

Bellaire Neurology
6565 West Loop South, Ste .401 Bellaire, TX 77401
713.715.6360 Phone ● 713.715.6367 Fax

New Patient Information & Questionnaire

Name _____ Date _____

Email address _____

Sex: M F Birthdate: _____ Marital Status _____ SSN: _____

Address: _____ City _____ State _____ Zip _____

Home Phone Number _____ Work phone number _____

Cell phone number _____

Responsible Party _____ Relationship to Patient _____

Responsible Party Employer _____

Responsible Party Birthdate _____

Parent or Legal Guardian _____ Address _____

City _____ State _____ Zip _____ Contact Number (s) _____

Patient's Employer _____ Contact Number _____

TDL# _____ Emergency Contact _____

Emergency Contact Relationship _____

Emergency Contact Number(s) _____

Primary Insurance Information

Name of Insurance Company _____ (give card to Receptionist)

Address for claims _____ City _____ State ____ Zip _____

Insured's Full Name _____ Insured's Date of Birth _____

Relationship of Patient to Insured _____ Group # _____ Policy ID _____

Note if your card indicates you are a member of Beech Street _____,

First Health _____, or PHCS _____

Secondary Insurance Information

Name of Insurance Company _____ (give card to Receptionist)

Address for claims _____ City _____ State ____ Zip _____

Insured's Full Name _____ Insured's Date of Birth _____

Relationship of Patient to Insured _____ Group # _____ Policy ID _____

Note if your card indicates you are a member of Beech Street _____,

First Health _____, or PHCS _____

For Office Use Only

Account Number _____ First Date of Service _____

TREATMENT AUTHORIZATION

Patient Name: _____ Date: _____
(Check and sign the applicable paragraph)

____ I authorize Bellaire Neurology, PA to examine, diagnose and treat me. I authorize and give Bellaire Neurology, PA consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient.

Signature of Patient Date _____

____ I hereby authorize Bellaire Neurology, PA to examine and treat _____ (name of patient). I authorize and give Bellaire Neurology, PA my consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study to include diagnosis for submission for payment to the insurance carrier for the named patient

Signature of Parent/Guardian Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Bellaire Neurology, PA to release any information necessary to my insurance company (ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

Signature Date _____

RESPONSIBLE PARTY AGREEMENT

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. If any charges are submitted to my insurance carrier by either Bellaire Neurology, PA or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services, I agree to pay for any balance deemed applicable according to my health insurance rules and regulations. I hereby agree that I am responsible for the payment of any co- payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I am not covered by any insurance carrier, I agree to pay for services rendered at the time of service.

Signature Date _____

MEDICARE/ MEDICAID AUTHORIZATION

I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to Bellaire Neurology, PA for any services furnished by my physician to the named patient. I understand my signature requests that payment be made directly to the provider of care and that the provider agrees to accept the charge determination of the Medicare/Medicaid carrier as the full charge, and that the insured patient is responsible only for the deductible, co-insurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare/Medicaid carrier. I attest that I am eligible for Medicare and/ or Medicaid coverage.

Signature Date _____

New patient medical information form for Bellaire Neurology, PA

Name _____ Date _____

Principal reason for seeing Dr. Loftus? _____

How long have you had this problem? _____

Any other Neurological issues? _____

Referred by Whom: _____

If referred by MD – Fax # _____ Phone _____

Current Medications (please attach another page if needed)

Name with dose and frequency	Reason for medication	Prescribing MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies and Adverse Reactions (please attach page if needed)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drugs previously tried for principal complaint but not currently taking

Name with dose and frequency	Reason for stopping	Prescribing MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other issues:	Yes	No
Do you feel excessive fatigue, tiredness, or bad in general?	_____	_____
Recent change in weight?	_____	_____
Recent fever?	_____	_____
Headaches?	_____	_____
Double vision or change in vision?	_____	_____
Shortness of breath at rest?	_____	_____
Shortness of breath with exercise?	_____	_____
Do you have a regular exercise routine?	_____	_____
Chest pain at rest (or not exercise related?)	_____	_____
Chest pain with exercise?	_____	_____
Diagnosed with cardiac disease?	_____	_____
Problems with nausea?	_____	_____
Problems with inability to control stools (incontinence)?	_____	_____
Problems with inability to control urine (incontinence)?	_____	_____
Problems with sexual activity (if currently sexually active)?	_____	_____
Problem with neck pain or arm pain?	_____	_____
Problem with low back pain or leg pain?	_____	_____
Do you feel that you are depressed?	_____	_____
Do you feel that you are overly anxious?	_____	_____
Do you wake up feeling refreshed?	_____	_____
Do you snore?	_____	_____
If female, do you have regular menstrual cycles?	_____	_____

Past Medical History (attach additional page if needed)

Other Medical Conditions	Date of Onset	Treating MD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past surgeries	Date performed	MD performed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diseases that run in your immediate family (parents, brother, sisters, children)

Does anyone in your immediate or extended family have the same condition or symptoms for which you are seeing Dr. Loftus?

Do you currently smoke or use any tobacco product? _____

Have you smoked greater than 100 cigarettes in your lifetime? _____

How much alcohol do you typically drink? _____

How much caffeine do you typically drink? _____

Have you used, or currently use, any illegal substances? _____

Please list the physicians you would like us to keep up to date on your care.

Name	Phone	Fax
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any other information you would like to tell us?

BELLAIRE NEUROLOGY, PA

Acknowledgement of Review of Notice of Privacy Practices

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 this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority

BELLAIRE NEUROLOGY, PA
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

1) **Treatment, Payment, Health Care Operations**

a) **Treatment**

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will share some or all of your medical information with that physician to facilitate the delivery of care.

b) **Payment**

We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

c) **Health Care Operations**

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. We may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care.

Other examples are:

2) **Disclosures That Can Be Made Without Your Authorization**

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

a) **Public Health, Abuse or Neglect, and Health Oversight**

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

b) **Legal Proceedings and Law Enforcement**

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- i) The information is released pursuant to legal process, such as a warrant or subpoena;
- ii) The information pertains to a victim of crime and you are incapacitated;
- iii) The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- iv) The information is about a victim of crime and we are unable to obtain the person's agreement;
- v) The information is released because of a crime that has occurred on these premises; or
- vi) The information is released to locate a fugitive, missing person, or suspect.

- 3) We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.
- a) Workers' Compensation
We may disclose your medical information as required by workers' compensation law.
 - b) Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.
 - c) Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.
 - d) Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.
 - e) Required by Law
We may release your medical information when the disclosure is required by law.
 - i) Your Rights Under Federal Law-The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.
 - f) Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.
You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.
To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.
 - g) Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.
 - h) Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document.
We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.
We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:
 - i) The information is psychotherapy notes.
 - ii) The information reveals the identity of a person who provided information under a promise of confidentiality.
 - iii) The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
 - iv) The information has been compiled in anticipation of litigation.
 We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.
Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee for copies.
 - i) Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:
 - i) The information wasn't created by this practice or the physicians in this practice.
 - ii) The information is not part of the designated record set.
 - iii) The information is not available for inspection because of an appropriate denial.

iv) The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

j) Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

4) Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

5) Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us.

6) Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

7) Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Blakely Long, Privacy Officer
6565 West Loop South, Suite 401
Bellaire, TX 77401

This notice is effective April 1, 2006

NOTICE CONCERNING COMPLAINTS

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

**Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018**

Assistance in filing a complaint is available by calling the following telephone number:

1-800-201-9353

For more information please visit our website at

www.tmb.state.tx.us

AVISO SOBRE LAS QUEJAS

Las quejas sobre médicos, así como sobre otros profesionales acreditados e inscritos en la Junta de Examinadores Médicos del Estado de Texas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugía, se pueden presentar en la siguiente dirección para ser investigadas:

**Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, Texas 78768-2018**

Si necesita ayuda para presentar una queja, llame al:

1-800-201-9353

Para obtener más información, visite nuestro sitio web en

www.tmb.state.tx.us