

KANE HALL BARRY NEUROLOGY

PATIENT INFORMATION

LAST NAME _____

DATE OF BIRTH _____

FIRST NAME _____ M.I. _____

SOCIAL SECURITY # _____ - _____ - _____

ADDRESS _____

MARITAL STATUS S M D W

CITY _____ STATE _____ ZIP _____

PRIMARY PHONE # (_____) - _____ - _____

EMPLOYER _____

HOME WORK MOBILE

EMPLOYER ADDRESS _____

SECONDARY PHONE # (_____) - _____ - _____

CITY _____ STATE _____ ZIP _____

HOME WORK MOBILE

REFERRAL SOURCE:

EMERGENCY CONTACT _____

PHYSICIAN _____

EMERGENCY PHONE # _____

FRIEND/FAMILY INSURANCE WEBSITE OUR WEBSITE

RELATIONSHIP OF CONTACT _____

WEB SEARCH PHONE BOOK OTHER _____

PRIMARY CARE PHYSICIAN _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

INSURANCE COMPANY _____

INSURED PARTY _____

GROUP ID # _____

INSURED'S DATE OF BIRTH _____

INSURED ID # _____

INSURED'S EMPLOYER _____

INSURED'S SSN _____

SECONDARY INSURANCE:

INSURANCE COMPANY _____

INSURED PARTY _____

GROUP ID # _____

INSURED'S DATE OF BIRTH _____

INSURED ID # _____

INSURED'S EMPLOYER _____

INSURED'S SSN _____

- ❖ 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 _____

FINANCIAL POLICY

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

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

NEW PATIENTS should be prepared to pay up to \$400 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 and are rendered at an additional fee.

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.

EXCEPTIONS:

MEDICARE – We will accept assignment on all Medicare claims. We will also file Medicare Supplement claims. Patients covered by Medicare Part B must bring the Medicare card & Supplemental Policy card to the first visit.

PLEASE NOTE: If you switch to a Medicare HMO Plan, you must inform us immediately.

HMO, PPO, EPO – Patients covered by a Managed Care or Participating Provider Plan of which the physician being seen is a participant, must bring the HMO/PPO/EPO card and be prepared to pay the Co-Pay amount at the time of service.

PLEASE NOTE: We want you to receive your maximum plan benefits. Our practice is not on every insurance plan and all of our physicians do not participate on the same plans. It is your responsibility to verify that the physician you are seeing is on your plan. If your plan requires a Primary Care Physician Referral, it is your responsibility to make sure you have a referral for every visit. It is your responsibility to inform us if the treatment or testing recommended to you requires insurance Pre-Authorization.

WORKER'S COMPENSATION – Injured workers covered under the Texas Workers Compensation Act will not be responsible for payment of medical services rendered unless the injury is finally adjudicated to not be compensated or the Texas Worker's Compensation Commission finds that the injured worker has violated Article 8303-4.62 or Article 8303-4.63 of the Texas Workers Compensation Act. We do not accept out of state worker's compensation insurance.

PRIVATE INSURANCE – We will file private insurance claims as a courtesy to our patients only if the day's charges exceed \$300. Payment for the Uninsured Portion (Deductible & Co-Insurance) is due at the time of service.

PLEASE NOTE: Your Insurance Policy is a contract between you and your insurance carrier. We are not a party to that contract. As Medical Providers, our relationship is with you – not your Insurance Carrier. Not all services are a covered benefit of all policies. We recommend you inform yourself of any policy exclusions, as payment for non-covered services will be your responsibility.

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

Signature of Patient or Guardian _____ Date _____

**ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES**

I HAVE REVIEWED THIS OFFICE'S NOTICE OF PRIVACY PRACTICES, WHICH EXPLAINS HOW MY MEDICAL INFORMATION WILL BE USED AND DISCLOSED. I UNDERSTAND THAT I AM ENTITLED TO RECEIVE A COPY OF THIS DOCUMENT.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

NAME OF PATIENT OR PERSONAL REPRESENTATIVE

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

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

<input type="checkbox"/> Alcoholism	Who? _____	<input type="checkbox"/> Migraine	Who? _____
<input type="checkbox"/> Alzheimer's Disease	Who? _____	<input type="checkbox"/> Multiple Sclerosis	Who? _____
<input type="checkbox"/> Cancer	Who? _____	<input type="checkbox"/> Muscle Disease	Who? _____
<input type="checkbox"/> Depression	Who? _____	<input type="checkbox"/> Neuropathy	Who? _____
<input type="checkbox"/> Diabetes	Who? _____	<input type="checkbox"/> Parkinson's Disease	Who? _____
<input type="checkbox"/> Epilepsy	Who? _____	<input type="checkbox"/> Schizophrenia	Who? _____
<input type="checkbox"/> Heart Disease	Who? _____	<input type="checkbox"/> Stroke	Who? _____
<input type="checkbox"/> High Blood Pressure	Who? _____	<input type="checkbox"/> Tremor	Who? _____
<input type="checkbox"/> Lung Disease	Who? _____	<input type="checkbox"/> _____	Who? _____

PATIENT SERIOUS ILLNESSES

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

Name: _____ DOB: _____

DRUG ALLERGIES

- | | | | |
|--|-------------------------------------|----------------------------------|--------------------------------|
| <input type="checkbox"/> No known drug allergies | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Vicodin | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

OPERATIONS

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Hip | <input type="checkbox"/> PEG Tube |
| <input type="checkbox"/> Back | <input type="checkbox"/> Cervical Spine | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Pituitary |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Lumbar Spine | <input type="checkbox"/> Subdural Hematoma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Pacemaker |

SYMPTOM REVIEW

- | | | | | |
|--|---|---|---|---|
| GENERAL | NEUROLOGICAL | CARDIOVASCULAR | GASTROINTESTINAL | ENDOCRINE |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Headaches | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Head injury | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Diabetes/blood sugar |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Shortness of breath
(with exertion) | <input type="checkbox"/> Constipation | <input type="checkbox"/> Intolerance to heat
or cold |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of breath
(lying flat) | <input type="checkbox"/> Diarrhea | |
| | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart attack (history) | <input type="checkbox"/> Heartburn | |
| EARS/NOSE/MOUTH/THROAT | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Ulcers | HEMATOLOGICAL/LYMPHATIC |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> History of anemia |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Numbness | <input type="checkbox"/> Leg Pain (walking) | <input type="checkbox"/> Change in stools | <input type="checkbox"/> Tendency to bleed |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Pain | <input type="checkbox"/> Swelling of legs | <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Tingling | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Rectal bleeding | <input type="checkbox"/> Swollen glands |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Burning | | <input type="checkbox"/> Black, tarry stools | |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Tremors | EYES | <input type="checkbox"/> Jaundice/Hepatitis | SKIN/BREASTS |
| <input type="checkbox"/> Prolonged hoarseness | <input type="checkbox"/> Speech problems | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Rashes/Easy bruising |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Unsteadiness of gait | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Gall Bladder disease | <input type="checkbox"/> Changes in hair/nails |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Blindness | GENITOURINARY | <input type="checkbox"/> Breast lumps |
| | <input type="checkbox"/> Disorientation | <input type="checkbox"/> Eye pain/redness | <input type="checkbox"/> Bladder control loss | <input type="checkbox"/> Breast pain/discharge |
| MUSCULOSKELETAL | <input type="checkbox"/> Behavior change | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Burning urination | ALLERGIC/IMMUNOLOGICAL |
| <input type="checkbox"/> Muscle weakness | | <input type="checkbox"/> Chest | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Muscle cramps | PSYCHIATRIC | <input type="checkbox"/> Cough | <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Asthma/Wheezing | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Allergic Reactions |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Coughing up blood | Date of last menstrual
period: _____ | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hallucinations | | | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Difficulty sleeping | | | |
| <input type="checkbox"/> Deformities | <input type="checkbox"/> Drug abuse | | | |

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

SIGNATURE: _____ DATE: _____