

NAME: _____ Date: _____

Your present/past occupation(s): _____ Highest schooling level _____

Which hand do you use for writing? Right Left

Please circle any symptoms you are currently experiencing and mark thru symptoms you do not have

GEN:	weight loss/gain	fatigue	trouble sleeping	sleepiness	snoring
	forgetfulness	confusion	dizziness	fevers	decrease appetite
Eyes:	blurred vision	double vision	loss of vision	trouble hearing	ear/eye pain
ENT:	ringing in the ears	sinus drainage	sinus allergies	problems swallowing	problems chewing
CV:	chest pain	palpations	swelling of the legs		
Resp:	shortness of breath	cough			
GI:	nausea/vomiting	diarrhea	constipation	blood in stool	abdominal pain
GU:	urine incontinence	increase frequency	blood in urine	pain with urination	sexual problems
Derm:	Rashes	dry skin	itchy skin		
Heme/endo:	bruising	bleeding	hot/cold intolerance	blood transfusions	
Muscle:	muscle pain	muscle weakness	muscle cramps	joint pain	
Neuro:	headaches	weakness	numbness/tingling	balance problems	loss of consciousness
	Head injury	tremor	neck pain	low back pain	speech problems
Psych:	depression	anxiety	mood swings	suicidal thoughts	hallucinations

Please indicate if you or your family have a history of any of the conditions noted below:

	You	Family		You	Family		You	Family		
Anemia	_____	_____	Arthritis	_____	_____	Asthma	_____	_____		
Bleeding Disorders	_____	_____	Cancer	_____	_____	High Cholesterol	_____	_____		
Diabetes, Type 1	_____	_____	Controlled _____	Uncontrolled _____	Depression	_____	_____	Heart Disease	_____	_____
Diabetes, Type 2	_____	_____	Controlled _____	Uncontrolled _____	Hypertension	_____	_____	Liver problems	_____	_____
Heart rhythm problems	_____	_____	Kidney problems	_____	_____	Kidney stones	_____	_____		
Lung Problems	_____	_____	Nerve disorders	_____	_____	Migraines	_____	_____		
Muscle disorders	_____	_____	Strokes	_____	_____	Seizures/Convulsion	_____	_____		
Poor circulation	_____	_____	Infections	_____	_____	Venereal Disease	_____	_____		
Glaucoma	_____	_____	Fibromyalgia	_____	_____	Blood transfusion	_____	_____		
Thyroid problems	_____	_____				HIV	_____	_____		

Other Medical illnesses not mentioned above: _____

List Surgeries: _____

Do you smoke: _____ no _____ yes: previously, but quit _____ pack per day: _____ how many years _____

Do you drink alcohol: _____ no _____ yes: what kind _____ how much a week _____

Did you drink heavily in the past: _____ no _____ yes Have you used street drugs: _____ no _____ yes: type _____

Please list any allergies to any medications: _____

Please list medications and strengths: _____

Neurology Clinic of New Braunfels

220 Hunters Village, New Braunfels, Tx, 78132
830-632-5133 www.NeuroNB.com

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time during normal business hours to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions.

I have the right to allow access to my medical information by another individual for the sole purpose of assisting myself and the physician in my care and financial concerns. I would like to designate _____ who can be reached at _____ to have access to my medical information and billing information. Any additional names and contacts may be listed below or on the back of this form.

Printed Patient Name: _____

Signature: _____

Date: _____

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Charges for medical services are due at each office visit. Payments may be made with cash, check, or credit card. Insurance forms will be provided to patients so you may file for reimbursement. The office will file medical claims for patients who have current health insurance coverage with which the doctor is contracted. **You are responsible for any Deductible, Co-Pay or amounts designated by your insurance contract at the time of your office visit.** *If your policy requires a referral from your PRIMARY CARE PHYSICIAN, it is your responsibility to insure the referral has been made and received by this office. Denial of payment based on lack of approved referral will result in the transfer of the full balance to the patient.* Benefits must be assigned to the doctor on all claims that are filed by this office.

MEDICARE PART B: Assignment is accepted by our physicians. We will file your claims for all covered services and Medicare will pay benefits directly to the doctor. ***Each year you are responsible for a deductible of _____ for Medicare Part B.*** If you have a supplemental insurance, please check on their policy of payment for your deductible. **If you do not have supplemental coverage you will be asked to pay the 20% of the Medicare allowed amount at the time of your visit.**

SELF PAY: Payment for Medical Services is due at the time services are rendered. To encourage full payment a discount is offered, this discount is not available on accounts carrying a balance.

RETURNED/NSF CHECKS: There will be an immediate charge of \$50 for each returned check. *Payment of the \$50 and the amount of the returned check is due before the next office visit.*

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICIES PRESENTED TO ME IN THIS DOCUMENT.

PRINTED NAME

SIGNATURE

DATE