HOUSTON Methodist LEADING MEDICINE

Methodist Sugar Land Neurology Associates
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Sugar Land, TX 77479
(281) 494-6387 (281) 494-6410 Fax

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Board Certified in Adult Neurology

We appreciate the trust you've placed in us to provide your specialty care. The following information clarifies our respective responsibilities in providing and receiving information. Our patient care procedures have been developed over time to maximize your visit experience and outcome.

New Patients: New patients are usually referred to us by their primary care physician or other specialist. If you have received diagnostic testing of any kind (x-ray, MRI, CT, laboratory) related to this visit, please bring the test results with you or have them forwarded to us prior to your visit.

If you are insured with an HMO, your primary care physician will provide a written referral that includes their diagnosis for referral. Without a referral, we will not be able to bill your insurance and you may be asked to pay in full at the time of visit.

Please bring the following:

- Written referral – HMO insurance only
- Results of tests ordered by referring MD
- New patient forms
- Insurance card
- Photo ID

Appointments: We attempt to contact patients 24-48 hours prior to their appointment. Our schedule is usually booked several weeks in advance, so we ask for at least one business day notice for cancellation. **Failure to notify our office of cancellation at least one full business day prior to your scheduled appointment or not appearing for your scheduled appointment will result in a No- Show Charge of $25.**

Test Results: Test results are given during a follow-up visit only. You will be asked to schedule an appointment to discuss results of any tests ordered by our physicians to avoid misunderstandings and improve the patient care outcome. Please do not contact the office for a copy, fax, or verbal disclosure prior to your follow-up appointment. NOTE: You will be contacted should any result require action prior to your scheduled follow-up appointment.

Forms: We will not complete disability, FMLA, or functional capacity evaluation forms.

Refills: Medications prescribed by our physicians may be refilled if you have been seen within the last year. Refills will not be approved after office hours or on weekends. We do not call mail order pharmacies as they require a written prescription.

Signature of Acknowledging Party:	Date:

Methodist Sugar Land Neurology Associates

Financial Policy

Methodist Physician Billing Office: 713-441-4347 Methodist Hospital Billing Office: 832-667-5900

In order to better serve you, please read and familiarize yourself with our financial policies so future billing misunderstandings can be avoided. If you have any questions, please do not hesitate to speak with our billing office at the number listed above.

1. You are in-network / out-of-network with our physician. If you would like a copy of the benefits we verified, please ask the receptionist. The insurance we verified was:

Aetna	Blue Cross / Blue Shield
United HealthCare	Medicare
Cigna	Other: _____

2. If we are out-of-network with your insurance, we will provide you with all the necessary documents for reimbursement.
3. We have a return check fee of $30.00.
4. We will provide an itemized statement of all services provided.
5. At any time if you do not understand your statement, we shall provide, in plain language, a written explanation of the charges for services or supplies previously made on a bill or statement.
6. We will refund you within 30 days after the date the facility determines an overpayment has been made. Therefore, if you are aware of any overpayment, please feel free to contact our billing office at the number listed above.
7. Co-pays, co-insurance and deductibles are due at the time of the visit.
8. Methods of payment include: cash, check, credit card.

Print Patient Name:	Date:
Signature of Acknowledging Party:	Date:

Note: 1,4,5,6 are required by S.B. 1731

PATIENT INFORMATION
COMPLETE FORM IN DETAIL

Patient's Name_____Date of Birth _____ Sex_____
(MM/DD/YYYY)

Home Address_____
(No P. O. Boxes) (Street, Apt. #) (City) (State) (Zip)

Phone: Home # _____ Cell # _____

SS#_____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name _____Work # _____Cell#_____

Emergency Contact _____Relation_____Daytime Phone # _____
(OTHER THAN SPOUSE)

Address_____City_____State_____Zip_____

Who is your Primary Care Doctor?

Name _____

Address_____

Phone # _____

Referring Physician (if not your PCP)

Name _____

Address_____

Phone # _____

INSURANCE INFORMATION

CURRENT VALID INSURANCE CARDS AND A PHOTO ID MUST BE PROVIDED

Is this a worker's compensation claim? ☐ ***Yes*** ☐ ***No*** ***Is this related in any way to an accident/injury?*** ☐ ***Yes*** ☐ ***No***

Primary Insurance:_____ ☐ PPO ☐ HMO ☐ POS

Subscriber name: (Last)_____(First)_____(MI)_____DOB_____

☐ Self ☐ Spouse ☐ Parent ☐ Other ID No._____ Group No._____

Secondary Insurance:_____ ☐ PPO ☐ HMO ☐ POS

Subscriber name: (Last)_____(First)_____(MI)_____DOB_____

☐ Self ☐ Spouse ☐ Parent ☐ Other ID No._____ Group No._____

I understand that I am responsible for my bill. I authorize Methodist Sugar Land Neurology Associates to act as my agent in helping me obtain payment from my insurance company/companies. I authorize payment directly to Methodist Sugar Land Neurology Associates. I authorize release of information necessary to collect payments to all my insurance companies. I further authorize release of medical information to any and all physicians involved in my care. I permit a copy of this authorization to be used in place of the original. I authorize the use of the "Signature on File" to be used on all my insurance submissions. I understand that I am responsible for notifying the office of any Precertification or referral needed for my insurance.

Signature of Patient or Guardian: _____ Date: _____

Methodist Sugar Land Neurology Associates

PAST MEDICAL HISTORY
COMPLETE IN DETAIL

SURGICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST SURGICAL HISTORY)*

☐ Appendectomy ☐ Cataract ☐ Gyn Surgery ☐ Gallbladder ☐ Tonsillectomy ☐ Hernia ☐ Heart Surgery
☐ Pacemaker ☐ Other Surgeries:_____

MEDICAL HISTORY *(CHECK BOXES THAT APPLY TO YOUR PAST MEDICAL HISTORY)*

☐ High Blood Pressure ☐ Diabetes ☐ Seizures ☐ Heart Disease ☐ Migraine ☐ Stroke
☐ Thyroid Disease ☐ High Cholesterol
☐ Cancer (Type of Cancer)_____
☐ Other Medical or Neurological Problems_____

CURRENT MEDICATIONS & DOSAGE *please complete in detail*

SOCIAL HISTORY

Smoking? ☐ No ☐ Yes (If yes, please list how many packs per day and for how many years you have smoked)
____Packs per day for ____ year(s). Date Quit Smoking_____

Alcohol? ☐ No ☐ Yes (If yes, please indicate the number of drinks per day, number of years, and type(s) of alcohol used)
____drink(s) per day for ___year(s). Type(s) of drinks ☐ Beer ☐ Wine ☐ Mixed Drinks
☐ Never used alcohol ☐ Hospitalized for alcohol use

EMPLOYMENT Job Title_____

Exposures: ☐ Noise ☐ Chemicals ☐ Toxins ☐ Fumes ☐ Gases

EDUCATION Highest level Achieved_____

FAMILY HISTORY *(please list those people in your family with the following illnesses):*

High Blood Pressure: _____
Diabetes: _____
Stroke: _____
Seizures: _____
Alzheimer's: _____
Heart Disease: _____
Cancer: _____
Migraine: _____
Parkinson's: _____
Other Neurological Problems:
_____

Patient Name: _____ Date: _____

☐ Select this box to answer No for all questions. After selecting this box, you can still modify individual questions.

Patient Symptoms

Constitutional Symptoms			If Yes, please explain
Good general health lately:	☐ No	☐ Yes	_____
Recent weight change:	☐ No	☐ Yes	_____
Fever:	☐ No	☐ Yes	_____
Fatigue:	☐ No	☐ Yes	_____
Headaches:	☐ No	☐ Yes	_____
Eyes			
Eye disease or injury:	☐ No	☐ Yes	_____
Wear glasses / contact lens:	☐ No	☐ Yes	_____
Blurred or double vision:	☐ No	☐ Yes	_____
Glaucoma:	☐ No	☐ Yes	_____
ENT			
Hearing loss or ringing:	☐ No	☐ Yes	_____
Nose bleeds:	☐ No	☐ Yes	_____
Swollen glands in neck:	☐ No	☐ Yes	_____
Cardiovascular			
Heart trouble:	☐ No	☐ Yes	_____
Chest pain or angina pectoris:	☐ No	☐ Yes	_____
Palpitation:	☐ No	☐ Yes	_____
Shortness of breath with walking or laying flat:	☐ No	☐ Yes	_____
Swelling of feet, ankles or hands:	☐ No	☐ Yes	_____
Respiratory			
Chronic or frequent coughs:	☐ No	☐ Yes	_____
Spitting up blood:	☐ No	☐ Yes	_____
Shortness of breath:	☐ No	☐ Yes	_____
Asthma or wheezing:	☐ No	☐ Yes	_____
Gastrointestinal			
Change in bowel movements:	☐ No	☐ Yes	_____
Nausea or vomiting:	☐ No	☐ Yes	_____
Rectal bleeding or blood in stool:	☐ No	☐ Yes	_____
Abdominal pain or heartburn:	☐ No	☐ Yes	_____
Peptic ulcer (stomach or duodenal):	☐ No	☐ Yes	_____
Genitourinary			
Frequent urination:	☐ No	☐ Yes	_____
Burning or painful urination:	☐ No	☐ Yes	_____
Blood in urine:	☐ No	☐ Yes	_____
Incontinence or dribbling:	☐ No	☐ Yes	_____
Kidney stones:	☐ No	☐ Yes	_____

Patient Name:_____ Date:_____

Patient Symptoms (cont.)

Musculoskeletal — If Yes, please explain

- Joint pain: ☐ No ☐ Yes _____
- Joint stiffness or swelling: ☐ No ☐ Yes _____
- Weakness of muscles or joints: ☐ No ☐ Yes _____
- Muscle pain or cramps: ☐ No ☐ Yes _____
- Back pain: ☐ No ☐ Yes _____
- Cold extremities: ☐ No ☐ Yes _____
- Difficulty in walking: ☐ No ☐ Yes _____

Integumentary (skin)

- Rash or itching: ☐ No ☐ Yes _____
- Change in skin color: ☐ No ☐ Yes _____
- Varicose veins: ☐ No ☐ Yes _____

Neurological

- Frequent or recurring headaches: ☐ No ☐ Yes _____
- Lightheaded or dizzy: ☐ No ☐ Yes _____
- Convulsions or seizures: ☐ No ☐ Yes _____
- Numbness or tingling sensations: ☐ No ☐ Yes _____

Psychiatric

- Memory loss or confusion: ☐ No ☐ Yes _____
- Nervousness: ☐ No ☐ Yes _____
- Depression: ☐ No ☐ Yes _____
- Insomnia: ☐ No ☐ Yes _____

Endocrine

- Excessive thirst or urination: ☐ No ☐ Yes _____
- Heat or cold intolerance: ☐ No ☐ Yes _____

Hematologic / Lymphatic

- Bleeding or bruising tendency: ☐ No ☐ Yes _____
- Anemia: ☐ No ☐ Yes _____
- Phlebitis: ☐ No ☐ Yes _____
- Past transfusion: ☐ No ☐ Yes _____

Allergies: History or Reaction to Medicines or Other Agents

☐ Select this box if you have No history of allergies or reactions to medication.

Penicillin: ☐ No ☐ Yes

Other antibiotics: ☐ No ☐ Yes (list): _____

Morphine, Demerol, or other narcotics: ☐ No ☐ Yes

Novocain or other anesthetics: ☐ No ☐ Yes

Aspirin or other pain remedies: ☐ No ☐ Yes

Iodine, methiolate or other antiseptic: ☐ No ☐ Yes

Tetanus antitoxin or other serums: ☐ No ☐ Yes

Other drugs / medications: _____

Patient Name: _____ Date: _____

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TMH PHYSICIAN ORGANIZATION AND ITS PHYSICIANS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

You have been given the Notice of Privacy Practices for TMH Physician Organization and its Physicians. This Notice describes your legal rights regarding your health information and will inform you of the legal duties and privacy practices of TMH Physician Organization and its Physicians with respect to health information created for services generated by TMH Physician Organization and its Physicians. If you receive services by your physician or other health care provider at a different location, you may want to ask about that office or clinic's health information privacy policies and notices because they could be different.

Your name and signature below indicate that you have been provided with a copy of this Notice of Privacy Practices.

If you have a question regarding any of the information set forth in this Notice of Privacy Practices, please do not hesitate to call the Privacy Official at 713.383.5129.

_____
Patient Name

_____ _____
Signature of Patient or Patient's Qualified Personal Representative Date

_____
Printed Name of Qualified Personal Representative

_____
Legal Authority to Act on Behalf of the Patient

Note: In the case of an Obstetrical patient, this signed acknowledgment for receipt of the Notice of Privacy Practices also serves as receipt of the Notice of Privacy Practices on behalf of the newborn(s).

For Staff Use Only

Date Acknowledgment noted in HIS/patient management system: _____

Comments if Notice not provided or Acknowledgment not obtained: _____

_____

Processed by: _____

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PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO FRIENDS AND FAMILY

We value your privacy and ask that you help us identify the persons whom you would like us to discuss your health care. (Including, but not limited to: test results, recent visits, medication requests, appointment information, and billing/insurance information).

☐ I GIVE PERMISSION for TMH Physician Organization dba Methodist Sugar Land Neurology Associates to disclose relevant health information to my family members and to the individual(s) I have listed below:

1st Name: _____ Relationship_____

Phone:_____

2nd Name: _____ Relationship_____

Phone: _____

3rd Name: _____ Relationship_____

Phone: _____

4th Name: _____ Relationship _____

Phone: _____

_____
Patient Name

_____ _____
Signature of Patient or Patient's Qualified Personal Representative Date

_____
Printed Name of Qualified Personal Representative

_____
Legal Authority to Act on Behalf of the Patient

***This does not authorize copies of PHI to be mailed or faxed to the persons listed. To obtain copies of PHI a valid HIPAA release is required**