Central Texas Neurological Association

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205 Woodhew Drive Suite 110
Waco, TX 76712

PATIENT INFORMATION FORM

Patient Name _____ D.O.B. _____

Age _____ Sex: Male Female Pregnant? Yes No SSN _____

Address _____ Telephone _____

City & Zip _____ Email _____

Referring Physician_____ Primary Care Provider _____

Patient's Employer _____ Patient Work Phone _____

Emergency Contact Name & Number _____ Relation _____

Marital Status _____ Preferred Language _____

Federal Regulations require us to ask your Race: ☐ Asian ☐ Caucasian ☐ African American ☐ American Indian ☐ Hispanic ☐ Other

REASON FOR VISIT

Reason for visit or chief complaint: _____ Duration of Symptoms _____

Is the condition you are being seen for today in any way relation to an on-the-job-injury? _____

MEDICATIONS/ ALLERGIES

Current Medications

Pharmacy: _____ Phone _____

Drug Allergies, including antibiotics: _____

I am allergic to Contrast Dye: yes no I am allergic to Iodine: yes no Currently on blood thinner: yes no

PAST MEDICAL HISTORY (CIRCLE WHAT APPLIES)

Nervous System	**HEENT**	**Cardiovascular**	**Pulmonary**	**Gastrointestinal**
Paralysis	Glaucoma	Heart Disease	Asthma	Hepatitis
Seizures	Blindness	Murmur	Emphysema	Liver Disease
Migraines	Blurry Vision	Chest Pain	COPD	Ulcers
Stroke	Difficulty Swallowing	High Blood Pressure	Bronchitis	Gallbladder Disease
Concussion	Ringing in Ears	Valve Disease	Pneumonia	Colitis
	Hearing Loss	Heart Attack	Tuberculosis	Diarrhea
	Voice Changes	Palpitation		Constipation

MEDICAL HISTORY CONT. (CIRCLE WHAT APPLIES)

Genito-Urinary	Endocrine	Immune System	Type	Psychological
Kidney Problems	Diabetes	Infectious Disease:		Depression
Prostate Problems	Hypo-thyroid	Immune Disease:		Anxiety
Urinary Problems	Hyper-thyroid	Skin Disorder:		Panic Attacks
Menopause	Pituitary	Arthritis:		Bipolar Disorder
	Adrenal			Schizophrenia

Hematologic (circle): Anemia Leukemia Lymphoma Sick Cell Disease

Cancers (circle):

Brain	Ovarian	Lung	Stomach	Colon/Rectal
Breast	Prostate	Liver	Skin	Other:

Past Surgical History:

_____

FAMILY MEDICAL HISTORY (EXAMPLE- DIEABETES, HIGH BLOOD PRESSURE, ETC)

SOCIAL HISTORY

Tobacco: no yes packs per day? _____

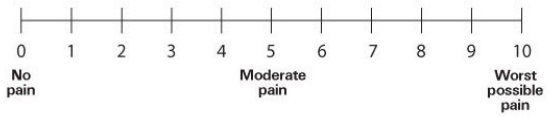
Alcohol: no yes how many drinks per day? ___ History of Alcohol Abuse: no yes how long sober? _____

Illicit Drug Use: no yes circle what applies: marijuana cocaine amphetamines other_____

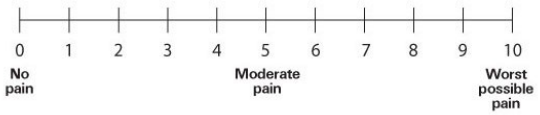
Have you ever had a problem with prescription medication (ie: misuse, abuse, addiction)? _____

PAIN INFORMATION

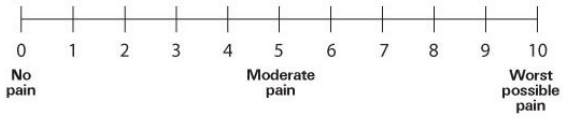
* IF YOU HAVE PAIN PLEASE FILL OUT THE FOLLWING, IF NOT SKIP TO SYSTEM REVIEW



Please rate your pain by circling the number that describes your pain at its **WORST**



Please rate your pain by circling the number that describes your pain at its **LEAST**



Please rate your pain by circling the number that describes your pain on the **AVERAGE**

How did the pain start (circle)?

Suddenly	Pulling	Lifting	Gradually	Twisting	Bending	Hit from behind
Fall	Sports Injury	Auto Accident	No apparent cause	Injured at Work	Other:_____	

What activities make the pain worse (circle)?

Nothing	Sitting	Weather	Driving	Standing	Sleeping	Working	Walking	Other: _____

What reduces the pain (circle)?

Nothing	Lying Down	Medication	Exercise	Sleeping	Massage
Standing	Heat	Sitting	Ice	Walking	Other: _____

PREVIOUS TEST

MRI Neck/Back/Other facility: _____ Previous Neck/Back Surgery performed by Dr._____

CT Scan Neck/Back/Other facility: _____ X-Rays facility: _____

Bone Scan facility: _____ EMG facility: _____

PREVIOUS TREATMENTS

Medicines Tried: (circle)

Aspirin	Celebrex	Norfelx (orphenadrine)	Nortriptyline	Acetaminophen
Cymbalta	Lyrica (pregabalin)	Elavil (amitriptyline)	Motrin (ibuprofen)	Tramadol (ultram)
Zanaflex (orphenadrine)	Zoloft (sertraline)	Aleve (naproxen)	Mobic (meloxicam)	Flexeril (cyclobenzaprine)
Prozac (fluoxetine)	Advil (ibuprofen)	Soma (carisoprodol)	Toradol (ketorolac)	Vicodin (hydrocodone)
Naprosyn (naproxen)				

Physical Therapy: within the last 6 months (circle)

None	Meske Sports & PT	Select PT	Providence PT	Hillcrest PT
Bosque River PT	Goodall Witcher PT	Scott & White PT	Other: _____	

Epidural Steroid Injection: within the last 6 months (circle)

None	Advanced Pain Care	Providence Hospital
Pain Clinic	Hillcrest Hospital	Other: _____

Other Treatments for this pain: within the last 6 months (circle)

None	Heat	Psychotherapy	Acupuncture	Ice
Traction	Chiropractic	TENS Unit	Other: _____	

In the last 6 months, I have seen the following for this pain:

SYSTEM REVIEW (CIRCLE WHAT YOU HAVE EXPERIENCED IN THE LAST YEAR)

General	**Eyes**	**Ears/Nose/Throat**	**Cardiovascular**	**Gastrointestinal**
Fever	Blurring	Earache	Chest Pain	Nausea
Chills	Double Vision	Ear Discharge	Palpitations	Vomiting
Sweats	Irritation	Tinnitus	Fainting	Diarrhea
Anorexia	Discharge	Deceased Hearing	Shortness of Breath	Constipation
Fatigue	Vision Loss	Nasal Congestion	Peripheral Edema	Change in Bowel Habits
Malaise	Eye Pain	Nosebleeds	**Respiratory**	Abdominal Pain
Weight Loss	Light Sensitivity	Sore Throat	Cough	Black Stool
Weight Gain		Hoarseness	Pneumonia	Bloody Stool
Aches		Difficulty Swallowing	Excessive Sputum	Jaundice
		Voice Changes	Bloody Cough	
			Wheezing	

Male Genito-Urinary	**Female Genito-Urinary**	**Musculoskeletal**	**Skin**	**Neurologic**
Painful Urination	Vaginal Discharge	Back Pain	Rash	Paralysis
Blood in Urine	Incontinence	Neck Pain	Itching	Weakness
Discharge	Painful Urination	Arm Pain	Dryness	Tingling
Urinary Frequency	Blood in Urine	Leg Pain	Suspicious Lesion	Seizures
Urinary Hesitancy	Urinary Frequency	Joint Pain	Hair Changes	Tremors
Night Urination	Absence of Menstruation	Joint Swelling		Vertigo
Incontinence	Heavy Menstruation	Muscle Cramps		Headaches
Genital Sores	Abnormal Vaginal Bleeding	Muscle Weakness		Numbness
Decreased Libido	Pelvic Pain	Stiffness		Speech Diff.
		Arthritis		
		Difficulty Walking		

Psychiatric	**Endocrine**	**Heme/Lymphatic**	**Allergic**
Depression	Cold Intolerance	Abnormal Bruising	Itching
Anxiety	Heat Intolerance	Bleeding	Hay fever
Memory Loss	Increased Thirst	Enlarged Lymph Nodes	Persistent Infections
Suicidal Thoughts	Increased Appetite	Anemia	HIV Exposure
Hallucinations	Increased Urination		UTI
Paranoia	Weight Change		Skin Infections
			History of Staph

WORKER'S COMPENSATION (required)

Is the condition you are being seen for today in any way related to an on-the-job injury? _____

If yes, have you filed a claim with your employer? _____

Type of Injury_____

Employer name and phone number_____

Has this condition ever been considered a work-related injury in the past? _____I understand that if at any time my condition is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be offered. If my Workers Compensation coverage is denied for any reason, or my employer fails to honor its agreement to pay my medical bills, I will be responsible for my medical bills. I understand that CTNA has elected to not participate in the Texas State Worker's Compensation Program.

PATIENT CONSENT AND RELEASE

I give CTNA permission to examine and treat my condition. I understand that telephone calls and office visits are recorded. If any insurance claim or Workers Compensation claim is filed, I agree that clinical and all other necessary information concerning my condition and treatment may be released to my insurance company, employer, or Workers Compensation Carrier. I authorize payment to CTNA. I understand that if at any time my condition is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be offered. I also understand that if my Workers Compensation coverage is denied for any reason, or my employer fails to honor its agreement to pay my medical bills, I will be responsible for my medical bills. In consideration of services rendered, I hereby assign and transfer to CTNA all rights, title and interest in the benefits payable for services rendered by all of my insurers and/or employee benefit plans, as well as all claims and/or causes of action (including but not limited to breach of fiduciary duty) that I have now and may have in the future related to the failure or refusal of any such insurer/employee benefit plan to properly pay benefits when due. I hereby authorize and instruct the insurers and/or employee benefit plans to pay directly to CTNA all benefits due under the terms of my insurance policy or policies and/or employee benefit plans. I will pay CTNA for all charges incurred or for all charges in excess of whatever sums may be paid for my insurers and/or employee benefit plans.

_____ _____

Signature Date

CTNA -- FINANCIAL POLICY

Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, the patient, not your insurance carrier. All charges are the responsibility of the patient whether the insurance carrier pays or not. If the insurance company does not pay your claim in full within 30 days, we ask that you contact the carrier to request prompt payment and to inform our office of their response. We accept payments in the form of MasterCard, Visa, money orders, cash and cashable personal checks.

Co pays: The patient is expected to present an insurance card at each visit to determine any changes in eligibility or copay assignments. All copayments and past due balances are due and payable at the time of service. NSF checks are assessed a $55 processing fee. Refund checks are processed twice a month. Refund checks are voided after 6 months.

Prepays: The patient portion of financial responsibility is due prior or at the time of service. This includes deductibles, coinsurance, or any services exempted from your insurance coverage. We recognize that determining expected out-of-pocket expenses can be complicated in some insurance coverage packages and have personnel to assist you. Based on the information provided by your insurance carrier(s), we will determine the payment expectations.

Referrals: If your insurance has designated a primary care physician (PCP), you are required to have prior authorization from your PCP prior to your clinic visit. This is the responsibility of the patient to ensure their PCP obtains this prior to the visit.

Medical Records: A Medical Records Release Form must be signed for any release of information. The fee for medical records is $25 for the first 20 pages and 50 cents/page for additional pages thereafter, plus postage. This fee applies to any third party. Please allow 14 days for medical records to be printed out and mailed. Please refer to our Notice of Privacy Practices in compliance with HIPAA regulations for guidelines on how your personal health information is protected.

No Show Fee: A $35 no show fee will be applied to patient accounts who do not call and cancel their appointments within 24 hours of the appointment. A $75 no show fee will be applied to EMG, EEG and Botox appointments who do not call and cancel their appointment within 24 hours of the appointment.

Disability/FMLA Forms: The completion of Disability or FMLA forms follows receipt of a $35 Form Fee. Each additional form request is treated and billed separately.

Prescription Refills: Please remember to ask the doctor about your medications or refills during your visit with him. Refill authorizations must be requested by dispensing pharmacy. Please allow 72 hours for all refill requests.

Nonparticipating Insurance Plans: While most major medical insurance carriers are accepted, we DO NOT accept Texas Star Worker's Compensation Program, McLennan County Indigent Card, (automobile insurance coverage), attorney letters of protection or letters of assignment, Superior Health, Molina, Ambetter or Scott & White.

Collection Agency: We may retain the services of an outside Collection Agency (RMP) for recovery of delinquent balances. We reserve the right to attach collection fees associated with recovery of an individual account to that account balance.

Billing Questions: Patient statements are sent monthly and provide detail about dates of services and balances due. We are always happy to answer any questions or concerns about your statements. Please call our office at (254)399-9291.

Recordings: All telephone calls are recorded.

This financial policy helps us provide quality consistent care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

PATIENT CONSENT AND RELEASE

I give Central Texas Neurological Association permission to examine and treat my condition. I understand all telephone calls are recorded. If any insurance claim or Workers Compensation claim is filed, I agree that clinical and all other necessary information concerning my condition and treatment may be released to my insurance company, employer, or Workers Compensation Carrier. I authorize payment to Central Texas Neurological Association. I understand that if at any time my condition is found to be work related, treatment must be authorized by my employer's Workers Compensation Carrier before any further treatment will be offered. I also understand that if my Workers Compensation coverage is denied for any reason, or my employer fails to honor its agreement to pay my medical bills, I will be responsible for my medical bills. In consideration of services rendered, I hereby assign and transfer Central Texas Neurological Association all rights, title and interest in the benefits payable for services rendered by all of my insurers and/or employee benefit plans, as well as all claims and/or causes of action (including but not limited to breach of fiduciary duty) that I have now and may have in the future related to the failure or refusal of any such insurer/employee benefit plan to properly pay benefits when due. I hereby authorize and instruct the insurers and/or employee benefit plans to pay directly to Central Texas Neurological Association all benefits due under the terms of my insurance policy or policies and/or employee benefit plans. I will pay Central Texas Neurological Association for all charges incurred or for all charges in excess of whatever sums may be paid for my insurers and/or employee benefit plans.

I have read and understood the above policy statements.

Signature _____ Date _____