Suzanne K. Gazda M.D. ❖ R. Braden Neiman M.D.

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

NISA
Neurology Institute
of San Antonio

Date:_____

Primary Care Physician(Last,First): _____

Patient Information:

Referring Physician(Last, First):_____

Name:_____
LAST FIRST M.I.

Address:_____

City:_____State:_____Zip:_____

Home Phone:(_____)_____Cell Phone:(_____)_____

E-mail: _____

Date Of Birth:_____/_____/_____Age:_____Sex: M / F Social Sec. #:_____-_____-_____

Marital Status:_____ Primary Language: English/Spanish/Other:_____

Race: White/Black/Hispanic/Other_____ Ethnicity: Hispanic/Latino? Yes/No

Employer:_____Phone:(____)_____

Emergency Contact:_____Relation:_____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:_____

NISA
Neurology Institute
of San Antonio

Dr. Suzanne Gazda ❖ *Dr. R. Braden Neiman*

Medical Questionnaire

Patient Name: _____Date Of Birth: _____

Medical History – **Check current and past problems.**

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

NISA
Neurology Institute
of San Antonio

Dr. Suzanne Gazda ❖ Dr. R. Braden Neiman

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.

___Diabetes
___Heart Disease
___Seizures
___Allergies
___Meniere's Disease
___Stroke

___Asthma
___Migraines
___Alcoholism
___Cancer
___Arthritis
___Glaucoma

___Osteoporosis
___Anemia
___Thyroid Problem
___High Blood Pressure
___Mental Illness
___High Cholesterol

Note:_____

Neurology Institute *of* San Antonio

MEDICATION LOG

Patient Full Name: **DOB:**

ALLERGIES TO MEDICATION:

CURRENT MEDICATION REGIMEN

MEDICATION	DOSE/SIG	DATE STARTED	DATE STOPPED	REASON TAKEN

ADDITIONAL INFORMATION

REFERRING PHYSICIAN:	**PHARMACY:**	**PHARMACY PHONE NUMBER:**

Dr. Suzanne Gazda ❖ Dr. R. Braden Neiman

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, PA Vargas, and PA Vecera will not call in medications for conditions or complaints they have not treated. Also, if a provider has 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, PA Vargas, and PA Vecera 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.

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: Please provide at least 72-hours' notice. You should first 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). **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**

Dr. Suzanne Gazda ❖ Dr. R. Braden Neiman

Megan Vargas, PA-C ❖ Michael Vecera, PA-C

NISA
Neurology Institute
of San Antonio

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. and R. Braden Neiman, 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 give you permission to call, speak with, and/or release any health information to the following person(s):_____
_____

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

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 _____.