GRACE NEUROLOGY CLINIC, LLC
2021 West Loop 281
Longview, Texas 75604
903-392-2307 – phone
903-392-2308 – fax

Last Name: _____ First Name: _____ Middle Initial_____

Male___ Female ___ Date of Birth: _____ Marital Status: Single Married Divorced Widow (circle one)

Address: _____City_____ State ___ Zip _____

Home Phone: _____ Mobile Phone: _____ Social Security# _____

Pharmacy Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Place of Employment: _____ Phone: _____

Insurance and Policy #: _____Co-pay _____

Email address: _____@_____

Nearest Relative or Person we may contact in case of an Emergency

Name: _____ Relationship_____

Address: _____ Telephone #: _____

Assignment of Benefits Authorization for Treatment:
I hereby authorize treatment and authorize direct payment of surgical/medical benefits to Grace Neurology Clinic for services rendered by Dr. Rajani Caesar in person or under her supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf.

PRINT PATIENT NAME: _____

SIGNATURE: _____DATE: _____

PLEASE NOTE: Our Office Policy states that (3) no-shows for office visits within a 12 month period will result in dismissal from Grace Neurology Clinic.

GRACE NEUROLOGY CLINIC
HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began August 17, 2020. This form is "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____

(PRINT NAME)

_____ **Date**_____

(SIGNATURE)

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Authorization for Use or Disclosure of (PHI) Protected Health Information

I hereby authorize the use and disclosure of individually identifiable health information related to me, which is called (PHI), protected health information, under a federal health privacy law, as described below.

I, _____, authorize Grace Neurology Clinic to release and obtain my private health information to/from (check all that applies): This authorization includes medical record request from any medical facility.

Name_____Relationship_____

Name_____Relationship_____

Are there any restrictions on PHI to be disclosed: ____Yes ____ No If yes: _____

_____No one other than myself may have access to my medical records

May our office leave a message on your machine: ____ Yes ____ No

The PHI will be disclosed to confirm appointments, to render caregivers counseling on my treatment, referral to a medical facility, request for medical records, for prescription pick-ups, and any other reason to ensure I obtain optimum treatment and care while I am patient Grace Neurology Clinic I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to attention Privacy Officer at 2021 W Loop 281, Longview TX. I understand that my revocation will not affect any actions taken Grace Neurology Clinic prior to receiving my revocation. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I understand that I may refuse to sign this authorization and that my refusal in no way affects my treatment. My physician will not condition my treatment or payment on whether I provide authorization for the requested use or disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____

Patient Signature or Authorized Representative and relationship Date

GRACE NEUROLOGY CLINIC

Patient History

Patient Name: _____ Date: _____

WHAT IS THE REASON FOR YOUR VISIT? _____

Have you ever had?	No	Yes		No	Yes			
Hypertension			Hepatitis					
High Cholesterol			Diabetes					
Heart Attack			Anemia					
Stroke			Gout					
Pacemaker			Thyroid Disease					
Cardiac Defibrillator			Phlebitis					
Asthma			Cancer – Type?					
COPD/Emphysema								
Sleep Apnea								
Kidney Disease								

Has your Mom, Dad, or Siblings had any of the follow?	**Please list what family member.**
Hypertension	Hepatitis
High Cholesterol	Diabetes
Heart Attack	Anemia
Irregular Heartbeat	Gout
Pacemaker	Thyroid Disease
Cardiac Defibrillator	Phlebitis
Asthma	Stroke
COPD/Emphysema	Cancer
Sleep Apnea	High cholesterol
Kidney Disease	

Social History	Current	Past	How Much?
Alcohol			
Illegal Drug Use			

Please Check Correct Box

Tobacco	Every day Smoker_____	Some day Smoker_____	Former Smoker_____	Never Smoked_____

Patient Signature: _____ Date: _____

GRACE NEUROLOGY CLINIC
MEDICATION LIST

Patient Name: _____ Date: _____

Medication Name	Strength	How taken
Surgeries & Date:	**Height:**	**Allergies:**
	Weight:	