Suzanne K. Gazda M.D. ❖ R. Braden Neiman M.D. ❖ Swann Van Delden M.D.

3603 Paesanos Park Way, Suite 300, San Antonio TX, 78231
Phone:(210) 692-1245 • Fax: (210) 692-9311

Date_________________________
Primary Care Physician: _______________ Referring Physician:____________________

Patient Information:

Name:____
LAST FIRST M.I.
Address:____
City:____State:____________________Zip:_____________________
Home Phone:(______)____________________________Cell Phone:(______)___________________________
Date Of Birth:_____/_____/_____Age:_____Sex: M / F Social Sec. #:_________-________-___________
Marital Status:_________________ Drivers License Number / State:_________________________________
E-mail: ____
Employer:____Phone:(____)__________________________
Address:___________________________________City:____________________State:________Zip:_______________
Emergency Contact:______________________________Phone:(____)_________________________
Address:___________________________________City:____________________State:________Zip:_______________
Responsible Party (If Patient Is a Minor, Name Of Guardian):____

Insurance Information:

•Primary **Date of Birth:** _____/_____/_______ (if other than patient)
Name Of Insurance Co.:_______________________________________Phone:(____)______________________
Address:___________________________________City:____________________State:________Zip:_______________
Name Of Insured Person:___________________________Social Sec. #:_________-________-__________
Insurance I.D. #:_________________________________Group # Or Name:___________________________

•Secondary **Date of Birth:** _____/_____/_______ (if other than patient)
Name Of Insurance Co.:_______________________________________Phone:(_____)_________________________
Address:___________________________________City:____________________State:________Zip:_______________
Name Of Insured Person:___________________________Social Sec. #:_________-________-__________
Insurance I.D. #:_________________________________Group # Or Name:___________________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign Neurology Institute of San Antonio my medical reimbursement benefits under my insurance policies listed above. I understand that services not covered by my insurance are my financial responsibility and are due at time of service unless other arrangements have been made.

HIPAA Notice of Privacy Practices:
I understand that Neurology Institute of San Antonio has established a Notice of Privacy Practices that provides information about how my protected health information can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options. I acknowledge that I have received a copy of the Notice of Privacy Practice to read and obtain a copy to keep by requesting one from the front office.

Patient's Signature:____Date:__________________________

Dr. Suzanne Gazda ❖ *Dr. R. Braden Neiman* ❖ *Dr. E. Swann Van Delden*

Medical Questionnaire

Patient Name: ____Date Of Birth:________________________________

Medical History – Check only **current** problems. Indicate age.

General
YES NO
- Fever
- Weight Loss
- Decreased Appetite
- Excessive Fatigue

Eyes
YES NO
- Wearing Glasses

Date Of Last Exam:____________________
- Glaucoma
- Cataracts
- Infections
- Injuries

Ear, Nose, Throat, Mouth
YES NO
- Wearing Hearing Aids

Date of last exam:_____________________
- Nose Bleed
- Congestion
- Inability to smell
- Sinus
- Sinus headaches
- Sore throat
- Mouth sores
- Hoarseness
- Difficulty swallowing

Cardiovascular
YES NO
- Chest pain/angina

Date Of Last EKG:____________________
- High Blood Pressure
- Irregular pulse
- Heart Murmur
- High Cholesterol
- Swollen hands/feet
- Leg pain while walking
- Pacemaker

Psychiatric
YES NO
- Depression
- Anxiety
- Mental Illness
- Sleeping difficulty

Endocrine
YES NO
- Diabetes
- Thyroid Disease
- Hormone problem
- Increased thirst/urination
- Increased appetite

Respiratory
YES NO
- Asthma
- Emphysema
- Bronchitis
- Chronic cough
- Shortness of breath
- Pneumonia
- Bloody Sputum
- Lung Cancer
- TB

Gastrointestinal
YES NO
- Persistent
- Nausea/vomiting
- Blood in vomit
- Heartburn
- Gallbladder problems
- Hernia
- Abdominal pain
- Ulcer/gastritis
- Change in bowel habits
- Liver disease
- Jaundice
- Diverticulitis
- IBS/Colitis
- Hemorrhoids
- Colon cancer

Genitourinary
YES NO
- Urinary tract infection
- Painful urination
- Blood in urine
- Loss of bladder control
- Kidney stones
- Sexually transmitted disease

MALES
- Prostate problems

FEMALES
- Menstrual flow irregular
- Menopause
- Uterine/cervical cancer
- Breast pain
- Birth control…

Method______________________________
Date of last PAP ____________________
Date of last mammogram ______________

Allergic/Immunologic
YES NO
- Food allergies
- Inhalant Allergies

Hematology/Lymphatic
YES NO
- Anemia
- Bleeding tendencies
- Phlebitis
- Persistent swollen glands/lymph nodes
- Blood transfusion…when?___________

Musculoskeletal
YES NO
- Back/neck pain
- Arm/leg pain
- Joint pain/swelling
- Arthritis
- Broken bones
- Osteoporosis

Integumentary
YES NO
- Skin disease/type .
- Rash/where

Neurological
YES NO
- Fainting/blackout spells
- Seizures
- Memory problems
- Disorientation/confused
- Concentration problems
- Difficulty with speech
- Double/blurred visions
- Facial weakness
- Headaches
- Strokes
- Muscle weakness
- Numbness/tingling
- Tremors/hand shaking
- Eat salty foods
- Add salt to your food
- Eat out frequently
- Drink coffee, tea, soda.
  - How much____________________
- Drink alcoholic drinks.
  - How much____________________
- Smoke cigarettes.
  - How much____________________
- Exercise regularly
- Other medical problems

____
____
____
- Living will
- Advanced Directive Power of Attorney

Dr. Suzanne Gazda ❖ Dr. R. Braden Neiman ❖ Dr. E. Swann Van Delden

Medical Questionnaire

Date:______________________________

Patient's Name:____

Patients Date of Birth:____

Reason For Visit:____

Surgeries	**Year**	**Complication**

Have you ever had problems with Anesthesia? **YES** **NO**

CT/MRI Studies	**Location**	**Date**	**Doctor Ordering**

Family History – Check if any blood relative has had any of the following. Indicate which relative.

Diabetes	**Asthma**	**Osteoporosis**	**Note:**
Heart Disease	**Migraines**	**Anemia**	
Seizures	**Alcoholism**	**Thyroid Problem**	
Allergies	**Cancer**	**High Blood Pressure**	
Meniere's Disease	**Arthritis**	**Mental Illness**	
Stroke	**Glaucoma**	**High Cholesterol**	

NISA
Neurology Institute of San Antonio

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Medication Log

Patients Full Name: __________ **DOB:** __________

CURRENT MEDICATION REGIMENT

MEDICATION	DOSAGE/SIG	Date Started	DC Date	Reason Taken	Appointment Date

PATIENT INFORMATION

Referring Physician:	Pharmacy:	Pharmacy's Phone Number:

ALLERGIGIES TO MEDICATIONS

Neurology Institute of San Antonio

Dr. Suzanne K. Gazda, Dr. R. Braden Neiman, Dr. E. Swann Van Delden

Financial Policy:

Thank you for choosing Neurology Institute of San Antonio as your health care provider. We are committed to providing you the best available medical care. We ask that all patients read and sign our financial policy as well as complete our Patient Information form prior to seeing the physician.

Payment for service is due at the time services are rendered. We accept cash, check, Visa and MasterCard. We will be happy to help process your insurance claim for reimbursement. In special instances, we may accept assignment of insurance benefits. However, you must understand the following:

Please initial each item and sign below:

___ Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges.

___ All charges not covered by your insurance benefit plan are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

___ Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.

___ Returned checks will be subject to a $35 penalty payment.

___ Our office is happy to complete any FMLA, Disability or Attending Physician Statements or copy Medical Records. Payment for these services is due BEFORE these forms are released.

___ If you need to cancel or reschedule your appointment, all cancellations must be made at least 24 hours in advance. If you fail to cancel your appointment, you may be charged $25 for each missed appointment.

___ Medication Refills are performed during regular business hours, Monday – Thursday 8:00am -2:00pm and Friday 8:00am – 11:30am. A refill request will not be granted if you have not seen the physician for treatment within a one year period. All medication refills are processed within 48 hours. If your insurance company uses a specialty pharmacy, the refill may take up to 1 week to process.

<u>The Doctor's Exchange cannot be used for medication refills. The exchange is reserved for emergency calls only.</u>

We encourage you to communicate with our business office any payment problems, so that we may assist you in the management of your account. Again, thank you for choosing Neurology Institute of San Antonio as your health care provider. We appreciate your trust in us and we look forward to the opportunity to serve you.

Patient's Signature: ____ Date: _______________

Visit our website at www.nisatx.com for more information or contact us at 210-692-1245.

Dr. Suzanne Gazda ❖ Dr. R. Braden Neiman ❖ Dr. E. Swann Van Delden

HIPAA FORM

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I,______________________________, understand that as part of my healthcare, Suzanne K. Gazda, M.D., R. Braden Neiman, M.D., and E. Swann Van Delden M.D, originates and maintains paper and/or electronic records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A source for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations.

I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereof. I also understand that refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by 45 CFR Section 164.506 of the Code of Federal Regulations.

I further understand that Suzanne K. Gazda, M.D., R. Braden Neiman, M.D., and E. Swann Van Delden M.D. reserve the right to change their practice policies and prior to implementation, in accordance with 45 CFR Section 164.520 of the Code of Federal Regulations. Should Suzanne K. Gazda, M.D., R. Braden Neiman, M.D., and E. Swann Van Delden M.D. change their notice, they will send a copy of any revised notice to the address provided (whether U.S. mail, if I agree, e-mail).

I understand that Neurology Institute of San Antonio has established a Notice of Privacy Practices which provides information about how my protected health information can be used and disclosed. I consent to the use of my protected health information for the treatment, payment, and health care options.

I wish to have the following restrictions to the use or disclosure of my health information:
____
____
____

I also understand that as part of this organization that release of RX history may become necessary in the process of planning my care and treatment. Initial Consent:

- __________ I **authorize** release of RX history
- __________ I **do not authorize** release of RX history

Integra Clinical Research, LLC is an entity of Suzanne Gazda, M.D. practice which conducts clinical research trials for neurologic indications such as Multiple Sclerosis, Seizures, Headaches and Alzheimer's disease. Please indicate below if Integra Clinical Research, LLC may review your health information for potential participation in these important clinical trials. Initial Consent:

- _________ I **authorize** Integra Clinical Research, LLC to include my name in their clinical trial database and review my health information for participation in potential clinical research studies.
- _________ I **do not authorize** Integra Clinical Research, LLC to include my name or health information for participation in potential clinical research studies.

Multiple Sclerosis Center of South Texas is a (501c3) non-profit organization that is dedicated to promoting education, hosting patient programs, providing special services, and offering support for those diagnosed with MS, as well as, to assist their families and caretakers.

- _________ I **authorize** the Multiple Sclerosis Center of South Texas to be given my name and contact information, in order to allow the non-profit organization the opportunity to communicate with me to update and inform me regarding upcoming events and functions, special programs, speaking engagements, services provided by the center, or for any other business pertaining to the Multiple Sclerosis Center of South Texas.

- _________ I **do not authorize** the Multiple Sclerosis Center of South Texas to be given my name and contact information, in order to allow the non-profit organization the opportunity to communicate with me to update and inform me regarding upcoming events and functions, special programs, speaking engagements, services provided by the center, or for any other business pertaining to the Multiple Sclerosis Center of South Texas.

I fully understand and **accept/decline** terms of this consent. (Circle one)

____________________________________ ____________________
Patient's Signature Date

FOR OFFICE USE ONLY
( ) Consent received by ________________________on__________________.
( ) Consent refused by patient, and treatment refused as permitted.
( ) Consent added to the patient's medical record on ________________________.

NAME:___________________________________ **DATE:**__________________

Visit to see: ☐ Dr Gazda ☐ Dr Neiman ☐ Dr Van Delden

Who may we specifically thank for your referral?

☐Dr. ☐Mr. ☐Mrs. ____

How did you hear about NISA and/or one of our doctors?

☐ Search Engine (please circle engine) Google Yahoo Bing Ask AOL Search Other

☐ Online Site (please indicate site or sites) ____

☐ Insurance Company (please write name of the company) ___________________________________

If checked above, how did you find the information (circle one)? Online Physician Directory Call Center Provider Directory (paper copy)

☐ Other:____

Generally, when scheduling an appointment with a new doctor, which of the following helps in determining which doctor you will choose to visit?

Please Select all that apply and rate on a scale from 1-5 to indicate how important that selection is in making your final decision of which doctor to choose.

Recommendation/referral from another doctor

☐ Highly Important ☐ Very Important ☐ Of some importance ☐ Not very important ☐ Not at all important

Recommendation from family or friend

☐ Highly Important ☐ Very Important ☐ Of some importance ☐ Not very important ☐ Not at all important

Ratings doctor or office received on health or medical websites

☐ Highly Important ☐ Very Important ☐ Of some importance ☐ Not very important ☐ Not at all important

Based on information found on websites or message boards

☐ Highly Important ☐ Very Important ☐ Of some importance ☐ Not very important ☐ Not at all important

Comments:____
____

Neurology Insitute of San Antonio (210) 692-1245 www.nisatx.com

Suzanne K. Gazda, M.D. R. Braden Neiman, M.D. E. Swann Van Delden, M.D. Cheryl A. Collins, MN, CRNP

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San Antonio, Texas 78231

Phone: (210)692-1245 • Fax: (210) 692-9311

Medication Refill Policy

You should first contact your pharmacy for medication refills. You may already have authorized refills, and most local pharmacies will contact our office for you if you do not have a refill. If you take a medication every day, you should initiate your refill request at least 5 days before the medication runs out. We will handle your request within 48 hours. It is impossible to handle refill requests in an urgent manner.

Our office handles medication refills during normal business hours **only**:
Monday through Thursday from 8:00a.m. to 4:00p.m.
Friday 8:00a.m. to 12:00p.m.

Dr. Gazda, Dr. Neiman, and Dr. VanDelden will not call in medications for conditions or complaints they have not treated. Also, if Dr. Gazda, Dr. Neiman, and Dr. VanDelden have not treated you within a one-year period, you must have an office visit before your refill can be granted.

PLEASE NOTE: The Doctors Answering Service is reserved for emergency calls only. Dr. Gazda, Dr. Neiman, and Dr. VanDelden will not refill medication during the weekend.

Patient's Signature:_______________________________________ Date:___________________________