AUSTIN NEUROLOGICAL CLINIC

OFFICE: 711 WEST 38TH STREET, BLDG. F, AUSTIN, TEXAS 78705
PHONE: 512-458-6121
FAX: 512-452-9171

NEUROLOGISTS

Albert B. Horn, M.D.
David W. Morledge, M.D.
Hana Aubrechtova, M.D.
Montgomery A. Verona, M.D.
Paula C. Wilson, CNS

Date: _____

_____
_____
_____

In anticipation of your visit to our clinic, enclosed are the following for your review:

1. Map to our office
2. Patient Registration Information
3. Health History Questionnaire
4. Notice of Privacy Policies with Acknowledgement
5. Clinic Financial Policies (blue)

Please complete the Patient Registration Information and Health History Questionnaire before you come into the office for your appointment. It will help with getting you in to see the doctor more quickly.

We are required by the Health Insurance Portability and Accountability Act (HIPAA) to inform you of our policies around protecting your personal health information. The Notice of Privacy Policies explains our policies and your individual rights as a patient of this clinic. We ask that you read this Notice before your appointment time. You will be asked to sign an acknowledgment form that you have read the policies when you come to the clinic for your appointment. Again, by reading the policy in advance, there will be less delay in seeing the doctor.

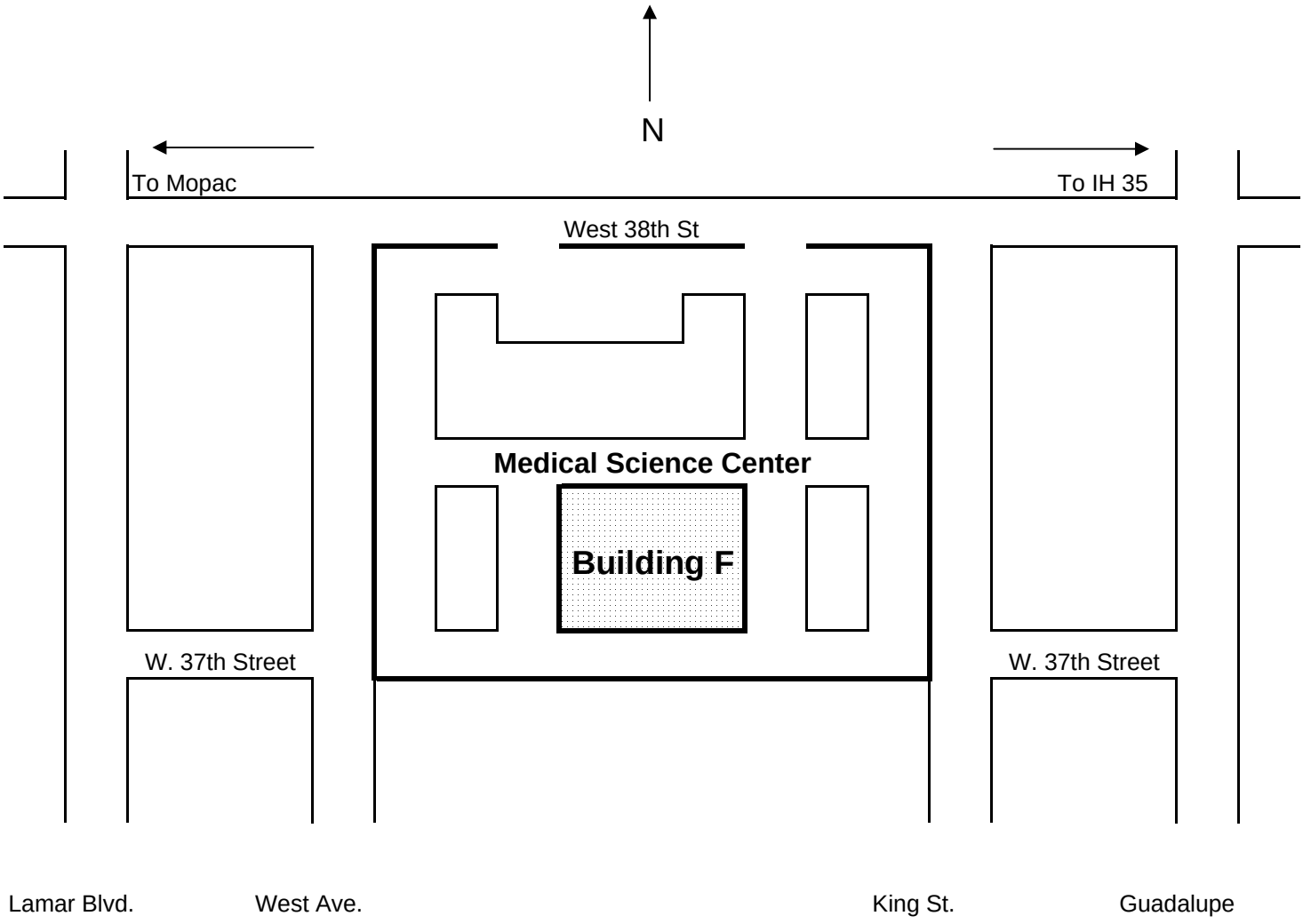
Finally we have included our financial policies regarding payment of your bill and filing of insurance claims. This form will need to be signed as well.

We apologize for the amount of paperwork involved in seeing our doctors, however we find it necessary to comply with regulatory requirements, assure payment for our services and, most importantly, provide you the very best healthcare. We hope that it is not too burdensome and look forward to seeing you in our office.

Sincerely,

AUSTIN NEUROLOGICAL CLINIC

AUSTIN NEUROLOGICAL CLINIC AND AUSTIN EEG LAB
Medical Science Center
711 West 38th Street, Building F
Austin, TX 78705
(512) 458-6121 CLINIC (512) 458-5223 EEG LAB
(512) 452-9171 FAX



AUSTIN NEUROLOGICAL CLINIC
Patient Registration Information
Please **PRINT** and complete **ALL** sections below

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

PERSONAL INFORMATION:

Name: _____ _____ _____ Sex: MALE FEMALE
Last Name First Name Initial

Marital Status: Single Married Divorced Widowed

Street address: _____ Apt #: _____ City: _____ State: _____ Zip _____

Home phone: (_____) _____ Cell phone: (_____) _____ Work phone: (_____) _____

Date of Birth: _____/ _____/ _____ Social Security #: _____-_____-_____ Driver's License: (State & #)_____
Month Day Year

Occupation: _____Employer/Name of School: _____ FULL TIME PART TIME

How do you wish to be addressed? _____ Email address _____

RESPONSIBLE PARTY INFORMATION:

Responsible party: _____ Relationship to patient: _____

Street address: _____ Apt #: _____ City: _____ State: _____ Zip _____

Home phone: (_____) _____ Work phone: (_____) _____ Social Security #: _____-_____-_____

Date of Birth: _____/ _____/ _____ Occupation: _____ Driver's License: (State & Number) _____

Employer: _____ Phone: (_____) _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip _____

Spouse's Name: _____ Work phone: (_____) _____

Social Security #: _____-_____-_____ Date of Birth: _____/ _____/ _____

Employer: _____ Phone: (_____) _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip _____

INSURANCE INFORMATION:

Primary insurance company name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip _____

Name of insured: _____ Date of Birth: _____/ _____/ _____ Relationship: Self Spouse Child Other

Insurance ID #: _____ Group #: _____

Secondary insurance company name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip _____

Name of insured: _____ Date of Birth: _____/ _____/ _____ Relationship: Self Spouse Child Other

Insurance ID #: _____ Group #: _____

REFERRAL INFORMATION:

Primary Care Physician: _____ Phone: (_____) _____

Referred by: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip _____

EMERGENCY CONTACT:

Name of person not living with you: _____ Relationship: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip _____

Home phone: (_____) _____ Work phone: (_____) _____

AUSTIN NEUROLOGICAL CLINIC
HEALTH HISTORY QUESTIONNAIRE

Please complete the following questionnaire as thoroughly as possible:

Name: _____ Today's Date: _____

Name of Referring Doctor: _____

Occupation: _____ DOB_____Age: _____

Married _____ Single _____ Widowed _____ Divorced _____ Separated _____

Right Handed? _____ Left Handed? _____ Both? _____

Allergies to medicines? Please list _____

_____

_____

_____

List all medications you are taking at the present time, both prescription and over the counter:

Name Dosage When Taken

_____

_____

_____

_____

_____

_____

_____

_____

Reason for seeing the doctor:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Significant past medical history: Please indicate approximate dates of any serious illnesses and/or surgeries for the categories below:

_____ Appendectomy	_____ Biopsy (site)	_____ Brain surgery
_____ Cataract surgery	_____ C-section	_____ Cosmetic surgery
_____ Gallbladder surgery	_____ Heart surgery	_____ Hernia repair
_____ Hip replacement	_____ Hysterectomy	_____ Joint repair
_____ Knee replacement	_____ Mastectomy	_____ Prostate surgery
_____ Spinal surgery	_____ Tonsillectomy	_____ Asthma
_____ Allergies	_____ Arthritis	_____ Cataracts
_____ Back pain	_____ Cancer	_____ Diabetes
_____ Chronic pain	_____ Depression	_____ Head injury
_____ Emphysema	_____ Glaucoma	_____ Hypertension
_____ Headache	_____ Heart disease	_____ Seizures
_____ Multiple sclerosis	_____ Parkinson's	_____ Tremor
_____ Stroke	_____ Tia's	_____ Ulcers

Other

_____

_____

_____

_____

_____

Family history: Were your parents or siblings treated for any of the above mentioned conditions?

Father: _____

Mother: _____

Brother: _____

Sister: _____

Do you use caffeine? _____ If yes, how much? _____

Do you or have you used tobacco? _____ If yes, how many packs per day? _____

If you quit smoking, when did you quit? _____

Do you use alcohol? _____ If yes, how much? _____

Do you use recreational drugs? _____

Optional question: Do you know your HIV status? If yes, what is it? _____

AUSTIN NEUROLOGICAL CLINIC
711 West 38th Street, Building F
Austin, Texas 78705

NAME: _____ **DATE:** _____

Please check any of the problems, which you now have or have had within the past year:

GENERAL
- ❑ Weight changes
- ❑ Fever or chills
- ❑ Night Sweats
- ❑ Fatigue or Tiredness

HEAD & NECK
- ❑ Trauma
- ❑ Lumps
- ❑ Headaches
- ❑ Masses
- ❑ Tenderness

EYES
- ❑ Loss of vision
- ❑ Double vision
- ❑ Blurred vision
- ❑ Aversion to light
- ❑ Pain or redness

ENT
- ❑ Hearing loss
- ❑ Ringing in the ears
- ❑ Nose Bleeds
- ❑ Allergies

CARDIAC
- ❑ Chest pain
- ❑ Palpitations
- ❑ Murmur
- ❑ Swelling feet/ankles
- ❑ Fainting

LUNGS
- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Pneumonia

DIGESTION
- ❑ Nausea/vomiting
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Stool changes

MUSCULOSKELETAL
- ❑ Chronic joint pain
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Gout

NEUROLOGICAL
- ❑ Head trauma
- ❑ Nerve damage
- ❑ Seizures
- ❑ Numbness
- ❑ Loss of memory
- ❑ Speech problems
- ❑ History of Stroke

HEMATOLOGICAL
- ❑ Anemia
- ❑ Easy bruising
- ❑ Easy bleeding
- ❑ Drug use
- ❑ Large lymph nodes

ENDOCRINE
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Excessive thirst
- ❑ Excessive hunger

GENITOURINARY
- ❑ Chronic urinary tract infections
- ❑ Brown or bloody urine
- ❑ Kidney stones
- ❑ Incontinence
- ❑ Difficulty urinating
- ❑ Impotence
- ❑ Testicular pain

PSYCHIATRIC
- ❑ Depression
- ❑ Anxiety

SKIN
- ❑ Rash
- ❑ Easy bruising

OTHER:_____
_____
_____
_____

THE FOLLOWING IS TO BE COMPLETED BY NURSE

HEIGHT_____ WEIGHT_____BLOOD PRESSURE_____

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Austin Neurological Clinic uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact the Privacy Officer.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physicians in this practice are specialists. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all

government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation
We may disclose your medical information as required by the Texas workers' compensation law.

Inmates
If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law
We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions
You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means
You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information
You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information
You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Administration
Austin Neurological Clinic, P.A.
711 West 38th Street, Bldg. F
Austin, Texas 78705

Telephone No.: 512-458-6121
Fax No.: 512-452-5567

This notice is effective on the following date: April 14, 2003.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

AUSTIN NEUROLOGICAL CLINIC

FINANCIAL POLICIES

Austin Neurological Clinic has a responsibility to provide quality healthcare services to patients. In the interest of maintaining a good doctor-patient relationship and continuing the delivery of quality healthcare, it is our hope that you will take responsibility for your financial obligation to our practice. Following are general policies we have established for our patients, which we believe allow the flexibility that some patients need. We encourage you to discuss your account, and any payment arrangements that you desire, with our office personnel. Discussion of these issues early on in your treatment process will prevent most concerns or misunderstandings.

1. **Insurance** – As a courtesy to our patients, we will file claims on all visits and procedures, if we are contracted with your insurance plan. There are many insurance companies with which we do not contract with, such as PHCS and Scott & White plans. This is ***not*** an all-inclusive list and you should check with your insurance company to be certain of our provider status. If we are *not* providers for your insurance plan, you will be required to pay for your services at the time of your appointment. We accept cash, check and credit cards (Visa, MasterCard & Discover). If we *are* contracted with your insurance plan, we will file claims and you will only be responsible for your office co-pay, deductibles and co-insurance. We will file claims with your insurance company for all hospital visits and procedures, regardless of insurance plan, but you will be expected to pay for any charges not covered by your plan. Please remember that insurance coverage is a contract between the patient and the insurance company. The ultimate responsibility for understanding your insurance benefits and for payment to your doctor rests with you.
2. **Referrals –** You are required to 1) know whether or not your insurance requires a referral and 2) be sure you have obtained a referral before you are scheduled to see one of our doctors. Referrals typically have an expiration date and a limited number of visits so you should be careful to monitor the dates and visits. Our office will not see a patient who does not have a valid referral.
3. **Ancillary Services** – Oftentimes our doctors will request that certain tests and evaluations be done to further diagnose or treat your condition. Your insurance company may have specific providers that are required or preferred for you to get the best benefit available under your insurance plan. We will assist you in making arrangements for tests and evaluations we require, but you will be responsible for telling our healthcare coordinator which facilities are on your plan. Failure to do so may result in charges to you by other facilities which your insurance company does not cover.
4. **No Insurance** – Patients who do not have insurance are expected to pay for all services rendered. Again, we accept cash, check and credit cards (Visa, MasterCard & Discover). We understand that individual circumstances may make it difficult to meet particular financial expectations and are happy to discuss other payment arrangements as needed.
5. **Returned Checks** – Your account will be charged a $25 fee for each returned check. In addition, you will be asked to bring cash to our office to cover the returned check and fee.
6. **Past Due Accounts** – Patients who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligation to us may be turned over to a collection agency. Patients who have allowed their account to be turned to an agency will be expected to satisfy their financial obligation to us, and to pay for any future services in advance, before being seen by one of our doctors.
7. **Cancellations & No Shows** – Should you need to cancel or reschedule your appointment, please notify our office at least 24 hours before your scheduled appointment time to avoid any charge. **New Patients will be charged $100.00 and return/follow-up visits will be charged $35.00 for each no show or late cancellation**. ***As a courtesy*** we will attempt to remind you of your scheduled appointment time, but it is the **responsibility of the patient** to remember his/her appointment. Insurances carriers generally will not pay this type charge so it will be patient responsibility. Should you incur a charge - a clinic doctor will not see you until your account is paid in full.

Assignment of Benefits

I hereby give lifetime authorization for payment of insurance to be made directly to Austin Neurological Clinic for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

AUSTIN NEUROLOGICAL CLINIC

Patient Name:_____ **Date of Visit:**_____

Acknowledgement of Financial Policies

❑ I have read and understand Austin Neurological Clinic's financial policies and agree to accept responsibility as described.

Assignment of Benefits

❑ I have read and understand Austin Neurological Clinic's assignment of benefits policy and agree to the assignment of benefits as described.

Acknowledgement of Review of Notice of Privacy Practices and authorization to Release Health Information

❑ I have read and understand Austin Neurological Clinic's privacy practices, which explains how my medical information will be used and disclosed. I have also granted release of information to the following individuals: _____

_____

_____

Permission for Telephone Messages

❑ Austin Neurological Clinic has permission to leave a detailed medical message for me at the telephone numbers I have previously provided and also the following numbers:

_____

_____

Messages may include information on the following:

Lab & x-ray results	Referring doctor
Prescriptions	Medical instruction

Appointments or any other appropriate message needed in order to communicate with the patient.

If you have any specific needs regarding phone messages please let us know here:

_____

_____

_____

Date: _____

Patient Signature: _____

or legal representative: _____