PATIENT INFORMATION

FIRST NAME_____ MIDDLE NAME_____ LAST NAME _____
DOB_____ GENDER_____ ADDRESS_____

_____ PHONE #_____

WHOM DOES THE CHILD LIVE WITH? _____

MARITAL STATUS OF PARENTS (CIRCLE ONE) MARRIED SINGLE SEPARATED

DIVORCED WIDOWED

ANY COURT ORDER IN PLACE FOR CHILD GUARDIANSHIP, CUSTODY, VISITATION

_____

IS IT OK TO CONTAT YOU VIA EMAIL AND MESSAGES? (CIRCLE ONE) YES / NO

MOTHER/LEGAL GUARDIAN INFORMATION

NAME_____ ADDRESS_____

CELL PHONE # _____ GENDER_____ RELATIONSHIP TO PATIENT_____

DOB_____ EMAIL _____

FATHER/LEGAL GUARDIAN INFORMATION

NAME_____ ADDRESS_____

CELL PHONE # _____ GENDER_____ RELATIONSHIP TO PATIENT_____

DOB_____ EMAIL _____

EMERGENCY CONTACT INFORMATION

NAME_____ PHONE #_____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

COMPANY NAME_____ POLICY/MEMBER/ID # _____

GROUP #_____ POLICY HOLDER NAME_____
DOB_____

318 W FM 544, Suite B1, Murphy, Texas 75094, United States

Phone # (469) 493 1964

Fax # (469) 242 9774

drdin@dinneurology.com

General Consent for Medical Treatment

I hereby authorize DIN NEUROLOGY AND DALLAS ADHD AND HEADACHE SPECIALIST (NEURO CARE LLC) to perform necessary medical examination and testing for the purpose of treatment of my child_____

_____

I also authorize DIN NEUROLOGY AND DALLAS ADHD AND HEADACHE SPECIALIST (NEURO CARE LLC) to release any necessary medical information pertaining to my child's examination, diagnosis or treatment, to any facility (including other physicians/clinics, laboratory, hospital or ancillary providers) to which my child may need to be referred.

I further authorize DIN NEUROLOGY AND DALLAS ADHD AND HEADACHE SPECIALIST (NEURO CARE LLC) to release any necessary medical information pertaining to my child's examination, diagnosis or treatment in order to process medical claims, to my insurance carrier.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

Parent/Guardian's Name: _____

Relationship to patient: _____

Signature: _____

Date: _____/_____/_____

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Acknowledgement of Notice of Privacy Practices (HIPAA)

I acknowledge that I have received the practice's Notice of Privacy Practices (HIPAA) of DIN NEUROLOGY AND DALLAS ADHD AND HEADACHE SPECIALIST (NEURO CARE LLC), which describes the ways in which the practice may use and disclose my child's healthcare information for treatment, payment, healthcare operations; and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice, if I have a question or complaint. To the extent permitted by law, I consent to the use, and disclosure of my child's information for the purposes described in the practice's Notice of Privacy. I understand that I may request a copy of the Notice of Privacy Practices (HIPAA) at any time.

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

Parent/Guardian's Name: _____

Relationship to patient: _____

Signature: _____

Date: _____/_____/_____

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Disclosure to Medical/ Financial Information to Family Members and Loved Ones

I authorize DIN NEUROLOGY AND DALLAS ADHD AND HEADACHE SPECIALIST (NEURO CARE LLC) to disclose medical/financial information to family members and / friends. I understand its an effort to adhere to HIPAA guidelines.

☐ I DO NOT agree or authorize the disclosure of my child's information to anyone other than the Biological Parents or Legal Guardians.

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

Parent/Guardian's Name: _____

Relationship to patient: _____

Signature: _____

Date: _____/_____/_____

Family / Friend Details_____

Family / Friend Details_____

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Financial Acknowledgement

I hereby assign all medical benefits, to which I am entitled, private insurance, and other plans to DIN NEUROOGY AND DALLAS ADHD AND HEADACHE SPECIALIST (NEURO CARE LLC).

I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

Parent/Guardian's Name: _____

Relationship to patient: _____

Signature: _____

Date: _____/_____/_____

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Private Pay or Patient Without Insurance

I understand and agree that if I don't have insurance coverage, I am expected to pay charges in full at the time services are rendered

Patient's Name: _____

Patient's Date of Birth: _____/_____/_____

Parent/Guardian's Name: _____

Relationship to patient: _____

Signature: _____

Date: _____/_____/_____

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Fax # (469) 242 9774

drdin@dinneurology.com

Primary care physician name: _____

Office Ph # _____

Address _____

HOW DID YOU HEAR ABOUT US?

_____