Kane Hall Barry NEUROLOGY

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

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PATIENT INFORMATION

*LAST NAME*_____

*FIRST NAME*_____ *M.I.*_____

*ADDRESS*_____

*CITY*_____ *STATE*_____ *ZIP*_____

EMAIL ADDRESS: _____

*EMPLOYER*_____

*EMPLOYER ADDRESS*_____

*CITY*_____ *STATE*_____ *ZIP*_____

PREFERRED LANGUAGE _____

RACE _____

ETHNICITY:

❑ *HISPANIC/LATINO* ❑ *NON-HISPANIC/LATINO*

❑ *PREFER NOT TO SAY*

PRIMARY CARE PHYSICIAN _____

*DATE OF BIRTH*_____

*SOCIAL SECURITY #*_____-_____-_____

MARITAL STATUS ❑ *S* ❑ *M* ❑ *D* ❑ *W*

PRIMARY PHONE # (_____) -_____ - _____

❑ *HOME* ❑ *WORK* ❑ *MOBILE*

SECONDARY PHONE # (_____) -_____ - _____

❑ *HOME* ❑ *WORK* ❑ *MOBILE*

*EMERGENCY CONTACT*_____

*EMERGENCY PHONE #*_____

*RELATIONSHIP OF CONTACT*_____

REFERRAL SOURCE:

❑ *PHYSICIAN*_____

❑ *FRIEND/FAMILY* ❑ *INSURANCE WEBSITE* ❑ *OUR WEBSITE*

❑ *WEB SEARCH* ❑ *PHONE BOOK* ❑ *OTHER* _____

PRIMARY INSURANCE:

*INSURANCE COMPANY*_____

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

SECONDARY INSURANCE:

*INSURANCE COMPANY*_____

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. <u>ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS</u>. 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: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

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 <u>not required</u>. 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)

_____

_____

_____

This 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:

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 <u>not required</u>.

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

_____

_____

-FINANCIAL POLICY-

PAYMENT IS DUE AT THE TIME OF SERVICE unless payment arrangements have been approved in advance.

***WE ACCEPT PAYMENT BY*:** Cash, Personal Check, Visa, MasterCard, American Express, or Discover Card

CHECK PAYMENTS: When you provide a check as payment, you authorize us to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction.

***NO-SHOW POLICY*:** Patients that miss their appointments without calling and canceling or rescheduling at least twenty-four hours in advance of the appointment will be assessed a *$25 no-show fee*. Patients that show up for their appointment more than 15 minutes late may need to reschedule their appointment to a later time/date as the original appointment time may no longer be available.

-INSURED PATIENTS-

Our practice is not on every insurance plan and all of our physicians *do not* participate on the same plans. *You are encouraged to verify that the physician you are seeing is on your plan.* If your plan requires a *Primary Care Physician Referral*, we will attempt to obtain a referral from your Primary Care Physician on your behalf. However, if a referral is not on file at the time of your appointment, your care may be delayed. If the treatment or testing recommended to you requires insurance *Pre-Authorization*, we will attempt to obtain the authorization for treatment in most cases. We will be unable to continue with treatment or testing until authorization is received. Not all services are a covered benefit of all insurance policies. *We recommend you inform yourself of any policy exclusions, as payment for non-covered services will be your responsibility.*

MEDICARE – We accept assignment on all Medicare claims. We will also file Medicare Supplement claims (except Medicaid). Patients covered by Medicare Part B must bring the Medicare card & Supplemental Policy card to the first visit. *If you switch to a Medicare Advantage Plan, please inform us immediately.*

MEDICAID – We do not accept Medicaid or Medicaid Advantage plans of any kind.

HMO, PPO – Patients covered by a Managed Care or Participating Provider Plan of which the physician being seen is a participant *must* bring the HMO/PPO card and be prepared to pay their copay, any deductible, and applicable coinsurance at the time of service.

WORKER'S COMPENSATION – Injured workers covered by an insurance plan approved by the Texas Department of Insurance's Division of Workers' Compensation will not be responsible for payment of medical services rendered *unless* the injury is adjudicated to not be compensated. *We do not accept out of state worker's compensation insurance.*

PRIVATE INSURANCE/OUT OF NETWORK INSURANCE – We will file private insurance claims and out-of-network claims as a courtesy to our patients *if we can verify benefits before time of service.* Payment for the *Uninsured Portion* (Deductible & Co-Insurance) is due at the time of service.

-UNINSURED PATIENTS-

Patients not covered by any insurance plans or covered by insurance policies that we are unable to bill directly should expect to pay for services billed at our standard rates. The following estimates are guidelines only.

NEW PATIENTS should be prepared to pay up to *$300 for the initial consultation*.

ESTABLISHED PATIENTS should be prepared to pay *$95 - $200 for each follow-up visit.*

ADDITIONAL SERVICES, such as diagnostic testing and labs, may be required during any visit. These additional services are not included in the estimates above and are rendered at an additional fee.

I AGREE TO ABIDE BY THE FINANCIAL POLICY OF KANE HALL BARRY NEUROLOGY:

Signature of Patient or Guardian_____ Date_____

Rev. 10/16/13

KANE HALL BARRY NEUROLOGY NEW PATIENT INFORMATION (COMPLETE BOTH SIDES)

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

☐Alcoholism	Who? _____	☐Migraine	Who? _____
☐Alzheimer's Disease	Who? _____	☐Multiple Sclerosis	Who? _____
☐Cancer	Who? _____	☐Muscle Disease	Who? _____
☐Depression	Who? _____	☐Neuropathy	Who? _____
☐Diabetes	Who? _____	☐Parkinson's Disease	Who? _____
☐Epilepsy	Who? _____	☐Schizophrenia	Who? _____
☐Heart Disease	Who? _____	☐Stroke	Who? _____
☐High Blood Pressure	Who? _____	☐Tremor	Who? _____
☐Lung Disease	Who? _____	☐_____	Who? _____

PATIENT SERIOUS ILLNESSES

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

KANE HALL BARRY NEUROLOGY NEW PATIENT INFORMATION (COMPLETE BOTH SIDES)

Name: _____ DOB: _____

DRUG ALLERGIES

- ☐ *No known drug allergies*
- ☐ Penicillin
- ☐ Vicodin
- ☐ _____
- ☐ Codeine
- ☐ Sulfa
- ☐ _____
- ☐ _____

OPERATIONS

- ☐ Appendectomy
- ☐ Back
- ☐ Brain Tumor
- ☐ Breast Augmentation
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Cervical Spine
- ☐ Gall Bladder
- ☐ Heart Bypass
- ☐ Heart Valve Replacement
- ☐ Hip
- ☐ Knee Replacement
- ☐ Hysterectomy
- ☐ Lumbar Spine
- ☐ Orthopedic
- ☐ PEG Tube
- ☐ Pituitary
- ☐ Shoulder
- ☐ Subdural Hematoma
- ☐ Pacemaker

SYMPTOM REVIEW

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other _____

HEENT
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat
- ☐ Visual Changes
- ☐ Other _____

RESPIRATORY
- ☐ Chronic Cough
- ☐ Cough
- ☐ Known TB Exposure
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Cludication
- ☐ Edema
- ☐ Palpitations
- ☐ Other _____

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other _____

GENITOURINARY
- ☐ Dysuria
- ☐ Hematuria
- ☐ Polyuria
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Retention
- ☐ Dribbling (Male)
- ☐ Slow Stream (Male)
- ☐ Other _____

REPRODUCTIVE
- ☐ Erectile Dysfunction
- ☐ Penile Discharge
- ☐ Sexual Dysfunction
- ☐ Other _____

METABOLIC/ENDOCRINE
- ☐ Brittle Hair
- ☐ Brittle Nails
- ☐ Cold Intolerance
- ☐ Hair Changes
- ☐ Heat Intolerance
- ☐ Hirsutism
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Other _____

NEUROLOGICAL
- ☐ Dizziness
- ☐ Extremity Numbness
- ☐ Extremity Weakness
- ☐ Gait Disturbance
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other _____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other _____

INTEGUMENTARY
- ☐ Contact Allergy
- ☐ Hives
- ☐ Itching
- ☐ Mole Changes
- ☐ Rash
- ☐ Skin Lesion
- ☐ Other _____

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Other _____

HEMATOLOGIC/LYMPHATIC
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymphadenopathy
- ☐ Other _____

IMMUNOLOGIC
- ☐ Environmental Allergy
- ☐ Food Allergy
- ☐ Seasonal Allergy
- ☐ Other _____

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

SIGNATURE: _____ DATE: _____