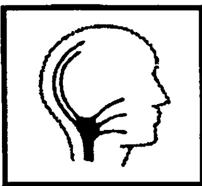

NORTH TEXAS INSTITUTE OF NEUROLOGY AND HEADACHE

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5150 Warren Pkwy Frisco TX, 75034
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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: ______________

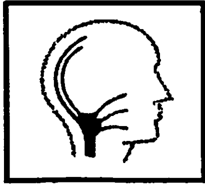
Address: ______________________________

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, including downloaded medication history.

Patient Signature: ______________________ Date: ______________



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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

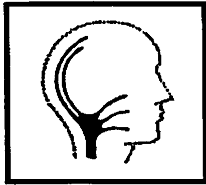
Medical record requests are now handled by a third party, HealthMark Group. To request your records, submit a request by creating an account at https://medrelease.healthmark-group.com/360. You may also request your records through our office. If you choose to submit a request through our office, a records 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.

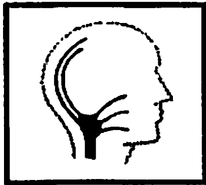
I have read the above standard policies for North Texas Institute of Neurology and Headache, and I agree to abide by these policies.

____

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.

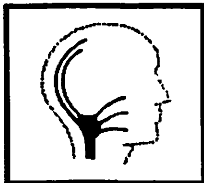
- Follow up appointments: $50.00
- Procedures (including EMG/NCV, injections, Biopsy or Botox/Dysport/Xeomin): $100.00
- Consult with different Provider in office: $75.00
- Acupuncture Consult: $150.00; Follow up: $100.00
- Counseling Consult and Follow Up: $150.00
- Radiology: $150.00
- Massage: $25.00

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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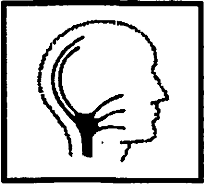
Patient Consent and Acknowledgement of Receipt of Privacy Notice

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:

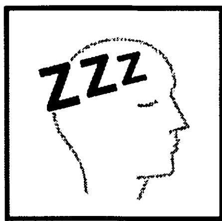
Name: ____

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:**____/____/____

INSTRUCTIONS: SO WE MAY UNDERSTAND BETTER THE HISTORY OF YOUR ILLNESS AND WHAT BRINGS YOU TO OUR OFFICE TODAY, PLEASE TAKE THE TIME TO ANSWER ALL QUESTIONS.

PHYSICIAN INFORMATION

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?

____

____

____

II. PRIOR MEDICAL HISTORY

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

☐ ADD/ADHD	☐ ATRIAL FIBRILLATION	☐ GERD	☐ KIDNEY DISEASE
☐ ANXIETY	☐ DEPRESSION	☐ HEART ATTACK	☐ MIGRAINE
☐ ALLERGIES	☐ DIABETES	☐ HIGH BLOOD PRESSURE	☐ SEIZURE
☐ ARTHRITIS	☐ DEVIATED SEPTUM	☐ HIGH CHOLESTEROL	☐ STROKE
☐ ASTHMA	☐ FIBROMYALGIA	☐ HYPOTHYROID	☐ TMJ

OTHER: ____

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

☐ BRAIN: ______	☐ SPINAL: ______	☐ COSMETIC: ______
☐ GALLBLADDER: ______	☐ HYSTERECTOMY: ______	☐ VASCULAR: ______
☐ KNEE: ______	☐ SHOULDER: ______	☐ BYPASS: ______
☐ FACIAL: ______	☐ HEART VALVE: ______	☐ C-SECTION: ______

OTHER

SURGERIES: ______

______

Last Menstrual Period: ______ Are you pregnant? Yes No
Are you breastfeeding? Yes No
Are you planning on conceiving? Yes No

III. MEDICATION HISTORY

DO YOU SUFFER FROM **ADVERSE EFFECTS OF MEDICATION / ALLERGIES** TO ANY MEDICATIONS? (Y/N)
IF YES, LIST THE MEDICATION AND EXPLAIN YOUR REACTION.

1. ______ 3. ______

2. ______ 4. ______

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

1. ______ 7. ______

2. ______ 8. ______

3. ______ 9. ______

4. ______ 10. ______

5. ______ 11. ______

6. ______ 12. ______

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IV. 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_______________________________________

V. 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)**

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

HAVE YOU EVER USED OR ABUSED ANY OF THE FOLLOWING:

☐MARIJUANA ☐COCAINE ☐HEROIN ☐SPEED ☐NARCOTICS

OTHER: ____

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VI. SLEEP HISTORY

Do you experience or has anyone told you that you:

	Frequently	Occasionally	Never	Don't Know
A sensation that you need to move your arms and/or legs in the evening or at bedtime?				
Snore				
Difficulty falling asleep				
Difficulty staying asleep				
Tired/sleepy during the day				
Gasp, choke, or pause during breathing while asleep				
Clench or grind your teeth during sleep				
Move excessively during sleep				
Nightmares				
Sleepwalking				
Act out your dreams				
Drooling /waking with a dry mouth				
Unrefreshing sleep				
Morning headaches				

Any other sleep issues or

complaints____

VII. CURRENT SLEEP SYMPTOMS

IN YOUR OWN WORDS, BRIEFLY DESCRIBE YOUR SLEEP-RELATED PROBLEMS:

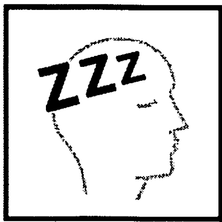
____

____

____

-WHAT TIME DO YOU GET INTO BED? _______-am –pm ______-am –pm

-WHAT TIME DO YOU TURN OFF THE LIGHTS TO GO TO SLEEP? _______-am –pm ______-am –pm



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-WHAT TIME DO YOU GET OUT OF BED TO START THE DAY? ______-am –pm ______-am –pm

-HOW MANY HOURS DO YOU ACTUALLY SPEND IN BED? ________________

-HOW MANY HOURS DO YOU THINK YOU ACTUALLY SLEEP? ________________

DO YOU HAVE A BED PARTNER WHO CAN OBSERVE YOUR SLEEP? (**CIRCLE ONE**)

-Regularly
-Rarely
-Sometimes
-Never

ON AVERAGE, HOW LONG DOES IT TAKE YOU TO FALL ASLEEP AT NIGHT? (**CIRCLE ONE**)

-Less than 5 minutes
-1-2 hours
-5-30 minutes
-More than 2 hours
-30 minutes-1 hour

IF IT TAKES YOU MORE THAN 30 MINUTES TO FALL ASLEEP, PLEASE INDICATE WHEN THIS STARTED? (**CIRCLE ONE**)

-Less than 3 months ago
-Following a specific event that occurred ________________months/years ago
-3 months to 1 year ago
-More than 1 year ago

HOW OFTEN DO YOU USE MEDICATION OR ALCOHOL TO HELP YOU FALL ASLEEP? (**CIRCLE ONE**)

-Never
-1-2 times/week
-3-5 times/week
-Every night
-1-2 times/month

IF YOU USE MEDICATION, WHAT TYPE DO YOU USE?

____

PLEASE DESCRIBE YOUR PREDOMINANT WORK SCHEDULE: (**CIRCLE ONE**)

-Day shift (9-5)
-Variable schedule
-Evening shift (3-11)
-Unemployed/retired
-Night shift (11-7)

HOW MANY DAYS PER WEEK DO YOU EXERCISE 30 MINUTES OR MORE? (**CIRCLE ONE**)

-0 days
-3-4 days
-1-2 days
-5-7 days

HOW MANY DAYS PER WEEK DO YOU NAP? (**CIRCLE ONE**)

-0 days
-3-6 days

-1-2 days -Daily

-IF YOU DO NAP, FOR HOW LONG? ________hours ________minutes

HOW OFTEN DO YOU WAKE UP IN THE MIDDLE OF THE NIGHT? **(CIRCLE ONE)**

Frequently Occasionally Never Don't Know

On average, how many times do you wake up? ____________________

If you wake up, what awakens you? ____________________

What do you do when you are awake? ____________________

How long does it take for you to get back to sleep? ____________________

How do you feel when you wake up in the morning? ____________________

VIII. PRIOR SLEEP TESTING OR TREATMENT

Have you ever:

Had an in-lab or home sleep study? Yes No
If so, where and when was it performed? ____________________

Been diagnosed with Obstructive Sleep Apnea? Yes No

Been diagnosed with Restless Legs Syndrome or Periodic Limb Movement Disorder? Yes No

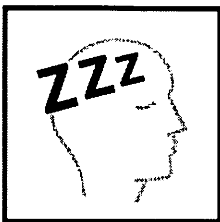
Performed a CPAP titration study? Yes No

Used a CPAP device for treatment of Obstructive Sleep Apnea? Yes No

Used a mouthguard or mandibular advancement device? Yes No

Used any of the following sleep aids/medications? **(CIRCLE ALL THAT APPLY)**

Ambien (zolpidem)
Ativan(lorazepam)
Elavil (amitriptyline)
Intermezzo (zolpidem)
Ambien CR (zolpidem ER)
Belsomra (suvorexant)
Flexeril (cyclobenzaprine)
Klonopin (clonazepam)



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Lunesta (eszopiclone)
Neupro (rotigotine)
Requip (ropinirole)
Seroquel (quetiapine)
Sonata (zaleplon)
Desyrel (trazodone)
Mirapex (pramipexole)
Neurontin/Horizant/Gralise(gabapentin)
Restoril (temazepam)
Silenor (doxepin)
Zanaflex (tizanidine)
Valium(diazepam)

Any medications not listed to help with sleep: ______________________

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

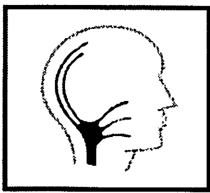
Is this visit related to:

Motor vehicle accident:	**Yes**	**No**
Workman's Compensation:	**Yes**	**No**
Personal Injury:	**Yes**	**No**

How did you hear about our practice? ______________________

PATIENT / GUARDIAN SIGNATURE: ______________________

DATE: ______________________



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How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0= No chance of dozing
1= Slight chance of dozing
2=Moderate chance of dozing
3=High chance of dozing

Situation	Chance of Dozing
Sitting and Reading	________
Watching T.V.	________
Sitting inactive in a public place (i.e. theater or meeting)	________
Passenger in car for an hour without a break	________
Lying down to rest in the afternoon when circumstances permit	________
Sitting and talking with someone	________
Sitting quietly after lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
Total Score	________

Are you clenching/grinding your teeth at night?	Yes / No
Do you snore?	Yes / No
Are you tired all the time?	Yes / No
Do you wake with a headache?	Yes / No
Are you aware that you twitch a lot when sleeping?	Yes / No
Is the person that sleeps with you aware that you twitch when sleeping?	Yes / No
Even if you feel you sleep through the night; do you feel groggy?	Yes / No
Have You Gained Weight?	Yes / No
Is it difficult for you to button your top button on your shirt?	Yes / No