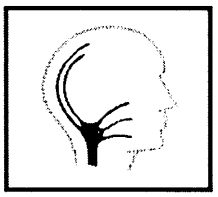

NORTH TEXAS INSTITUTE OF NEUROLOGY AND HEADACHE

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5150 Warren Pkwy Frisco TX, 75034
Office (972) 403-8184 Fax (972) 403-0685

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Karen Bontia, MD
Elaine C. Timm, MD
George R. Nissan, DO
Kathleen Scott, DO
Sara Freeman, PA-C
Viktoria Sattar. NP-C

PATIENT INFORMATION:

Name: _____ Sex: M F Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Drivers License #: _____ Social Security #: _____ Marital Status: S M D W

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____ Employer : _____ Phone #: _____

Employer's Address: _____

Referring Physician: _____ Family Physician: _____

Referring Doctor's Address: _____ Phone #: _____

SPOUSE/DOMESTIC PARTNER/RESPONSIBLE PARTY IF MINOR (PT UNDER 18):

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F Date of Birth _____ Social Security #: _____ Employer: _____

INSURANCE INFORMATION:

Name of Primary Insurance Co: _____ Co-Pay Amount $_____ Effective Date _____

Insured's Name: _____ DOB: _____ SS# _____

ID# _____ Group #: _____ Employer _____

Claims Address: _____ City _____ State _____ Zip _____

Name of Secondary Insurance Co: _____ Co-Pay Amount $_____ Effective Date _____

Insured's Name: _____ DOB: _____ SS# _____

ID# _____ Group #: _____ Employer _____

Claims Address: _____ City _____ State _____ Zip _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

CONSENT:

I hereby authorize direct payment of my insurance benefits to NTINH for services rendered to myself or my dependents. I understand it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand I am responsible for any co-pay or balance due that is determined by my insurance carrier for any reason. I authorize release of any information that may be necessary for medical evaluation, treatment, consultation, or processing of insurance benefits. I hereby consent to evaluation, testing and treatment as directed by NTINH.

Patient Signature: _____ Date: _____

Neurology
Sleep
Neur-Allergy
NeuroDiagnostics
Massage

Evaluate, Integrate, Recuperate
Setting The Standard In Headache Medicine

Headache
Acute Headache
Concussion / Sports
Imaging
Acupuncture

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OFFICE POLICIES

Office Hours:
Monday – Friday: 8:00 AM - 4:00 PM Lunch- 12:00 PM – 1:30 PM
Saturday: 9:00 AM-1:00 PM Sunday: Closed

Insurance Payment Policy
Please present your insurance card and driver's license at the time of check in. We do not verify benefits for most follow up appointments. Please be aware that it is ultimately your responsibility to know your healthcare benefit coverage. If you do not know your benefits we strongly recommend that you contact your insurance carrier with any questions you may have regarding your coverage prior to your services rendered. On each date of service, you will be expected to pay the co pay/coinsurance/deductible amount that is listed on your insurance card. Please note this is only an estimated amount. After your insurance company has paid their portion, it is probable that you will receive a bill from North Texas Institute of Neurology and Headache for any amount that has been applied to your deductible or coinsurance.

Self-Pay Patients
Our office does not see self-pay patients.

Forms of Payment
We do not accept checks on the initial appointment. Payment is accepted in the forms of cash, checks, or debit cards (Visa, MasterCard, American Express, or Discover).

Medical Records
Medical record requests are now handled by a third party, HealthMark Group. To request your records, submit a request by creating an account at https://medrelease.healthmark-group.com/360. You may also request your records through our office. If you choose to submit a request through our office, a records release form will need to be completed in our office or sent to the office via fax. Should any fees be required, HealthMark Group will send out an invoice. Records will be available within 24-48 hours, unless pending payment. If you have not received any response regarding your request, please call our office.

Medication Refills
Please allow our office 72 hours for medication refills. Medication refills will only be filled during our normal business hours listed above. The on-call physician will not fill standard, non-urgent refills after hours.

Outside Venues
Our office may have contractual financial interests in venues such as Sleep Studies, EEGs, UAs, MRIs and Compound Pharmacies.
These interests do not in any way impact medical decisions, treatment options or financial obligations for our patients.

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Courtesy Policy

Due to the sensitive nature of the conditions that we treat, we ask that all patients refrain from cell phone use, the use of heavy perfumes, lotions and tobacco products. We thank you in advance for your cooperation in this matter.

I have read the above standard policies for North Texas Institute of Neurology and Headache, and I agree to abide by these policies.

_____
Patient Name (please print)

_____ _____
Patient/Guarantor Signature Date

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CANCELLATION/NO SHOWS

Cancellations

We do our best to confirm appointments with our patients 72 hours in advance, however it is ultimately the responsibility of the patient to confirm or cancel your appointment within 24 hours. Appointments that have not been confirmed by 3:00 PM the day prior to your appointment will be canceled and considered a no show, so that we are able to accommodate patients who are on the waiting list. Patients that no show their appointment or cancel it on the same day of service will be charged with the fee listed below.

- Follow up appointments: $50.00
- Procedures (including EMG/NCV, injections, Biopsy or Botox/Dysport/Xeomin): $100.00
- Consult with different Provider in office: $75.00
- Acupuncture Consult: $150.00; Follow up: $100.00
- Radiology: $150.00
- Massage: $25.00

Late Policy

If you are more than 15 minutes late, please call our office so we can reschedule your appointment. Please be aware, this will be considered a No Show and a fee will be assessed. Please respect this policy as it ensures that physicians and patients stay on time.

_____
Patient Name (Please Print)

_____ _____
Patient/Guarantor Signature Date

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Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, North Texas Institute of Neurology and Headache creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.
By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.
This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

Patient Name (Please print)	Date
Patient/Guarantor Signature	Last four of SSN#
Witness (Optional)	Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Information

Name: _____

Social Security Number: _____ DOB: _____

I, the above mentioned person, release that the following medical information be sent from North Texas Institute of Neurology and Headache.

_____ All Medical Records _____ All Billing Records

I, the above mentioned person, release North Texas Institute of Neurology and Headache, and their staff from any liability concerning the above mentioned records. Information can be released and sent to:

Who is authorized to receive information:

Name: _____

Name: _____

Name: _____

By signing this form, I the above named person release the physician and his staff from any liability concerning my medical records.

_____ _____ _____
Printed Name Signature Date

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Name: _____ **Date of Birth:** _____/_____/_____ **AGE**_____

SO THE PROVIDER MAY UNDERSTAND YOUR HISTORY, PLEASE TAKE THE TIME TO ANSWER THESE QUESTIONS AS CLEAR AND ACCURATE AS POSSIBLE

WHO REFERRED YOU TO OUR OFFICE? _____ PHONE: _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ PHONE: _____

WHAT IS THE NAME OF YOUR PHARMACY? _____PHONE: _____

PLEASE LIST ALL OTHER PROVIDERS INVOLVED IN YOUR CARE; WHO YOU WOULD LIKE A COPY OF YOUR REPORTS SENT TO.

1. _____

2. _____

WHAT IS THE **SPECIFIC REASON** FOR TODAY'S VISIT?

_____

_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM? _____

HAVE YOU HAD ANY TESTS FOR THIS PROBLEM? (MRI, CT, EEG, EMG, etc....)

_____

_____

WHAT MEDICATION(S) AND/OR TREATMENT(S) HAVE YOU HAD FOR THIS PROBLEM?

_____

_____

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WHAT MAKES SYMPTOMS BETTER? _____

WHAT MAKES SYMPTOMS WORSE? _____

MEDICATION HISTORY:

DO YOU SUFFER FROM MEDICATION ALLERGIES? (YES / NO)

_____

_____

_____

DO YOU SUFFER FROM ANY KNOWN FOOD ALLERGIES? (YES / NO)

_____

_____

_____

WHAT MEDICATIONS DO YOU **CURRENTLY** TAKE? PLEASE INCLUDE ALL OVER THE COUNTER MEDICATIONS **(NAME/STRENGTH/AMOUNT PER DAY)**

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____
7. _____	8. _____	9. _____
10. _____	11. _____	12. _____
13. _____	14. _____	15. _____
16. _____	17. _____	18. _____

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PRIOR MEDICAL HISTORY:

DO YOU CURRENTLY SUFFER FROM OR PREVIOUSLY SUFFERED FROM ANY OF THE FOLLOWING CONDITIONS?

- ☐ ADD/ADHD
- ☐ ALCOHOLISM
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ BIPOLAR
- ☐ CELIAC DISEASE
- ☐ CLUSTER HEADACHE
- ☐ DEPRESSION/ANXIETY
- ☐ DIABETES
- ☐ DRUG ADDICTION
- ☐ FIBROMYALGIA
- ☐ HEART ATTACK
- ☐ HIGH BLOOD PRESSURE
- ☐ HIGH CHOLESTEROL
- ☐ HYPERTHYROID
- ☐ HYPOTHYROID
- ☐ KIDNEY DISEASE
- ☐ LIVER DISEASE
- ☐ LUPUS
- ☐ LYME DISEASE
- ☐ MIGRAINE
- ☐ OBSTRUCTIVE SLEEP APNEA
- ☐ TENSION HEADACHE
- ☐ SCHIZOPHRENIA
- ☐ SEASONAL ALLERGIES
- ☐ SEIZURES
- ☐ STROKE
- ☐ OTHER PSYCHIATRIC CONDITION
- ☐ CANCER: (TYPE) _____
- ☐ OTHER: _____

_____

HAVE YOU HAD ANY **MAJOR SURGERY**? IF YES, APPROXIMATE YEAR AND NUMBER OF TIMES.

- ☐ BYPASS: _____
- ☐ BRAIN: _____
- ☐ C-SECTION: _____
- ☐ COSMETIC: _____
- ☐ FACIAL: _____
- ☐ GALLBLADDER: _____
- ☐ HEART VALVE: _____
- ☐ HYSTERECTOMY: _____
- ☐ KNEE: _____
- ☐ SHOULDER: _____
- ☐ SPINAL: _____
- ☐ THORACIC OUTLET SYNDROME: _____
- ☐ VASCULAR: _____
- ☐ OTHER: _____

REVIEW OF SYSTEMS: (Circle yes or no)

Have you ever had any of the following symptoms in the past year?

Unexplained fever	Yes	No
Frequent night sweats	Yes	No
Unexplained weight gain	Yes	No
Unexplained weight loss	Yes	No
Fatigue	Yes	No
Double vision	Yes	No
Dry eyes	Yes	No
Difficulty hearing	Yes	No
Ringing in the ears	Yes	No
Hoarseness	Yes	No

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Dry mouth	Yes	No
Trouble swallowing	Yes	No
Indigestion	Yes	No
Frequent heart burn	Yes	No
Frequent diarrhea	Yes	No
Shortness of breath	Yes	No
Unexplained cough	Yes	No
Heart murmur	Yes	No
Palpitation	Yes	No
Frequent Headaches	Yes	No
Loss of sensation	Yes	No
Loss of muscle power	Yes	No
Tremor	Yes	No
Trouble sleeping	Yes	No
Heavy snoring	Yes	No
Falling asleep driving	Yes	No
Trouble walking	Yes	No
Trouble with your speech	Yes	No
Frequent dizziness	Yes	No
Memory problems	Yes	No
Bleeding problems	Yes	No
Bruising easily	Yes	No
Joint pain or swelling	Yes	No
Neck pain	Yes	No
Back Pain	Yes	No
Skin Rash	Yes	No
Suicidal thoughts	Yes	No
Miscarriages	Yes	No
Currently breast feeding	Yes	No
Bowel incontinence	Yes	No
Bladder incontinence	Yes	No
Erectile dysfunction	Yes	No

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FAMILY HISTORY:

ARE YOU ADOPTED? (YES / NO)

FATHER: AGE___ ☐ALIVE ☐DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH_____

MOTHER: AGE___ ☐ALIVE ☐DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH_____

SIBLINGS: AGE___ ☐ALIVE ☐DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH_____

SIBLINGS: AGE___ ☐ALIVE ☐DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH_____

SIBILINGS: AGE___ ☐ALIVE ☐ DECEASED;
ANY MAJOR ILLNESS / CAUSE OF DEATH _____

SOCIAL HISTORY:

OCCUPATION: _____ ARE YOU DISABLED? YES / NO

☐MARRIED ☐SINGLE ☐SEPARATED ☐DIVORCED ☐WIDOWED

DO YOU CURRENTLY SMOKE? (YES / NO) IF *YES*, HOW MUCH? _____ (PER DAY, WEEK)
IF YOU QUIT, WHEN? _____

DO YOU CONSUME CAFFEINE (YES / NO) IF *YES*, HOW MUCH? _____ (PER DAY, WEEK)
(Including: coffee, tea, energy drinks, soda, Excedrin, etc.)

IF YOU DO NOT HAVE CAFFEINE, DO YOU EXPERIENCE HEADACHES? (YES / NO)

DO YOU CURRENTLY CONSUME ALCOHOL? (YES / NO) IF *YES*, HOW MUCH? _____ (PER DAY, WEEK)
IF QUIT, WHEN? _____

ARE YOU CURRENTLY USING / TAKING: ☐MARIJUANA ☐COCAINE ☐HEROIN ☐METHAMPHETAMINES (ADDERAL / VYVANSE / RITALIN / AMPHETAMINE ☐NARCOTICS (NORCO / HYDROCODONE / PERCOCET / OXYCODONE / OXYCONTIN BUTRANS / FENTAYL)

IF YES, HOW FREQUENT: _____

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BRING ALL PERTINENT RADIOLOGY AND LABWORK TO APPOINTMENT, AS THIS WILL ASSIST WITH TREATMENT. IF YOU SHOW UP TO THE APPOINTMENT WITHOUT RADIOLOGY AND LABWORK YOU MAY BE ASKED TO RESCHEDULE.

This office does not participate in **NO FAULT (AUTOMOBILE ACCIDENT CASES), PERSONAL INJURY** or **WORKMAN'S COMPENSATION** cases.

Is this visit related to: Motor vehicle accident: Yes No Workman's Compensation: Yes No Personal Injury: Yes No

☐ I **HAVE NOT** AND CURRENTLY **DO NOT** TAKE ANOTHER PERSON'S MEDICATION. _____
(PATIENT INITIAL'S)

IF YES WHAT? _____

_____

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____

Note to the patient:

I understand the providers and staff are here to help my condition. The testing and recommendations are for my benefit. I understand non-compliance can result in a significant impact in my future care which may include dismissal.

_____
(PATIENT INTIALS)