Employer:		Status: ☐ FT ☐ PT ☐ Self-Employed ☐ Student ☐ Retired ☐ None	
Address:	City:	State:	Zip Code:
Work Phone:	Occupation:		

Emergency Contact Information

Contact Name:	Phone #:	Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other

Health Care Providers Information

Primary Care Physician:	☐ None	Phone #:
Neurologist:	☐ None	Phone #:
Psychiatrist:	☐ None	Phone #:
Psychologist:	☐ None	Phone #:
Cardiologist:	☐ None	Phone #:

Pharmacy Information

Name of preferred pharmacy:	Zip Code:	Phone #:

Insurance Information

Only complete the following if the Primary or Secondary policy holder is NOT the patient. ☐ Primary ☐ Secondary

Last Name:	First Name:	Middle Initial:	SSN:	DOB:
Patient Relationship to Policy Holder: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**			Gender: ☐ **Male** ☐ **Female**	

Primary Insurance Payor:		**Secondary Insurance Payor:**	
Policy/ID#:	Group#:	Policy/ID#:	Group#:
Insurance Phone #:		Insurance Phone #:	

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TEXAS NEUROLOGY & MOVEMENT DISORDERS

Patient Name: _____ **Date:** _____ **Acct:** _____

Treatment Authorization

I hereby authorize Texas Neurology and Movement Disorders, PA to examine, diagnose, and treat (name of patient) _____. I authorize and give Texas Neurology and Movement Disorders, PA consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analysis and study and to include diagnosis submission for payment to the insurance carrier for the named patient.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative

Research: Research to improve patient care is conducted at this clinic and is approved and monitored by the Institutional Review Board. This review and monitoring assures strict confidentiality with regard to who may view my medical records. I consent to the use of information in my record for research purposes. I understand that I might subsequently be asked if I would be willing to participate in research projects if they require activities outside of normal clinical care, and that I have the right to decline participation.

Medical and Surgical Consent: I consent to Texas Neurology and Movement Disorders, PA to provide me with the necessary medical services, treatments, and diagnostic tests. My consent to treat includes any examinations, X-rays, laboratory procedures, tests, medications, medical treatment, and/or other services rendered by the attending physician or other treating or consulting physicians, their associates, technical assistants and other healthcare providers including nurses and other medical personnel, which in the judgement of such practicioners, are advisable during the course of evaluation, diagnosis, and treatment. I consent to allow medical residents, students, and authorized individuals to observe or participate in the care provided as determined by the treating physicians and as permitted by clinic policy.

Accidental Exposure of the Healthcare Worker: I understand that Texas law provides, if any healthcare worker is exposed to the patients blood or other bodily fluid, that Texas Neurology and Movement Disorders, PA may perform test(s) on the patient's blood or other bodily fluid to determine the presence of human immunodeficiency virus (HIV, the virus associated with AIDS). I consent to the testing for other communicable diseases, including but not limited to hepatitis and syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient while a patient of Texas Neurology and Movement Disorders, PA.

Authorization to Photograph: I grant permission to photograph the patient for purpose of patient identification.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative

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TEXAS NEUROLOGY & MOVEMENT DISORDERS

Authorization to Obtain or Release Medical Information

I, (name of patient) _____ hereby authorize Texas Neurology and Movement Disorders, PA to release/request any information necessary to/from my insurance company (ies), governmental health care insurers (such as Medicare and Medicaid), and/or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the case of a subpoena, if the release/requesting of information is necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care. Texas Neurology and Movement Disorders, PA is released and discharged from any liability, and the undersigned will hold Texas Neurology and Movement Disorders, PA harmless for complying with this information.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative

_____ (initials) **Release of Information**: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

Miscellaneous Fees

☐ **Filling Out Disability Forms: $25**
Note: The patient may also need to schedule an appointment with their physician for an exam.
☐ **Medical Records Fee: $25**
Note: Requests for recent office visit notes will be sent to other physicians for no charge as a courtesy but requests for complete charts or extensive records will be charged at the rates listed above. The patient will be responsible for any charges incurred for their medical records.
☐ **Returned Check Fee: $35**

I acknowledge the clinic's policies for miscellaneous fees.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative

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TEXAS NEUROLOGY & MOVEMENT DISORDERS

Statement of Financial Responsibility

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 and Movement Disorders, PA files claims for Medicare assignment and only the commercial care plans with which we are contracted. Claims will not be filed with other insurance carriers. By signing below, you are accepting financial responsibility for payments towards your deductible, co-payment, co-insurance, and/or all medical bills not covered by your insurance.

No Show & Late Cancellation Policy:

Our Goal here at Texas Neurology and Movement Disorders is to provide quality service to all of our patients in a timely manner. Failure to keep scheduled appointments is costly to the practice, and those time slots could be offered to other patients in need.

Patients who fail to show up for their scheduled appointments or fail to give 24 hours' notice when canceling or rescheduling their appointments place an extra burden on the staff. Furthermore, since the appointment goes unfilled, this represents either a delay to see another patient or a financial burden to TPMD. Therefore, TPMD has implemented the following policy:

- A **$25 charge** will be assessed for **"no-showing"** or **failing to give 24-hour notice** of the need to cancel **routine follow-up appointments.**
- A **$100 charge** will be assessed for **"no-showing"** or **failing to give 24-hour notice** of the need to cancel **scheduled procedures, including EEG's, EMG's, etc.**

These charges are not billable to your insurance company and will ultimately be the responsibility of the patient. All no-show and late cancellation fees will need to be paid before your next appointment with the physician. If a patient has 3 no-show or late cancellations, they may be dismissed from the practice.

☐ **Self-Pay Agreement** (Check if you do NOT have insurance): I certify that I have NO insurance and will be solely responsible for the payment in full.

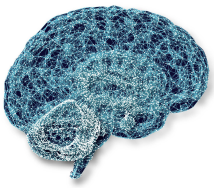
☐ I certify that the insurance reported to Texas Neurology and Movement Disorders, PA is a complete listing. I understand that the office will not extend credit on, or submit a claim for any insurance not reported at the time of service. I will be responsible for any unpaid charges.

☐ I certify that charges will be protected by an LOP provided by my attorney. I also understand that, if for any reason, I no longer have attorney representation, that I become fully responsible for all charges incurred.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative



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TEXAS NEUROLOGY & MOVEMENT DISORDERS

Patient Communication & PHI (Protected Health Information)

Authorization to leave text/voicemail/e-mail with PHI:

With my consent (please initial only one of the following paragraphs):

_____ (Initials) Texas Neurology and Movement Disorders may call/text my home and/or cell phone to leave a message on my answering machine/voice mail/cell phone(via text). Texas Neurology and Movement Disorders may also send mail or email to me in reference to any items that assist the practice, Texas Neurology and Movement Disorders, in carrying out treatment, payment or operations such as appointment reminders, billing information, insurance items and any call pertaining to my clinical care including examination and test (laboratory, etc.) results.

_____ (Initials) I direct that Texas Neurology and Movement Disorders not leave any voice mail messages or text messages on my answering machine or speak to anyone in my household other than myself.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative

Who may we speak to regarding your treatment?

I give permission to Texas Neurology and Movement Disorders, PA to release my private health information, including appointment day/time, to the following person(s); spouse, family member, etc: ☐ **Only disclose to me**

Print Name: _____ **Phone:** _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Sibling ☐ Child

Print Name: _____ **Phone:** _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Sibling ☐ Child

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TEXAS NEUROLOGY & MOVEMENT DISORDERS

General

_____ (initials) **Irrevocable Assignment of Rights:** You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

_____ (initials) **Demand for Payment:** To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

_____ (initials) **Statue of Limitations:** I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

_____ (initials) **Limited Power of Attorney**: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

_____ (initials) **Termination of Care Waiver:** I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

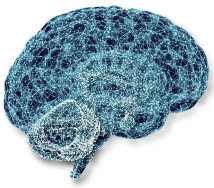
I have read and understand the above information and hereby authorize Texas Neurology and Movement Disorders to prescribe and provide treatment.

A photocopy of this instrument will serve as the original.

Print Name: _____ **Date:** _____ **Time:** _____

Signature: _____

Relationship to patient: ☐ Self ☐ Legally Authorized Representative



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TEXAS NEUROLOGY & MOVEMENT DISORDERS

Comprehensive History & Physical

What is the reason for your visit?

Medical History

Have you ever had or been told you have any of the following? (Mark all that apply) ☐ None

☐ Hyperthyroid Disease
☐ Hypothyroid Disease
☐ Hyper tension
☐ Angina/Coronary Artery Disease/Heart Attack
☐ Congestive Heart Failure
☐ Atrial Fibrillation
☐ Stroke
☐ Migraines
☐ Memory Loss
☐ Renal Disease
☐ Anemia
☐ Depression
☐ Arthritis
☐ Osteoporosis

☐ Asthma/COPD
☐ Multiple Sclerosis
☐ Diabetes
☐ GERD
☐ High Cholesterol
☐ Hepatitis
☐ Prostate Disease
☐ Anxiety Disorder
☐ Seizures
☐ Sleep Apnea
☐ Rheumatoid Arthritis
☐ Cancer _____
☐ Other _____

Have you been treated by a Psychiatrist or Counselor? ☐ Yes ☐ No

Surgeries

☐ Neck or Lumbar Surgery ☐ Vascular Surgery ☐ Sinus, facial, or dental surgery
☐ Other _____

Family History

	Father	Mother	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Tremors	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐
Brain Tumor	☐	☐	☐	☐	☐	☐	☐
Peripheral Nerve Disorder	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorder	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

Social History

Are you currently employed or retired? ☐ Employed ☐ Retired Employer: _____

Do you drink alcohol? ☐ Seldom ☐ Occasionally ☐ Never

Do you smoke? ☐ Nonsmoker ☐ Current everyday smoker ☐ Current somedays smoker ☐ Former Smoker

Other drug use: _____

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TEXAS NEUROLOGY & MOVEMENT DISORDERS

Current Medication List

Medication Name	Dose	Frequency	Prescribing Physician	Start Date

Allergies

Medication	Severity	Reaction
	☐Mild ☐Moderate ☐Severe	
	☐Mild ☐Moderate ☐Severe	
	☐Mild ☐Moderate ☐Severe	

Additional Comments:

Are there any new medical problems you would like to address today? ☐ Yes ☐ No If yes, please explain.

Have you undergone any testing since your last visit? ☐ Yes ☐ No If yes, please explain.

Review of Symptoms

Constitutional	☐ Fever ☐ Chills ☐ Night Sweats ☐ Unintentional Weight Gain ☐ Unintentional Weight Loss ☐ Fatigue
Eyes	☐ Dryness ☐ Visual Disturbances
Ears, Nose, Throat, Mouth	☐ Hearing Loss ☐ Heavy snoring ☐ Chronic sinus congestion ☐ Change in voice ☐ Ringing in ears
Respiratory	☐ Cough ☐ Phlegm/sputum production ☐ Shortness of breath
Cardiovascular	☐ Chest discomfort ☐ Palpitations ☐ Leg swelling ☐ Calf or buttock pain w/walking ☐ Fainting
Gastrointestinal	☐ Change in appetite ☐ Difficulty swallowing ☐ Heartburn/indigestion ☐ Nausea/vomiting ☐ Constipation
Genitourinary	☐ Urination at night ☐ Sexual problems ☐ Incomplete emptying ☐ Frequent urination
Musculoskeletal	☐ Persistent/Severe neck pain ☐ Persistent/Severe back pain ☐ Persistent/Severe joint pain ☐ Muscle pain or cramping
Skin/Breast	☐ Rash ☐ New or changing moles
Neurological	☐ Tremor ☐ Dizziness ☐ Memory loss ☐ Muscle weakness ☐ Involuntary movement
Psychosocial	☐ Anxiety/nervousness ☐ Insomnia ☐ Feeling sad/depressed ☐ Panic
Endocrine	☐ Cold/Heat intolerance ☐ Hot Flashes ☐ Excessive thirst
Blood/Lymphatics	☐ Excessive bruising ☐ Easy bleeding
Allergy/Immune	☐ Severe allergic reactions