

Welcome to Texas Neurology Center. Please carefully fill out the following required information.

PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH / /	SEX M F	MARITAL STATUS
HOME ADDRESS (NO POX BOXES)	CITY	STATE	ZIP CODE	HOME PHONE NUMBER () -	

MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE	CELL PHONE OR PAGER () -	
--------------------------------	------	-------	----------	------------------------------	--

E-MAIL ADDRESS

EMPLOYER'S NAME OR RETIREMENT DATE	EMPLOYMENT STATUS () FULL () PART () RET	SOCIAL SECURITY NUMBER - - ()	WORK PHONE/ EXT # - -
------------------------------------	--	-----------------------------------	--------------------------

STUDENT STATUS () FULL TIME () PART TIME	SCHOOL'S NAME	DRIVER'S LICENSE NUMBER
---	---------------	-------------------------

EMERGENCY CONTACT NAME	AND	TELEPHONE NUMBER (S) () - () -	AND RELATIONSHIP TO YOU
------------------------	-----	-------------------------------------	-------------------------

REFERRING / CONSULTING DOCTOR'S FULL NAME, ADDRESS AND TELEPHONE NUMBER	SEND COPY OF RFEPORT () YES () NO
---	--

FAMILY DOCTOR'S FULL NAME, ADDRESS AND TELEPHONE NUMBER	SEND COPY OF RFEPORT () YES () NO
---	--

DATE OF FIRST SYMPTOM / /	DATE OF INJURY OR ACCIDENT / /	LIST STATE	WORK RELATED () NO () YES	AUTO RELATED () NO () YES	OTHER
------------------------------	-----------------------------------	------------	--------------------------------	--------------------------------	-------

DRUG ALLERGIES:

PHARMACY NAME, TELEPHONE NUMBER, FAX NUMBER, E-MAIL

PRIMARY INSURANCE INFORMATION

POLICY HOLDER'S NAME OR () SAME AS ABOVE	DATE OF BIRTH / /	SEX () M () F	SOCIAL SECURITY NUMBER - -
---	----------------------	--------------------	-------------------------------

PATIENT RELATIONSHIP TO POLICY HOLDER: () SELF, () SPOUSE, () CHILD, () OTHER

ADDRESS IF DIFFERENT FROM PATIENT	CITY	STATE	ZIP	HOME TELEPHONE NUMBER () -
-----------------------------------	------	-------	-----	--------------------------------

EMPLOYER'S NAME OR RETIREMENT DATE	WORK TELEPHONE/ EXT # () -	CELL TELEPHONE OR PAGER () -
------------------------------------	--------------------------------	----------------------------------

INSURANCE COMPANY'S NAME OR () INSURANCE CARD PROVIDED	POLICY NUMBER	GROUP NUMBER
---	---------------	--------------

ADDRESS FOR CLAIMS	CITY	STATE	ZIP	TELEPHONE NUMBER () -
--------------------	------	-------	-----	---------------------------

SECONDARY INSURANCE INFORMATION

POLICY HOLDER'S NAME OR () SAME AS ABOVE	DATE OF BIRTH / /	SEX () M () F	SOCIAL SECURITY NUMBER - -
---	----------------------	--------------------	-------------------------------

PATIENT RELATIONSHIP TO POLICY HOLDER: () SELF, () SPOUSE, () CHILD, () OTHER

ADDRESS IF DIFFERENT FROM PATIENT	CITY	STATE	ZIP	HOME TELEPHONE NUMBER () -
-----------------------------------	------	-------	-----	--------------------------------

EMPLOYER'S NAME OR RETIREMENT DATE	WORK TELEPHONE/ EXT # () -	CELL TELEPHONE OR PAGER () -
------------------------------------	--------------------------------	----------------------------------

INSURANCE COMPANY'S NAME OR () INSURANCE CARD PROVIDED	POLICY NUMBER	GROUP NUMBER
---	---------------	--------------

ADDRESS FOR CLAIMS	CITY	STATE	ZIP	TELEPHONE NUMBER () -
--------------------	------	-------	-----	---------------------------

SIGNATURE: _____ DATE: _____

Health History

Patient's Name: _____ DOB: _____
Date of Service: _____ Are you Right Handed _____ Left Handed _____

Do you have any of the following?

Allergies Cancer Glaucoma Kidney Disease Rheumatic Fever
 Anxiety Cataracts Heart Disease Liver Disease Stroke/TIA
 Arthritis Depression High Blood Pressure Lung Disease Syphilis
 Asthma Diabetes High Cholesterol Gastroesophageal reflux Thyroid Problem
 Other _____

List all surgeries:

Date:	Hospital:	Procedures:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Do you have any **allergies** to medications? Please describe the reaction you had to the medication and the name of the medication: _____

List your medications, including over-the-counter medicines, vitamins, and herbal supplements:

1. _____	4. _____	7. _____	10. _____
2. _____	5. _____	8. _____	11. _____
3. _____	6. _____	9. _____	12. _____

Marital Status:

Never Married Married Divorced Separated Widowed Significant Other
Never Smoked When did you quit smoking? _____ How old were you when you started smoking? _____
How much do/did you smoke per day? _____
How much alcohol do you drink each day? _____
Previous or current illicit drug use? _____
Highest education level achieved: _____
What is/was your occupation? _____ When did you retire? _____

Family History:	Age if Living	Age at Death	Illnesses and/or Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brother (s)	_____	_____	_____
Sister (s)	_____	_____	_____
Children	_____	_____	_____

Reason you came for evaluation: _____

Patient Signature

Date

Jennifer A. York, M.D.

Date

Name: _____

DOB: _____

System Review: Do you have any of the following?

Date of Service: _____

General:

Weight gain	No	Yes
Weight loss	No	Yes
Fatigue	No	Yes
Fevers	No	Yes
Loud snoring	No	Yes
Hot flashes	No	Yes

Skin:

Rashes, hives, eczema	No	Yes
-----------------------	----	-----

Head-Eyes-Ears-Nose-Throat:

Poor vision	No	Yes
Cataracts	No	Yes
Do you wear glasses?	No	Yes
Blurred vision	No	Yes
Double vision	No	Yes
Headaches	No	Yes
Dizziness	No	Yes
Poor hearing	No	Yes
Frequent colds	No	Yes

Neck:

Stiffness	No	Yes
Enlarged glands	No	Yes

Breasts:

Lumps	No	Yes
Nipple discharge	No	Yes

Respiratory:

Chronic cough	No	Yes
Asthma or wheezing	No	Yes
Difficulty breathing	No	Yes

Cardiovascular:

Chest pain	No	Yes
Shortness of breath	No	Yes

High blood pressure	No	Yes
Irregular heartbeat	No	Yes
Heart murmur	No	Yes
Awaken in the night	No	Yes
Swelling in legs	No	Yes
Palpitations	No	Yes

Gastrointestinal:

Poor appetite	No	Yes
Frequent indigestion	No	Yes
Frequent nausea or vomiting	No	Yes
Frequent heartburn	No	Yes
Difficulty swallowing	No	Yes
Pain in swallowing	No	Yes
Pain in the abdomen	No	Yes
Stomach or duodenal ulcer	No	Yes
Gallstones	No	Yes
Black stools	No	Yes
Change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Chronic constipation	No	Yes

Genitourinary:

Inability to control urine	No	Yes
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Difficulty with sexual function	No	Yes
Irregular periods	No	Yes
Painful periods	No	Yes
Abnormal Pap smear	No	Yes

Musculoskeletal:

Painful or swollen joints	No	Yes
Back problems	No	Yes
Back injury	No	Yes

Hematologic:

Are you slow to heal after cuts?	No	Yes
Anemia	No	Yes
Excessive bruising	No	Yes
Bleeding tendencies	No	Yes

Endocrine:

Hair loss	No	Yes
Excessive thirst	No	Yes
Intolerance to hot or cold	No	Yes

Psychiatric:

Have you ever had psychiatric care?	No	Yes
Depression	No	Yes
Difficulty sleeping	No	Yes
Crying spells	No	Yes
Nervousness	No	Yes

Patient Signature

Date

Jennifer A. York, M.D.

Date

TEXAS NEUROLOGY CENTER

Jennifer A. York, M.D.
5750 Balcones, Suite 110
Austin, Texas 78731-4204

Telephone: (512) 744-0015
Fax: (512) 744-1654

“The HIPAA Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient’s authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506.”

RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize the release of my health information *from* any physician, hospital, or clinic to facilitate my treatment by Jennifer York, MD.

I would like the following health care providers to receive copies of Dr. York’s findings:

Check if you authorize us to speak to the following:

Spouse _____ Mother _____ Father _____ Daughter _____ Son _____

Please write the name of any other friends or family members you authorize us to speak with:

E-MAIL: If you provided your e-mail address, please note that e-mailing is not necessarily a secure method of communication.

- Yes, you may contact me by e-mail
- No, you may not contact me by e-mail

Patient/Guardian Signature: _____ Date: _____
(Valid for one year from date signed)

This office will disclose information for treatment, payment, and operation purposes, as explained in our Notice of Privacy Practices.

TEXAS NEUROLOGY CENTER

Jennifer A. York, M.D.
5750 Balcones, Suite 110
Austin, Texas 78731-4204

Telephone: (512) 744-0015
Fax: (512) 744-1654

MEDICARE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature _____ Date _____
Month, Day, Full Year

Print patient name _____

Or _____ By _____ Date _____
Patient's Name Representative Month, Day, Full Year

Representative's Address: _____

Relationship to Patient: _____

Reason Patient Cannot Sign: _____
(For example: "physically unable")

MEDIGAP AUTHORIZATION

I authorize any holder of medical or other information about me to release to _____ any information needed for this or a related Medigapclaim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature _____ Date _____
Month, Day, Full Year

Policy Number _____

Or _____ By _____ Date _____
Patient's Name Representative Month, Day, Full Year

Representative's Address: _____

Relationship to Patient: _____

Reason Patient Cannot Sign: _____
(For example, physically unable)

(This is a "one-time" authorization which will be valid until revoked by the patient or the patient's representative.)

TEXAS NEUROLOGY CENTER

Jennifer A. York, M.D.
5750 Balcones, Suite 110
Austin, Texas 78731-4204

Telephone: (512) 744-0015
Fax: (512) 744-1654

Financial Policy

Thank you for choosing us as your healthcare 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.

Payment is due at the time service is rendered. We accept cash, check, Discover, MasterCard or Visa. A fee of \$25.00 is charged for any returned checks.

1. Filing of Contracted Insurance Claims:

We are happy to file your insurance claims if we are contracted with the insurance. All co-payments are due prior to treatment, unless stated otherwise in your contract.

2. Referrals/Authorization:

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.

3. Non-Contracted Insurance Claim:

We are happy to file your insurance claims. If payment is not received from your insurance company within 45 days, you will be responsible for payment in full. Your insurance policy 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 your plan.

4. 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.

5. Collection Costs:

I understand that I will be legally responsible for all collection costs involved with the collection of this account if I default on this agreement

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's Printed Name

Date of Birth

Signature of Responsible Party

Date

NOTICE OF PRIVACY PRACTICES TEXAS NEUROLOGY CENTER

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to a specialist, we will share some or all of your medical information with that physician to facilitate the delivery of care. The physician in this practice is a specialist. When we provide treatment, we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. For example, we may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that only the best health care is provided by this practice.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state or local government for the collection of information about diseases, vital statistics (likes births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided that the information:

- Is released pursuant to legal process, such as a warrant or subpoena;
- Pertains to a victim of crime and you are incapacitated;
- Pertains to a person who has died under circumstances that may be related to criminal conduct;
- Is about a victim of crime and we are unable to obtain the person's agreement;
- Is released because of a crime that has occurred on these premises; or
- Is released to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation

We may disclose your medical information as required by the Texas Workers' Compensation Law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may release your medical information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

To request a restriction, submit the following in writing: (a) The information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below.

We can refuse to provide some of the information you ask to inspect or ask to be copied if the information:

- Includes psychotherapy notes.
- Includes the identity of a person who provided information if it was obtained under a promise of confidentiality.
- Is subject to the Clinical Laboratory Improvements Amendments of 1988.
- Has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review.

Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPAA. In any event, the *lower* of the fee permitted by HIPAA or the fee permitted by the TSBME will be charged.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information:

- Wasn't created by this practice or the physicians here in this practice.
- Is not part of the Designated Record Set.
- Is not available for inspection because of an appropriate denial.
- If the information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment we will inform you in writing. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know we have the incorrect information.

Accounting of Certain Disclosures

The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person listed below. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period, we are permitted to charge for the cost of providing the list. If there is a charge, we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health-Related Benefits

We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. We may leave test results via telephone, mail or voice mail/answering machines. If you do not want messages left on voice mail or answering machines, please inform our front receptionist.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us. The contact information for the United States Department of Health and Human Services is:

Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202
(214) 767-4056
TDD (214) 767-8940

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Sheri Espinosa
5750 Balcones, Suite 110, Austin, Texas 78731
Telephone: (512) 744-0015 ext 100 Facsimile: (512) 744-1654

This notice is effective on the following date: November 2004

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

TEXAS NEUROLOGY CENTER

**Jennifer A. York, M.D.
5750 Balcones, Suite 110
Austin, Texas 78731-4204**

**Telephone: (512) 744-0015
Fax: (512) 744-1654**

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority