NISA
Neurology Institute
of San Antonio

Patient Information

Name:_____
LAST *FIRST* *MIDDLE INITIAL*

Address:_____ City:_____ State:_____ ZIP Code:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Email:_____

Social Sec. #:_____ DOB:_____ Age:_____
MONTH / DATE / YEAR

Sex: ☐M ☐F Gender Identity:_____ Marital Status:_____

Primary Language:_____ Race:_____ Ethnicity: N/A Hispanic Latino

Employer:_____ Phone: (_____) _____

Contact:_____ Relation:_____ Phone: (_____) _____

Address:_____ City:_____ State:_____ ZIP Code:_____

Responsible Party *(If patient is a minor, name of guardian)*:_____

Insurance Information

Primary — Name of Insurance Co.:_____ DOB:_____
IF OTHER THAN PATIENT

Address:_____ City:_____ State:_____ ZIP Code:_____

Name of Insured Person:_____ Social Sec. #:_____

Insurance ID #:_____ Group Name or #:_____

Secondary — Name of Insurance Co.:_____ DOB:_____
IF OTHER THAN PATIENT

Address:_____ City:_____ State:_____ ZIP Code:_____

Name of Insured Person:_____ Social Sec. #:_____

Insurance ID #:_____ Group Name or #:_____

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.keep by requesting one from the front office.

Patient's Signature:_____ Date:_____

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Medical Questionnaire

Check boxes on all current and past conditions.

Patient Name:_____ DOB:_____
MONTH / DATE / YEAR

General
- ☐ Decreased appetite
- ☐ Excessive fatigue
- ☐ Fever
- ☐ Weight loss

Allergic/Immunologic
- ☐ Food allergies
- ☐ Inhalant allergies
- ☐ Drug allergies

Cardiovascular
- ☐ Chest pain/angina

Last EKG Date:_____
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Irregular pulse
- ☐ Leg pain while walking
- ☐ Pacemaker
- ☐ Swollen hands/feet

Ear, Nose, Throat, Mouth
- ☐ Wearing hearing aids

Last Exam Date:_____
- ☐ Congestion
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Inability to smell
- ☐ Mouth sores
- ☐ Nose bleed
- ☐ Sinus
- ☐ Sinus headaches
- ☐ Sore throat

Endocrine
- ☐ Diabetes
- ☐ Hormone problem
- ☐ Increased appetite
- ☐ Increased thirst/urination
- ☐ Thyroid disease

Eyes
- ☐ Wearing glasses

Last Exam Date:_____
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Infections
- ☐ Injuries

Gastrointestinal
- ☐ Abdominal pain
- ☐ Blood in vomit
- ☐ Change in bowel habits
- ☐ Colon cancer
- ☐ Diverticulitis
- ☐ Gallbladder problems
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ IBS/Colitis
- ☐ Jaundice
- ☐ Liver disease
- ☐ Nausea/vomiting
- ☐ Persistent
- ☐ Ulcer/gastritis

Genitourinary
- ☐ Breast pain
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Loss of bladder control
- ☐ Menstrual flow irregular
- ☐ Menopause
- ☐ Painful urination
- ☐ Prostate problems
- ☐ Sexually transmitted disease
- ☐ Urinary tract infection
- ☐ Uterine/cervical cancer

Birth control method:_____
Last PAP Date:_____
Last Mammogram Date:_____

Hematology/Lymphatic
- ☐ Anemia
- ☐ Bleeding tendencies
- ☐ Phlebitis
- ☐ Persistent swollen glands or lymph nodes
- ☐ Blood transfusion

Date:_____

Integumentary
- ☐ Skin disease

Type:_____
- ☐ Rash

Location:_____

Lifestyle
- ☐ Add salt to your food
- ☐ Advanced Directive Power of Attorney
- ☐ Eat out frequently
- ☐ Eat salty foods
- ☐ Exercise regularly
- ☐ Living will
- ☐ Drink alcoholic drinks

Frequency:_____
- ☐ Drink coffee, tea, soda

Frequency:_____
- ☐ Smoke cigarettes

Frequency:_____

Musculoskeletal
- ☐ Back/neck pain
- ☐ Arm/leg pain
- ☐ Joint pain/swelling
- ☐ Arthritis
- ☐ Broken bones
- ☐ Osteoporosis

Neurological
- ☐ Concentration problems
- ☐ Difficulty with speech
- ☐ Disorientation/confused
- ☐ Double/blurred visions
- ☐ Facial weakness
- ☐ Fainting/blackout spells
- ☐ Headaches
- ☐ Memory problems
- ☐ Muscle weakness
- ☐ Numbness/tingling
- ☐ Seizures
- ☐ Strokes
- ☐ Tremors/hand shaking

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Mental illness
- ☐ Sleeping difficulty

Respiratory
- ☐ Asthma
- ☐ Bloody sputum
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic cough
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ TB

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Medical Questionnaire *Continued*

Patient Name:_____ DOB:_____
MONTH / DATE / YEAR

Reason for Visit:_____

Surgeries	Year	Complication

Hospitalizations	Year	Complication

Has the patient had past complications with Anesthesia? ☐ Yes ☐ No

CT/MRI Studies	Location	Date	Doctor Ordering

Family Medical History *Check boxes on all conditions that apply, indicate the affected relative(s).*

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Meniere's disease
- ☐ Mental illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid problem

Relative(s):

_____

_____

_____

_____

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Medication Log

Patient Name:_____ DOB:_____
MONTH / DATE / YEAR

Allergies to Medication:_____

Current Medication Regimen

MEDICATION	DOSE/SIG	DATE STARTED	DATE STOPPED	REASON TAKEN

Additional Information

Referring Physician:_____

Pharmacy:_____ Pharmacy Phone:_____

NISA
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Medication Fill & Refill Policy

Patients should contact their respective pharmacies to initiate all medication refills. Your pharmacy will contact our office for you if you do not have a refill available. If you take a daily medication, you should initiate your refill request at least 5 days before the medications run out. Your request will be handled within 48 hours of receipt of the refill request. It is impossible to handle refill requests in an urgent manner.

Our office handles medication refills during normal business hours only:

Monday - Thursday, 8:00 a.m. - 4:00 p.m.

Friday, 8:00 a.m. - 12:00 p.m.

None of our providers will refill or prescribe any medications for conditions or complaints they have not treated you for previously. You must have made an appointment with your provider within a one-year period for your refill to be granted. If you have not seen your provider within the year, you must schedule an appointment for continued refills.

By signing below, I am acknowledging understanding of the medication refill policy.

Patient's Signature:_____ Date:_____

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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 DOB

NISA
Neurology Institute
of San Antonio

New Patient Information: Office Policies

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.

CONTINUED

NISA
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Office Policies *Continued*

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

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. 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 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.

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 phone number and time at which you can be reached. Your call will be returned at the first opportunity; please do not leave duplicate messages as it increases processing time.

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/Legal Guardian Signature Date Time

NISA
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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, Neurology Institute of San Antonio, 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 Neurology Institute of San Antonio reserves 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 Neurology Institute of San Antonio 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.

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HIPAA Form *Continued*

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

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.

I fully understand and accept/decline terms of this consent (check box).
Initial Consent:

☐ I **authorize** release of RX history ☐ I **do not authorize** release of RX history

_____

Patient/Legal Guardian Signature Date Time

_____

Patient Printed Name Patient DOB

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 _____.

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Assignment of Benefits

I, _____ the undersigned (the "Patient"), having healthcare benefit coverage through a group (including a self-funded and employer/employee benefit plan), Medicare, Medicaid and/or individual healthcare plan (collectively, the "Plan"), hereby appoint and assign as my designated authorized representative, Neurology Institute of San Antonio and/or Neurology Institute of Kerrville and/or Neurology Institute of Kerrville @ Boerne (the "Provider"), and/or designated business associates, the right to pursue payment for all benefits entitled under my plan or policy. This authorization includes, taking any and all necessary steps, including pursing administrative appeals, requesting disclosures and remedies, filing suit and all causes of action and all other protected rights wholly in my stand, for benefit payment of all medical benefits otherwise payable to the Patient for medical services, treatments, therapies, and/or medications rendered or provided by the Provider, regardless of the Provider's managed care network participation status.

The Patient hereby appoints the Provider, and/or the Provider's appointed business associates, the Patient's rights, title, and interests in and to, and related to the recovery of, any and all benefits which the Patient is entitled to receive under the Plan or insurance policy, and authorizes the Provider to release all medical information necessary to pursue and process the Patient's benefits and claims thereunder. I certify that the health insurance information that I provided is accurate and that I am responsible for keeping it updated. I hereby authorize provider. to submit claims, on my and/or my dependent's behalf, to the benefit plan (or its administrator) to be paid in full compliance of governing laws. I further authorize my plan, its fiduciaries, and/or its third-party administrators to release to my health care provider, and/or the Provider's appointed business associates, all EDI and other information necessary for my healthcare provider to claim such benefits. I also hereby instruct my benefit plan (or its administrator) to pay the Provider directly for services rendered to me or my dependents.

To the extent that my current policy prohibits direct payment to provider, I hereby instruct and direct my benefit plan (or its plan administrator) to provide governing plan documentation stating such non-assignment to myself and the provider upon request and its standing to governing laws. Upon proof of such non-assignment, I instruct my benefit plan (or its administrator) to make the check payable to me and mail it directly to the provider. I understand there are state and federal consumer protections that support even for out of network providers that may be associated with my care or surgery, that I am responsible for co-payments,co-insurance, and deductibles at no more than my in-network cost share rate. I understand, agree, and hereby certify that I am obligated to pay, as charged, and billed for global service charges, regardless of if the above services are covered under my health insurance or plan.

I understand that "Deductible" is defined, under the Uniform Glossary from ERISA & the Patient Protection & Affordable Care Act (ACA) as: *"The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay,"* and that I have no knowledge of any plan exclusion or limitation for the charges for healthcare services rendered by the above listed provider, in case that I can't afford to pay for 100% deductible. I understand the payments are due at the time of the services unless otherwise applicable to any PPO or ACA discount once my claim for benefits is processed in full compliance with plan terms and governing laws. I understand I am fully protected against any unexpected medical bills or charges by my provider's applicable ACA or indigency discount policy; including any non-compliant or arbitrary and capricious PPO Discounts or Re-pricing Discounts received from my health insurance plan. My satisfaction is guaranteed in connection with my provider's initiative-taking reasonable efforts to collect or make a good faith determination for ACA Discount qualifications solely based on my unique ability to pay and individual health need. I hereby assign billed charges for healthcare services rendered as my legal claims to the above listed provider as full payment..

CONTINUED

NISA
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Assignment of Benefits *Continued*

I hereby designate, authorize and appoint the Provider, it's attorneys or other designated business associate as my authorized representative to: (1) release any information necessary to my health benefit plan (or its administrator) regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; (3) To file and participate in any administrative or judicial review process; (4) to give the provider and its attorneys standing to pursue payment and file suit for benefits and any fiduciary breach and all causes of action available under ERISA and Section 502, 27 § U.S.C. 1132(a). (5) to pursue all necessary benefit payments, appeal rights, remedies and all causes of action, wholly in my stead; (6) to pursue a claim for benefits and to recover all applicable penalties for any fiduciary breach or failure by my plan, its fiduciary and/or its claims administrator to comply with 29 USC § 1132 and (7) allow a photocopy of my signature to be used to process insurance claims. This authorization will remain in effect until all benefits are paid in full compliance with applicable federal and state laws.

I hereby confirm and ratify all actions taken by my authorized representative pursuant to the authority granted herein. I hereby authorize my plan administrator, fiduciary, insurer, and/or attorney to release to the above-named health care provider or its designated business associated any and all relevant Plan and claim related documents, requested disclosures, complete insurance policy, and/or settlement information upon written request from the provider, its attorneys or designated business associates in order to secure and claim such medical benefits due and owed me under my plan or policy.

I authorize the release or disclosure of my protected health information to my authorized representative in order to secure and claim medical benefits due; (1) obtain information or submit evidence regarding the claim to the same extent as me; (2) make statements about facts or law; (3) act as my authorized representative in connection with filing, providing or receiving notice of any claim or appeal proceedings, to include any external review by applicable state or Federal External Review Process. I understand that I will be held financially responsible for all fees accumulated for collection agency fees. Administrative fees, attorney fees and court costs incurred by the provider listed above for any delinquent account requiring outside collection assistance, to the fullest extent of the law.

This order will remain in effect until revoked by me in writing. I understand revocation of this appointment will not affect any action taken in reliance on this appointment before my written notice of revocation is received. Unless revoked in writing, this assignment is valid for any and all requested administrative and judicial reviews rightfully due me under my governing plan or policy and to the fullest extent permitted by law. A photocopy of this assignment is to be considered valid, the same as if it were the original. I understand that, by signing this form, I am confirming my appointment of my designated authorized representative, the scope of my authorized representative's authority, and the option of revocation of this appointment. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

Patient/Legal Guardian Signature | Date | Time

Patient Printed Name | Patient DOB