



Neurology Institute  
of San Antonio

3603 Paesanos Parkway ~ Suite 300 ~ San Antonio, Texas 78231

**PATIENT INFORMATION**

Patient Name (Print): \_\_\_\_\_ Date: \_\_\_\_\_

Address (Street or PO Box): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F Social Security #: \_\_\_\_\_

Race: \_\_\_ White \_\_\_ Black \_\_\_ Hispanic \_\_\_ Other Ethnicity Hispanic/Latino? Yes / No

Primary Language: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Person (If patient is a minor. Name of guardian): \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary** Date of Birth (if other than the patient): \_\_\_\_\_

Insurance company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_ Social Sec #: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group # or Name: \_\_\_\_\_

**Secondary** Date of Birth (if other than the patient): \_\_\_\_\_

Insurance company Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of Insured Person: \_\_\_\_\_ Social Sec #: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group # or Name: \_\_\_\_\_

**PHYSICIAN:** Name of physician who referred you: \_\_\_\_\_

**Please be sure to complete all sections and update the information, if needed, each time you visit us.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Suzanne K. Gazda, M.D**

**R. Braden Neiman, M.D.**

**Swann Van Delden, M.D.**



**NISA**  
Neurology Institute  
of San Antonio

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
- Drug Allergies

**Hematology/Lymphatic**

YES NO

- Anemia
- Bleeding tendencies
- Phlebitis
- Persistent swollen glands or 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

Hospitalizations	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.

- |  |                                     |  |  |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Osteoporosis        | Note: _____<br>_____<br>_____<br>_____ |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Migraines  | <input type="checkbox"/> Anemia              |  |
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Thyroid Problem     |  |
| <input type="checkbox"/> Allergies         | <input type="checkbox"/> Cancer     | <input type="checkbox"/> High Blood Pressure |  |
| <input type="checkbox"/> Meniere's Disease | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Mental Illness      |  |
| <input type="checkbox"/> Stroke            | <input type="checkbox"/> Glaucoma   | <input type="checkbox"/> High Cholesterol    | _____                                  |





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

3603 Paesanos Parkway , Suite 300

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: \_\_\_\_\_



Neurology Institute  
of San Antonio

**CONSENT TO TREAT  
RELEASE OF MEDICAL INFORMATION  
FINANCIAL RESPONSIBILITY**

**CONSENT TO TREATMENT:** I voluntarily consent to receive medical and healthcare services provided by the Neurology Institute of San Antonio ("NISA") physicians, physician assistants, nurses, technicians, and other NISA employees, as my physician deems reasonably necessary. I understand that this general consent applies to examinations, testing, procedures, and treatment. I am aware that the practice of medicine is not an exact science and I further acknowledge that no guarantee has been or can be made as to the results of the treatments or examinations at NISA.

This general consent to treatment will be valid and remain in effect as long as I am a patient at NISA, unless I revoke this consent, in writing.

**RELEASE OF MEDICAL INFORMATION:** Your protected health information pertains to your diagnosis, treatment and billing information obtained by NISA. Our Notice of Privacy Practices provides information about how NISA may use and disclose your protected health information for your treatment, for your health insurance and as permitted by law. NISA staff will provide you a copy of our Notice of Privacy Practices. You may ask to view that notice at any time.

**FINANCIAL RESPONSIBILITY:** In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to NISA.

I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to NISA. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by NISA, to NISA.

_____	_____	_____
Patient/Legal Guardian Signature	Date	Time
_____	_____	
Patient Printed Name	Patient Date of Birth	



## Neurology Institute of San Antonio

# PATIENT INFORMATION

Please take a moment to familiarize yourself with the Neurology Institute of San Antonio patient information.

**Appointments:** All patients are scheduled by appointment only and the time is scheduled exclusively for you. Appointments are scheduled with the intent to see you at the scheduled time. However emergencies sometimes occur and emergency patients are provided the necessary time for treatment. Delays may sometimes occur.

New patients and patients who are scheduled for a test will be reminded of the appointment two days prior via an automated system and one day prior via a phone call from the office. Follow-up appointments will receive an automated reminder two days prior to the appointment. Patients who do not confirm the appointment are subject to having the appointment cancelled and another patient booked in that appointment slot.

**New patient Forms:** For your convenience new patient forms are available on the NISA website. If these forms are not completed prior to your appointment, please plan to arrive 30-minutes prior to your scheduled appointment to allow time to complete them. Depending upon the nature of your visit, you may need to complete additional forms. **If you have not completed all of the forms prior to your scheduled appointment time, your appointment may be rescheduled for another time or date.**

NISA realizes these forms require considerable information. However, medical history and documentation regarding your history and symptoms is important for the clinical providers to manage your care. We apologize for any inconvenience.

**Clinical Providers:** Due to the nature of our practice, NISA staff will schedule patients for the soonest possible appointment. NISA employs Physician Assistants to support the physicians with the volume of patients requiring medical care each day. These clinical providers are highly qualified and trained specifically to treat the medically complex patients seen in this office. We attempt to schedule patients for the first available appointment. Therefore, patients may be scheduled with any of our clinical providers. The physician supervises the care of each and every patient but does require assistance to ensure patients are cared for in a timely manner.

**Cancellations/Late Arrival:** We reserve your appointment exclusively for you. In order that we may serve all of our patients, we ask that if you need to cancel your appointment, you provide notice not less than 24-hours prior to your scheduled appointment. **For appointments cancelled with less than a 24-hour notice, cancellation fees apply: \$50 for a follow-up appointment; \$100 for a new patient appointment and \$150 for a procedure or test appointment.**

If you are going to be late for your scheduled appointment, please contact the office as soon as possible. Dependent upon the schedule, late patients may be moved to a later appointment, as close to the originally scheduled appointment as possible, or rescheduled for another day.

**Identification:** For your protection, valid photo identification will be required at the time of your appointment. If you do not have valid picture identification with you at the time of your appointment, it will be necessary to reschedule the appointment.

Additionally, NISA will require a copy of the front and back sides of your current health insurance card(s). Should you not have this available, it will be necessary to indicate you are a private-pay patient necessitating that you are responsible for all charges related to the appointment, at the time the services are provided.

**12.2018**

**Medical Records:** It is important that NISA maintains a current and accurate medical record on your behalf. Therefore, at the time of each appointment, NISA staff will ask you if any information has changed (e.g. name, address, guarantor, insurance, telephone, medications, new medications, symptoms or conditions). It is your responsibility to ensure any updates are provided. We appreciate your cooperation in keeping us informed so that we may better serve you.

**Payment for Services:** Payment for services is required at the time services are provided. For your convenience we accept: Master Card, Visa, American Express, debit cards, and local checks. Payment options may be available through the NISA billing office. Please contact our billing department to discuss payment plan options.

**Insurance:** NISA accepts various insurance plans. Each insurance plan has its own unique stipulations, coverage limits and requirements for the plan participant (you the patient). Insurance is generally a contract between you, (generally) your employer and the insurance company. NISA is not a party to that insurance contract. Our relationship is with you, the patient! The staff at NISA will verify your benefits prior to the time of your appointment. However, due to the various plan types, and the variations in coverage, we ask that you take the time to discuss your visit with your insurance provider or your employer's benefits manager, so that you are aware of your responsibilities and all applicable fees for which you will be responsible for at the time of your appointment.

All charges not covered by the insurance plan are the guarantor's responsibility.

**HMO:** If your insurance is through an HMO, it is your responsibility as the patient to coordinate all necessary referrals prior to your appointment, including a determination as to whether or not the NISA physician is a "participating physician" with your individual HMO insurance plan. If NISA is not a participating provider, it will be your responsibility to pay all applicable charges at the time services are provided.

**Prescription Refills:** You should contact your pharmacy and ask them to contact our office for the authorization to refill. Some prescription requests are sent electronically. For those refills, the pharmacy will contact NISA through electronic means. Once the refill has been authorized, your pharmacy will be notified, generally within 24-hours (excluding weekends and holidays). You may also request a refill through your patient portal. (If you do not have patient portal access, please contact the office.) **Refills will not be authorized through the after-hours emergency contact line. If you have not seen a NISA physician within the last twelve (12) months, a refill request will not be authorized.**

**Clinical Questions:** Please call the main office number at (210) 692-1245 to leave a message. Calls left on the answering machine at night, on the weekends, or on a holiday will be managed the next business day. Clinical questions will be documented on a message log and routed to the appropriate clinical provider. Please provide the numbers where you may be reached, both day and evening. Your call will be returned at the first opportunity. Making multiple calls or leaving multiple voice mails slows the process for you and all other patients. NISA staff attempt to answer all messages by the end of each business day.

**Documents** FMLA, Disability and similar documents will be completed as applicable. There are fees for completing these documents. Payment must be made **before** the document(s) will be released.

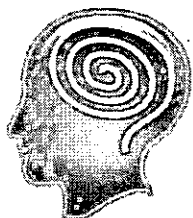
**Questions:** Please feel free to ask questions of any of our friendly staff. We are happy to assist you and to ensure you have answers to your questions. You may also ask to speak with a supervisor or with the administrator at any time.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Date





**NISA**  
Neurology Institute  
of San Antonio

## HIPAA NOTICE TO PATIENTS

### 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 this office 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 have been provided with a summary Notice of Information Practices that provides a more complete description of the uses and disclosures of my health information. YOU have the right to ask for a new review a full copy of the Notice of Privacy Practices document. I understand that I have rights under the HIPAA regulations. **I may revoke this consent at any time, provided that such revocation is in writing and presented to any of the office staff.**

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

I give you permission to call, speak with, and/or release any health information to the following person(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I fully understand and accept terms of this consent.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Use Only

( ) Consent added to the patient's medical record on \_\_\_\_\_