Kane Hall Barry NEUROLOGY

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

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

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*_____

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

*ADDRESS*_____

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

EMAIL ADDRESS: _____

*Pharmacy Name*_____

*Pharmacy 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. 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)

_____

_____

_____

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:

_____

_____

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 3RD PARTY INSURANCE)*
- *IF YOU MISS AN APPOINTMENT WITHOUT NOTIFYING US, YOU MAY BE CHARGED $25*
- *NEUROPSYCHOLOGY TESTING APPOINTMENTS REQUIRE A $100 DEPOSIT 3 DAYS BEFORE THE APPOINTMENT. THIS DEPOSIT IS CONVERTED TO A NO SHOW FEE IF THE APPOINTMENT IS MISSED OR APPLIED TO OUT OF POCKET EXPENSES IF THE APPOINTMENT IS KEPT. IF A REFUND IS DUE, IT WILL BE PROCESSED THE DAY OF THE APPOINTMENT.*
- *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 _____

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-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 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/3RD 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 though 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. Due to the extensive length of neuropsychology testing, we require a $100 deposit 3 days before the appointment. This deposit is converted to a no show fee if the appointment is missed *or* applied to any out of pocket expenses if the appointment is kept. Refunds are available at the time of appointment if warranted.

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.

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: _____