Texas Parkinson and Movement Disorders

Please provide name and phone number for the following treating providers if applicable

Primary Care Doctor_____

Phone: _____

Neurologist: _____

Phone: _____

Psychiatrist: _____

Phone: _____

Psychologist: _____

Phone: _____

Cardiologist: _____

Phone: _____

Pharmacy: _____

Phone: _____

Texas Parkinson and Movement Disorders

Patient Information **Date**:

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print and **FILL OUT COMPLETELY**. All information is Confidential.

Name:
First Middle Last

Birth Date: SS#: Sex: [ ] M [ ] F

Address: Apartment#:

City: State: Zip:

Primary Phone #: Type: [ ] Home [ ] Cell [ ] Work

Secondary Contact #: Type: [ ] Home [ ] Cell [ ] Work

Email Address: Occupation:

How would you like to be contacted for appointment confirmations?

[ ] Primary Phone [ ] Text Message [ ] E-mail (Please provide email above)

Check Appropriate: [ ] Minor [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Race: Ethnicity:

Emergency Contact: Relation: Ph.:

Financial Policy

It is customary to pay for professional services at the time of service. Patients with private health insurance must remember that they are responsible for the amount their insurance company does not cover. This is considered as copayment. If you have a secondary insurance, please provide that in the above section as this will cover your co-pay if any. During the course of treatment by Texas Parkinson and Movement Disorders, charges will be accumulated and routinely filed with your insurance company. Charges not covered by your insurance company, patient co-pays, deductibles and co-insurance will be your responsibility and are due at the time of service. By signing below, you are accepting financial responsibility for copayment, and/or all medical bills not covered by your insurance.

Our Goal here at Texas Parkinson's and Movement Disorder is to provide quality service to all of our patients in a timely manner. Failure to keep scheduled appointments is costly to the practice, and those time slots could be offered to other patients in need. This letter is to inform you of our policy concerning "No Shows/Cancellations." Patients who are unable to keep their appointments are requested to give 72 hour notice prior to their appointment time. Providing such notice allows the clinic time to offer other patients the opportunity to see our physician.

This is to inform you of our policy concerning "No show/Cancellation." Patients who are unable to keep their appointments are requested to give 48 hour notice prior to their appointment time. Providing such notice allows the clinic time to offer other patients the opportunity to see our physician.

If established patients fails to provide notice, or no- show it will be necessary to charge them $ 25.00 which the patient will owe that fee at the time of the next visit.

If patient fails to keep his/her appointment on a regular basis, or misses 3 consecutive appointments, he/she will be dismissed from the practice and a letter of dismissal will follow.

[ ] I certify that I have NO insurance and will be solely responsible for payment in full.

[ ] I certify that the insurance reported to Texas Parkinson and Movement Disorders is a complete listing. I understand that the office will not extend credit on, or submit a claim for any insurance not reported at the time of service. I will be responsible for any unpaid charges.

[ ] I certify that charges will be protected by an LOP provided by my attorney. I also understand that, if for any reason, I no longer have attorney representation, that I become fully responsible for all charges incurred.

Patient Signature: _____Date:_____

Parent or Guardian of child under age:

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Assignment of Benefits

Primary Insurance Payer:	Secondary Insurance Payer/Medicare Supplement:
Insurance Name:	Insurance Name:
ID#:	ID#:
Group #:	Group #:
Ins. Co Phone:	Ins. Co Phone:
Primary Policy Card Holder's Information: Name:	Primary Policy Card Holder's Information: Name:
DOB:	DOB:
SSN:	SSN:
Relationship to patient:	Relationship to patient:

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collection, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

I have read and understand the above information and hereby authorize Texas Parkinson and Movement Disorders to prescribe and provide treatment.

A photocopy of this instrument will serve as the original.

Print Name: Date:

Signature of Patient:

Texas Parkinson and Movement Disorders

Comprehensive History & Physical

Please take a few minutes to complete this worksheet. This information will help us in providing your care.

Name: _ Date of Birth: Sex: F / M Height:_ Weight:

What is the reason for your visit? _____

Medical History:

Have you ever had or been told you have (Circle all that apply): [ ] NOT APPLICABLE

[ ] Hyperthyroid Disease
[ ] Hypothyroid Disease
[ ] Hypertension
[ ] Angina/Coronary Artery Disease/Heart attack
[ ] Congestive Heart Failure
[ ] Atrial Fibrillation
[ ] Strokes
[ ] Migraines
[ ] Memory loss
[ ] Renal Disease
[ ] Anemia
[ ] Depression
[ ] Arthritis
[ ] Other _____

[ ] Osteoporosis
[ ] Asthma/COPD
[ ] Multiple Sclerosis
[ ] Diabetes
[ ] GERD
[ ] High Cholesterol
[ ] Hepatitis
[ ] Prostate Disease
[ ] Anxiety Disorder
[ ] Seizures
[ ] Sleep Apnea
[ ] Rheumatoid Arthritis
[ ] Cancer _____

Have you been treated by a Psychiatrist or Counselor? _____

Surgeries:

[ ] Neck or Lumbar Surgery
[ ] Vascular Surgery
[ ] Sinus, facial, or dental surgery
[] Other_____

Family History: (Please check appropriate): [ ] NOT APPLICABLE

	Father	Mother	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Tremors							
Parkinson's Disease							
Alzheimer's Disease							
Migraine Headaches							
Brain Tumor							
Peripheral Nerve Disorder							
Diabetes							
Psychiatric Disorder							
Other:							

Social History:

Are you currently employed or Retired?

If so where: _____

Do you drink any alcohol: Seldom Occasionally Never

Smoker: Current Every day Smoker Current Someday Smoker Never Other drug use:

Texas Parkinson and Movement Disorders

Please list all medications that you are currently taking including any vitamins and over-the-counter medications

Allergies:	**Medication or Substance**	**Reaction**
	_____	_____
	_____	_____
	_____	_____

Current Medication:	**Label-Name**	**Dose**	**Frequency**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Are there any new medical problems you would like to address today?

_____

_____

_____

Have you undergone any testing since your last visit? Please explain

_____

_____

_____

Pharmacy: _____

Texas Parkinson and Movement Disorders

Review of Symptoms

Please circle any of the following if applicable

Constitutional
Fever
Chills
Night Sweats
Unintentional weight gain
Unintentional weight loss
Excessive Fatigue

Eyes
Dryness
Visual disturbances

Ears/Nose/Throat/Mouth
Hearing loss
Heavy snoring
Chronic sinus congestion
Change in voice
Ringing in ears

Respiratory
Cough
Phlegm/sputum production
Shortness of breath

Cardiovascular
Chest discomfort
Palpitations
Leg swelling
Calf or buttock pain with walking
Fainting

Gastrointestinal:
Change in appetite
Difficulty swallowing
Heartburn/indigestion
Nausea/Vomiting
Constipation

Genitourinary
Urination at night
Sexual problems
Incomplete emptying
Frequent urination

Musculoskeletal:
Persistent or Severe neck pain
Persistent or severe back pain
Persistent or severe joint pain
Muscle pain or cramping

Skin/Breast
Rash
New or changing moles

Neurological
Tremor
Dizziness
Memory loss
Muscle weakness
Involuntary movement

Psychosocial
Anxiety/nervousness
Insomnia
Feeling sad or depressed
Panic

Endocrine
Cold/Heat intolerance
Hot Flashes
Excessive thirst

Blood/Lymphatics
Excessive bruising
Easy bleeding

Allergy/Immune
Severe allergic reactions

Texas Parkinson and Movement Disorders

Authorization to release Medical Records

Patient Name: _____ DOB: _____

SS#:_____ Ph#:_____

I, _____ ***AUTHORIZE*** _____ ***TO*** **RELEASE COPIES OF MY MEDICAL RECORDS TO THE INDIVIDUAL OR ORGANIZATION NAMED BELOW:**

Release:

[ ] Entire Record [ ] Radiology /Imaging [ ] Laboratory Results [ ] Progress Notes DOS: _____

To: [ ] Self or

Dr. Aanchal Taneja		469-994-1817	469-444-6054
Name/Family Member/Doctor's Office/Etc.		Phone:	Fax:
8230 Walnut Hill Ln. Bldg. 3 Suite 212	Dallas	TX	75231
Address	City	State	Zip Code

This authorization gives Texas Parkinson and Movement Disorders to request/release your medical records from/to any healthcare provider that you may have received treatment from. Texas Parkinson and Movement Disorders is authorized to furnish information even though the confidentiality of the information may be protected by Federal or State Laws and regulations. This includes any and alcohol and/or drug treatment records or psychiatric records and any information related to HIV or sexually transmitted disease testing or results that are in the record, unless specified above. Texas Parkinson and Movement Disorders is released and discharged from any liability, and the undersigned will hold Texas Parkinson and Movement Disorders harmless for complying this information.

I understand the following:

- **Incomplete forms will be null and voided: no exceptions.**
- I am not required to sign this authorization.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I may revoke this authorization at any time by presenting my written revocation to Texas Parkinson and Movement Disorders 8230 Walnut HIll Ln. Bldg 3 Suite 212.
- The revocation will not apply to information that has already been used or released under this authorization.
- Physician's office has the right under Texas State Law to require payment up front for reasonable costs of copying and mailing before furnishing the medical records.

_____ _____

Signature of patient or Legal representative Printed Name of patient or Legal Representative

_____ _____

Relationship to Patient or Legal Representative Date

Texas Parkinson and Movement Disorders

Medical Information Release Form
(HIPAA Release Form)

Patient Name: _____ DOB: _____

[ ] I authorize this release of information including the diagnosis, records; examination rendered to me and claims information. The information may be released to:

Full Name Relation Phone#
[ ] Release all Health Information
[ ] Release all Billing (including payments, collections, etc.)
[ ] Release Other (Specify):

Full Name Relation Phone#
[ ] Release all Health Information
[ ] Release all Billing (including payments, collections, etc.)
[ ] Release Other (Specify):

[ ] May NOT be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell phone: _____

If unable to reach me:

[ ] You may leave a detailed message regarding my test results.

[ ] Please leave a message for me to return your call.

Patient Signature: _____ Date:

Texas Parkinson and Movement Disorders

Office Policies

Appointments: _____ (initial)

- Our office hours are 8 am-12pm, and 1pm-4:30pm Monday through Thursday. Please note that Fridays the office closes at noon.

Financial Policy: _____ (initial)

- An estimated payment is due at the time of service by cash, credit card (We do NOT accept American Express)
- Patients are responsible for copays, deductibles, and co-insurance if applicable at the time of service.
- Any balance on an account that is greater than 30 days old is considered past due. A statement will be mailed monthly and will reflect the current balance for all services rendered prior to the date on the statement, Payment is due upon receipt of statement.

Insurance: _____ (initial)

- Your insurance policy is a contract between you and your insurance company. While our billing professionals will do all they can to help our patients in communicating and negotiating with their insurance plan or other persons, we must inform patients that have any questions regarding coverage, benefits or payment for services provided, is their responsibility to resolve.
- *In the event of denials, errors, or non-covered services. (The patient is responsible for all services rendered.* If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days. Texas Parkinson and Movement Disorders and its employees do not guarantee that payment will be authorized for medical services: there-fore this office is not responsible for any adverse payment decisions or misuse of information.
- Notification of any change in your insurance status (i.e. new company, deductible, co-pay amounts) must be provided to the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Miscellaneous Charges: _____ (initial)

- For medical records you will be charged $25.00 and may take up to 3-5 business days to obtain.
- *If you do not cancel your appointment 24 hours in advance our policy is to charge the rate of $25.00 and is payable prior future visits.* These will not be billed to your insurance company. Please help us to serve you better by keeping your scheduled appointments or canceling in advance.

Refill Requests: _____ (initial)

- All requests for prescription refills must be made through your pharmacy. Your pharmacy will send us a refill request on your behalf, this will be the only way we can refill your medication if you are calling the office for them. If it is a narcotic, you will need to schedule an appointment to be seen.

Emergency Situations |After Office Hours: _____ (initial)

- Any phone messages left after 3:00pm Monday through Thursday will be returned the next business day.
- In the event that you call our office and the doctor is out, your call will be returned the next business day.
- If you feel that your call needs urgent attention you should go to the nearest emergency room or urgent care.

I have read and understand the Office/Practice, Privacy Policies and I agree to accept responsibility as described. If you have any questions, please feel free to ask our staff for assistance. Thank you for choosing us for your care.

Patient Name Date:

Patient Signature Witness