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 ZI P CODE HOME PHONE NUMBER ( ) -

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

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:** _____

Standardization for Health Care Quality Improvement
RACE, ETHNICITY AND LANGUAGE DATA-Provision of HITECH ACT

The Health Information Technology for Economic and Clinical Health (HITECH) Act provides the Department of Health & Human Services (HHS) with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health IT, including electronic health records and private and secure electronic health information exchange.

DATE: _____

PATIENT'S NAME: _____ DOB: _____
(PRINTED)

RACE:

- ☐ White
- ☐ Black
- ☐ Asian
- ☐ Hawaiian
- ☐ Indian/Alaskan
- ☐ Pacific Isle
- ☐ Other/Multi
- ☐ Declined
- ☐ Hispanic – White
- ☐ Hispanic – Black
- ☐ Hispanic – Asian
- ☐ Hispanic – Indian/Alaskan
- ☐ Hispanic – Pacific Isle
- ☐ Hispanic – Other/Multi

ETHNICITY:

- ☐ Hispanic
- ☐ Non-Hispanic

PREFERRED LANGUAGE:

- ☐ English
- ☐ American Sign Language
- ☐ Declined
- ☐ Spanish
- ☐ Other_____

_____ _____
PATIENT'S OR CAREGIVER'S SIGNATURE DATE

_____
PRINTED NAME OF CAREGIVER

TEXAS NEUROLOGY CENTER

Jennifer A. York, M.D.
5750 Balcones, Suite 110
Austin, Texas 78731-4252

Telephone Number: (512) 744-0015
Facsimile: (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:

_____

_____

_____

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 78731-4252

Telephone Number: (512) 744-0015
Facsimile: (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

PAYMENT AUTHORIZATION

I give authorization for payment of insurance benefits to be made directly to Jennifer York, M.D., P.A., for services rendered. I hereby authorize this healthcare provider to release all information necessary to secure the payment for benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____

Signature Date

Fee Policies

1. Texas Neurology Center charges a fee for missed appointments ("no-shows" and appointments which are not cancelled with a 24-hour advance notice). This fee will be directly billed to the patient as it is not covered by insurance and must be paid prior to the next appointment.

    a. $35 for office visits
    b. $75 for testing (Sleep studies, NCV/EMG and EEG)

    If our office schedules an interpreter for our hearing impaired patients, we will require 48 hour cancellation notice so that we can provide the interpretation service their required 24 hour notice to avoid any fees. You will be billed their current rate for services if you don't provide us adequate notice. At this time, their fee is $125.00.

2. If you request Dr. York to generate a letter or complete FMLA forms on your behalf, there is a charge of $35.00. Payment is due prior to the request being released.

3. If you request a copy of medical records, there is a charge of $25.00. Payment is due prior to the request being released.

Thank you for your understanding and cooperation as we strive to better serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

_____

Print Name

_____ _____

Signature *Date*

TEXAS NEUROLOGY CENTER
NOTICE OF PRIVACY PRACTICES
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.
EFFECTIVE September 1, 2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to TEXAS NEUROLOGY CENTER, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

H. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

I. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

J. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

K. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

L. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

M. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

N. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

O. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional

Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

P. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

Q. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

R. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

S. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

T. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

U. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

V. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

W. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

X. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

Y. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Z. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

TEXAS NEUROLOGY CENTER
Attn: HIPAA Officer
5750 Balcones Drive, Ste. 110
Austin, TX 78731
512-744-0015

TEXAS NEUROLOGY CENTER

Jennifer A. York, M.D.
5750 Balcones, Suite 110
Austin, Texas 78731-4252

Telephone Number: (512) 744-0015
Facsimile: (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

Texas Neurology Center

Appointment Information

Your physician has requested that you have a sleep study performed. This test is noninvasive and completely painless. While having sensors placed on you is a bit uncomfortable, we pride ourselves on providing a warm and professional setting where you can relax and get a good night's sleep. Every effort has been made to provide you with a comfortable, non-clinical environment. We use the "Sleep Number Bed" by Select Comfort as well as temperature-sensitive contoured pillows.

Please fill out a sleep questionnaire before your appointment. We realize that all of these forms can be a little long, but please keep in mind that accurate results are directly dependent upon the information you provide. If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. ***Late cancellations, late rescheduling, and no-shows are billed at $75 per occurrence.***

Follow these instructions prior to your test date.

- ☐ Please bathe and shampoo and dry your hair prior to your test.
- ☐ Avoid using skin creams, oils, or hairspray.
- ☐ Avoid caffeine usage—which includes coffee, most carbonated beverages, and chocolate—for at least 12 hours prior to the study.
- ☐ Avoid alcohol usage for at least 12 hours prior to the study.
- ☐ Bring loose-fitting pajamas to sleep in.
- ☐ Feel free to bring your own pillow and teddy-bear with you for the night.
- ☐ Your study will end by 6:30 AM.
- ☐ Take all medications as you would normally take them, ***unless*** otherwise instructed.
- ☐ Bring all your medications with you to your study.
- ☐ Try not to take naps during the day if you can help it.

Once the study ends, you may have some coffee, tea, or juice. If you have any questions, please call us at 512-744-0015 during business hours or at 512-431-5291 after 3:30 p.m. Visit our website **www.texasneurologycenter.com** for more information on sleep studies and detailed information on sleep disorders.

Coming from the north: Go south on MoPac to the Northland / 2222 exit. Take the off ramp to the stoplight. Turn right at the light onto Northland. Pass the Shell gas station on your right. Turn right onto Balcones Drive. Texas Neurology Center is in a red brick building on your left across from the McDonald's. The sleep lab entrance in on the north side of the building.

Coming from the south: Go North on MoPac to the Northland / 2222 exit. Take the off ramp to the stoplight. Turn left (under MoPac) and get into the right lane. Pass the Shell gas station on your right. Turn right onto Balcones Drive. Texas Neurology Center is in a red brick building on your left across from the McDonald's. The sleep lab entrance is on the north side of the building.

Texas Neurology Center

PATIENT NAME _____ DATE _____

Please fill out this questionnaire before you come to your appointment. Complete and accurate responses are to your benefit. Please take your time, and feel free to add additional comments.

BEDTIME

Do you have any difficulty falling asleep? _____

If so, how long has this been a problem? _____

How long do you estimate it takes you to fall asleep? _____

What prevents you from falling asleep? _____

How long has this been a problem? _____

Do you require special noise, light, or position to fall asleep? _____

If so, give details: _____

Have you ever experienced vivid dream-like episodes when attempting to fall asleep? _____

When falling asleep or awakening, do you ever feel paralyzed? _____

When resting awake in bed, do you ever experience an uncontrollable urge to move your legs?

_____

DAYTIME SLEEPINESS

Do you find yourself falling asleep during the day when you don't want to? _____

If so, how long has this been a problem? _____

How likely are you to doze off or fall asleep in the following situations? Use the following scale to rate the likeliness of falling asleep. (Epworth Sleepiness Scale)

Would never doze	0
Slight chance of dozing	1
Moderate chance of dozing	2
High chance of dozing	3

	0	1	2	3
1. Sitting and reading	☐	☐	☐	☐
2. Watching television	☐	☐	☐	☐
3. Sitting inactive in a public place (movie theatre)	☐	☐	☐	☐
4. As a car passenger for an hour without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after lunch without alcohol	☐	☐	☐	☐
8. In a car while stopping for a few minutes in traffic	☐	☐	☐	☐

Total _____

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Patient Name _____

REGULARITY AND DURATION OF SLEEP

What time do you usually go to bed? _____

Do you feel that you usually get enough sleep? _____

Do you work odd hours? If so, list them. _____

How often do you travel across time zones? _____

Do you walk/talk in your sleep (include frequency)? _____

Do you ever awaken from sleep screaming, confused, or violent? _____

AWAKENINGS

Are you having difficulty sleeping through the night? _____

What awakens you? _____

How long has this been a problem? _____

How often do you wake up? _____

How long do you remain awake? _____

What keeps you from falling back to sleep? _____

At what time do you usually awaken in the morning? _____

What is your mood like in the morning? _____

SNORING

Have you or anyone else noticed that you snore loudly? _____

Have you or anyone else noticed that you stop breathing in your sleep? _____

GENERAL

Do you smoke (or have you ever)? _____

If so, how much and how often? _____

Are you exposed to second-hand smoke? _____

If so, how much and how often? _____

Do you consume alcohol? _____

If so, how much and how often? _____

Do you consume caffeinated beverages? _____

If so, how much and how often? _____

What is your height and weight? Ht _____ Wt _____

Have you ever lost consciousness (or felt weak) when suddenly surprised, angered, or frightened? _____

Has anyone in your family been diagnosed with narcolepsy? _____

If so, what is their relation to you? _____

Patient Name _____

MEDICAL HISTORY

Please mark any of the following that you have a **diagnosed history** of:

- ☐ Respiratory disease (type?)
- ☐ Allergies
- ☐ Asthma
- ☐ Congestive heart failure
- ☐ Emphysema
- ☐ Sinus congestion/infections
- ☐ Diabetes
- ☐ Hypertension
- ☐ Anxiety disorder
- ☐ Head injury
- ☐ Claustrophobia
- ☐ Neurological disease
- ☐ Thyroid problems
- ☐ Muscle/joint pains
- ☐ Illegal drug use
- ☐ Indigestion
- ☐ Chronic pain
- ☐ Obstructive Sleep Apnea
- ☐ Seizures
- ☐ Headaches/Migraines
- ☐ GERD
- ☐ Night terrors
- ☐ Insomnia
- ☐ Narcolepsy
- ☐ Teeth grinding
- ☐ Leg movement disorder
- ☐ Depression
- ☐ Heart attack/disease
- ☐ Stroke
- ☐ Cancer (location?) _____
- ☐ Liver disease (type?) _____
- ☐ Kidney disease (type?) _____
- ☐ Other _____

Please mark and date any of the following **surgeries** that have been performed:

- ☐ Tonsillectomy DATE:
- ☐ Palate Surgery DATE:
- ☐ Thyroidectomy DATE:
- ☐ Adenoidectomy DATE:
- ☐ Heart Surgery DATE:
- ☐ Sinus Surgery DATE:
- ☐ Nasal Surgery DATE:

Please list all medications you have taken in the last two weeks. Include non-prescription medications, supplements, herbs, and extracts. Also note if you have recently discontinued any of these medications.

_____

_____

_____

_____

_____

_____

_____

_____

Patient Name _____

BED PARTNER QUESTIONNAIRE

Please have your bed partner, or a person who has observed your sleep, complete this page.

How often have you observed this person's sleep? _____

Does sleepiness appear to affect this person's daily activities? _____

If so, how? _____

Has this person fallen asleep in dangerous situations? _____

Are you forced to sleep in a separate bedroom? _____

Check all of the following you have observed in this patient at nighttime. Circle the frequency as it applies.

Behavior While Sleeping	Frequency of Behavior		
☐ Light snoring	Nightly	Weekly	Infrequently
☐ Choking	Nightly	Weekly	Infrequently
☐ Becoming rigid	Nightly	Weekly	Infrequently
☐ Loud snoring	Nightly	Weekly	Infrequently
☐ Pauses in breathing	Nightly	Weekly	Infrequently
☐ Anxiety at night	Nightly	Weekly	Infrequently
☐ Occasional snorts	Nightly	Weekly	Infrequently
☐ Twitching	Nightly	Weekly	Infrequently
☐ Head rocking	Nightly	Weekly	Infrequently
☐ Acting out dreams	Nightly	Weekly	Infrequently
☐ Kicking	Nightly	Weekly	Infrequently
☐ Nocturnal eating	Nightly	Weekly	Infrequently
☐ Aggressive/violent behavior	Nightly	Weekly	Infrequently
☐ Sleep walking	Nightly	Weekly	Infrequently
☐ Teeth grinding	Nightly	Weekly	Infrequently
☐ Bed wetting	Nightly	Weekly	Infrequently
☐ Sleep talking	Nightly	Weekly	Infrequently
☐ Other activity (describe below)			

Please describe this person's sleep or report any other sleep-related behavior:

_____

_____

_____

_____

_____

Texas Neurology Center

Sleep Diary

Name _____

Over the period of a week, answer the following questions in the morning. Please indicate if you feel this is a normal week for you.

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
What time did you go to bed last night?							
How long did it take you to fall asleep?							
How many times did you wake up last night?							
What time did you wake up this morning?							
How many naps did you take yesterday?							
How long were the naps?							
How much of the following did you consume yesterday?							
• Soda (caffeinated)							
• Coffee							
• Chocolate							
• Alcohol							

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Additional Reminders **J**

Please follow all instructions listed in the sleep study packet prior to your scheduled sleep study.

When coming to the facility for your sleep study, you will use the side door on the right side of the building (when facing the front of the building). Please park on the right side of the parking lot under the trees. Your car will not be towed or ticketed in these spots.

There is a sign on the door that says “Sleep Lab Entrance”. You will see a white doorbell that needs to be rung in order to let the technician know that you have arrived. She will let you in and the set-up will take approximately 45 minutes to one hour.

The rooms are equipped with a TV that has cable and a DVD player, fans for white noise, Wi-Fi internet connection, and a lamp for reading. The room has a microphone so if you need any help, the technician will be able to hear you. Please do not get out of bed without the assistance of the technician so as to avoid pulling on your skin or the machinery. Your study will be completed between 6:30a and 7:30a. If you have a specific wake-up time, please let the technician know so she can accommodate you.

Thank you and we look forward to seeing you.