

Patient Last Name			Patient First Name			Middle		
Street Address			City		State	Zip	Home Phone #	
F Sex	M Date of Birth	Age	Marital Status		Social Security #		Driver's Licenses #	
Employer			Employer's Address			Business Phone #		
Spouse's Name			Employer's / Employer's Address			Business Phone #		
Primary Insurance			Insurance Company Address			Policy Holder's Name		
Secondary Insurance			Insurance Company Address			Policy Holder's Name		

Policy Holder To Complete Information Below

Name		Address			City	State	Zip
Home Phone #	Relation to Patient	Date of Birth	Insurance ID#	Group #			
Employer		Employer's Address			Business Phone #		
Policy Holder's Social Security Number				Driver's License Number and State			
Nearest Relative or Friend and Address for Emergencies (Not Living with Patient)				Relation to Patient		Phone #	
Please Indicate Method Of Payment			Check	Cash	Visa	Mastercard	Discover

I hereby authorize the Neurological Clinic of Texas, PA to furnish information to insurance carriers concerning any illness and treatments and I hereby assign to the physician (s) all payments for medical and surgical benefits to include major medical benefits to which I am entitled for medical services rendered to my dependents or myself. I understand that I am responsible for all charges whether or not paid by said insurance. A photocopy of this agreement is to be considered as valid as an original. I further understand that I am responsible for obtaining all necessary referrals needed, unless otherwise stated in contract between my insurance carrier and the physician(s).

Signature of Patient, Responsible Party or Legal Guardian

Primary Care Physician	Phone #	Fax #
MD or Dr. Requesting Consult	Phone #	Fax #

PATIENT CONSENT FORM

I understand that as part of my healthcare, the physicians of Neurological Clinic of Texas, P.A. (NCT) 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 is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

NCT's *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I understand that a copy of the *Notice of Privacy Practices* is available at the front desk and understand that I have the right to review the notice prior to signing this consent. I understand that NCT reserves the right to change the *Notice of Privacy Practices*. Prior to implementation of the revised *Notice of Privacy Practices*, the revised *Notice* will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that NCT is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that NCT has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time.

Neurological Clinic of Texas, P.A. must obtain your written authorization to use your Private Health Information (PHI) for any purpose other than treatment or billing. If you want NCT to have access to disclose your PHI to your spouse or any other person during your treatment, please sign below.

I agree to allow NCT to disclose my PHI (including date/time of appointments) to:

_____ My Spouse _____ Printed Name and Phone Number

_____ Other Member(s) of my Family _____
Print Name and Phone Number

_____ Other _____ Printed Name and Phone Number

_____ Myself only, no other family member.

This does not serve as Authorization to Release Medical Records

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I understand that I have access to or have reviewed NCT's *Notice of Privacy Practices* revised written on November 8, 2002.

Signature of Patient or Legal Representative

Date

Print Name of Patient or Legal Representative

Neurological Clinic of Texas, P.A.
7777 Forest Lane, Suite B116
Dallas, Texas 75230
(972) 566-7684

FULL PAYMENT IS EXPECTED AT THE TIME OF SERVICE. WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, APPROVED CHECKS AND MONEY ORDERS. IN ORDER TO PREVENT ANY MISUNDERSTANDING ABOUT INSURANCE, WE ADVISE YOU THAT:

1. ALL SERVICES FURNISHED BY US ARE CHARGED TO THE PATIENT OR, IF A MINOR, HIS/HER AUTHORIZED GUARANTOR. WHEN APPROPRIATE WITH PRIOR APPROVAL AND VERIFICATION, WE WILL FILE YOUR CLAIM FOR YOU. HOWEVER, YOU STILL REMAIN TOTALLY RESPONSIBLE FOR PAYMENT. IF YOUR CARRIER HAS NOT PAID IN SIXTY (60) DAYS, WE WILL EXPECT FULL PAYMENT FROM YOU.
2. WE DO ACCEPT MEDICARE ASSIGNMENT. DEDUCTIBLES AND CO-INSURANCE AMOUNTS ARE DUE AT THE TIME SERVICES ARE RENDERED.
3. WE DO NOT ACCEPT WORKER'S COMPENSATION AND/OR LIABILITY CLAIMS. PATIENT WILL BE SEEN ON A CASH ONLY BASIS. NCT WILL FURNISH PATIENT WITH A COPY OF STATEMENT AND HE/SHE CAN FILE HIS/HER OWN CLAIM. IF FURTHER DOCUMENTATION IS NEEDED, THE PATIENT WILL BE RESPONSIBLE FOR THIS ADDED EXPENSE.
4. IF YOU ARE ON AN HMO OR PPO IN WHICH WE PARTICIPATE, WE WILL FOLLOW THE CONTRACTUAL TERMS REQUIRED, BUT IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY WITH HIS/HER CARRIER THAT SAID DOCTOR IS A PARTICIPATING PROVIDER. PATIENT MUST PRODUCE PROPER IDENTIFICATION AND WHEN REQUIRED, A PROPER REFERRAL. PLEASE ADVISE US UPON ARRIVAL AS TO WHAT INSURANCE YOU CURRENTLY HAVE. ALL COPAYS AND CO-INSURANCE AMOUNTS ARE DUE AT THE TIME SERVICES ARE RENDERED.

WE WILL MAKE AVAILABLE OUR FEE SCHEDULE FOR MEDICAL SERVICES/PROCEDURES UPON REQUEST. MOST FEES ARE FOR OFFICE AND/OR HOSPITAL PROCEDURES. HOWEVER, FEES WILL ALSO BE INCURRED WHEN YOU REQUEST SERVICES IN ADDITION TO YOUR REGULAR SERVICES. THE FOLLOWING IS A BRIEF, NON-COMPREHENSIVE LISTING OF SUCH ADDITIONAL SERVICES:

- * **INDIVIDUAL DISABILITY FORMS** **\$25.00**
- * **TELEPHONE CONFERENCES LONGER THAN 5 MINUTES**
\$35.00 FOR 1ST 15 MIN
- * **FOR EACH ADDITIONAL FIVE MINUTES** **\$10.00**
- * **RECORDS PROCESSED FOR TRANSFER*** **\$15.00 AND UP**
- * **RETURNED CHECKS (NSF)** **\$25.00**
- * **APPEAL LETTERS FOR RX PRIOR AUTHORIZATION DENIALS** **\$15.00**
- * **WRITTEN CORRESPONDENCE TO EMPLOYER OR SCHOOL** **\$25.00**
- * **REPLACEMENT OF LOST PRESCRIPTIONS** **\$20.00**
- * **FORMS COMPLETED BY PHYSICIAN** **\$50.00**
- * **APPOINTMENT NO SHOW/SAME DAY CANCELLED APPT.** **\$50.00**

ALL THE ABOVE FEES MAY NOT BE COVERED BY YOUR INSURANCE PLAN.

*** NO CHARGE FOR RECORDS FOR DISABILITY BENEFITS UNDER STATE OR FEDERAL SYSTEMS**

*** NO CHARGE FOR RECORDS WHEN NCT FORWARDS DIRECTLY TO REQUESTING PHYSICIAN.**

NO SHOW/CANCELLED APPOINTMENTS

****YOU MUST CALL THE DAY BEFORE (MON-FRI) YOUR APPOINTMENT BY NOON OR YOU WILL BE CHARGED \$50.00 FOR THE VISIT. WE ALLOW CANCELLED APPOINTMENTS WITHIN 24 HOURS NOTICE WITHOUT CHARGE.**

WE ASK THAT YOU PLEASE INDICATE BY YOUR SIGNATURE BELOW THAT YOU HAVE READ THE ABOVE POLICY AND ACKNOWLEDGE THAT YOU ARE RESPONSIBLE FOR THE PAYMENT OF ALL SERVICES PROVIDED BY THE PHYSICIANS OF THE NEUROLOGICAL CLINIC OF TEXAS, P.A.

Date

Signature

The Neurological Clinic of Texas, PA

7777 Forest Lane, Dallas, Texas 75230

Medical History Questionnaire - Routine

Patient Name:	_____	Date	_____
Referring MD:	_____	Date of Birth	_____
MD's Address	_____	Age	_____
MD's Phone	_____	Sex	<u> </u> M/F <u> </u>
MD's Fax	_____		

Medical & Injury History:

Please provide date of diagnosis for each condition. If you have an illness not shown, please specify below.

Yes No

- | | | |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | High blood pressure |
| <input type="radio"/> | <input type="radio"/> | Diabetes |
| <input type="radio"/> | <input type="radio"/> | High cholesterol or lipids |
| <input type="radio"/> | <input type="radio"/> | Emphysema or lung disease |
| <input type="radio"/> | <input type="radio"/> | Kidney disease |
| <input type="radio"/> | <input type="radio"/> | Asthma |
| <input type="radio"/> | <input type="radio"/> | Thyroid disease |
| <input type="radio"/> | <input type="radio"/> | Heart disease |
| <input type="radio"/> | <input type="radio"/> | Tumor, cancer, malignancy |
| <input type="radio"/> | <input type="radio"/> | Stroke or TIA |
| <input type="radio"/> | <input type="radio"/> | Diagnosis of epilepsy or seizures |
| <input type="radio"/> | <input type="radio"/> | Skin Lesions or tumors |
| <input type="radio"/> | <input type="radio"/> | Reflux or heartburn |
| <input type="radio"/> | <input type="radio"/> | Arthritis |
| <input type="radio"/> | <input type="radio"/> | Encephalitis or Meningitis |
| <input type="radio"/> | <input type="radio"/> | Head injury with loss of consciousness |
| <input type="radio"/> | <input type="radio"/> | Injury to spine |
| <input type="radio"/> | <input type="radio"/> | Injury to hand, arm, leg, or foot |
| <input type="radio"/> | <input type="radio"/> | Other injuries, fractures, etc. |
| <input type="radio"/> | <input type="radio"/> | Anxiety |
| <input type="radio"/> | <input type="radio"/> | Depression |
| <input type="radio"/> | <input type="radio"/> | Hayfever/seasonal allergies |
| <input type="radio"/> | <input type="radio"/> | Sinus problems |
| <input type="radio"/> | <input type="radio"/> | Trouble breathing through nose |
| <input type="radio"/> | <input type="radio"/> | Convulsions with fever |
| <input type="radio"/> | <input type="radio"/> | Previous treatment by psychiatry/psychologist |
| <input type="radio"/> | <input type="radio"/> | <i>Other medical problem or comments:</i> |

Surgical and Pregnancy History:

Please provide dates of operations or pregnancies.

Yes No

- | | | |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Brain surgery |
| <input type="radio"/> | <input type="radio"/> | Neck or back operation |
| <input type="radio"/> | <input type="radio"/> | Facial surgery |
| <input type="radio"/> | <input type="radio"/> | Tonsillectomy |
| <input type="radio"/> | <input type="radio"/> | Dental Surgery |
| <input type="radio"/> | <input type="radio"/> | Sinus surgery |
| <input type="radio"/> | <input type="radio"/> | Vascular surgery |
| <input type="radio"/> | <input type="radio"/> | Heart or lung surgery |
| <input type="radio"/> | <input type="radio"/> | Abdominal surgery |
| <input type="radio"/> | <input type="radio"/> | Hysterectomy |
| <input type="radio"/> | <input type="radio"/> | Tubal ligation |
| <input type="radio"/> | <input type="radio"/> | C-sections |
| <input type="radio"/> | <input type="radio"/> | <i>More information, listed below or on back:</i> |

List Surgeries or add Comments:

Family History:

Other information:

Significant medical illnesses in mom, dad, sisters or brothers, aunts or uncles, grandparents, children, or grandchildren ... especially those that are similar to your current problem.

Which hand do you use for writing? Right
 Left

What is (was) your occupation? working
 retired
 unemployed
 disabled

Who lives with you at home?

How many children do you have?

Allergies to medications:

Marital Status:
 Married
 Single
 Divorced
 Widowed

Current medications:

List name, dosage, and how often you take them.
Example: Dilantin, 100 mg, three times per day.

Do you smoke cigarettes? Never
(or use any form of tobacco) Quit
 Yes

1.

Do you drink beer, wine, alcohol? Never
 Quit
Beer/Wine? Some
Liquor? Daily

2.

3.

4.

5.

Have you lost or gained weight recently? If so, how much? Gained
 Lost
Over what time period? 🖊

6.

7.

What is your caffeine consumption per day? (coffee, tea, colas or chocolate):

Other medications, vitamins, herbs:

Coffee:

Tea:

Colas:

Chocolate:

Please add below any comments about the above information:

The Neurological Clinic of Texas, PA

7777 Forest Lane, Dallas, Texas 75230

Symptom inventory

Please mark a check in the appropriate boxes below to indicate whether you have had symptoms *within the past year or so*. If you answer yes for any item, please briefly describe it in the appropriate blank.

Yes No

<input type="radio"/>	<input type="radio"/>	Headache	
<input type="radio"/>	<input type="radio"/>	Neck or back pain	
<input type="radio"/>	<input type="radio"/>	Blurred or double vision; blindness	
<input type="radio"/>	<input type="radio"/>	Hearing loss	
<input type="radio"/>	<input type="radio"/>	Ringling in the ears	
<input type="radio"/>	<input type="radio"/>	Dizziness or vertigo	
<input type="radio"/>	<input type="radio"/>	Impairment of speech	
<input type="radio"/>	<input type="radio"/>	Difficulty swallowing	
<input type="radio"/>	<input type="radio"/>	Smell or taste impairment	
<input type="radio"/>	<input type="radio"/>	Trouble walking	
<input type="radio"/>	<input type="radio"/>	Falling down	
<input type="radio"/>	<input type="radio"/>	Weakness all over	
<input type="radio"/>	<input type="radio"/>	Weakness in a specific arm or leg	
<input type="radio"/>	<input type="radio"/>	Numbness or tingling	
<input type="radio"/>	<input type="radio"/>	Passing out	
<input type="radio"/>	<input type="radio"/>	Spells of altered awareness	
<input type="radio"/>	<input type="radio"/>	Hallucinations	
<input type="radio"/>	<input type="radio"/>	Memory loss	
<input type="radio"/>	<input type="radio"/>	Depression	
<input type="radio"/>	<input type="radio"/>	Trouble sleeping	
<input type="radio"/>	<input type="radio"/>	Loss of appetite	
<input type="radio"/>	<input type="radio"/>	Unexplained weight loss	
<input type="radio"/>	<input type="radio"/>	Recent cold or flu	
<input type="radio"/>	<input type="radio"/>	Prolonged fevers	
<input type="radio"/>	<input type="radio"/>	Night sweats	
<input type="radio"/>	<input type="radio"/>	Nasal congestion, sinus problems	
<input type="radio"/>	<input type="radio"/>	Mouth sores	
<input type="radio"/>	<input type="radio"/>	Chest pain or tightness	
<input type="radio"/>	<input type="radio"/>	Palpitations	
<input type="radio"/>	<input type="radio"/>	Cough, or shortness of breath	
<input type="radio"/>	<input type="radio"/>	Persistent stomach discomfort	
<input type="radio"/>	<input type="radio"/>	Nausea and/or vomiting	
<input type="radio"/>	<input type="radio"/>	Persistent diarrhea	
<input type="radio"/>	<input type="radio"/>	Persistent constipation	
<input type="radio"/>	<input type="radio"/>	Change in stool	
<input type="radio"/>	<input type="radio"/>	Change in how often you urinate	
<input type="radio"/>	<input type="radio"/>	Urinary incontinence	
<input type="radio"/>	<input type="radio"/>	Pain or burning on urination	
<input type="radio"/>	<input type="radio"/>	Sexual dysfunction	
<input type="radio"/>	<input type="radio"/>	Skin rashes	
<input type="radio"/>	<input type="radio"/>	Joint or bone pain	

Have you recently had any of these tests?

Y	N	Date	Where done	Result	
<input type="radio"/>	<input type="radio"/> MRI			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> CT scan			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> EEG (brain wave recording)			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> EP (evoked potential) study			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> EMG and nerve conductions			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> Cerebral arteriogram			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> Carotid doppler			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> Echocardiogram			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> LP (spinal tap)			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> Myelogram			<input type="radio"/> Normal	<input type="radio"/> Abnormal
<input type="radio"/>	<input type="radio"/> Blood tests (specify)			<input type="radio"/> Normal	<input type="radio"/> Abnormal

Other test not listed above:

What is the main issue, which brought you here?

Sometimes you will be asked to draw things during your neurologic exam.
Please leave this space blank.

For Physician Use Only

Date: _____

Signature: _____

Neurological Clinic of Texas, PA

SLEEP HABIT QUESTIONNAIRE

Name _____ Date: _____

Below, briefly describe your sleep problem (what kind of problem, when it started, how often your sleep or wake problem occurs), then answer the following questions about your sleep.

- 1) Do you have difficulty sleeping during the night? Yes or No. *If you answered yes*, please answer all of the following questions. *If you answered no*, please answer questions #5 through #17.
- 2) How many nights per week on the average have you been troubled by disturbed sleep? _____
For how many years has this occurred? _____
- 3) Four common complaints about sleep are: (a) trouble getting to sleep, (b) awakenings during the night, (c) awakenings towards morning and being unable to go back to sleep, and (d) sleepiness during the day. Please rate these problems on a 1-5 scale by circling the appropriate number.

<i>1 = Not a Problem</i>	<i>5 = Major Difficulty</i>				
Trouble getting to sleep	1	2	3	4	5
Awakenings during the night	1	2	3	4	5
Early morning awakening	1	2	3	4	5
Daytime sleepiness	1	2	3	4	5

- 4) Do you think you feel excessively sleepy during the day? Yes or No
- 5) What time do you usually go to bed on workdays? _____
- 6) What time do you usually go to bed on non-workdays? _____
- 7) What time do you usually get up in the morning? Workdays _____ Non-workdays _____
- 8) Do you usually feel refreshed when you awaken? Yes or No
- 9) How long does it take you to go to sleep (in minutes)? _____
- 10) How many hours a night do you think you sleep on the average? _____
- 11) When you get up in the morning during workdays, do you use an alarm clock or do you awaken by yourself? _____ Other days? _____
- 12) Have you ever taken prescription or over the counter sleeping pills? Yes or No If so, which one(s)?

- 13) How do you sleep away from home? Same Better or Worse

14) Do you fall asleep when you are not trying to? Yes or No If so, please describe examples:

15) Characterize your normal sleep habits: (What rituals do you have in preparing for bed? Do you awaken during the night? If so, what for and how many times?)

16) Do you snore? Yes or No If so, how long have you been reported to snore? _____ yr(s)

17) Have you experienced weakness in any part of your body at times of extreme laughter, sadness or excitement? Yes or No Please describe below:

18) Have you experienced unusual sensations or feelings in your lower legs (such as “creepy crawling”)? Yes or No Please describe:

19) Do you have recurrent vivid dreams that you actually feel are occurring? Yes or No If so, what part of sleep do they occur? (At onset, during sleep or at awakening?) _____

20) Have you ever awakened paralyzed (aware of your surroundings but unable to move for a brief period)? Yes or No

21) Have you ever eaten food, consumed alcohol or smoked cigarettes without full awareness or control (i.e. semi-consciously or unconsciously) during sleep or during partial awakenings at night? Yes or No If so, please describe:

22) Have you ever had any of the following?

Sleep Walking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bedwetting	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Marked Insomnia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Excessive Sleepiness	Yes <input type="checkbox"/>	No <input type="checkbox"/>

23) Do you awaken or has your bed partner witnessed gasping or choking episodes during your sleep? Yes No

24) Have you had or do others report that you have had personality changes or cognitive difficulties related to fatigue? Yes No

25) Have you had any automobile or work-related accidents due to fatigue? Yes No

Neurological Clinic of Texas, PA

THE EPWORTH SLEEPINESS SCALE

NAME _____ DATE _____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation:

- 0 (zero) = would **never** doze
- 1 (one) = **slight** chance of dozing
- 2 (two) = **moderate** chance of dozing
- 3 (three) = **high** chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading☛	_____
Watching TV☛	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)☛	_____
As a passenger in a car for an hour without a break☛	_____
Lying down to rest in the afternoon when circumstances permit☛	_____
Sitting and talking to someone☛	_____
Sitting quietly after a lunch without alcohol☛	_____
In a car, while stopped for a few minutes in traffic☛	_____

Record your weight, height and neck circumference (“collar” size in inches) below:

Weight: _____ (pounds) Height: _____ (feet, inches)

Neck Size: _____ (inches)