Carrolton	Mckinney	Frisco	Plano	Grapevine	Fort Worth
4325 North Josey Lane	7300 Eldorado Pkwy	5375 Coit Road	8080 Independence Pkwy	1600 W College St	9525 N Beach St
Plaza III, Suite 203	Suite 200	Suite 130	Suite 230	Suite 470	Suite 405
Carrolton TX 75010	Mckinney, TX 75070	Frisco, TX 75035	Plano, TX 75025	Grapevine, TX 76051	Ft Worth, TX 76244

LONE STAR NEUROLOGY

Maushmi Sheth, M.D.	Martin Solomon, M.D.	Samantha Daniels, FNP-BC
Ramin Ansari, M.D.	Jodie Moore, ACNP-BC	Amanda Wesberry, FNP-C
Nnamdi C. Dike, D.O.	Amanda Skelton, FNP-BC	Kristen Papa, PA-C
Sandeep Dhanyamraju, M.D	Nissi Varghese, FNP-C	Jeff Adams, Ph.D.

Name: _____ Social Security: _____Date of birth: _____

Full Address: _____Phone#:_____

E-Mail _____

Chief Complaint:

Allergies to Medication:

Medical History:

Do you have or have you ever had any of these conditions?
If you have an illness not shown, please specify below.

Yes	No	
__	__	High blood pressure
__	__	Diabetes
__	__	High cholesterol or lipids
__	__	Heart attack/AFIB/CHF
__	__	Thyroid disease
__	__	Tumor/cancer/leukemia
__	__	Stroke/TIA
__	__	Epilepsy/Seizures
__	__	Depression/anxiety/bipolar/insomnia
__	__	COPD/Asthma/pneumonia
__	__	Kidney Disease
__	__	Autoimmune disease
__	__	Osteoarthritis
__	__	Blood clotting/anemia/sickle cell
__	__	Liver Disease
__	__	Other – please list below

_____

_____

_____

Surgical, injury, and Pregnancy History:

Please provide dates of operations, pregnancies, or injuries.
Please list more information on next page if more space needed.

Yes	No	
__	__	Brain surgery
__	__	Neck or back surgery
__	__	Sinus, facial or dental surgery
__	__	Vascular surgery
__	__	Heart surgery
__	__	Abdominal surgery
__	__	Hysterectomy/tubal ligation/C-Section
__	__	Lung Surgery
__	__	Head injury
__	__	Spinal injury
__	__	Hand, arm, leg or foot injury
__	__	Other injuries, fractures, etc.

Pregnancies:

How many times have you been pregnant? _____

How many live babies have you delivered? _____

Hospitalizations:

Please list diagnosis and year

_____

_____

Current Medications, Alternatives and Vitamins:

Name of Drug Dose (include strength and number of pills per day)

_____

_____

_____

_____

_____

_____

_____

Family History

Significant medical history in parents, siblings, children, aunts, uncles, grandparents

_____

_____

_____

_____

Other Information:

Which hand do you use for writing? ____Right _____Left

What is your present work status?
Working____, Retired____,
Unemployed____, Disabled_____

Do you drink coffee/ caffeine?
Never___, No___, Yes___, How many cups_____

How many alcoholic beverages do you consume?
#_____ per Day[__] or #_____Per Week[__]

Have you been exposed to toxins?
Don't know____, No____, Yes____

What is (was) your occupation?

Who lives with you at home?

How many children do you have?

Do you smoke cigarettes? (*or use any form of tobacco*)
Past/quit___, No___, Yes___, How many____

Have you been exposed to HIV?
Don't know____, No____, Yes____

Have you had the Flu vaccine?
Date administered _____

Have you recently had any of these tests?

Yes	NO		Date/ Location	Normal	Abnormal
__	__	MRI Brain	_____	__	__
__	__	CT Scan	_____	__	__
__	__	EEG (Brain Wave Recording	_____	__	__
__	__	EP (Evoked Potential) Study	_____	__	__
__	__	EMG and Nerve Conductions	_____	__	__
__	__	Cerebral Arteriogram	_____	__	__
__	__	Carotid Doppler	_____	__	__
__	__	Echocardiogram	_____	__	__
__	__	LP (Spinal Tap)	_____	__	__
__	__	Myelogram	_____	__	__
__	__	Blood Tests (Specify)	_____	__	__

Primary Care Physician: _____Office Phone#:_____

Address: _____City, State, Zip:_____

Pharmacy: _____ City _____ Phone:_____

Emergency Contact:_____Relationship:_____

Phone #:_____

Review of Systems

Check the box next to the symptoms that you have noticed over the last year; leave blank if none apply.

Constitutional

No complaints___

Poor Appetite__	Weight loss__	Fever__	Chills__
Night sweats __	Weight gain__	Fatigue__	Snoring__
Always tired__	Malaise__	Apnea__	Choking__
Restful sleep__	Blackouts__	AM Headaches__	
Hot flashes__	Sleepiness__	Dizziness	

Other/ Comments: _____

Eyes/Head

No complaints___

Vision changes__	seeing spots__	Itchy eyes__
Watery eyes__	Headaches__	Double/vision__

Other/Comments: _____

Ear/Nose/Throat

No complaints___

Hearing loss__	Ringing ears__	Ear pain__	Nasal polyps__
Nasal congestion__	Nasal drainage__	Change smell__	Nose bleed__
Sneezing__	Sinus pain__	Hoarseness__	Bad breath__
Sore throat__	Change in taste__		

Other/Comments: _____

Respiratory

No complaints___

Cough__	Pneumonia__	Phlegm__	Wheezing__
Chest tightness__	Chest injury__	Pleurisy__	Coughing blood__
Exposure to tuberculosis__		Shortness of breath at rest__	
Shortness of breath with walking__			

Other/Comments: _____

Heart

No complaints___

Chest pain__	Leg swelling__	Heart skipping__	Heart murmur__
Passing out__	Heart fluttering__	Palpitations__	
Waking up short of breath__		Shortness of breath while lying flat__	

Other/Comments: _____

Gastrointestinal

No complaints___

Indigestion__	Nausea__	Vomiting__	Bowel changes__
Constipation__	Belly pain__	Bloody stools__	Heartburn__
Tar-colored stools__	Choking on food__	Acid taste in mouth__	Diarrhea__
Pain Swallowing__			

Other/Comments: _____

Genitourinary

No complaints___

Bloody urine__	Frequent urination__	Burning with urination__	Incontinence__
Urination at night__	Recent Mammogram__	Recent pap smear__	Abnormal periods__
Vaginal discharge__	Decrease urine flow__		

Other/Comments: _____

Endocrine

No complaints___

Excessive thirst__	Frequent urination__	Increased appetite__
Heat intolerance__	Cold intolerance__	

Other/Comments: _____

Musculoskeletal

No complaints___

Arthritis__	Muscle pain__	Muscle weakness__
Joint stiffness__	Osteoporosis__	Back pain__

Other/Comments: _____

Skin/Breast

No complaints___

Easy Bruising__	Nail changes__	Warts__	Acne__
Hair loss__	Hives__	Moles__	Itching__
Discoloring__	Bolls__	Rash__	Lesions__
Breast lump__	Nipple discharge__		

Other/Comments: _____

Neurological

No complaints___

Epilepsy__	Seizures (“fits) __	Paralysis__	Speech changes__
Tingling__	Numbness__	Memory problems__	Headaches__
Lack of concentration__	Poor balance__	Tremors__	

Other/Comments: _____

Herme/Lymph

No complaints___

Anemia__	Easy bruising__	Swollen glands__	Hemophilia__
Easy bleeding__	Sickle cell disease__		

Other/Comments: _____

Allergy/Immunology

No complaints___

Nasal drainage__	Crusting__	Seasonal allergies__	Lupus__
Allergy shots__	frequent colds__	frequent infections__	autoimmune disease__

Other/Comments: _____

Lone Star Neurology Financial Policies

I agree to assign insurance benefits to **Lone Star Neurology**. We bill insurance companies as a courtesy for our patients and make every effort to inform patients of network status, however, patients are responsible for confirming with their insurance carrier if they deem our providers as in or out of network. I understand that if my contractual agreement with my insurance provider requires me to pay a copayment, deductible, and/or coinsurance, I must do so at the time of service to receive treatment.

I acknowledge full financial responsibility for services rendered by **Lone Star Neurology** and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to **Lone Star Neurology** and authorize said assignee to release all information necessary, including medical records, to secure payment.

I understand that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with ancillary healthcare provider(s) to whom I, the patient, may be referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such provider. Iunderstand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Changes in Insurance Coverage
If you have a change in insurance coverage, it is your responsibility to make sure we have all of the pertinent information on file including effective dates. Any medical expenses not covered by your insurance plan will be billed to you.

Returned Checks
A service charge of $10 will be added to all checks returned for Non-Sufficient Funds.

FMLA/PAPERWORK POLICY
Any FMLA, disability, or other paperwork requiring physician review and completion is subject to a minimum of $50 fee per form. Please allow up to 2 weeks for this paperwork to be completed.

Cancelled Appointments
We require twenty-four hours notice for cancellation of all doctor visits. It is the policy of Lone Star Neurology to bill a cancellation fee to a patient that does not show or cancel at least 24 hours in advance of a procedure, EMG, test, or appointment. This is to ensure that our treatment team is using their time to diagnose and treat patients that are in need of our services. A patient that arrives 20 minutes past the time of the appointment will be considered a “no show” for the purposes of this policy. Fees for no show appointments will be as follows:

EEG $100.00 EMG $100.00 Office Appt. $50.00

Please sign below indicating you have read and understand all policies above.

Patient Signature **Date**

MEDICATION REFILL POLICY

In order to provide excellent quality care, Lone Star Neurology adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our physician, allowing you to update our physicians on any changes in your medication regimen or advise of any new or ongoing symptoms.

- Lost, misplaced, or stolen prescriptions will not be replaced.
- Refilling of controlled substances will require an office appointment.
- Refills will only be addressed during regular office hours Monday - Thursday. Refill requests made Friday after 12 PM will not be processed until the following Monday.
- Approval of a refill may take up to 3 business days. I understand that it is my responsibility to contact the clinic in a timely manner.
- It is my responsibility to follow the medication in the dosage as prescribed. Early refill requests will not be approved.
- It is my responsibility to maintain my scheduled appointments with my provider. Repeated no shows and cancellations will result in a denial of refills.
- Early refills due to extenuating circumstances will be processed at the physician's discretion.

CONTROLLED SUBSTANCE POLICY

Controlled substance medications can be useful but have a high potential for misuse and are closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. If Lone Star Neurology prescribes controlled substance medications to help manage pain and/or anxiety, I agree to the following conditions:

I understand that if I refuse the recommendation of my doctor to seek the council of a high risk pain medication specialist when deemed necessary during my treatment, my medication may be discontinued.
I agree to comply with random urine, blood, or other testing to document the proper compliance and use of medication. I understand that I am responsible for all costs related to these screenings.
I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state.
I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined, and my treatment may change at any time. I understand, accept, and agree that there may be known (physical and psychological dependence) and unknown risks associated with the long-term use of controlled substances. I understand that my physician will advise me of any advances in this field and will make treatment changes as needed.
Our practice utilizes Electronic Medical Records (EMR) and electronically prescribes medications when possible in order to minimize delays at the pharmacy, provide low-cost formulary options, and to reduce the chance of medication error. In order for us to provide this service, we must have your permission to have the pharmacy clearinghouse communicate your current medications with our office.

___ Yes, my physicians at Lone Star Neurology may crosscheck for interactions and may have access to my medication profile.

___ No, my physicians at Lone Star Neurology may not electronically crosscheck for interactions and have access to my medication profile.

I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit drugs, I may be reported to all my physicians, medical facilities and appropriate authorities.

I have reviewed the above and have had a chance to ask questions about the same

Patient Signature **Date**

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Lone Star Neurology and/ or all of its affiliates understand that the medical information about you and your health is personal, and we are committed to protect this information. We create a record of the care and services you receive at our facilities in order to provide quality care and to comply with legal requirements. We comply with HIPAA policy which describes the disclosure and access of your health information. A copy of our Privacy Notice will be provided to you upon request. By signing below you acknowledge you have either obtained a copy of our Privacy Notice, received satisfactory clarification of particular conditions, or choose to obtain a copy at a later date.

Our practice reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

RESPONSIBLE PARTY INFORMATION

Name		DOB
Relationship to Patient *(Circle)*	Spouse Parent Other	
SSN		
Contact Numbers		

Cell Home Work Other

INSURANCE INFORMATION

Primary Insurance

Please Circle	Group (Employer)	Individual	Worker's Compensation*	Auto Accident Other
Insurance Name				
Policy Holder Name				
Policy Number		Group Number		
Relationship to Policy Holder *(Circle)*	Self	Spouse	Child	Other

Secondary Insurance

Insurance Name				
Policy Holder Name				
Policy Number		Group Number		
Relationship to Policy Holder *(Circle)*	Self	Spouse	Child	Other

*Workers Compensation *If Worker's Compensation injury, please provide the following information*

Employer	
Employer Address	
Employer Phone	
Adjustor Name	

Authorization to Release Information/ Assignment of Benefits
I authorize the physicians' office to release all Medical Information Necessary to process all claims for payment of medical service provided. I further authorize payment of all medical services directly to Lone Star Neurology.

Patient Signature_____Date_____

LONE STAR NEUROLOGY

Medical Records Request Form

FULL NAME: _____ Date of Birth: _____

Social Security#:_____

I hereby authorize_____
(Facility or covered entity)

To disclose medical records information with all labs and imaging and/or protected health information of the patient listed above to:
Name: Lone Star Neurology Providers
Address**:** 5375 Coit Road, Suite 130, Frisco, TX 75035 (all records go to main office only)
Phone #: 214-619-1910 Fax#: 214-619-1913

Records Requested: _____

- ○ Imaging Results
- ○ Labwork
- ○ Consult Notes
- ○ Discharge Summary

_____I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV initials testing, HIV results or AIDS information.

If this authorization is for disclosure of genetic information, please describe_____

Expiration: This authorization will not expire, unless as provided otherwise upon the Expiration Date or event given here:

_____

I understand that I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to clinic receiving the revocation. Further details may be found in the Notice of Privacy Practices.

If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

I understand that treatment and payment are not a condition of signing this authorization. I may receive a copy of this form after I have signed it.
I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____ _____
Date Signature of Patient/Parent/Representative Relationship to Patient

RELEASE OF MEDICAL INFORMATION AUTHORIZATION:

I give **Lone Star Neurology** authorization for the release of "Medical Records/Privacy Information", which includes your PHI, any medical conditions and/or billing and financial information to the following:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

I am issuing this letter for granting access to any of my medical records, like all X-rays, CT scans, MRI scans and other information relating to my treatment which I am undergoing at Lone Star Neurology under the care and treatment of Maushmi Sheth, M.D., Ramin Ansari, M.D., Nnamdi Dike, D.O., Sandeep Dhanyamraju, M.D. However, I notify that this disclosure of my personal medical information should not be for any other purpose other than this.

_____
Full Name of Patient

_____
Signature of Patient

_____
Date