



LONE STAR NEUROLOGY

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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.*

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

- | | | |
|---|---|-------------------------------------|
| — | — | 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 |

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 (was) your occupation?

What is your present work status?

Working___, Retired___,

Unemployed___, Disabled___

Who lives with you at home?

How many children do you have?

Do you drink coffee/ caffeine?

Never___, No___, Yes___, How many cups___

Do you smoke cigarettes? *(or use any form of tobacco)*

Past/quit___, No___, Yes___, How many___

How many alcoholic beverages do you consume?

___ per Day[] or # ___ Per Week[]

Have you been exposed to HIV?

Don't know___, No___, Yes___

Have you been exposed to toxins?

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. I understand 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

Phone: 214-619-1910

Website: <http://www.lonestarneurology.net>

Fax: 214-619-1913

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., Sandeep Dhanyamraju, M.D., Yu Zhao, M.D., Satish Gaddam, M.D., Riaz Tadia, M.D., John Harney, M.D. or Mahmood Akhavi, 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