Date: ____________

Greater Austin Neurology Clinic

13915 N Mopac Expwy, Suite 302, Austin, TX 78728 Phone: 512-228-3800 Fax: 512-228-3801

Patient Registration Form

Patient Information:

Name: ____________________

Address: ____________________ Home Phone: ____________

City: ____________ State: ________ Zip Code: ____________

SSN ____________ DOB ________ Age: ____________

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer: ____________________ Business Phone: ____________

Address: ____________________ Occupation: ____________

Who should we thank for referring you? ____________________

Emergency contact: ____________ Relationship ________ Phone: ____________

Reason for visit today: ____________________

Is this due to an accident? (Circle) Work / Auto/ Other Explain ____________

Primary Insurance:

Insurance Name: ____________ Policy # ________ Group # ____________

Claim Address: ____________________ Phone # ____________

Policy Holder Name: ____________________

DOB ____________ SSN ____________ Relationship ____________

Need A Referral? (Circle) Yes / No

Secondary Insurance (If Applicable):

Insurance Name: ____________ Policy # ________ Group # ____________

Claim Address: ____________________ Phone # ____________

Policy Holder Name: ____________________

DOB ____________ SSN ____________ Relationship ____________

Need A Referral? (Circle) Yes / No

Workers Comp Insurance / Auto Insurance (If Applicable) :

Insurance Name: ____________ Policy # ________ Group # ____________

Claim Address: ____________________ Phone # ____________

Name of Caseworker / Adjuster: ____________ Phone # (If different) ____________

Insurance Name: ____________ Policy # ________ Group # ____________

Claim Address: Phone #

Date of accident: ____________________

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Patient History Questionnaire

Patient Name: ______________________________ Date of Visit: ______________________

Date of Birth: ______________________________ Social Sec. No: ______________________

Dear Patient:
Welcome to Greater Austin Neurology Clinic. Please complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your habits. If possible, please fill this form out prior to your visit, and bring it with you on the date of your appointment so that there will be no delay when you arrive.
This questionnaire is confidential and will be kept as part of your medical record.

NAME, ADDRESS, PHONE NUMBER, AND SPECIALTY OF **THE DOCTOR WHO REFERRED YOU HERE** (If applicable):

Full Name: Dr. ____

Address: ____

Phone: (   ) ___________________________ Fax: (   )___________________________

Specialty: ____

If you were not referred by a doctor, then who were you referred by? ______________________

PLEASE LIST ALL THE PHYSICIANS, IN ADDITION TO THE REFERRING PHYSICIAN, WHO SHOULD RECEIVE A COPY OF YOUR EVALUATION.

1) Name: ____

Address: ____

Phone: (   ) ___________________________ Fax: (   ) ___________________________

2) Name: ____

Address: ____

Phone: (   ) ___________________________ Fax: (   ) ___________________________

3) Name: ____

Address: ____

Phone: (   ) ___________________________ Fax: (   ) ___________________________

History of Present Illness:

Briefly describe your symptoms or problems.____

How severe are the symptoms?____

When did the symptoms originally start? ____

How often do the symptoms occur? ____

How long do the symptoms last? ____

What makes the symptoms worse?____

What measures or drugs relieve the symptoms? ____

What treatment, if any, have you received for this problem? ______________________________

Past Medical History:

Please list all other current medical problems as well as major illnesses you have had in the past with approximate dates.

1. ______________________ 5.______________________
2. ______________________ 6.______________________
3. ______________________ 7.______________________
4. ______________________ 8.______________________

Please list **All Operations** you have had in the past with approximate dates.

1. ______________________ 4.______________________
2. ______________________ 5.______________________
3. ______________________ 6.______________________

Please list **All Current Medications**, doses and frequency of use.

1. ______________________ 6.______________________
2. ______________________ 7.______________________
3. ______________________ 8.______________________
4. ______________________ 9.______________________
5. ______________________ 10.______________________

Please list all medications used in the past and reason for discontinuation.

1. ______________________ 4.______________________
2. ______________________ 5.______________________
3. ______________________ 6.______________________

Allergies: Please name any medicines you are allergic or sensitive to and describe the reaction.

____

____

Social and Personal History:

Do you smoke? Yes/ No If you smoked and quit, date you quit?_______________________________
If you smoke, how many packs per day? ________ For how long have you been smoking?________
Do you drink? Yes/ No If you drank and quit, when did you quit? _____________________________
If you drink, how many drinks per week (approximately)? _____________________________________
Have you ever had problem with alcohol or drugs? ____

Are you: (Circle One) Single/ Married/ Divorced/ Separated
Spouse's occupation (If applicable) ____
Current living arrangement: (Circle One): Live; alone -- with spouse -- with roommate --with parents/siblings
Please circle your highest level of education:
1) Grade School 2) High School 3) College/Vocational 4) Graduate
Where do you work and in what status? (If retired, list most recent place of employment and date of retirement)____
Hobbies: ____

Current weight ________________________ Current height __________________________________
(Circle One) Are you Left handed or Right handed?

For Women Only

Last menstrual period ____
Have you ever been pregnant? Yes/ No If so, how many times________________________________
How many deliveries have you had? ____
Have you ever had a miscarriage? Yes/ No Have you ever had an abortion? Yes / No
Are you post-menopausal? Yes/ No. If yes approximate date of menopause____________________

Family History:

Please list all **medical problems** and current age of the following family members. If any are deceased, please list cause and approximate age of death. Please do not write names of your family members.

Grandparents: Maternal GM:____________________ Maternal GF:____________________
Paternal GM:_____________________ Paternal GF:_____________________
Father: ____
Mother:____
Brothers: (List age & medical history) ____
____
Sisters: (List age & medical history) ____
____
Children: (List age, sex, & medical history) ____
____
____
Grandchildren: (List age, sex, & medical history) ____

Review of Systems: Please review the following symptoms and check "Yes" or "No" based on your current or recent symptoms.

Constitutional	Yes	No
Fever	□	□
Chills	□	□
Fatigue	□	□
Loss of appetite	□	□
Night sweats	□	□
Excessive weight gain	□	□
Excessive weight loss	□	□
Malaise	□	□
Excessive sleepiness	□	□
Unable to sleep	□	□

Neurological	Yes	No
Headache	□	□
Tremors	□	□
Numbness in the feet/legs	□	□
Numbness in the arms/hands	□	□
Weakness in the legs	□	□
Weakness in the arms	□	□
Trouble walking	□	□
Poor balance	□	□
Falls	□	□
Loss of consciousness	□	□
Seizures	□	□
Loss of memory	□	□
Memory impairment	□	□
Confusion	□	□
Difficulty in speech	□	□
Trouble chewing	□	□
Trouble swallowing	□	□
Vertigo	□	□
Concussion	□	□

Psychiatric	Yes	No
Anxiety	□	□
Depression	□	□
Insomnia	□	□
Hallucinations	□	□
Delusions	□	□
Unusual stress	□	□
Hyperactivity	□	□
Difficulty concentrating	□	□
Nervousness	□	□
Mania	□	□

Cardiovascular	Yes	No
Chest pain	□	□
Palpitations	□	□
Shortness of breath on exertion	□	□
Shortness of breath at rest	□	□
Shortness of breath on lying flat	□	□
Leg swelling	□	□
Syncope/fainting spells	□	□
Heart murmurs	□	□
Heart failure	□	□
High blood pressure	□	□
Low blood pressure	□	□

Eyes	Yes	No
Blurring of vision	□	□
Double vision	□	□
Loss of vision	□	□
Discharge from the eyes	□	□
Decreased vision in the eyes	□	□
Glaucoma	□	□

Respiratory	Yes	No
Cough	□	□
Wheezing	□	□
Expectoration	□	□
Chest pain on deep breathing	□	□
Blood in sputum	□	□
Shortness of breath	□	□

Musculoskeletal	Yes	No
Back pain	□	□
Neck pain	□	□
Muscle weakness	□	□
Muscle pain (myalgia)	□	□
Fatigue	□	□
Muscle wasting	□	□
Muscular cramps	□	□
Joint pains	□	□
Joint swelling	□	□
Joint stiffness	□	□
Morning stiffness of joints	□	□

Endocrine	Yes	No
Diabetes	□	□
Thyroid disease	□	□
Excessive thirst (polydipsia)	□	□
Swelling in the neck (goiter)	□	□
Lethargy	□	□
Heat intolerance	□	□
Cold intolerance	□	□
Sexual dysfunction	□	□

Ear/Nose/Throat	Yes	No
Ringing in the ears (tinnitus)	□	□
Dizziness	□	□
Vertigo	□	□
Sore throat	□	□
Loss of smell (anosmia)	□	□
Loss of taste (aguesia)	□	□
Post Runny nose	□	□
Earache	□	□
Ear discharge	□	□
Hoarseness of voice	□	□
Dry cough	□	□
Decreased hearing/deafness	□	□
Sores in mouth	□	□
Bleeding gums (gingiva)	□	□

Hematological	Yes	No
Lumps under the skin	□	□
Lumps in the axillae	□	□
Lumps in the groin	□	□
Unusual bleeding	□	□
Unusual bruising	□	□
Sickle cell disease	□	□

Gastrointestinal	Yes	No
Loss of bowel control	□	□
Nausea	□	□
Vomiting	□	□
Abdominal pain	□	□
Rectal bleeding	□	□
Abdominal distension	□	□
Jaundice	□	□
Diarrhea	□	□
Constipation	□	□
Halitosis (bad breath)	□	□
Excessive bloating	□	□
Gastric ulcer	□	□
Gastric bleeding	□	□
Hepatitis	□	□
Pancreatitis	□	□

Genitourinary	Yes	No
Loss of urine control	□	□
Urinary urgency	□	□
Frequency of urination	□	□
Painful urination	□	□
Blood in urine	□	□
Dark-colored urine	□	□
Kidney stones	□	□
Decreased urinary stream	□	□
Impotence	□	□
Sexually-transmitted disease	□	□

Skin	Yes	No
Rash	□	□
Itching (pruritus)	□	□
Photosensitivity	□	□
Masses under the skin	□	□
Tumors	□	□
Moles	□	□
Abnormal loss of hair	□	□
Pitting on the nails	□	□

Allergy	Yes	No
Seasonal nasal allergy	□	□
Frequent infections	□	□

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FINANCIAL POLICY

Greater Austin Neurology Clinic is committed to providing high quality services to its patients. Please understand that payment for the services rendered is your responsibility and the payment is due at the time of service.

- **INSURED:** If you have insurance that is contracted with the Greater Austin Neurology Clinic, the claims for all applicable visits and procedures will be filed with your insurance. You are responsible for payment of all the co-insurance, deductibles, and non-covered services at the time of service. If your insurance carrier does not remit payment within 45 days, the balance will be due in full from you. Please understand that your insurance is a contract between you and your insurance company and ultimately it is your responsibility to pay for the services.
- **REFERRALS AND PRE-AUTHORIZATION:** If your insurance plan requires a referral or pre-authorization for services provided at this clinic, it is your responsibility to bring the required information with you. Our staff can assist you in obtaining the referral. Please make sure that your referral is valid for the date of visit.
- **NOT INSURED:** If you do not have insurance, you are required to pay in full for the eservices rendered on the day of visit.
- **INSURANCE/WORK RELATED FORMS:** There is a $25-$50 fee for filling out insurance and work related forms depending upon the complexity of the forms.
- **PAYMENTS:** We accept cash, checks, and credit cards including Visa, Master, and Discover.
- **RETURNED CHECKS:** A fee of $50 is charged for checks that are dishonored or returned for any reason.
- **PAST DUE ACCOUNTS:** The accounts that are past due more than 90 days from the date of service are turned over to a collection agency. Once the account has been transferred for collections, all correspondence should be addressed to the collection agency regarding the balance.

By signing below you acknowledge that you understand and agree with the above policies. You also acknowledge that if you fail to make any of the payments for which you are responsible in a timely manner, you will be responsible for all costs of collecting funds owed, including court costs, attorney fees, and collection agency fees if applicable.

I fully understand the above information and I understand my responsibility to pay for the services provided and billed.

____________________________________ __________________________

Signature: Patient / Guardian / Responsible Party Date

____________________________________ __________________________

Greater Austin Neurology Clinic representative / Witness Date

Greater Austin Neurology Clinic

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Consent For Care And Treatment

Patient Name (Please Print) ____

I, the undersigned, do hereby agree and give my consent to Greater Austin Neurology Clinic to provide medical care and treatment to ___________________________________, considered appropriate and necessary in diagnosing and/or treating his/her medical condition.

_______________________________ _______________________________

Patient / Guardian Signature Date

Benefit Assignment And Release Of Information

I hereby assign all medical and/or surgical benefits to which I am entitled, including private insurance, Medicare, Medicaid, and third party payers to Greater Austin Neurology Clinic. I hereby authorize Greater Austin Neurology Clinic to release all information necessary, including Medical Records, to secure payment. A photocopy of this assignment is to be considered as valid as the original.

_______________________________ _______________________________

Patient / Guardian Signature Date

Authorization for Release of Medical Information

I, ____ authorize
(Patient's Name – PLEASE PRINT CLEARLY)

____ Whose address is
(Releasing Physician/Facility)

____
(Street, City, State, Zip Code)

to release information from the medical record of:

______________________	____________	______________
Patient Name	Birth Date	Social Security No.

____
(Current Address, City, State, Zip) (Current Phone)

To

Greater Austin Neurology Clinic
13915 N Mopac Expwy, Suite 302, Austin, TX 78728
Tel: 512-228-3800 Fax: 512-228-3801

Dates Requested: **From** ______________________ To: **Present**

Information to be released: (Reports may include information on drug/alcohol abuse, psychological/psychiatric diagnoses, and communicable diseases including HIV.)

- ☑ History & Physical
- ☑ Consultations
- ☑ Progress Notes
- ☑ Radiology/MRI/CT
- ☑ Laboratory studies
- ☑ HIV/AIDS, if applicable

Other ____

Purpose for release of information:

- ☑ Continuing Medical Care
- ☑ Insurance
- ☐ Social Security/ Disability
- ☐ Legal Purposes
- ☐ Personal Use
- ☐ Other __________

I understand that I may revoke this consent anytime except to the extent that action has already been taken before receipt of such revocation. This authorization expires automatically one hundred eighty (180) days from the date of signatures or earlier if otherwise specified. I understand that I may be charged for copies of my medical records. I understand that these records are protected under federal and state laws and cannot be disclosed without my consent except when required by law. I understand that the organization releasing my records will not be responsible for dissemination or disclosure of my confidential medical information when this clinic provides such information, at my request, to my health insurer, employer, attorney or other designee.

Patient's Name: ___________________________ ✕ ______________________________
(Please print) (Signature of Patient or Guardian)

This authorization to obtain medical records expires in four years or on _________________

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Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

____ Accepted ______ Denied

Signature **X** ____________________________________

Date: ________________________

Signature of Representative Witness ___________________________________

Notice Effective Date ___________________________________