



5807.0001@direct.khb.nextgenshare.com  
KaneHallBarry.com

GENERAL NEUROLOGY | NEUROLOGICAL TESTING | MOVEMENT DISORDERS  
NEUROMUSCULAR DISORDERS | NEUROPSYCHOLOGY | INFUSION

1305 Airport Freeway Suite 205 Bedford, TX 76021 (817) 267-6290  
4525 Heritage Trace Parkway Suite 117 Keller, TX 76244 Fax (817) 267-0950

### PATIENT INFORMATION

LAST NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_

MARITAL STATUS  S  M  D  W

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PRIMARY PHONE # (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

HOME  WORK  MOBILE

Pharmacy Name \_\_\_\_\_

SECONDARY PHONE # (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Pharmacy ADDRESS \_\_\_\_\_

HOME  WORK  MOBILE

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

PREFERRED LANGUAGE \_\_\_\_\_

EMERGENCY PHONE # \_\_\_\_\_

RACE \_\_\_\_\_

RELATIONSHIP OF CONTACT \_\_\_\_\_

ETHNICITY:

HISPANIC/LATINO  NON-HISPANIC/LATINO

REFERRAL SOURCE:

PREFER NOT TO SAY

PHYSICIAN \_\_\_\_\_

FRIEND/FAMILY  INSURANCE WEBSITE  OUR WEBSITE

PRIMARY CARE PHYSICIAN \_\_\_\_\_

WEB SEARCH  PHONE BOOK  OTHER \_\_\_\_\_

PRIMARY INSURANCE:

SECONDARY INSURANCE:

INSURANCE COMPANY \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_

PLEASE SHOW YOUR PRIMARY INSURANCE CARD AT CHECK-IN SO THAT WE MAY MAKE A COPY OF IT.

PLEASE SHOW YOUR SECONDARY INSURANCE CARD AT CHECK-IN SO THAT WE MAY MAKE A COPY OF IT.

- ❖ I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO OTHER PHYSICIANS PARTICIPATING IN MY CARE.
- ❖ I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO THE INSURANCE COMPANY LISTED ABOVE FOR THE PURPOSE OF PROCESSING MY INSURANCE CLAIMS.
- ❖ I AUTHORIZE THAT ANY BENEFITS DUE BE MADE PAYABLE TO KANE HALL BARRY NEUROLOGY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**VII. ACKNOWLEDGEMENT AND OPTIONAL AUTHORIZATIONS AND RESTRICTIONS.**

**AUTHORIZATIONS:**

If you wish to request an authorization to release your records per Section III, Paragraph A of the *Notice of Privacy Practices*, please complete this section. This section is not required. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon signing of this authorization section.

You have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. Authorization can be revoked at any time except to the extent that action has already been taken based on this authorization.

**I hereby authorize the following individuals to view, discuss, or receive my information:**

(Please include the individual's name, relationship, and phone number)

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The above authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom this authorization is made OR the following specified date:

Authorization expires on: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

**RESTRICTIONS:**

If you wish to request a restriction on the release of your records per Section IV, Paragraph D of the *Notice of Privacy Practices*, please complete this section. This section is not required.

**I hereby request the following restrictions on the use and/or disclosure of my information:**

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**SIGNATURES [REQUIRED]:**

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient Name (Please print): \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

Patient or Legal Representative (Sign here): \_\_\_\_\_ Date: \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_



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## -FINANCIAL AND OFFICE POLICIES-

Thank you for choosing Kane Hall Barry Neurology. We are committed to building a successful relationship with you and your family. Your clear understanding of our financial and office policies is an important part of that relationship. Below are the key points. For the full version of this policy you may request a copy from our staff, or visit our website at <http://kanehallbarry.com/resources/financial-policy/>.

- *WE ARE COMMITTED TO UNDERSTANDING YOUR BENEFITS AND PROVIDING YOU WITH A COST ESTIMATE FOR YOUR CARE BEFORE YOUR APPOINTMENT*
- *BEFORE YOUR APPOINTMENT, PLEASE INFORM US OF ANY CHANGES TO YOUR INFORMATION SUCH AS NAME, ADDRESS, PHONE NUMBERS AND/OR INSURANCE INFORMATION*
- *WE WILL COLLECT FOR TODAY'S CARE AND ANY OUTSTANDING BALANCE WHEN YOU CHECK IN*
- *FINANCING IS AVAILABLE THROUGH CARE CREDIT*
- *WE DO NOT ACCEPT LETTERS OF PROTECTION (LOP), NEW WORKERS' COMPENSATION CASES, MEDICAID INSURANCE, AND WE DO NOT FILE AUTO INSURANCE CLAIMS (ALSO KNOWN AS 3<sup>RD</sup> PARTY INSURANCE)*
- *IF YOU MISS AN APPOINTMENT WITHOUT NOTIFYING US, YOU MAY BE CHARGED \$25*
- *PLEASE LET US KNOW IF YOU ARE RUNNING LATE TO YOUR APPOINTMENT*

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU WERE GIVEN THE OPTION TO REVIEW THE FULL FINANCIAL AND OFFICE POLICIES DOCUMENT BEFORE SIGNING, AND YOU AGREE TO THE POLICIES DETAILED IN THE FULL POLICY.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Today's Date

## -FINANCIAL AND OFFICE POLICY DETAILS-

**PAYING FOR YOUR VISIT:** We are committed to understanding your benefits and providing you with a cost estimate for your care before your appointment. Estimates are just that – estimates. Things can, and do, sometimes turn out differently, and we appreciate timely payment of any outstanding balances.

With that in mind, please inform us of any changes to your information such as name, address, phone numbers and/or insurance information before your appointment.

We will contact you before your appointment if you will owe anything other than your typical, specialty office co-pay, including any balances from previous appointments. If you have any questions, please call us before your appointment so there are no surprises when you check in.

When you check in, we will collect your co-pay, deductible, co-insurance, and/or any balances left on the account from previous visits. We accept payment by cash, personal check, Visa, MasterCard, American Express, Discover Card and CareCredit. When you provide a check as payment, you authorize us to use information from your check to make a one-time electric funds transfer from your account or to process the payment as a check transaction.

If you cannot afford to pay for your visit, we suggest you contact CareCredit before your visit for financing options. They can approve your application before your appointment, typically within minutes of submitting your information, allowing you to pay for your visit over time. To learn more, visit [www.carecredit.com](http://www.carecredit.com) or call 1-800-677-0718. Please note, all financing is done through CareCredit, not through Kane Hall Barry Neurology.

**PRE AUTHORIZATIONS/REFERRALS** - If your insurance plan requires a primary care physician referral or treatment pre-authorization, we will request these. However, if we have not received the referral or authorization before your appointment, we may suggest you reschedule in order to fully utilize your insurance benefits. If you choose to be seen without the required authorizations, you will need to sign an ABN (Advanced Beneficiary Notice) acknowledging you understand the costs may not be covered by your insurance and will be your responsibility should insurance refuse to pay.

**AUTO INSURANCE CLAIMS/LETTERS OF PROTECTION/3<sup>RD</sup> PARTY INSURANCE CLAIMS** – We do not file 3rd party insurance claims such as those from a car accident, or in any instance where another person or entity is offering to pay on your behalf (exception for Workers' Compensation). In addition, we will not accept Letters of Protection in lieu of payment. However, you may pay for your care and file for reimbursement independently. We will be happy to provide you with all of the necessary documentation to file your claim.

**WORKERS' COMPENSATION** - If your visit is due to a work related incident, it should be filed through your company's workers' compensation insurance. While we want to ensure you have the best care available, we are currently not accepting new workers' compensation cases. If your care is filed under personal insurance, there is a high possibility your insurance company will not pay for your care and may require you to repay any expenses paid on your behalf. In addition, you may forfeit your rights to care through your employer's workers' compensation insurance.

**MEDICAID** - Unfortunately, we are not currently accepting any new patients that have Medicaid as a form of insurance whether primary or secondary.

**MISSED APPOINTMENTS:** We understand that sometimes you may need to cancel an appointment due to unforeseen circumstances. We appreciate cancellations made at least one business day before the appointment. If you miss an appointment with no notification, we may charge \$25.

**LATE ARRIVAL:** If you are running late, please let us know so that we can work with you to determine the best way to provide your care.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Who is your general physician(PCP)? \_\_\_\_\_

Please list the symptoms you are having and wish to bring to our attention:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are your symptoms due to an injury? Yes No

If yes, please specify date and type of injury: \_\_\_\_\_

Have you seen a neurologist before? Yes No

If yes, please specify date and who you saw: \_\_\_\_\_

**MEDICATIONS (PLEASE ATTACH LIST IF NECESSARY)**

MEDICATION	DOSE (MG)	HOW OFTEN

**SOCIAL HISTORY**

Occupation: \_\_\_\_\_ Homemaker Retired

Marital Status: Single Married Divorced Widow Widower

Education: Grade School High School College Post-Graduate

Do you smoke? Yes No If so, how many cigarettes/packs per day? \_\_\_\_\_

Did you smoke in the past? Yes No If so, for how long? \_\_\_\_\_

Do you drink Alcohol? Yes No If yes: Beer Wine Liquor How much? \_\_\_\_\_

Have you used recreational drugs? Yes No If yes: Marijuana Cocaine Heroin Methamphetamines MDMA/"X"

**FAMILY HISTORY**

<input type="checkbox"/> Alcoholism	Who? _____	<input type="checkbox"/> Migraine	Who? _____
<input type="checkbox"/> Alzheimer's Disease	Who? _____	<input type="checkbox"/> Multiple Sclerosis	Who? _____
<input type="checkbox"/> Cancer	Who? _____	<input type="checkbox"/> Muscle Disease	Who? _____
<input type="checkbox"/> Depression	Who? _____	<input type="checkbox"/> Neuropathy	Who? _____
<input type="checkbox"/> Diabetes	Who? _____	<input type="checkbox"/> Parkinson's Disease	Who? _____
<input type="checkbox"/> Epilepsy	Who? _____	<input type="checkbox"/> Schizophrenia	Who? _____
<input type="checkbox"/> Heart Disease	Who? _____	<input type="checkbox"/> Stroke	Who? _____
<input type="checkbox"/> High Blood Pressure	Who? _____	<input type="checkbox"/> Tremor	Who? _____
<input type="checkbox"/> Lung Disease	Who? _____	<input type="checkbox"/> _____	Who? _____

**PATIENT SERIOUS ILLNESSES**

<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Muscle Disease	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> _____
<input type="checkbox"/> Depression	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Migraine	<input type="checkbox"/> Passing Out/Syncope	<input type="checkbox"/> _____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**DRUG ALLERGIES**

- |  |                                     |                                  |                                |
|--|-------------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> No known drug allergies | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Vicodin | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Codeine                 | <input type="checkbox"/> Sulfa      | <input type="checkbox"/> _____   | <input type="checkbox"/> _____ |

**OPERATIONS**

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Appendectomy        | <input type="checkbox"/> Carpal Tunnel           | <input type="checkbox"/> Hip              | <input type="checkbox"/> PEG Tube          |
| <input type="checkbox"/> Back                | <input type="checkbox"/> Cervical Spine          | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Pituitary         |
| <input type="checkbox"/> Brain Tumor         | <input type="checkbox"/> Gall Bladder            | <input type="checkbox"/> Hysterectomy     | <input type="checkbox"/> Shoulder          |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Heart Bypass            | <input type="checkbox"/> Lumbar Spine     | <input type="checkbox"/> Subdural Hematoma |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Orthopedic       | <input type="checkbox"/> Pacemaker         |

**SYMPTOM REVIEW**

- |   |  |   |   |  |
|---|--|---|---|--|
| <b>CONSTITUTIONAL</b>                   | <b>RESPIRATORY</b>                           | <b>GENITOURINARY</b>                          | <b>NEUROLOGICAL</b>                         | <b>MUSCULOSKELETAL</b>                         |
| <input type="checkbox"/> Chills         | <input type="checkbox"/> Chronic Cough       | <input type="checkbox"/> Dysuria              | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Back Pain             |
| <input type="checkbox"/> Fatigue        | <input type="checkbox"/> Cough               | <input type="checkbox"/> Hematuria            | <input type="checkbox"/> Extremity Numbness | <input type="checkbox"/> Joint Pain            |
| <input type="checkbox"/> Fever          | <input type="checkbox"/> Known TB Exposure   | <input type="checkbox"/> Polyuria             | <input type="checkbox"/> Extremity Weakness | <input type="checkbox"/> Joint Swelling        |
| <input type="checkbox"/> Malaise        | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Urinary Frequency    | <input type="checkbox"/> Gait Disturbance   | <input type="checkbox"/> Muscle Weakness       |
| <input type="checkbox"/> Night Sweats   | <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Headache           | <input type="checkbox"/> Neck Pain             |
| <input type="checkbox"/> Weight Gain    | <input type="checkbox"/> Other _____         | <input type="checkbox"/> Urinary Retention    | <input type="checkbox"/> Memory Loss        | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Weight Loss    | <b>CARDIOVASCULAR</b>                        | <input type="checkbox"/> Dribbling (Male)     | <input type="checkbox"/> Seizures           | <b>HEMATOLOGIC/LYMPHATIC</b>                   |
| <input type="checkbox"/> Other _____    | <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Slow Stream (Male)   | <input type="checkbox"/> Tremors            | <input type="checkbox"/> Easy Bleeding         |
| <b>HEENT</b>                            | <input type="checkbox"/> Cludication         | <input type="checkbox"/> Other _____          | <input type="checkbox"/> Other _____        | <input type="checkbox"/> Easy Bruising         |
| <input type="checkbox"/> Ear Drainage   | <input type="checkbox"/> Edema               | <b>REPRODUCTIVE</b>                           | <b>PSYCHIATRIC</b>                          | <input type="checkbox"/> Lymphadenopathy       |
| <input type="checkbox"/> Ear Pain       | <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Anxiety            | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Eye Discharge  | <input type="checkbox"/> Other _____         | <input type="checkbox"/> Penile Discharge     | <input type="checkbox"/> Depression         | <b>IMMUNOLOGIC</b>                             |
| <input type="checkbox"/> Eye Pain       | <b>GASTROINTESTINAL</b>                      | <input type="checkbox"/> Sexual Dysfunction   | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Environmental Allergy |
| <input type="checkbox"/> Hearing Loss   | <input type="checkbox"/> Abdominal Pain      | <input type="checkbox"/> Other _____          | <input type="checkbox"/> Other _____        | <input type="checkbox"/> Food Allergy          |
| <input type="checkbox"/> Nasal Drainage | <input type="checkbox"/> Blood in Stool      | <b>METABOLIC/ENDOCRINE</b>                    | <b>INTEGUMENTARY</b>                        | <input type="checkbox"/> Seasonal Allergy      |
| <input type="checkbox"/> Sinus Pressure | <input type="checkbox"/> Change in Stool     | <input type="checkbox"/> Brittle Hair         | <input type="checkbox"/> Contact Allergy    | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Sore Throat    | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Brittle Nails        | <input type="checkbox"/> Hives              |  |
| <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Cold Intolerance     | <input type="checkbox"/> Itching            |  |
| <input type="checkbox"/> Other _____    | <input type="checkbox"/> Heartburn           | <input type="checkbox"/> Hair Changes         | <input type="checkbox"/> Mole Changes       |  |
|   | <input type="checkbox"/> Loss of Appetite    | <input type="checkbox"/> Heat Intolerance     | <input type="checkbox"/> Rash               |  |
|   | <input type="checkbox"/> Nausea              | <input type="checkbox"/> Hirsutism            | <input type="checkbox"/> Skin Lesion        |  |
|   | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Polydipsia           | <input type="checkbox"/> Other _____        |  |
|   | <input type="checkbox"/> Other _____         | <input type="checkbox"/> Polyphagia           |   |  |
|   |  | <input type="checkbox"/> Other _____          |   |  |

Please sign and date below. This questionnaire will become part of your medical record.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_