New Braunfels Neurology
BHS PHYSICIANS NETWORK

**PATIENT INFORMATION:** **TODAY'S DATE**_____

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____ Sex: ____Male ____Female SS#:_____ Marital Status:_____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Contact Preference: (Home Phone) (Work Phone) (Mobile Phone) (Mail) (Patient Portal)

**AUTHORIZATION**: I authorize you to leave automated reminder calls on my mobile device ____YES ____NO

Referring Provider: _____ Patient PCP: _____

Race: (Arab) (Asian) (Black or African American) (Other Race) (White) (Other) Preferred Language: English Other _____

Ethnicity: (Central American) (Cuban) (Dominican) (Hispanic or Latino/Spanish) (Latin American/Latin, Latino) (Mexican) (Not Hispanic or Latino) (Puerto Rican) (South American) (Spaniard)

How did you hear about us? (Physician) (Internet Search) (Newspaper) (Television) (Hospital Partner) (BHS Screening Bus) (Baptist Community Event) (Website) (Insurance Company) (Baptist Emergency Hospital) (Friend/Family) (Employer) (Other _____)

**GUARDIAN INFORMATION:**

Guardian Last Name: _____ Guardian First Name: _____ M. Name:_____

**EMERGENCY CONTACT INFORMATION:**

Last Name:_____ First Name:_____ Phone:_____ Relationship:_____

**INSURANCE INFORMATION:** *Please bring insurance card(s) to the visit*

Insurance Plan Name: _____ Policy Holder Name: _____ Policy Holder DOB: _____

**EMPLOYER INFORMATION:**

Employer Name: _____ Employer Phone: _____ Occupation:_____

**CLINICAL INFORMATION:**

Preferred Pharmacy: _____Phone: _____ Fax: _____

Preferred Laboratory: _____

**Protected Health Information Authorization:**

**Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.**

| Name | Relationship to Patient | Type of information | | | |
|---|---|---|---|---|---|
| | | All | Schedule | Medical | Billing |
| _____ | _____ | Y/N | Y/N | Y/N | Y/N |
| _____ | _____ | Y/N | Y/N | Y/N | Y/N |
| _____ | _____ | Y/N | Y/N | Y/N | Y/N |
| _____ | _____ | Y/N | Y/N | Y/N | Y/N |

**Specific Instructions or Limitations:**_____

**We will continue to rely on the information given here when communicating with family members or others involved in you care unless you request changes. Please promptly notify our office if you wish to alter the designations above.**

**Signature of Patient:**_____ **Date:**_____

**To revoke this authorization, please send a written request to our office.**

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**POLICY ACKNOWLEDGEMENTS AND RELEASES**

**Please read each of the following statements carefully and sign as your authorization, understanding, and agreement to each statement.**

**ASSIGNMENT AND RELEASE:** I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer and/or any third party vendor.

Signed: _____ Date: _____

**MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE:** I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by _____. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

Signed: _____ Date: _____

**FINANCIAL OBLIGATION:** I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.

Signed: _____ Date: _____

**CONSENT FOR TREATMENT:** I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

Signed: _____ Date: _____

**ADVANCED DIRECTIVE:** Do you have an advance directive (living will/power of attorney)?

_____Yes _____No If yes, please provide a copy for our records.

**MEDICATION HISTORY AUTHORITY**: I authorize BHS Physicians Network and BHS Physicians Specialty to obtain Medication History Authority.

Signed: _____ Date: _____

**NO SHOW POLICY**

Patients who fail to present for a scheduled appointment will be considered a “no show”. Patients who fail to cancel the appointment 24 hours prior to the appointment will also be considered a “no show”.

A patient determined to be a “no-show” will be charged $25.00 for each episode.

Patients who have missed 3 appointments in a 12 month period will be considered a “chronic no show”. A patient determined to be a “chronic no show” may be discharged from the practice.

_____ has read and understand the above stated policy.
Patient Signature

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: You may refuse to sign this acknowledgement.**

I, _____, DOB, _____,

have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

**For Office Use Only:**

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____Individual refused to _____accept Notice _____ sign Acknowledgment

_____Communications barriers prohibited obtaining the acknowledgment

_____An emergency situation prevented us from obtaining acknowledgment

Other (Please specify)_____

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We appreciate the opportunity to serve you. The following information and expectations are set forth in an effort to provide all our patients with the highest quality care:

____ **MEDICATION REFILL REQUESTS:** We request that you first contact your pharmacy for refills. We will not do same day refills. The pharmacy will work with us to process your requests. Refills should be requested at least 72 hours (3 business days) prior to your refill date. The practice is closed on weekends and refill requests will not be accepted. Please contact our office to confirm that we have received the refill request. If you have not been seen by our provider in the past year, we will not refill your medication without an appointment.

____ **PAYMENTS:** All applicable fees, deductibles, coinsurance, co-pays or outstanding balances must be paid at the time of your appointment. We accept cash, checks, Visa, MasterCard, Discover and American Express. There is a $25 charge for all returned checks.

____ **CHANGES OF INFORMATION:** Please provide us with any changes regarding your address, phone number or insurance information as soon as possible. Failure to notify us of any updates may result in you being financially responsible for the services rendered.

____ **FMLA & OTHER FORMS:** Should you require our office to complete FMLA or other applicable forms, there is a fee starting at $35. Fees are due when forms are completed. Please allow 7 business days for us to complete forms. Please inquire with the staff regarding forms that need to be completed and applicable fees.

____ **APPOINTMENT TIME:** We ask that you arrive on time for your appointments. Arrivals later than 15 minutes will require appointment rescheduling.

____ **CELL PHONES:** We ask you to please have your cell phone off during your office visit.

____ **CANCELLATION/NO SHOWS:** If you need to cancel your appointment, we ask that you give us 24 hour notice. If you fail to notify us and miss your appointment, there will be a $25 fee and possible termination from the office if excessive. There will also be a fee of $25 if you cancel your appointment on the same day.

____ **Office Visits:** At the time of scheduling, please notify the staff of all the reasons for which you are requesting an appointment. In respect to all our patients' time and to maintain the efficiency of the practice, only complaints for which the visit was scheduled will be addressed. We will address all your healthcare needs, but it may require multiple visits.

We ask that you initial each area and sign below. By signing below, you acknowledge having read, understood and are in agreement with the above information and expectations.

_____ _____ _____

**Patient Signature** **Printed Name** **Date**

# New Braunfels Neurology
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*Please complete this two-page form and return it to the front desk prior to your examination today. This will greatly help the provider's assessment of your condition. Thank you.*

Today's Date:_____

Patient's Name:_____

Age:_____ *circle the appropriate selection below*

Male Female Right Handed Left Handed

Name of referring physician:_____

Any tests that have been performed:_____

_____

_____

Briefly describe the problem for which you are seeking treatment today:_____

_____

_____

_____

_____

Current Medications:

| Medication | Dose | How Often? |
|---|---|---|
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*Circle if you have had problems with any of the following*:

Anemia
Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Bleeding Disorder
Cancer (specify which type) _____
Cataracts
Congestive Heart Failure
COPD or Emphysema
Depression
Dementia or Memory Loss
Diabetes
Glaucoma
Heart Attack
High Blood Pressure
High Cholesterol
Kidney Disease (specify type) _____
Liver Disease (specify type) _____
Migraines
Neuropathy
Parkinson's Disease
Seizures
Stomach Problems (specify type) _____
Stroke
Syncope or Passing out
Thyroid Disease (specify type) _____
Other (please specify) _____

Please list any past surgical procedures:

| Month & Year | Procedure |
|---|---|
| | |
| | |
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| | |

Allergic to any medications? *circle your response*

Yes No

Please list the medications:_____

_____

Marital Status: *circle your response*

Single Married Widowed

Separated Divorced

Number of children: _____

Work Status: *circle your response*

Full Time Part Time Retired

Unemployed Disabled

Occupation: _____

Education: *circle your highest level completed*

Lower School Grade: 4 5 6 7 8

High School Grade: 9 10 11 12 GED

College Year: 1 2 3 4

College Degree: Associates Bachelors

Masters Doctorate

Do you smoke? *circle your response* Yes No

How much:_____How long:_____

If no, did you smoke previously? Yes No

How much:_____How long:_____

Do you drink alcohol? *circle your response* Yes No

How much:_____How long:_____

If no, did you drink previously? Yes No

How much:_____How long:_____

Family History: *circle appropriate selections*

Adopted

**Mother**: Alive Deceased Unknown

**Father**: Alive Deceased Unknown

List any family members with significant health problems:

_____

_____

_____

_____

Review of Systems:

*Please circle any selections that you have experienced recently.*

**Constitutional**
- Weight gain
- Weight loss
- Fever
- Sleep difficulty
- Fatigue
- None

**Ear, Nose & Throat**
- Hearing loss
- Ringing in the ears
- Sinus congestion
- Nose bleeds
- Sore throat
- Swallowing difficulty
- None

**Cardiovascular**
- Chest pain
- Palpitations
- Swelling of feet
- None

**Respiratory**
- Cough
- Shortness of breath
- Asthma
- Wheezing
- Spitting up blood
- None

**Gastrointestinal**
- Abdominal pain
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Rectal bleeding
- Blood in stool
- None

**Genitourinary**
- Painful urination
- Blood in urine
- Incontinence
- Frequent urination
- Male erectile difficulty
- None

**Musculoskeletal**
- Joint pain
- Joint stiffness
- Muscle cramps
- Back pain
- Muscle weakness
- None

**Dermatology**
- Rash
- Itching
- Change in hair
- Change in nails
- Change in moles
- None

**Neurological**
- Dizziness
- Loss of consciousness
- Tremor
- Balance difficulty
- Memory loss
- Frequent headaches
- Double vision
- Blurred vision
- Numbness
- None

**Psychiatric**
- Depression
- Nervousness
- Hallucinations
- Paranoia
- None

**Endocrine**
- Hot flashes
- Excessive thirst
- Cold intolerance
- None

**Heme-Lymph**
- Easy bruising
- Bleeding tendency
- Swollen lymph nodes
- Cancer
- Past blood transfusion
- None