NEUROAUSTIN

PATIENT CONSENT TO TREAT

I hereby give my consent to **NEUROAUSTIN NEUROLOGY ASSOCIATES, PLLC** and authorize him or her to provide my medical treatment. I understand that **NEUROAUSTIN NEUROLOGY ASSOCIATES** will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. *I understand that office visits may be scheduled with a certified Physician Assistant and/ or Nurse Practitioner working under the supervision of the Physician*. I authorize **NEUROAUSTIN NEUROLOGY ASSOCIATES** to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I agree to allow the reconciliation of medication history.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

_____

Patient Printed Name

_____ _____

Patient Signature **Date**

_____ _____

Signature of Treating Provider **Date**

NEUROAUSTIN

PATIENT ATTESTATION
TO ORIGIN OF CONDITION OR INJURY

Patient Name: _____ **Date Of Birth:** _____

Member Agreement

I, _____, certify that I am being seen by NeuroAustin Neurology Associates, PLLC today, _____, 20___, for a condition that is **NOT** associated with a motor vehicle accident, a work- related injury, or any other injury or condition for which a third party has financial responsibility.

I agree that, should any financial disputes arise regarding a motor vehicle accident, or work or other injury, I will be **SOLELY** responsible for all charges incurred at NeuroAustin Neurology Associates, PLLC.

I understand that NeuroAustin Neurology Associates, PLLC **DOES NOT** participate in the Workman's Compensation system.

_____ _____

Patient Signature **Date**

NEUROAUSTIN

PATIENT MEDICAL HISTORY

Today's Date _____ **Name (Last)** _____ **DOB** _____

Reason for seeing Dr. Raymond today _____

Name of Primary Care Physician_____

Name of Referring Physician _____

Circle One: Right Hand Left Hand Ambidextrous

OFFICE USE ONLY
WT:
HT:
B/P:
P:

Do you have a history of (circle any that apply)

High Blood Pressure	High Cholesterol	Heart Disease	Tremor
Stroke	Migraines	Aneurysm	Lower Back Pain
Diabetes	Cancer	Lung Disease	Neck Pain
Multiple Sclerosis	Seizures	Neuropathy	Headaches
Depression	Bipolar Disorder	Anxiety Disorder	Schizophrenia

Other: _____

Family History

Please comment on relatives below whether living or deceased, including medical history.

(ex: Mother: living – Diabetes, Stroke, Heart Attack… or Deceased 85, Diabetes, Stroke)

Father: _____

Mother: _____

Sister(s):(How Many)_____

Brother(s):(How Many)_____

Children: (How Many)_M _____ F_____

Marital Status (circle that applies): Single Married Widowed Divorced Other

Social History

Do you drink caffeinated beverages? Yes No How many day/wk/month____ Coffee____Tea ____Soda

Do you use/prior use tobacco product? Yes No About ____ packs per day /Quit Date_____

Do you drink alcohol? Yes No About ____ drinks per day/week

Do you or have used street drugs? Yes No If so, type of drugs_____

NEUROAUSTIN

Name: (Last) _____DOB: _____

Preference Pharmacy:

Name:_____ Location:_____

Phone #:_____

Medication

Please list you current medications and doses. Use back page if necessary. If you have a medication list, please attach here.

_____
_____
_____
_____
_____
_____
_____
_____

Allergies

Name of Drug Reaction

_____
_____
_____
_____
_____

Mental Health History

Have you seen a Mental Health Provider for any reason (this includes, Psychiatrist, Psychologist, Counselor, etc.)? Yes / No. If yes, please list who and when. _____
_____

Reason (Diagnosis) and if you were hospitalized: _____
_____
_____
_____

Are you currently taking any medications for this reason? _____
_____
_____

Past Surgical and Hospitalization History

Type Date

_____
_____
_____
_____
_____
_____
_____

NEUROAUSTIN

PATIENT REGISTRATION

Name (*First M.I. Last)* _____ Date of Birth _____

Address _____ City _____ State_____ Zip_____

Home Phone Number_____ Cell Phone Number_____

Email Address _____

Social Security # _____ Driver's License #_____State_____

Marital Status: Single, Married, Widowed, Separated, Divorced Gender: Male / Female

In Case of Emergency Notify _____ Phone Number_____

Relationship to Patient _____

Please Select One of the Following

Race: American Indian/Native Asian Black/African American Pacific Islander White Other Decline

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline

EMPLOYMENT

Employed: Full-Time Part-Time Not working Retired

Employer _____ Occupation_____

Employer Address _____ Phone Number_____

Student: No / Full-Time / Part-Time, School Name _____

INSURANCE INFORMATION

Primary Insurance_____ Policy # _____

Insured's Name _____ Relationship to Insured: Self / Spouse / Child / Other

Insured's SS# _____ Insured's Date of Birth _____ Gender: Male / Female

Secondary Insurance _____ Policy# _____

Insured's Name _____ Relationship to Insured: Self / Spouse / Child / Other

Insured's Social Security Number _____ Date of Birth _____ Gender: Male / Female

I hereby assign, transfer, and set over to **NEUROAUSTIN NEUROLOGY ASSOCIATES, PLLC** all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. **I understand that I am financially responsible for all charges whether or not they are covered by insurance.**

_____ _____

Patient Signature **Date**

NEUROAUSTIN

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payments for services rendered are part of your treatment. Along with your intake information, this financial policy must be signed prior to treatment.

Please prepare to pay your co-payment is due at the time service is rendered. We accept Cash, Check, Discover, Visa, or MasterCard. A fee of $25 will be charged for any returned check.

FINANCIAL RESPONSIBILITY: I understand that I am ultimately responsible for payment on my account. **Payment is expected at the time of service**. I understand **that I AM RESPONSIBLE for any Referral or Authorization that my insurance may require**. I understand that I am responsible for any charges not covered by my insurance plan, including Co-payments, Co-insurance, and Deductibles. Claims will be filed for PPO and HMO participants and Medicare. Payment of benefits will be made directly to NeuroAustin.
INSURANCE COVERAGE: I understand that I am responsible for providing NeuroAustin with **any and all insurance coverage at each and every visit**. I will be responsible for any balances due as a result of not disclosing this information.

INSURANCE PROVIDER: I certify that _____ is my primary insurance provider.

SECONDARY INSURANCE PROVIDER: **Please check one of the following**
___ I certify I do have a secondary insurance policy. I also understand that NeuroAustin will file my secondary insurance.
___ I certify I do **NOT** have a secondary insurance policy.

Filing of Contracted Insurance Claims: We are happy to file your insurance claim if we are contracted with the insurance company. All co-payments, deductibles and co-insurance payments are due prior to treatment, unless stated otherwise in our contract.

Non-Contracted Insurance Claims: We are happy to file your insurance claim. All co-payments, deductibles, and co-insurance payments are due prior to treatment, unless stated otherwise in our contract. If payment is not received from your insurance company within 45 days, you will be responsible for payment in full. Your insurance company is a contract between you and your insurance as we are not a party to that contract. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare program and/or other insurance plans.

Referrals/Authorizations: If your insurance requires an authorization or referral to be seen by our office, it is your responsibility as the patient to be sure this information is obtained and received by our office. If we do not receive this information, you will be responsible for payment in full.

Letters of Protection: We only accept letters of protection with pre-payments that has been approved prior to your initial visit. If we do not have this approval, you are responsible for payment in full. You are responsible for full payment regardless of whether there is a settlement or not. Also, if it is a work injury or accident with Personal Injury Protection, we cannot file on your private insurance.

Usual and Customary Rates: We are committed to providing the best treatment for our patients. We are not above the reasonable or necessary charges for our area. The patient/guardian is responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Please let us know if you have any questions regarding this policy. Your signature below confirms you have read our policy and agree to continue with treatment.

_____ _____

Patient Signature **Date**

NEUROAUSTIN

OFFICE POLICY

In keeping with our philosophy of respect for our patients and staff, we have developed the following office policies

---

MEDICAL EMERGENCY: I understand that when I call this office, **I may or may not be able to speak with a live person right away**. I understand that if I am having a **medical emergency**, I should not call this office, but should call 911. When calling this office about a medical question, I am aware that the doctors are very limited by my report and are limited in what they can observe over the phone**. If I have new symptoms, worsening symptoms, and unexplained symptoms, I understand I should present to the emergency room immediately for an evaluation**. I will then need to schedule a visit with the doctor, so that he/she can review my questions and concerns thoroughly. **I understand not all of my calls can be answered immediately, due to time and personnel constraints.**

NO SHOW/CANCELLATION: We do have a 24 hour cancellation/No show policy. This policy states that if you cancel or reschedule your appointment without 24 hour notice (this does not apply to same day appointments) you will be responsible for a **$50 fee payable** before next date of service. This also applies to patients who no show/no call for their scheduled appointments. _____ (Initial)

LATE: If you arrive 10 minutes or later after your appointment time, please realize that someone else has scheduled that time and you may be asked to reschedule your appointment. _____ (Initial)

FEE FOR FORMS COMPLETION: I understand there will be a charge for any forms I bring to be completed by NeuroAustin physicians or staff. (Example: Disability forms, FMLA forms, etc.). I will be required to schedule a re-visit with the doctor to discuss these forms and there will be a charge of **$25.00 for 1 to 2 pages, $50 for 3 to 4 pages, $75 for 4 or more pages** for their completion. I understand it is my financial responsibility, not my health plan's responsibility, to pay this. Forms will not be completed until this fee is paid. _____ (Initial)

REFILL REQUEST: For refill requests, please make sure you allow 48 - 72 hours turnaround time on ALL prescription refill request. As a rule, please contact your pharmacy firsthand have them fax over the refill or new prescription request**.** _____ (Initial)

Please let us know if you have any questions regarding this policy. Your signature below confirms you have read our policy.

_____ _____

Patient Signature **Date**

NEUROAUSTIN

OFFICE POLICY AGREEMENT

Please review, initial each entry and sign below indicating that you understand these office protocols and agree to abide by them. Lack of signature does not invalidate these protocols.

- I understand that I am an active participant in my health care and agree to abide by the treatment plan given and reviewed with me at each visit. I understand that any changes in condition may need an office visit for reassessment. For acute changes in my condition, I may need to access care through the emergency room. _____ (Initial)

- I understand that this practice utilizes mid-level practitioners such as Physician Assistants and Nurse Practitioners, and I consent to treatment from these providers. They provide care in terms of assessing new patients; assessing patients on routine follow-ups; assessing any changes in conditions; education of patient on condition, medications, and treatment options. _____ (Initial)

- I understand that my access to care via telephone or on site will require my behavior to be in a manner that is not abusive to the staff. I agree to refrain from behavior that reflects yelling, cursing, name-calling or multiple calls in same day. I understand that this behavior may terminate my relationship with this practice. _____ (Initial)

- I agree to provide advance notice of cancellations of appointments. I understand that frequent cancellations and/ or not showing up for an appointment without calling in advance, may be a factor in the continuation or discontinuation of my care with this group. _____ (Initial)

Please let us know if you have any questions regarding this policy. Your signature below confirms you have read our policy.

_____ _____

Patient Signature **Date**

NEUROAUSTIN

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPAA)

Patient Printed Name _____

Date of Birth _____

I acknowledge that **NeuroAustin Neurology Associates, PLLC** provided me with a written copy of their **Notice of Privacy Practices**.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature **Date**

_____ _____

RELEASE OF INFORMATION

I _____ allow the following person to have full access of my medical records.

Names:_____ Relation:_____

Names:_____ Relation:_____

Names:_____ Relation:_____

Names:_____ Relation:_____

Names:_____ Relation:_____

ANDREA RAYMOND, MD
NEUROAUSTIN NEUROLOGY ASSOCIATES, PLLC
4544 S. LAMAR BLVD, SUITE 760
AUSTIN, TX 78745
PHONE (512) 433-6333
FAX (512) 433-6331