PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will remain confidential.

Today's Date: _____ Patient Name: _____

□ Male □ Female SS#:_____ DOB: _____ Age: _____

Check appropriate Box: □ Single □ Married □ Widowed □ Divorced □ Separated □ Minor

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

E Mail Address (used for appointment reminders): _____

Name of Emergency Contact for all Patients (Required): _____

Emergency Contact Phone Number: _____ Relationship to patient: _____

Who were you referred by: _____

Family Physician (If different than referring): _____

COMPLETE IF PATIENT IS A MINOR:

Parent's/Guardian's Name:_____ Relationship to patient: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Is the reason for visit due to an auto accident or any injury? _____ *Date of Injury* _____

Are you using an attorney? _____ *Name of Attorney:* _____

This office does not file Workman's Compensation, PI insurance, auto insurance, or secondary commercial insurance (unless it is secondary to Medicare). Any patient using an attorney must present payment at the time of the visit.

Medicaid patients are required to show their card at every visit and inform office immediately if their Medicaid coverage changes. You must present any primary insurance in addition to your Medicaid coverage.

Private Insurance and Medicare Patients: Please notify office immediately if your coverage is terminated or changes. Any outstanding balance due to dropped coverage will be the responsibility of the patient or insured.

INSURANCE INFORMATION

Name of person/agency responsible for this account:_____

Relationship to patient:_____

Address (if different than patient):_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Primary Insurance Company:_____

ID #:_____ GROUP#:_____ Ins. Phone: _____

Name of insured (if not patient):_____ Relationship to patient: _____

Insured's DOB: _____ Insured's SS#: _____

Insured's Employer: _____

Secondary Insurance (for Medicare Patients only)

Secondary Insurance Company :_____

ID#: _____ GROUP#: _____ Ins. Phone: _____

Name of Insured (if not patient):_____ Insured's DOB: _____

Please note that you will be responsible for any charges not covered by insurance due to preexisting condition, erroneous information provided to our office, or any non-covered procedure. All copayments and deductibles are due at the time of visit. This office does not accept postdated checks or attorney liens.

HMO covered patients will be responsible for full charges if insurance premiums are not paid and insurance company requests refund from Dr. Brown for services provided to the patient.

I authorize release of any information concerning my (or my child's) health care, advise, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also authorize payment of insurance benefits otherwise payable to me to be paid directly to Dr. Brown.

X_____ _____

Signature of patient (or guardian if patient is a minor) Date

PATIENT INTAKE FORM

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____ AGE: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____ **THIS IS REQUIRED FOR ALL PATIENTS EVEN CHILDREN!**

SEX: _____MALE _____FEMALE IF FEMALE ARE YOU PREGNANT? _____ IF YES HOW FAR ALONG? _____

Reason for your visit:

_____

_____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE BEEN TREATED IN THE PAST FOR BY A PHYSICIAN.

ADHD _____ Alzheimer's Disease _____ Anxiety _____ Arthritis _____ Diabetes Type 1_____ Diabetes Type 2_____

Depression _____ Fibromyalgia _____ Headaches _____ Hypertension _____ High Cholesterol _____

Heart Disease Explain _____ Heart Attack_____ Insomnia _____ Migraines _____ Multiple Sclerosis _____

Neck or Back problems Explain _____ Parkinson's Disease_____

Seizures Type _____ Stroke _____ Thyroid Problems_____

OTHER CONDITIONS NOT LISTED:_____

LIST ANY MAJOR SURGERIES: _____

_____

PLEASE LIST ANY MAJOR ILLNESS OF FAMILY MEMBERS:

Father: Living_____ Deceased_____ Medical Issues_____

Mother: Living_____ Deceased_____ Medical Issues_____

Other family members: _____

TOBACCO SECTION MUST BE ANSWERED ENTIRELY.

Do you use tobacco products? No_____ Yes_____ Cigarettes___ Cigars_____ Chewing Tobacco____ Dip_____ Vape____

What age did you first start using product? _____ If you have quit when did you stop? _____

Do you consume any alcohol products? No_____ Yes_____ IF YES, How much and type of alcohol? _____

DO YOU HAVE ANY IMPLANTED DEVICES SUCH AS PACEMAKERS, DEFIBRILLATORS, OR METAL RODS:

No_____ Yes _____ Type: _____

HAVE YOU HAD ANY CT SCANS OR MRI'S WITHIN THE LAST 5 YEARS: NO_____ YES_____

IF YES, WHAT IMAGING CENTER WERE THEY PERFORMED AT? _____

MEDICATION LIST

PATIENT NAME ______________________ BIRTHDATE _____/_____/_____ PATIENT # ______________

ALLERGIES - DRUG REACTIONS

PHONE # ______________________

PHARMACY ______________________

PHONE # ______________________

PROBLEM(S)	MEDICATION/STRENGTH	DIRECTIONS	NUMBER REFILLS	NURSE TO REFILL	DATE	REFILLS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
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				NO	STOP	INITIALS					

MEDICATION LIST

PROBLEM(S)	MEDICATION/STRENGTH	DIRECTIONS	NUMBER REFILLS	NURSE TO REFILL	DATE	REFILLS					
				YES	START	DATE					
				NO	STOP	INITIALS					
				YES	START	DATE					
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Item 077-0339/16655 Patterson Office Supplies 800-637-1140

Carl D. Brown, D.O.
8050 E HWY 191 Ste 205
Odessa, TX 79765

PHONE: (432) 332-2858 FAX: (432) 333-3697

OFFICE POLICIES

Effective 10/08/03 Revised 04/24/2024

PAYMENT IN FULL IS EXPECTED AT THE TIME OF THE VISIT BEFORE SEEING THE DOCTOR. THIS INCLUDES CO-PAYMENTS, DEDUCTIBLES, AND CASH VISITS. MEDICARE CO-PAYMENTS ARE TO BE PAID AT THE END OF THE VISIT. YOU MUST PRESENT YOUR INSURANCE, MEDICARE, OR MEDICAID CARD AT YOUR VISIT. FAILURE TO DO SO WILL RESULT IN THE APPOINTMENT BEING RESCHEDULED. THERE ARE NO EXCEPTIONS. IF PAYMENT CANNOT BE MADE, YOU WILL BE RESCHEDULED.

THERE WILL BE A $35.00 CHARGE FOR ALL RETURNED CHECKS.

WE DO NOT PROVIDE AN INTERPRETER IN THE OFFICE. YOU MUST BRING ONE WITH YOU TO YOUR APPOINTMENT IF YOU REQUIRE ASSISTANCE. ALL INTERPRETERS MUST BE OVER THE AGE OF 17. IF YOU ARRIVE WITHOUT AN INTERPRETER WE WILL NEED TO RESCHEDULE YOU.

ALL CHILDREN SEEN MUST BE ACCOMPANIED BY A PARENT OR GUARDIAN AT EVERY APPOINTMENT. DUE TO THE LIMITED SIZE OF OUR WAITING ROOM, THERE IS A LIMIT OF 2 PEOPLE PER PATIENT. ANY PERSON WHO IS NOT A PATIENT, INCLUDING A CHILD, IS EXPECTED TO GIVE UP THEIR SEAT TO A SCHEDULED PATIENT. PLEASE DO NOT BRING CHILDREN TO THE CLINIC IF THEY ARE NOT TO BE SEEN. YOU WILL BE ASKED TO TAKE THEM OUTSIDE. THIS DOES NOT INCLUDE INFANTS OR SPECIAL NEEDS CHILDREN. CHILDREN MUST BE KEPT UNDER CONTROL AT ALL TIMES.

THERE IS A $40.00 CHARGE FOR FILLING OUT ANY DISABILITY FORMS, LIFE INSURANCE FORMS, OR FOR A BRIEF MEDICAL STATEMENT. THIS IS TO BE PAID IN ADVANCE BEFORE THE FORM WILL BE FILLED OUT.

ANY PATIENT WHO SHOWS UP WITH EXCESSIVE PERFUME, COLOGNE, CIGARETTE, OR BODY ODORS MAY NEED TO BE RESCHEDULED. THIS IS OUT OF RESPECT TO OUR MIGRAINE SUFFERERS.

ALL REQUESTS FOR MEDICAL RECORDS MUST BE IN WRITING. PER TSMB GUIDELINES, THERE IS A $25.00 MINIMUM CHARGE FOR THE FIRST 20 PAGES AND A 50 CENT PER PAGE FEE FOR EACH ADDITIONAL PAGE. THIS MUST BE PREPAID IN CASH BEFORE RECORDS ARE COPIED. WE DO NOT PERMIT PATIENTS OR FAMILY MEMBERS TO ARRIVE AT THE OFFICE AND VIEW THE RECORDS. THIS DISRUPTS THE FLOW OF CARE TO OUR PATIENTS. THERE IS NO CHARGE FOR FAXING RECORDS TO ANOTHER PHYSICIAN'S OFFICE. WE WILL ONLY FAX RECORDS ONCE TO ANOTHER PHYSICIAN'S OFFICE. WE PROCESS REQUESTS FOR MEDICAL RECORDS ON FRIDAYS. YOU CAN ACCESS YOUR MEDICAL RECORDS AND PRINT OUT REPORTS AT NO CHARGE THROUGH YOUR PATIENT PORTAL.

THE OFFICE NURSE DOES NOT ACCEPT PHONE CALLS. ALL PATIENTS MAY MESSAGE STAFF THROUGH THEIR PERSONAL PATIENT PORTAL. THE NURSE RETURNS MESSAGES THROUGH THE PORTAL WITHIN AN HOUR. ALL PATIENTS ARE REQUIRED TO ACTIVATE THEIR PORTAL IN ORDER TO MESSAGE STAFF, VIEW APPOINTMENTS, AND ACCESS THEIR MEDICAL RECORDS.

DUE TO GOVERNMENT REGULATIONS REGARDING PRIVACY POLICIES, NO TEST RESULTS WILL BE GIVEN OVER THE PHONE. APPOINTMENTS MUST BE MADE TO REVIEW ANY TESTING ORDERED.

IF YOU ARRIVE MORE THAN 15 MINUTES LATE TO YOUR SCHEDULED APPOINTMENT TIME YOU MAY BE RESCHEDULED. PLEASE NOTIFY THE OFFICE IF YOU ANTICIPATE YOU WILL ARRIVE LATE. YOU MUST ARRIVE 30 MINUTES BEFORE YOUR APPOINTMENT TIME TO FILL OUT ALL NEW PATIENT PAPERWORK. IF YOU ARRIVE AT YOUR SCHEDULED APPOINTMENT TIME WITHOUT PAPERWORK YOU WILL NEED TO BE RESCHEDULED.

ANY REQUESTS FOR MEDICATON REFILLS MUST BE DONE BY THE PHARMACIST VIA FAX OR ESCRIBE. WE DO NOT CALL IN REFILLS. ALL PRESCRIPTIONS, OTHER THAN CONTROLLED SUBTANCES, WILL BE ELECTRONICALLY TRANSMITTED TO YOUR PHARMACY ON RECORD. PRESCRIPTIONS SHALL BE ISSUED WITH THE NUMBER OF REFILLS TO CORRESPOND WITH YOUR NEXT VISIT.

PLEASE TURN OFF ALL CELL PHONES ONCE YOU ARE CALLED BACK TO THE EXAM ROOM AREA.

(over)

PLEASE READ THIS SECTION CAREFULLY REGARDING OUR NO SHOW POLICY

ANY PATIENT WHO CANCELS THE DAY BEFORE THEIR APPOINTMENT MAY BE ASSESSED A $35 LATE CANCEL FEE. ANY PATIENT WHO CHOOSES TO LEAVE THE OFFICE AFTER SIGNING IN WILL BE CONSIDERED A NO SHOW AND MAY BE CHARGED AN $85.00 NO SHOW FEE. IF YOU CANCEL THE DAY OF YOUR APPOINTMENT OR NO SHOW YOUR APPOINTMENT YOU WILL BE MARKED AS A NO SHOW AND MAY BE CHARGED AN $85.OO NO SHOW FEE. IF WE ARE UNABLE TO REACH YOU THE DAY BEFORE YOUR APPOINTMENT FOR ANY REASON, TO INCLUDE: DISCONNECTED PHONES, WRONG NUMBERS, ETC., IT IS STILL YOUR RESPONSIBILITY TO KEEP YOUR SCHEDULED APPOINTMENT. IF YOU HAVE A MONDAY APPOINTMENT YOU MUST CALL BY THE THURSDAY BEFORE TO AVOID ANY FEES. ANY PATIENT WHO NO SHOWS TWO APPOINTMENTS IN A ROW WILL BE DISMISSED. A COMBINATION OF THREEE NO SHOWS OR LATE CANCELS IN A ONE YEAR PERIOD MAY RESULT IN DISMISSAL FROM THE PRACTICE. NO MEDICATIONS WILL BE REFILLED FOR PATIENTS WHO FAIL TO KEEP THEIR APPOINTMENTS. WE DO OF COURSE TAKE INTO ACCOUNT EXTENUATING CIRCUMSTANCES SUCH AS THE WEATHER, ILLNESS, AND FAMILY EMERGENCIES. WAIVING ANY LATE OR MISSED FEES IS AT THE DISCRETION OF THE OFFICE MANAGER AND IS BASED ON THE PATIENT'S OVERALL ATTENDANCE. WE APOLOGIZE TO THOSE PATIENTS WHO TAKE THE TIME TO KEEP THEIR APPOINTMENTS AND SHOW COURTESY TO THE STAFF AND DR. BROWN BY GIVING PROPER NOTIFICATION WHEN CANCELLING. WE HOPE YOU UNDERSTAND.

THE PATIENT (OR RESPONSIBLE PARTY) IS RESPONSIBLE FOR ANY CHARGES NOT COVERED BY THEIR INSURANCE. THIS APPLIES TO DEDUCTIBLES, NON-COVERED SERVICES, RETRO CANCELLED POLICIES, OR PRE-EXISTING CONDITIONS. WE MAKE EVERY EFFORT TO VERIFY BENEFITS BEFORE YOU ARE SEEN, BUT CANNOT FORSEE WHETHER A POLICY WILL PAY A CLAIM.

THIS OFFICE WILL NOT WRITE ATTENDENCE NOTES FOR MILEAGE REIMBURSEMENT FOR MEDICAID TRANSPORTATION. YOU WILL NEED TO BRING THE FORM WITH YOU TO THE APPOINTMENT TO BE STAMPED, OR MAIL IT TO THE OFFICE IN A SELF ADDRESSED STAMPED ENVELOPE.

THIS OFFICE DOES NOT SEE WALK-INS. WHETHER YOU ARE AN ESTABLISHED OR A NEW PATIENT, YOU MUST HAVE AN APPOINTMENT TO SEE DR. BROWN. PLEASE DO NOT SHOW UP AT THE WINDOW UNANNOUNCED FOR MEDICATION REFILLS, QUESTIONS ABOUT YOUR VISIT, OR TO HAVE MEDICAL FORMS FILLED OUT.

IF YOU WERE REFERRED TO SEE DR. BROWN BY THE EMERGENCY ROOM, YOU MUST PRESENT YOUR DISCHARGE PAPERS, IN ADVANCE, TO OUR OFFICE.

ANY ABUSIVE LANGUAGE TO THE STAFF, EITHER IN PERSON OR OVER THE PHONE, IS GROUNDS FOR IMMEDIATE DISMISSAL. THIS APPLIES TO THE PATIENT OR PATIENT'S FAMILY OR FRIENDS.

IF FOR ANY REASON YOU ARE DISMISSED FROM THE PRACTICE. YOU WILL RECEIVE A LETTER STATING YOUR DISMISSAL DATE, REASON, AND THE NAME OF OTHER PHYSICIANS YOU MAY USE. WE WILL FAX YOUR RECORDS TO YOUR NEW PHYSICIAN ONCE WE HAVE A SIGNED RELEASE.

IT IS OUR GOAL TO MAKE YOUR VISIT HERE PLEASANT AND STRESS FREE. WE DO NOT DOUBLE BOOK OUR PATIENTS AND STRIVE TO STAY VERY CLOSE TO SCHEDULE. WE HAVE FOUND THAT BY ADHERING TO THESE POLICIES IT HAS PROVIDED A RELAXING AND ENJOYABLE RELATIONSHIP WITH OUR STAFF, DR. BROWN, AND THE PATIENT. PLEASE DO NOT TAKE THESE POLICIES AS AN INSULT; RATHER, AS A WAY TO KEEP YOUR WAIT TIME TO A MINIMUM AND YOUR EXPERIENCE POSITIVE. THERE ARE ALWAYS EXCEPTIONS TO SEVERAL OF THE ABOVE POLICIES SO DO NOT HESITATE TO CONTACT OUR OFFICE IF YOU REQUIRE ASSISTANCE.

BY SIGNING BELOW, I AM STATING THAT I HAVE READ AND UNDERSTAND THE POLICES ABOVE.

ABSOLUTELY NO FOOD OR DRINK IS PERMITTED ANYWHERE IN THIS OFFICE.

Printed Name: _____ Signature: _____ Date: _____

Carl D. Brown, D.O.
AOA Board Certified Neurology
8050 E Highway 191 Suite 205
Odessa, TX 79765

Bus (432) 332-2858 **Fax (432) 333-3697**

Acknowledgment of Receipt of Notice on Privacy Practices

Use and disclosure of protected health information is regulated by a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under HIPAA, providers of healthcare are required to inform patients of their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a ***written*** acknowledgment that this notice was received.

Therefore, I, _____(printed name of patient or personal representative), acknowledge that **Carl D. Brown, D.O.** has provided a written copy of his Notice of Privacy Practices for Protected Health Information to (check one) _____ **myself** or _____ **specify:**_____.
(If signing as a personal representative, documentation of your legal right to do so must be provided).

_____ ____/_____/20____.
Printed Name **Date**

_____ _____
Signature of Patient or Personal Representative **Relationship to patient (If not self)**

To be completed by Carl D. Brown, D.O.

We made a good faith attempt to provide the above named patient with a copy of our Notice of Privacy Practices for Protected Health Information, but we were not successful for the following reason:

_____

_____

_____ _____ _____ ___/___/20__
Printed Name Title Signature Date

Carl D. Brown, D.O.
AOA Board Certified Neurology
8050 E Highway 191 Suite 205
Odessa, TX 79765

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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (i.e. opioid analgesics or pain pills, tranquilizers, and barbiturates) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or the ability to work. Because my physician is prescribing controlled substance medications to help manage my pain, I agree to the following conditions:

1. I will list all controlled substance prescriptions from my other doctors and keep Dr. Brown updated on any changes in these medications. If it is discovered that I have received controlled substance prescriptions from any other physician not listed in my chart, or I am using multiple pharmacies to obtain controlled substances, I will be discharged from Dr. Carl Brown's care immediately.
2. I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, stolen, or if I "run out early", I understand that it **WILL NOT** be replaced.
3. It may be deemed necessary by my doctor that I see a medication-use specialist at any time while I am taking controlled substance medications. I understand that if I do not attend such appointments, my medications may be discontinued or may not be refilled beyond a tapering dose to completion. I understand that if the specialist feels I am at risk for psychological dependence (addiction), my medications will no longer be refilled.
4. I agree to comply with random urine or blood testing, as deemed necessary by my doctor, in order to document the proper use of my medications and confirm compliance. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking controlled substance medications. I also understand that I should avoid the use of alcohol while taking controlled substance medications.
5. Refills of Class II narcotic medications will be made during regular office hours Monday through Thursday in person, once a month, during scheduled office visits. Refills will not be handled after office hours, on weekends, holidays, or via the fax machine.
6. I understand that if I violate any of the above conditions, my prescriptions for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, altering a prescription, or the concomitant use of non-prescribed illicit (illegal) drugs, I will be reported all of my physicians, medical facilities and appropriate authorities.
7. I understand that the main treatment goal is to reduce pain and improve my ability to function and/or work. In consideration of this goal, and the fact that I am being given potent medication to help reach this goal, I agree to assist myself by following better health habits: exercise, weight control, and avoidance of the use of tobacco and alcohol also understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and my treatment may change at any time at the discretion of my physician.
8. I know that patients may develop a tolerance to opioid analgesics, necessitating a dosage increase to achieve the desired effect and that there is a risk of physical dependence on the medication. This will occur if I am on opioid analgesics for several weeks; therefore, when I need to stop taking the medication, I must do so slowly and under medical supervision to prevent withdrawal symptoms.

I have read this contract and fully understand the consequences of non-adherence.

Date_____ Patient Signature_____ Witness Signature_____