Neurology Clinic of New Braunfels

Phone: 830-632-5133, Fax: 830-608-9701, Email: Office@NeuroNB.com, Website: NeuroNB.com

Patient Demographic Form

Patient Information

- **Full Name:** _____
- **Date of Birth:** ____ / ____ / _____
- **Gender:** ☐ Male ☐ Female ☐ Prefer Not to Answer
- **Social Security Number:** _____
- **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
- **Street Address:** _____
- **City:** _____
- **State:** _____ **Zip Code:** _____
- **County:** _____
- **Primary Language:** _____
- **Email Address:** _____
- **Mobile Phone Number:** _____
- **Home Phone Number:** _____
- **Preferred Method of Contact:** ☐ Phone ☐ Email ☐ Text Message ☐ Mail
- **Race:** (Select one or more)
    - ☐ White
    - ☐ Black or African American
    - ☐ Asian
    - ☐ Native American or Alaska Native
    - ☐ Native Hawaiian or Other Pacific Islander
    - ☐ Other: _____
    - ☐ Prefer Not to Answer
- **Ethnicity:**
    - ☐ Hispanic or Latino
    - ☐ Not Hispanic or Latino
    - ☐ Prefer Not to Answer

Emergency Contact

- **Name:** _____
- **Relationship:** _____
- **Phone Number:** _____

Primary Insurance Information

- **Insurance Company: _____**
- **Policy Number: _____**
- **Group Number: _____**
- **Policy Holder's Name: _____**
- **Policy Holder's Date of Birth: ____ / ____ / _____**
- **Policy Holder's Relationship to Patient: _____**

Referral Information

- **Referring Physician: _____**
- **Phone Number: _____**

Consent to Receive Text Messages

- ☐ I consent to receive text messages from the Neurology Clinic of New Braunfels for appointment reminders, updates, and other relevant information. I understand that I can opt out of receiving text messages at any time by contacting the clinic directly or following the opt-out instructions provided in the messages.

Consent and Authorization

I, the undersigned, consent to the collection and use of my personal and medical information for the purpose of treatment, billing, and administrative processes at the Neurology Clinic of New Braunfels. I understand that my information will be kept confidential in accordance with privacy laws and regulations.

Patient Signature: _____ Date: ____ / ____ / _____

For Clinic Use Only

- **Date Received: ____ / ____ / _____ Entered by: _____**

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
No-Show Policy

Purpose:

The purpose of this policy is to ensure that our clinic can provide timely and effective care to all patients. When a patient fails to attend a scheduled appointment without proper notice, it impacts not only the availability of the appointment slot for other patients but also disrupts the clinic's operational efficiency.

No-Show Definition:

A "No-Show" occurs when a patient fails to arrive for a scheduled appointment and does not provide a minimum of 24 hours' notice of cancellation or rescheduling.

Policy Details:

1. Cancellation and Rescheduling:
    - Patients are required to provide at least 24 hours' notice if they need to cancel or reschedule an appointment.
    - Notices of cancellation or rescheduling should be communicated to the clinic by phone or through the clinic's patient portal, if available.
2. No-Show Fee:
    - A fee of $50 will be charged to the patient's account for each missed appointment where no prior notice is given.
    - This fee will be billed to the patient and is not covered by insurance.
3. Repeated No-Shows:
    - Patients who have multiple no-shows or cancellations may be subject to review by the clinic. Repeated occurrences may lead to additional fees or limitations on future appointments.
4. Waiver of Fee:
    - The no-show fee may be waived in cases of emergency or extenuating circumstances. Patients must contact the clinic within 48 hours of the missed appointment to request a waiver and provide supporting documentation if necessary.
5. Payment of Fee:
    - The no-show fee is payable upon receipt of the billing statement. Unpaid fees may be sent to collections and could affect future appointments or access to services.
6. Appeals:
    - Patients who believe that the no-show fee has been wrongly applied or who wish to appeal the fee may do so by contacting the clinic's billing department. Appeals should be submitted in writing within 30 days of receiving the billing statement.

Contact Information:

For any questions or to discuss your appointment, please contact us at:

Phone: (830) 632-5133 Email: Office@NeuroNB.com

Acknowledgment:

By signing below, you acknowledge that you have read, understood, and agree to the No-Show Policy of the Neurology Clinic of New Braunfels.

Patient Signature: _____
Date: ____ / ____ / _____

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