Smart Neuro Health & Wellness Centers

PATIENT INFORMATION

Patient's Name (First, Middle, Last): ____________________

Address: ____________________

City:__________ State:______ Zip Code:__________ Email: __________

Main Contact#:__________ Alternate#:__________ Work#: __________

Date of Birth:_____/_____/______ Sex: ○ Male ○ Female SS# (optional): __________

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: __________

Patient Referred By:__________ Spouse's Name: __________

Spouse's Date of Birth:_____/_____/______ Main Contact#: __________ Alternate#: __________

Emergency Contact:__________ Relationship:__________ Phone#: __________

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other:__________(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other:__________(Please Specify)

Insurance Information

Primary Insurance:__________ Policy/ID# __________

Name of Policy Holder:__________ DOB:_____/_____/_____ Group/Acct #:__________

Employer:__________ Employer Address: __________

City: __________ State: ______ Zip Code:__________ Work #: __________

Secondary Insurance:__________ Policy/ID#: __________

Name of Policy Holder:__________ DOB:_____/_____/_____ Group/Acct #:__________

Employer:__________ Employer Address: ______

City: __________ State: ______ Zip Code:__________ Work #: __________

Complete – Only if Patient is a Minor

Parent/Guardian Name: __________ Relationship:__________

Parent/Guardian Name: __________ Relationship: __________

Siblings:__________ DOB:_____/_____/_____ Other Siblings:__________ DOB:_____/_____/______

Smart Neuro Health & Wellness Centers

GENERAL CONSENT FORM

Patient Name:____ **Date of Birth:**______/______/________

Assignment of Benefits. I authorize Smart Neuro Health & Wellness Centers, (SNHWC) to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that SNHWC will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: __________

Consent for Treatment. I consent for SNHWC to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, SNHWC may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at SNHWC's expense.

Patient Initials: __________

Electronic Prescription. I understand SNHWC utilizes electronic prescribing technology and facilitates the electronic transmission of prescription information between providers and pharmacists. All triplicate refills between appointments will be charged $20.

Phone Calls. By providing contact information, I authorize SNHWC, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize SNHWC to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** __________

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #:__________________________

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Secondary Phone #: __________________________

- ☐ Leave message with contact number only.
- ☐ Leave message with detailed information.
- ☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** __________

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** __________

Minor Patient Photograph (when applicable)

I consent for SNHWC to photograph the minor patient for identification purposes only. **Patient Initials:** __________

____

Print Name of Patient or Personal Representative

________________________________ ________________

Signature of Patient or Personal Representative Date

Smart Neuro Health & Wellness Centers

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: ________________

NAME:____**D.O.B.**______/_____/_______

LAST FIRST M.I.

OCCUPATION:____

REASON FOR VISIT TODAY: ____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name:______________________________Phone #:____________________Fax #: _______________

Address:____________________________City:______________________State/Zip:_____________

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: ________ No. of Deliveries: _______ Last Menstrual cycle: ___________

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of__________packs/day for_________years. I quit in________(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify ____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____________________

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

Smart Neuro Health & Wellness Centers

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: ________________

NAME: ____________________ (LAST) ____________________ (FIRST) ______ (M.I.) **D.O.B.** ______/_____/________

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General
- Fatigue / Tired ☐Yes ☐No
- Fever / Chills ☐Yes ☐No
- Headache ☐Yes ☐No
- Weight Loss ☐Yes ☐No
- Weight Gain ☐Yes ☐No
- Other: ____________________

Eyes
- Difficulty Seeing ☐Yes ☐No
- Other: ____________________

Head Ears Nose Throat
- Dry Mouth ☐Yes ☐No
- Hearing Problems ☐Yes ☐No
- Hoarseness ☐Yes ☐No
- Lumps/Swelling in Neck ☐Yes ☐No
- Sore Throat ☐Yes ☐No
- Trouble Swallowing ☐Yes ☐No
- Other: ____________________

Cardiac (Heart)
- Chest Pain ☐Yes ☐No
- Irregular Heart Beat ☐Yes ☐No
- Pain with Walking ☐Yes ☐No
- Shortness of Breath ☐Yes ☐No
- Swelling in Feet/Ankles ☐Yes ☐No
- Other: ____________________

Neuro
- Dizziness ☐Yes ☐No
- Fainting ☐Yes ☐No
- Headache ☐Yes ☐No
- Memory Loss ☐Yes ☐No
- Numbness ☐Yes ☐No
- Weakness ☐Yes ☐No
- Other: ____________________

Respiratory
- Cough ☐Yes ☐No
- Shortness of Breath ☐Yes ☐No
- Use of Inhalers ☐Yes ☐No
- Wheezing ☐Yes ☐No
- Other: ____________________

Gastro-Intestinal
- Abdominal Pain ☐Yes ☐No
- Blood in Stool ☐Yes ☐No
- Change in Bowel Habits ☐Yes ☐No
- Constipation ☐Yes ☐No
- Heartburn ☐Yes ☐No
- Loss of Appetite ☐Yes ☐No
- Nausea ☐Yes ☐No
- Vomiting ☐Yes ☐No
- Other: ____________________

Males Only
- Blood in Urine ☐Yes ☐No
- Difficulty Achieving Erection ☐Yes ☐No
- Foul Odor in Urine ☐Yes ☐No
- Pain in Testicles ☐Yes ☐No
- Trouble Urinating ☐Yes ☐No
- Other: ____________________

Females Only
- Breast Discomfort ☐Yes ☐No
- Irregular Bleeding ☐Yes ☐No
- Last Menstrual Cycle *Date:* ____________________
- Painful Intercourse ☐Yes ☐No
- Post Menopausal Bleeding ☐Yes ☐No
- Trouble Urinating ☐Yes ☐No
- Vaginal Discharge ☐Yes ☐No

Musculoskeletal
- Back Pain ☐Yes ☐No
- Joint Pain ☐Yes ☐No
- Muscle Pain ☐Yes ☐No
- Swelling ☐Yes ☐No
- Other: ____________________

Skin Hair Nails
- Bruising ☐Yes ☐No
- Hair Loss ☐Yes ☐No
- Nail Problems ☐Yes ☐No
- Rash ☐Yes ☐No
- Skin Changes ☐Yes ☐No
- Other: ____________________

Mental Health
- Anxiety ☐Yes ☐No
- Depression ☐Yes ☐No
- Difficulty Sleeping/Concentrating ☐Yes ☐No
- History of Physical/Mental Abuse ☐Yes ☐No
- Mood Swings ☐Yes ☐No
- Stress ☐Yes ☐No
- Suicidal ☐Yes ☐No
- Other: ____________________

Recent Tests/ Health Maintenance (Give month/year of last exam in right column. Check left column if date is estimated.)

- ☐ Bone Density: ____________________
- ☐ Colonoscopy: ____________________
- ☐ Diabetic Foot Exam: ____________________
- ☐ Eye Exam: ____________________
- ☐ Mammogram: ____________________
- ☐ Pap Smear: ____________________
- ☐ Physical: ____________________
- ☐ PSA: ____________________
- ☐ Tetanus Shot: ____________________

Smart Neuro Health & Wellness Centers

FINANCIAL POLICY NOTICE

Name: ____________________

Date of Birth: ________________

Thank you for choosing SNHWC. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, MasterCard, Visa and Discover.

Please review and sign after reading each policy listed below

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify SNHWC of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Copayments: I understand that all copays are due at the time of my appointment.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between SNHWC and my insurer will be due at the time of service.

Benefit Representation: I understand that the staff of SNHWC will make every effort to accurately verify my insurance benefits but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at SNHWC all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize the SNHWC to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand that SNHWC utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from SNHWC. I acknowledge that payments made to /SNHWC are for services rendered by SNHWC and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that SNHWC does not accept Worker's Compensation cases.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact SNHWC before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

____ ______________________________

Signature of Patient or Guardian/Guarantor **Date**

____

Relationship

Smart Neuro Health & Wellness Center

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO SNHWC

Name of Patient:____D.O.B.__________Age:_____
LAST FIRST M.I.

I,____, hereby authorize
(Name of patient or legal representative)

____
(Name of person/entity who should release records)

____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically or orally to SNHWC:

Address: __________________________________

____

Phone: __________________________________

Fax: __________________________________

Information is for:

☐ Dr. ____________________

For the purpose of: ____

☐ All Health Information
☐ Statements of Charges or Payments
☐ AIDS or HIV Information *Initials* ________
☐ History and Physical Examination
☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* ________
☐ Progress Notes
☐ Substance Abuse Records *Initials* ________
☐ Genetic Information (inc. genetic test results) *Initials* _______
☐ Discharge Summary
☐ Consultation Reports
☐ Hepatitis Information
☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

____

☐ Other (must be specific):

____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. SNHWC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

______________________________ ____________________
Patient/Legal Representative Signature Date

______________________________ ____________________
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

______________________________ ____________________
Witness Signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

______________________________ ____________________
Signature of Minor Individual Date