AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____Phone_____ Fax_____

to release healthcare information of the patient named above to:

Neurology and Movement Disorders Center of North Texas
Halim Fadil, M.D.
801 W Road to Six Flags, Suite 127
Arlington, TX 76012
Phone: 817-697-8000 Fax: 817-697-8800

This request and authorization applies to:

☐ All healthcare information
☐ Healthcare information relating to the following treatment, condition or dates:
_____
☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, condyloma, chlamydia, non-specific urethritis, syphilis, VDRL, cancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE SIGNED OR AT THE PATIENTS WRITTEN REQUEST.

HIPAA ACCESS FORM FOR PROTECTED HEALTH INFORMATION

I understand that it is the policy of Neurology and Movement Disorders Center of North Texas, (Halim Fadil, MD) to restrict access to my Protected Health Information in accordance with federal law. This authorization shall be in effect until the patient notifies the clinic in writing, one year from signature date or two (2) years after the death of the patient. The following may have access to my healthcare information

1) Healthcare provider
2) My insurance company(-ies) for payment of my claim
3) The person(s) indicated below:

Name (s) Please print	DOB	Information Access Preferences
1. Myself (patient or legal guardian)		Clinical Information (please check one)
2.		o All or o Restricted
3.		o All or o Restricted
4.		o All or o Restricted
5.		o All or o Restricted

*If you circle Restricted below, please specify what clinical information you do NOT wish to share with the person(s) in the below boxes:

Sexually Transmitted Disease(s)
Pregnancy
Terminal Illness
Mental/Behavioral Health
Other: _____

Communication preferences:

□ I give consent for you to leave confidential clinic information on my answering machine

□ I do **NOT** give consent for you to leave confidential clinical information on my answering machine

_____

Patient Signature Date Witness Signature

_____

Printed Patient Name Printed Witness Signature

Neurology and Movement Disorders Center of North Texas

Name: _____ Date of Birth: _____

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 neurology 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

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? _____	□ Other	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	

Neurology and Movement Disorders Center of North Texas

Name: _____ Date of Birth: _____

Drug Allergies

☐ No known drug allergies ☐ Penicillin ☐ Vicodin ☐ _____
☐ Codeine ☐ Sulfa ☐ _____ ☐ _____

Operations

☐ Appendectomy ☐ Carpal Tunnel ☐ Hip ☐ PEG Tube
☐ Back ☐ Cervical Spine ☐ Knee Replacement ☐ Pituitary
☐ Brain Tumor ☐ Gall Bladder ☐ Hysterectomy ☐ Shoulder
☐ Breast Augmentation ☐ Heart Bypass ☐ Lumbar Spine ☐ Subdural Hematoma
☐ Cancer ☐ Heart Valve Replacement ☐ Orthopedic ☐ Pacemaker
☐ Other _____

Symptom Review

Constitutional

☐ Chills
☐ Fatigue
☐ Fever
☐ Night Sweats
☐ Weight Gain
☐ Weight Loss
☐ Other _____

Respiratory

☐ Chronic Cough
☐ Cough
☐ Shortness of Breath
☐ Wheezing
☐ Other _____

Genitourinary

☐ Dysuria
☐ Hematuria
☐ Polyuria
☐ Urinary Frequency
☐ Urinary Incontinence
☐ Urinary Retention
☐ Other _____

Neurological

☐ Dizziness
☐ Extremity Numbness
☐ Extremity Weakness
☐ Gait Disturbance
☐ Headache
☐ Memory Loss
☐ Seizures
☐ Tremors
☐ Other _____

Musculoskeletal

☐ Back Pain
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Weakness
☐ Neck Pain
☐ Other _____

HEENT

☐ Ear Drainage
☐ Ear Pain
☐ Eye Discharge
☐ Eye Pain
☐ Hearing Loss
☐ Nasal Drainage
☐ Sinus Pressure
☐ Sore Throat
☐ Visual Changes
☐ Other _____

Gastrointestinal

☐ Abdominal Pain
☐ Blood in Stool
☐ Change in Stool
☐ Constipation
☐ Diarrhea
☐ Heartburn
☐ Loss of Appetite
☐ Nausea
☐ Vomiting
☐ Other _____

Metabolic/Endocrine

☐ Brittle Hair
☐ Brittle Nails
☐ Cold Intolerance
☐ Hair Changes
☐ Heat Intolerance
☐ Other _____

Psychiatric

☐ Anxiety
☐ Depression
☐ Insomnia
☐ Other _____

Hematologic/Lymphatic

☐ Easy Bleeding
☐ Easy Bruising
☐ Lymphadenopathy
☐ Other _____

Cardiovascular

☐ Chest Pain
☐ Edema
☐ Palpitations
☐ Other _____

Skin

☐ Contact Allergy
☐ Hives
☐ Itching
☐ Rash
☐ Skin Lesion
☐ Other _____

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

Signature: _____ Date: _____

Neurology and Movement Disorders Center of North Texas

~PATIENT CONSENT / OFFICE AND FINANCIAL POLICES~

Thank you for choosing Neurology and Movement Disorders Center of North Texas. 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 of our policies. For the full version of this policy you may request a copy from our staff.

- 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 plan.
- Any copay, deductible amounts, or outstanding balance from previous visits are due when you check in for your appointment.
- Payment arrangements are available if needed. Please ask the front office staff for details.
- We do not accept Letters of Protection (LOP), 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 24 hours in advance of your appointment time, you will be charged a no show fee of $25.00, which is not payable by insurance companies.
- Please let us know if you are running late to your appointment. If you are late 15 minutes or more from your appointment time, we may have to reschedule you.
- If you reschedule or cancel your appointment with LESS than 24 hours' notice, you will be charged a $25.00 fee.

By signing below, you acknowledge that you were given the option to review the full office and financial polices 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

~OFFICE AND FINANCIAL 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 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 that 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 and Discover Card.

If you cannot afford to pay for your visit in full at the time of service, we suggest you speak to our office staff about setting a payment arrangement. We will work with each patient on an arrangement that will work for both the patient and the clinic.

PAYMENT OF POST VISIT BALANCES: All post visit balances must be paid within 30 days of when the balance becomes the patient's responsibility and a statement from Neurology and Movement Disorders Center of North Texas is received. An acceptable payment arrangement may be made in order to prevent outside collection activity. If your account becomes past due and we have to refer your account to a collection agency, a $35.00 collection agency fee will be added to your outstanding balance.

INSURANCE COVERAGE: Please inform the receptionist of any type of insurance coverage you may have. You are responsible for knowing the specific rules of your insurance carrier. We are contracted (in-network) with several insurance carriers. However, if we are not contracted with your insurance carrier, you may be required to pay a higher fee than if you were seen by a contracted (in-network) provider. It is your responsibility to pay any copay, coinsurance, deductible, other non-covered amounts not paid by your insurance carrier at the time of service. Failure to present your current insurance information prior to services being rendered may result in the denial of your claim and subsequent billing for unpaid services.

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.

~OFFICE AND FINANCIAL POLICY DETAILS~

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. 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: We do not accept Workers' Compensation Claims. If your visit is related to a work injury you will need to contact your company's workers' compensation insurance to determine the correct provider you need to schedule with for your treatment.

COMPLETION OF OUTSIDE PAPERWORK: We charge a processing fee of $15.00 (+) $5.00 per page, if more than 3 pages, to complete outside paperwork. This includes Disability Forms and FMLA Paperwork. Payment is required in advance and paperwork will not be processed until payment is received. Please allow one week for paperwork to be completed.

MISSED APPOINTMENTS: We understand that sometime you may need to cancel an appointment due to unforeseen circumstances. We appreciate that our patients cancel their appointment at least 24 hours prior to the appointment time. This will give us the opportunity to offer that time slot to another patient. If you miss an appointment with no notification, we will charge you a No Show fee of $25.00 that is not covered by insurance, and is the responsibility of the patient.

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. If you arrive 15 or more minutes past your appointment time, we may have to reschedule your appointment.

HIPPA NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given or offered the Neurology and Movement Disorders Center of North Texas HIPPA Notice of Privacy Practices.

AUTHORIZATION OF CARE: I grant permission for Neurology and Movement Disorders Center of North Texas to render such services that my physician may deem necessary for my diagnosis and treatment. I understand that such services may include medical treatment and minor surgical procedures.

Patient Name: _____

_____

Signature of Patient or Representative Relationship to Patient Date

*If the patient is unable to sign this agreement or is a minor, I am entering into the agreement on behalf of and as the legally authorized representative of the Patient.

Neurology and Movement Disorders Center of North Texas

PATIENT INFORMATION

LAST NAME _____ ***DATE OF BIRTH*** _____

FIRST NAME _____ ***M.I.*** _ ***SOCIAL SECURITY #*** _____-_____-_____

ADDRESS _____ ***MARITAL STATUS*** ☐ ***S*** ☐ ***M*** ☐ ***D*** ☐ ***W***

CITY _____ ***ST*** _____ _ ***ZIP*** _____ ***PRIMARY PHONE #*** (_____) -_____ - _____

EMAIL ADDRESS: _____ ☐ ***HOME*** ☐***WORK*** ☐ ***MOBILE***

PHARMACY NAME _____ ***SECONDARY PHONE #*** (_____) -_____ - _____

PHARMACY ADDRESS _____ ☐ ***HOME*** ☐***WORK*** ☐***MOBILE***

PREFERRED LABORTORY _____

PREFERRED IMAGING FACILITY _____

EMERGENCY CONTACT _____

PREFERRED LANGUAGE _____ ***EMERGENCY PHONE #*** _____

RACE _____ ***RELATIONSHIP OF CONTACT*** _____

ETHNICITY:
☐***HISPANIC/LATINO***
☐ ***NON-HISPANIC/LATINO***
☐ ***PREFER NOT TO SAY***

REFERRAL SOURCE:

☐***PHYSICIAN*** _____

☐ ***FRIEND/FAMILY*** ☐***INSURANCE WEBSITE***
☐ ***OUR WEBSITE*** ☐***PHONE BOOK***
☐ ***WEB SEARCH*** ☐*OTHER* _____

PRIMARY CARE PHYSICIAN
_____

PRIMARY INSURANCE:

Insurance Company _____

SECONDARY INSURANCE:

Insurance Company _____

PLEASE SHOW YOUR INSURANCE CARD AT CHECK-IN SO THAT WE CAN MAKE A COPY.

- 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 PUIRPOSE OF PROCESSING MY INSURANCE CLAIMS.
- I AUTHORIZE THAT ANY BENEFITS DUE BE MAKE PAYABLE TO NEUROLOGY AND MOVEMENT DISORDERS CENTER OF NORTH TEXAS

SIGNATURE: _____ **DATE:** _____