NEUROLOGY SPECIALISTS

NAME: _____

CHIEF COMPLAINT please write a ***brief*** chronological statement describing your neurological condition, symptoms (i.e. the reason for neurological consultation): _____

_____

_____

LIST ALL CURRENT MEDICATIONS: _____

_____

PAST MEDICAL HISTORY please list any previous and/or current illnesses (i.e. diabetes, high blood pressure, cancer, etc.): _____

_____

ALLERGIES TO MEDICATION: _____

PAST OPERATIONS (i.e. hernia, gall bladder, etc.): _____

_____

FAMILY MEDICAL HISTORY:

Father:	Alive ☐ Deceased ☐	*Has/Had the following conditions:*
Mother	Alive ☐ Deceased ☐	*Has/Had the following conditions:*

SMOKING HISTORY:

No ☐	Former ☐	Yes ☐	If yes, how many per day?

DO YOU HAVE OR COMPLAIN OF:

Change in appetite ☐	Chills ☐	Fatigue ☐	Fever ☐	Headaches ☐	Light ☐ Headiness
Sleep disturbance ☐	Weight gain ☐	Weight loss ☐			
Joint stiffness ☐	Leg cramps ☐	Muscle aches ☐	Painful joints ☐	Sciatica ☐	Weakness ☐
Balance difficulty ☐	Difficulty speaking ☐	Dizziness ☐	Fainting ☐	Walking problems ☐	Headaches ☐
Irritability ☐	Loss of strength ☐	Loss of use of extremities ☐	Lower back pain ☐	Memory problems ☐	Pain ☐
Seizures ☐	Ticks ☐	Tingling and / or numbness ☐	Transient loss of vision ☐	Tremors ☐	
Anxiety ☐	Hallucinations ☐	Delusions ☐	Depression ☐	Difficulty sleeping ☐	

HOW MUCH DO YOU WEIGH? _____ **AND HOW TALL ARE YOU?** _____

NEUROLOGY SPECIALISTS

PATIENT INFORMATION

NAME:_____ DOB:_____
FIRST MIDDLE LAST

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

GENDER: _____ MALE _____ FEMALE _____ TRANSGENDER

SSN: _____

MARITAL STATUS: _____ SINGLE _____MARRIED _____ PARTNER _____ DIVORCED

_____ WIDOWED _____ OTHER

ETHNICITY: _____ WHITE _____ BLACK/AFRICAN AMERICAN _____ ASIAN _____ HISPANIC

_____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER _____ NATIVE INDIAN _____ OTHER

EMAIL: _____

CONTACTS

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

PHONE: _____

REFERRING DOCTOR: _____
PHONE: _____ FAX: _____

PRIMARY CARE PHYSICIAN: _____
PHONE: _____ FAX: _____

PHARMACY NAME: _____
PHONE: _____ FAX: _____

COMMUNICATION PREFERENCES

HOME PHONE	WORK PHONE	MOBILE PHONE
(_____) _____-_____	(_____) _____-_____	(_____) _____-_____
MAY WE LEAVE PERSONAL/MEDICAL INFORMATION ON YOUR VOICEMAIL?	MAY WE LEAVE PERSONAL/MEDICAL INFORMATION ON YOUR VOICEMAIL?	MAY WE LEAVE PERSONAL/MEDICAL INFORMATION ON YOUR VOICEMAIL?
YES _____	YES _____	YES _____
NO _____	NO _____	NO _____

MY PREFERRED NUMBER TO REACH ME AT IS: _____ HOME _____ WORK _____ MOBILE

INSURANCE INFORMATION

IT IS VERY IMPORTANT THAT YOU BRING YOUR INSURANCE CARD(S) AND I.D. ON THE DAY OF YOUR APPOINTMENT.

PLEASE REMEMBER THAT IT IS YOUR RESPONSIBILITY TO OBTAIN A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN IF IT IS REQUIRED BY INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
CARRIER: _____	CARRIER: _____
SUBSCRIBER I.D: _____	SUBSCRIBER I.D: _____
GROUP #: _____	GROUP #: _____
NAME OF INSURED: _____	NAME OF INSURED: _____
INSURED'S D.O.B: _____	INSURED'S D.O.B: _____
RELATIONSHIP TO INSURED: _____	RELATIONSHIP TO INSURED: _____

INSURANCE AUTHORIZATION: I HEREBY AUTHORIZE NEUROLOGY SPECIALISTS TO FURNISH MEDICAL RECORDS AND/OR TEST RESULTS INCLUDING HIV STATUS, VIA FAX OR MAIL, TO MY REFERRING DOCTOR, INSURANCE COMPANIES AND THE DOCTOR TO WHOM I AM REFERRED, CONCERNING MY ILLNESS AND TREATMENT. I WILL NOT HOLD NEUROLOGY SPECIALISTS OR ITS EMPLOYEES RESPONSIBLE FOR MISDIRECTED RECORDS OR CORRESPONDENCE. I UNDERSTAND THAT ALL PAYMENTS AND/OR CO-PAYMENTS INCLUDING NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO NEUROLOGY SPECIALISTS FOR ALL SERVICES RENDERED.

BY SIGNING THIS FORM I CONSENT TO TREATMENT NECESSARY FOR THE CARE OF THE PATIENT INDICATED ON THIS FORM.

_____ _____

PATIENT / GUARDIAN SIGNATURE DATE

NEUROLOGY SPECIALISTS

As of October 15, 2014, we are now accepting the independent insurance policies (Affordable Healthcare)except for UHC Marketplace plans. Any patients with these plans can be seen, however you must provide us with proof of payment for your monthly premium. Please let us know immediately if you have one of these policies. (*PLEASE NOTE*: Failure to provide proof of payment will cause your appointment to be rescheduled.)

☐ **I do have an Affordable Healthcare plan**

☐ **I do not have an Affordable Healthcare plan**

☐ **I do not know if I have an Affordable Healthcare plan**

We ask that you indicate, by your signature below, that you have read the above statements and understand that in the event that the premium is not paid, and the insurance company does not pay or takes payment back, you are responsible for all payments if you do have one of these policies.

Date: _____ Signature _____

NEUROLOGY SPECIALISTS

AFTER-HOURS PHONE CALLS:

Our phones are answered from 9:00 AM-3:00 PM Monday through Thursday, and 9:00 AM-12:00 PM on Fridays. There is a doctor on call for after-hours phone calls. This service is intended for emergencies only. Prescription refills, general questions, or appointment inquiries will not be handled by the doctor on call, you will have to call back during regular business hours. **Please be advised, there is a $50 fee to speak to the on call doctor. This is not covered by your insurance and is an extra charge. It is due at the time of your next visit**. (***NOTE***: the fee is for every individual time you call the doctor and not a per-day charge)

_____ _____

PATIENT'S PRINTED NAME DATE

_____

PATIENT'S SIGNATURE

N E U R O L O G Y S P E C I A L I S T S

Ziad Blaik, M.D.

BOARD CERTIFIED- Neurology

ADMINISTRAIVE SERVICES CHARGE LIST

$25 for the first 20 pages	
$0.05 for each additional page	*Medical Records (Doctor-to-doctor: FREE)
$40 MIN.	Financial Records
$400	Narrative Report
$50 MIN.	Composing a letter or filling out forms of any kind (up to 4 pages)
$50 MIN.	**Emergency phone visits with physician (scheduled consult, up to 15 minutes)
$50	***Missed appointment fee (for no-shows or rescheduling with less than one business day notice)
$100	Subpoena/custodian of records questionnaire and notary
$40	Retrieval fee from Iron Mountain Archives
$0	**OFFICE VISITS ARE REQUIRED AFTER A MAXIMUM OF 3 PHONE CALLS.**

NOTE: These payments only apply when necessary or requested. Payment is due at the time of the request. You may walk-in or pay over the phone (credit card only by phone).

*"Medical Records"- The fee only applies for any requests from the patient or when needed for personal reason, or by an employer, insurance company, or attorney. This fee is not covered by the insurance company, unless otherwise stated on the form.

**"Emergency Phone Visits"- These are prescheduled, live telephone consultations with the physician. These appointments last up to 15 minutes and may be used in lieu of a traditional office visit in emergency situations (This does not apply to non-emergency questions). Conditions such as colds, bladder infection, back pain, and management of chronic conditions may be managed in this setting. It is also an opportunity to discuss laboratory/x-ray results or medication changes. This service is only available to established patients at a cost of $50.

*** "Missed Appointment Fee"- Patients more than 15 minutes late must be rescheduled so the next patient can be seen on time. If patients run late, they delay the doctor and all the patients after them. The doctor tries to see patients on a timely basis; however, for every missed or late appointment, another patient that is sick may be turned away. We respect your time and ask for you to do the same for your fellow patients. If you must reschedule, please call 24 hours before your appointment to avoid a $50 No-show/No call fee.

**** Medical Records Custodian I.D. #: 921438224

I understand the above fees and agree that as a patient of Neurology Specialists , I am subject to payment of the fees at the time of service.

_____

Printed Name

_____ _____

Signature Date

NEUROLOGY SPECIALISTS

Ziad Blaik, M.D.

_____
BOARD CERTIFIED- Neurology

TO: OUR PATIENTS
FROM: NEUROLOGY SPECIALISTS OF DALLAS
TITLE: INSURANCE PRECERTIFICATIONS

Please be aware that almost all elective hospitalizations and most routine radiologic or laboratory studies must first be pre-certified by your insurance carrier as part of the authorization process. Our office staff works diligently on your behalf to obtain these pre-certifications. The process of pre-certification is often different depending on the rules and regulations set forth by your insurance carrier. The following services often require insurance pre-certification.

1. Non-emergency hospitalizations (Elective admissions).
2. MRI scans, CT scans, EMG, EEG, and other laboratory studies.
3. Medications prescribed by the physician may also require insurance pre-certification. Different insurance companies have different pharmacy regulations, which influence what medication and the amount of medications, which may be dispensed.

Pre-certification process with an insurance company is frequently a lengthy procedure and may take as long as one to two weeks before an authorization is obtained. Please be assured that our office staff does everything possible to expedite this process. Your assistance in this process is also crucial. Since a member of our staff may be on the phone with an insurance company for 30 to 45 minutes to obtain one insurance approval, those patients who call on a daily or regular basis to inquire about the status of their pre-certification, simply add to the volume of calls that we already receive. This indirectly delays the pre-certification process. As soon as an authorization for a hospital admission, procedure, or even approval for medication is obtained from the insurance carrier, our staff will notify you and advise you as quickly as possible.

We are deeply committed to helping all our patients with their healthcare needs and appreciate your understanding and cooperation regarding the insurance pre-certification process.

DATE: _____
INITIAL: _____

NEUROLOGY SPECIALISTS

HIPAA CONSENT

IS THERE ANYONE YOU WOULD LIKE TO AUTHORIZE TO SPEAK WITH US CONCERNING YOUR TREATMENT OR ACCESS YOUR MEDICAL RECORDS?

NO _____ YES _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

DOCTOR: _____ SPECIALTY: _____ PHONE: _____

DOCTOR: _____ SPECIALTY: _____ PHONE: _____

DOCTOR: _____ SPECIALTY: _____ PHONE: _____

DOCTOR: _____ SPECIALTY: _____ PHONE: _____

_____ _____

PATIENT'S PRINTED NAME DATE OF BIRTH

_____ _____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE DATE

NEUROLOGY SPECIALISTS
Payment Policy & Authorization to file Insurance

We would like to take this opportunity to acquaint you with our Payment Policies.

Full payment is expected at the time of service. We accept cash, MasterCard, Visa, Discover, and American Express, approved checks and money orders. All services furnished by us are charged to the patient or, if a minor, to his/her authorized guarantor.

1. **If you are in a HMO/PPO in which we participate, we will follow the contractual terms required, but *it is your responsibility to verify with your carrier* that your doctor is a participating provider. You must provide proper identification and when required a proper referral. Please advise us upon arrival that you are a member. All co-insurance amounts are due at the time services are rendered.**

2. **We accept Medicare assignment and will file your insurance for you. Deductibles and co-insurances are due at the time services are rendered.**

3. **When appropriate, with prior approval and verification, we will file your claim for you. However, if your carrier has not paid in sixty (60) days, you will be responsible for full payment.**

4. **We do not accept Workers Compensation and/or liability claims. The patient will be treated as a cash patient. We will supply a copy of patient statement so the patient can file their own claim. If further documentation is needed, the patient will be responsible for added expense.**

We ask that you indicate by your signature below that you have read the above policies and acknowledge that you are responsible for the payment of all services provided.

Date: _____ Signature: _____

I hereby authorize Neurology Specialists to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician(s) all payment for medical and surgical benefits to include major medical benefits to which I am entitled for medical services rendered to my dependents or myself. I understand that I am responsible for all charges whether or not paid by said insurance. A photocopy of this assignment is to be considered as valid as an original.

Date: _____ Signature: _____

N E U R O L O G Y S P E C I A L I S T S

Ziad Blaik, M.D.

TO MEDICARE PATIENTS ONLY:

PLEASE SIGN BELOW STATING YOU ARE AWARE THAT IF YOU HAVE A MEDICARE ADVANTAGE PLAN. AND WE ARE **NOT** NOTIFIED AT, OR BEFORE, CHECK-IN, YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED IF THE CHARGES ARE NOT PAID FOR BY THE PLAN.

WE ARE RECEIVING STANDARD MEDICARE CARDS IN PLACE OF THE MEDICARE ADVANTAGE CARDS, (i.e. Wellcare, Aetna, Humana, etc…). WE DO NOT ACCEPT SOME OF THESE PLANS.

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

PATIENT NAME PRINTED	SIGNATURE
GUARANTOR	DATE