NEUROLOGY ASSOCIATES OF FORT WORTH

1325 PENNSYLVANIA AVE. SUITE 700, FORT WORTH, TEXAS 76104
PHONE (817) 332-2876
FAX# (817) 877-3672

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last*)______________________________

Date of Birth ______________ **Age** ______ **Male / Female** **Marital Status: S M W D**

Which of the following describes you best?
African American, Caucasian, Asian, Hispanic, Mediterranean, Native American, Other

What is your native language? __________

Address__________________**City**________**State**______**Zip**________

Phone Number ______________ **Mobile Phone Number** ______________

E-Mail Address ________________ **Social Security #** ______________

Referring Physician ________________ **Physician Phone Number** __________

RESPONSIBLE PARTY

Name __________________**Relationship to Patient**________

Power of Attorney: Yes / No

Address__________________**City**________**State**______**Zip**________

Phone Number ______________

Emergency Contact ________________**Relationship**______________

Phone Number ______________

INSURANCE INFORMATION

Primary Insurance ______________ **Primary Member ID #** ______________
Primary Group # ______________

Secondary Insurance ______________ **Secondary Member ID#** ______________
Secondary Group#______________

Primary Insured's Name ________________ **Date of Birth** __________
Relationship to Patient: Self/Spouse/Dependent

Consent/Release/Assignment
I request and authorize Neurology Associates of Ft. Worth to treat me. I authorize photographs and recordings to be made for documentation, research, and educational purposes. I authorize the release of any medical information to process any insurance claim by said physician; and I assign and transfer to Neurology Associates of Fort Worth any benefits payable to or for my benefit under hospitalization, sickness, or accident insurance. I authorize Neurology Associates of Fort Worth to leave any recorded message regarding my care on an answering machine device or voice mail. My signature affirms all of the statements made above.

Patient Signature or Authorized Person's Signature________________ **Date**__________

NEUROLOGY ASSOCIATES OF FORT WORTH

Roger S. Blair, M.D.

FINANCIAL POLICY

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED this includes co-pays, coninsurances and deductibles. The patient will be responsible for non-covered services.

We accept Payment by cash, personal check, Mastercard, Visa, and American Express.

Self Pay new patients should be prepared to pay $190.00 to $370.00 for the first visit. Any testing or additional services will be rendered at an additional fee.

HMO and PPO: Patients covered by a Health Maintenance Organization (HMO) or Participating Provider Organization (PPO), of which NEUROLOGY ASSOCIATES OF FORT WORTH is a participant, must bring the HMO/PPO card and be prepared to pay the CONTRACT CO-PAY AMOUNT at the time of service.

MEDICARE: We accept assignment on all Medicare Claims. Patients covered by MEDICARE PART B, must bring the Medicare card. We will also file MEDICARE SUPPLEMENT claims.

WE WILL FILE PRIVATE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. If you wish us to file for you, please bring your insurance card to your first visit so we may verity your coverage. Payment for the UNINSURED PORTION is due at the time services are rendered. This includes DEDUCTIBLE and COINSURANCE as verified by the insurance carrier.

HMO: If the insurance is an HMO, and requires a referral, it is the patients' responsibility to verify the office has received proper authorization from the insurance company. The authorization/referral would come from the patients' primary care Physician.

PLEASE NOTE: Your Insurance Policy is a contract between you and your Insurance carrier. We are not a party to the contract. As medical care providers our relationship is with you, not your Insurance Carrier. Not all services are a covered benefit in all policies. Some insurance carriers select services that will not be covered. We recommend you inform yourself of any policy exclusions. THE PATIENT WILL BE RESPONSIBLE FOR NON-COVERED SERVICES.

Our fees fall within the reasonable, usual and customary range considered by most carriers. I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF NEUROLOGY ASSOCIATES OF FORT WORTH.

SIGNATURE OF PATIENT OR GUARDIAN DATE

CANCELLATION POLICY

It is important for you to keep your scheduled appointment. Patients who do not show up for their scheduled appointment cause significant disruption to the office, and to other scheduled patient appointments.

If you do not show up for an appointment without providing at least twenty-four (24) hours' notice in advance, you will then be subject to termination from the practice of Neurology Associates of Fort Worth.

We appreciate you keeping your scheduled appointment in a timely manner. You are important to us.

SIGNATURE OF PATIENT OR GUARDIAN DATE

1325 Pennsylvania Ave., Suite 700 Fort Worth, Texas 76104 TELEPHONE: (817) 332-2876 FAX: (817) 877-3672

NEUROLOGY ASSOCIATES OF FORT WORTH

Roger S. Blair, M.D.

It is our policy that you must confirm your appointment by noon the business day before, or it may be cancelled. You will be called two days ahead by our automated service asking you to confirm. If we do not receive a response, you will be called again the following day. If we do not receive confirmation by noon, then your appointment will be cancelled or rescheduled.

If your phone number or address has changed (or phone is out of order/disconnected), please contact our office to update your information. If we are unable to reach you to confirm your appointment, it may be cancelled or rescheduled depending on patient volume. You are important to us. Thank you for assisting us with your care.

SIGNATURE OF PATIENT OR GUARDIAN DATE

1325 Pennsylvania Ave., Suite 700 Fort Worth, Texas 76104 TELEPHONE: (817) 332-2876 FAX: (817) 877-3672

NEUROLOGY ASSOCIATES OF FORT WORTH

Roger S. Blair, M.D.
Diplomate of American Board of Psychiatry and Neurology (in Neurology)
Diplomate of American Board of Electrodiagnostic Medicine
Diplomate of American Board of Psychiatry and Neurology (in Clinical Neurophysiology)
Fellow of the American Academy of Disability Evaluating Physicians
Fellow of the American Association of Electrodiagnostic Medicine

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Neurology Associates of Fort Worth to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Neurology Associates of Fort Worth to use or disclose my PHI to:

____

the following individually identifiable health information (specifically describe the information to be released, such as date(s) of service, level of detail to be released, origin of information, etc.).

____

____

This authorization will expire on: ______________________________.

(Expiration Date or Defined Event).

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Neurology Associates of Fort Worth has acted in reliance upon this authorization. My written revocation must be submitted to Neurology Associates of Fort Worth's Privacy Officer at 1325 Pennsylvania Ave.
Suite 700, Fort Worth, TX 76104.

Signed by: ______________________________ ______________________

Signature of Patient or Legal Guardian | Relationship to Patient

______________________________ ______________________

Patient's Name | Date

____

Print Name of Patient or Legal Guardian

NEUROLOGY ASSOCIATES OF FORT WORTH

Roger S. Blair, M.D.

PRESCRIPTION REFILL POLICY

Dr. Blair is happy to help you with your neurological needs. That includes supplying needed medication for our patient's. We do have certain guidelines for refilling your medications that are prescribed.

- If you need a refill on your medications, please call your pharmacy and tell them which medication you need refilled. They, in turn, will call or fax us with all of the information we need to allow us to refill your medications. (If you call us, we will ask you to call your pharmacy and follow the steps above.)
- We do not refill medications after business hours or on weekends. Dr. Blair does not have access to your medical records after business hours. **Please make sure to contact your pharmacy at least 2 days before you run out of medication completely to allow time for the refill to be processed.**
- We process prescription refills in the afternoon. Any calls for medications received after 3:00 pm will be addressed the following business day.

Pharmacy Information

Please list pharmacies you patron regularly and provide their names and phone numbers.

If you participate in a **mail order** program please provide us with the Name of the Pharmacy, and a member identification number that is associated with the mail order pharmacy.

RX Member Identification Number: ______________________

Neurology Associates of Fort Worth will not be able to provide a prescription until the requested information is obtained.

Pharmacies:

1. ______________________ City: ____________________ Phone: ________________

2. ______________________ City: ____________________ Phone: ________________

HIPAA Patient Consent Agreement

- Neurology Associates of Fort Worth has my permission to view my claims medication history.
- I have been notified that Neurology Associates of Fort Worth will have access to my claims medication history through their electronic prescription service.

Patient Signature or Authorized Person's Signature ________________________ Date _____________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Neurology Associates of Fort Worth to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Neurology Associates of Fort Worth's Notice of Privacy Practices provides a more complete description of such uses and disclosures.) Furthermore, with this consent, Neurology Associates of Fort Worth may disclose any protected healthcare information to any person I choose to accompany me in the doctor's office regardless of affiliation.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Neurology Associates of Fort Worth reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Neurology Associates of Fort Worth Privacy Officer at 1325 Pennsylvania Ave. Suite 700, Fort Worth, TX 76104.

With this consent, Neurology Associates of Fort Worth may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Neurology Associates of Fort Worth may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Neurology Associates of Fort Worth may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Neurology Associates of Fort Worth restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to NEUROLOGY ASSOCIATES OF FORT WORTH's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NEUROLOGY ASSOCIATES OF FORT WORTH may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ____________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

Many thanks for filling out the above information. It really helps me to help you.

Roger S. Blair, M.D

Neurology Associates of Fort Worth
New Patient Medical Evaluation Questionnaire

To adequately understand your medical problem, we need to carefully review your history. While this is a long questionnaire, when completed, it will really help us to diagnose and treat your medical problem(s). Several areas of the questionnaire, may not apply to you, or you may not wish to complete all items. **If** so, please skip those areas.

Please complete the first 8 pages of this questionnaire, sign the PHI consent form on page 8, and bring it with you to your examination. We will review all of your information at the time of your visit. During the visit we will review your history, medical records, and any available studies. We will also perform a physical examination. We look forward to seeing you.

Thank you very much for completing this questionnaire.

Patients Name	**Date**

1. How old are you? ____________ Are you? Right Handed Left Handed Either

2 **WHY are you here for today's visit?** (Including your DATE OF INJURY if any)

____

____

____

____

Please Draw on the Figure Below where you feel pain if you have any pain.

4. **WHEN**, **HOW** and **WHERE** did the medical problem(s) begin?

____

____

____

____

____

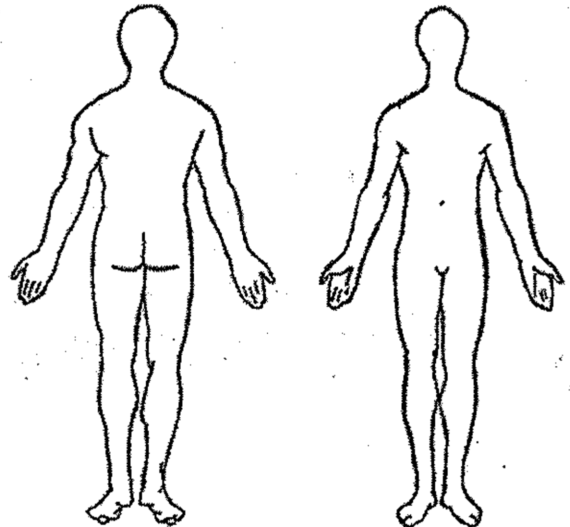
____

____

____

____

____



PAIN DRAWING

Pain Scale

1 2 3 4 5 6 7 8 9 10

5. Have you had any special Diagnostic Tests (EMG, EEG, MRI, CT Scan, Myelogram, Discogram, etc.) performed to diagnose your medical problem(s)? Please bring your films / reports with you if possible.

Diagnostic Tests		
Type of Test	Date	Result
1.		
2.		
3.		
4.		
5.		
6.		

6. What **Medical** Treatments have you had for these medical problem(s)?

____

____

____

____

____

7. Have you had any **Chiropractic** treatment for your medical problem(s)? Yes No
If yes, was Chiropractic treatment **Helpful**? Yes No

8. Please list all medications you are currently taking for all of your medical problems.

Medicine		
Medication	Dose / mg. Strength	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

9. Have you had any **Physical Therapy** for your medical problem(s)?

Type of Therapy	Yes	No			Yes	No
Hot Packs				Did It Help?		
Ultrasound				Did It Help?		
Electro-stimulation				Did It Help?		
Active Exercises				Did It Help?		
McKenzie Exercises				Did It Help?		

10. Have you had any **Surgical Treatment** for medical problem(s)?

Surgery	Date	Surgery Surgeon	Result

11. Have your ever had any Previous Problems or Injuries, Including Any Other Work-related, Recreational, or Motor Vehicle Injuries? % Yes % No % Not Sure If yes, Please describe.

____

____

12. Have you had any **MEDICAL** hospitalizations? % Yes % No % Not Sure If yes, Please describe.

____

____

____

13. Are you **ALLERGIC** to any medications? % Yes % No % Not Sure If yes, please describe.

____

____

14. What is your OCCUPATION? ______________________________

15. Are you working now? % Yes % No Are you DISABLED? % Yes % No

Please circle you current working status: Regular Duty Light Duty Retired Homemaker Student

16. Has your doctor, or anyone, prescribed any WORK RESTRICTIONS? % Yes % No % Not Sure

17. Are you currently **Smoking?** % Yes % No If so, how much?______________

If you smoked in the past, what year did you quit? ______ How much did you smoke? __________

18. Do you use smokeless tobacco? % Yes % No

19. Do you drink ALCOHOLIC BEVERAGES? % Yes % No If so, how much per week?__________

What kind of alcoholic beverage to you consume? Beer Wine Whiskey

20. Do **You** or your **Family** have any other medical problems? If yes, check (:) below:

Disease	Me	Family
Multiple Sclerosis		
High Blood Pressure		
Diabetes		
Headaches		
Epilepsy		
Cancer		
Leukemia		
Alzheimer's		
Parkinson's		
Muscular Dystrophy		
Heart Disease		
Myasthenia Gravis		
Lung Disease		
Ulcers		
Skin Conditions		
Syphilis		
Ulcerative Colitis		
Stroke		
Charcot-Marie-Tooth Disease		
Benign Essential Tremor		
Other progressive Neurological Disease		
Other Diseases		

27. **Educational History:** Indicate highest level of education attained.

Grade School — 1 2 3 4 5 6 7 8 9 10 11 12

College — Fr. So, Jr. Sr.

Graduate School — List Degree ______

28. **Marital Status:** % Yes % No % Divorced % Widowed

How many times have you been divorced, if applicable? 0 1 2 3 4 More

New Patient Review of Systems

Constitutional	Yes	No	Additional Explanation
Do you experience frequent fever?			
Do you experience frequent chills?			
Do you experience fatigue?			
Have you lost or gained any significant weight?			
How many pounds? (PLEASE SPECIFY GAIN OR LOSS)			

Eyes	Yes	No	Additional Explanation
Do you experience double vision?			
Do you have cataracts?			
Do you experience any eye pain?			

Ears, Nose, Mouth, Throat	Yes	No	Additional Explanation
Do you experience any deafness?			
Do you experience vertigo or dizziness in the ears?			
Do you experience ringing in the ears?			

Cardiovascular / Respiratory	Yes	No	Additional Explanation
Do you experience ankle swelling?			
Do you experience shortness of breath?			
Have you noticed any heart palpitation?			

Gastrointestinal	Yes	No	Additional Explanation
Do you frequently experience abdominal pain?			
Do you experience difficulty swallowing?			
Have you ever experienced jaundice?			
Have you ever noticed blood in your stool?			

Genitourinary	Yes	No	Additional Explanation
Have you ever noticed blood in your urine?			
Do frequently experience urinary infections?			
Do you have kidney stones?			
Do you frequently urinate at night?			
Do you frequently experience urinary retention?			
Do you frequently experience urinary urgency?			

Musculoskeletal	Yes	No	Additional Explanation
Do you frequently experience back pain?			
Do you frequently experience neck pain?			
Do you frequently experience stiffness?			
Do you frequently experience joint limitation?			

Integumentary	Yes	No	Additional Explanation
Have you noticed any unusual hair loss?			
Have you noticed any unusual skin lesions?			
Breast			
Have you noticed any unusual masses or lumps?			
Do you frequently experience breast pain?			
Have you ever noticed any unusual discharge?			

Neurological	Yes	No	Additional Explanation
Do you frequently experience headaches?			
Have you ever experienced a seizure?			
Have you ever experienced any unusual weakness?			
Have you ever experienced any tremors?			
Have you ever had a stroke?			
Do you ever experience difficulty walking?			
Do you ever experience loss of sensation?			

Psychological	Yes	No	Additional Explanation
Do you experience depression?			
Do you experience anxiety?			
Do you experience trouble with your memory?			
Have you ever had thoughts about suicide?			
Endocrine	Yes	No	Additional Explanation
Do you usually feel cold?			
Do you usually feel very warm?			
Do you drink more water now than usual?			

Hematological / Lymphatic	Yes	No	Additional Explanation
Do you bleed from your gums or skin frequently?			
Do you have knots in your groin or neck?			
Do you have scattered red dots on your skin?			
Has you skin become unusually pale?			