Focus Neurohealth

Focus Neurohealth
New Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Residence Type:	☐ Private Residence ☐ Nursing Home (Not a SNF) ☐ Skilled Nursing Facility or Assisted Living				
Sex:	☐ Male ☐ Female ☐ Transgender ☐ Other				
Marital Status:	☐ Single ☐ Divorced ☐ Married ☐ Partnered ☐ Widowed ☐ Legally Separated ☐ Other				
Ethnicity:	☐ Caucasian ☐ African American ☐ Asian/Pacific-Islander ☐ Hispanic ☐ Other				
Employment:	☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Full-Time Student ☐ Retired				
Employer:			Occupation:		
SSN #:			Email:		
Home Phone:		Cell Phone:		Work Phone:	
☐ <u>This is my preferred number.</u> May we leave personal/medical information on your voicemail? ☐ Yes ☐ No		☐ <u>This is my preferred number.</u> May we leave personal/medical information on your voicemail? ☐ Yes ☐ No *I understand that a cellular phone is not a secure and private line.*		☐ <u>This is my preferred number</u>	

REMINDER NOTIFICATION PREFERENCES

You will receive reminders for appointments, lab results, routine health maintenance, Rx confirmations, and general notifications based on your selection below.

☐ I wish to receive reminders via phone call (Voice)

☐ I wish to receive reminders via text message (SMS)

☐ I wish to receive reminders via phone call and text message (Voice & SMS)

INSURANCE COVERAGE

Please ensure you **bring your photo ID and insurance card(s)** to your appointment. If your insurance requires a referral, remember it's your responsibility to obtain one from your primary care physician.

Primary Insurance	
Carrier:	
ID#:	
Group#:	
Name of insured:	
Insured's date of birth:	
Relationship to insured:	☐ Self ☐ Spouse ☐ Other: _____

Secondary Insurance ☐ I do not have a secondary insurance.	
Carrier:	
ID#:	
Group#:	
Name of insured:	
Insured's date of birth:	
Relationship to insured:	☐ Self ☐ Spouse ☐ Other: _____

Name: _____ Date of Birth: _____ Date Packet Completed: _____

EMERGENCY CONTACTS

Please check the box below indicating whether or not you would like to have the selected contact(s) added as an authorized HIPAA contact.

Primary Emergency Contact	
☐ I authorize: ☐ I do NOT authorize:	the disclosure of my Protected Health Information (PHI) to the person listed as my Primary Emergency Contact.
Name:	
Main Phone:	
Work Phone:	
Relationship:	☐ Spouse ☐ Partner ☐ Sibling ☐ Parent ☐ Child ☐ Friend ☐ Other: _____

Secondary Emergency Contact	
☐ I authorize: ☐ I do NOT authorize:	the disclosure of my Protected Health Information (PHI) to the person listed as my Secondary Emergency Contact.
Name:	
Main Phone:	
Work Phone:	
Relationship:	☐ Spouse ☐ Partner ☐ Sibling ☐ Parent ☐ Child ☐ Friend ☐ Other: _____

Primary Care Provider (PCP)	
Name:	
Phone:	

Referring Provider	
Name:	
Phone:	

HOW DID YOU HEAR ABOUT US?

☐ Physician/Provider Referral ☐ Family or Friend ☐ Website or Search Engine ☐ Other: _____

REASON FOR VISIT

PAST MEDICAL HISTORY (E.G. DIABETES, HIGH BLOOD PRESSURE, CANCER, ETC.)

SURGICAL & HOSPITALIZATION HISTORY

List all surgeries, hospitalizations, and major injuries and specify the month and year they occurred.

PREVIOUS DIAGNOSTICS & TESTING

Please list any previous imaging or diagnostic tests, including MRI, CT, EEG, and specify where they were performed.

Name:_____ Date of Birth:_____Date Packet Completed: _____

FAMILY HISTORY

List any major illnesses in your family, including parents, grandparents, siblings, or children, (e.g. diabetes, cancer, etc.)

ALLERGIES

List any allergies you have to medications

PHARMACY INFORMATION

Primary Pharmacy			
Type:	☐ Local ☐ Mail-Order ☐ Specialty		
Name:			
Address:			
City:		Zip:	
Phone:		Fax:	

Secondary Pharmacy			
Type:	☐ Local ☐ Mail-Order ☐ Specialty		
Name:			
Address:			
City:		Zip:	
Phone:		Fax:	

CURRENT MEDICATIONS

List all medications you are currently taking, including prescribed, over-the-counter, and herbal supplements.

Medication	Start Date	Dose/Frequency	Prescribing Physician	Comments

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (____) _____ **ALT. PHONE** (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____) _____ Fax (_____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: Focus Neurohealth
Address: 3101 EAST GEORGE BUSH HIGHWAY, SUITE 105
City: RICHARDSON State: TEXAS Zip Code: 75082
Phone: (214) 540-1400 Fax: 972-234-4985

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

SIGNATURE X _____ _____
Signature of Minor Individual **DATE**

Focus Neurohealth

Acknowledgement and Assignment of Benefits, Agreement & Guaranty

By signing my name below, I:

- Consent to receive the following documents electronically which are available through our Patient Portal or through our website unless I request a non-electronic paper copy of the documents disclosed herein.
    - Focus Neurohealth's Notice of Privacy Practices
    - Focus Neurohealth's Financial Policy
    - Focus Neurohealth's Advanced Practice Provider (APPs) Information Guide
- Authorize:
    - To release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to Focus Neurohealth. I understand that Focus Neurohealth must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect necessary otherwise is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered.
    - I understand that the following authorizations are to be used by Focus Neurohealth and all the physicians associated therewith to affect the collections on my behalf. These authorizations become effective on the date of the first service rendered on my behalf and remain in effect until specifically revoked in writing by me. Copies of this agreement will be valid as this original
- Understand the following policies:
    - Patient Portal Use: The use of our patient portal is mandatory. You will receive access to this account where you can view lab results, notes, and imaging ordered by our practice. If you have any questions or concerns, please contact us to schedule a follow-up appointment. Please note that Focus Neurohealth will not be liable for any delay in results or abnormal results if you choose not to access your account.
    - Communication Policy: To ensure we can service your account or collect any payments you owe, our team may contact you at any telephone number associated with your account, including wireless numbers. Please note that this may result in charges to you. We may also send text messages or emails to any address you provide. Our methods of contact may include pre-recorded/artificial voice messages and/or the use of automatic dialing devices. By agreeing to this policy, you confirm that Focus Neurohealth, its employees, and/or agents may contact you as described above.
    - Compliance with Policies: Your agreement to these policies is important to us. Please understand that failure to comply with any of the above policies may result in your discharge from Focus Neurohealth.

Patient/Legal Representative Signature | Patient Printed Name | Date

Relationship (if legal guardian)

Focus Neurohealth

Medical Appointment Cancellation and No Show Policy

Thank you for choosing Focus Neurohealth for your neurological care. We are committed to providing you with exceptional service and the highest quality of care. We would like to remind you that when you schedule an appointment with us, we allocate enough time specifically for you to ensure that your health needs are adequately addressed.

If for any reason you need to reschedule or cancel your appointment, we kindly request that you inform our office as soon as possible, and at least 24 hours prior to your scheduled appointment. This will allow us to offer your appointment slot to other patients who may be waiting for an appointment. In addition, to help you keep track of your appointments, we provide automated reminder calls as a courtesy service.

Please see our Appointment Cancellation / No Show Policy below:

As per our policy, any established patient who fails to show for a scheduled appointment, or cancels or reschedules an appointment without providing at least 24 hours' notice, will be considered a "No Show". Please be aware that a Rescheduling Fee will be assessed to the patient's account in the event of a "No Show". This fee is the responsibility of the patient, not the insurance company. Payment of this fee is due at or before the patient's next office visit. The aim of this policy is to allow us to better serve the needs of all patients. By providing us with at least 24 hours' notice for cancellations or rescheduling, we are able to offer the appointment slot to another patient who may be in need of our care.

Follow Up Visit Cancellation/Rescheduling Fee: $40
Procedure Cancellation/ Rescheduling Fee: $100

You may contact Focus Neurohealth at (214)-540-1400 or by logging into our Patient Portal. Should it be after hours or a weekend, you may always leave a message.

I have read and understand the Medical Appointment Cancellation / No Show Policy and agree to its terms.

Patient/Legal Representative Signature	Patient Printed Name	Date

Relationship (if legal guardian)