SNI NEUROLOGY & SLEEP

1215 Kinwest Pkwy Ste 120
Irving TX 75063
214-496-0500

SNI NEUROLOGY AND SLEEP is a specialty clinic for Neurology and Sleep medicine. Enclosed you will find medical information forms, consent forms, and our privacy notice that you will need to complete ***prior*** to the arrival for your appointment. Completion of these forms is vital for an efficient and thorough evaluation of your condition and health needs. ***If these forms are not complete at the time of your arrival, please arrive 30 minutes early to finish. If you are late to your appointment, rescheduling may be necessary.***

Our office hours vary according to individual physician schedules, but office staff will be available from 8:00 a.m. to 4:00 p.m. Monday through Friday. After hours calls are handled by an answering service. Our office is not equipped to manage life threatening emergencies. You should call 911 or go to an emergency room for all medical emergencies.

Your copayment, co-insurance or payments toward your insurance deductible will be collected at the time of your visit. If you do not have health insurance, payment is expected at the time of your appointment, in the form of cash, or major credit cards. If your insurance policy requires a referral you will need to have your PCP fax us authorization to see you **PRIOR** to your appointment otherwise, you will need to pay for your visit in full at time of service.

If your medical condition requires testing, pre-approval from your insurance company may be necessary. We will attempt to make the appropriate arrangements as quickly as possible, but your assistance and notification of your insurance carrier may be required. You should understand that in some instances, our requests for tests are denied by the insurance carrier.

We will provide refills for medication that we have prescribed if certain guidelines are followed. ***PLEASE DO NOT WAIT UNTIL YOU HAVE EXHAUSTED YOUR SUPPLY OF MEDICATION BEFORE REQUESTING REFILLS.*** If your request is appropriate and is received prior to 3:00 p.m. on a regular business day, we will attempt to refill the same day. After hours, on weekends, and on holidays, the on-call physician CANNOT refill prescriptions or begin new medications.

Thank you for choosing **SNI Neurology and Sleep.** As a patient, you will receive excellent neurological and sleep care and have access to the most modern neuro-diagnostic and sleep testing facilities in our community.

Thank you for taking the time to read this information and completing the enclosed forms. We hope that the above information will be useful, and we look forward to seeing you in the future.

I have read and understand the above office polies. _____

(Sign and Date)

SNI NEUROLOGY AND SLEEP

Patient information Form

Patient's Full Name, as listed on your primary insurance card:

_____

Street Address, City, State, Zip:

_____

Primary Phone _____ Secondary Phone _____

Social Security Number _____ DOB _____

Gender_____

Employers Name _____ Occupation _____

Primary Insurance Carrier _____

Name of Policy Holder _____ Policy Holder DOB_____

Identification Number _____ Group Number _____

Insurance Address _____

Secondary Insurance Carrier _____

Name of Policy Holder _____ Policy Holder DOB_____

Identification Number _____ Group Number _____

Insurance Address _____

Which physician referred you to this office? _____ Phone _____

Name of your Primary Care Physician _____ Phone _____

In case of an emergency, please list relatives or friends we may contact.

Name *Relation* *Phone*

_____ _____ _____

_____ _____ _____

I understand that *SNI NEUROLOGY AND SLEEP* will file my insurance. I hereby authorize this office to furnish medical information to insurance agencies if necessary to file my claim. I also understand that if my insurance claim is not paid in 90 days, I am fully responsible for payment of any and all charges.

Signature _____ Date _____

Medical Information Form

Part One

Please completely fill out the following pages regarding the medical condition of yourself and your family. Completing these forms will greatly assist in your care, and these pages will become part of your confidential medical records.

1. What symptoms are you here to see the doctor for?

2. Please list your past and present medical conditions

3. Have your ever been hospitalized for an illness or for surgery? Please list below.

Date	**Reason**

4. Are you allergic to any medications? List and explain the reaction below.

Medication Name	**Type of reaction**

5. Please list all medications you take with dosage and frequency. This includes **prescription and over the counter medications.**

Medication Name	**Strength**	**How pills and frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		

Medical Information Form
Part Two

6. Do you smoke? _____ How much per day? *Cigarettes* _____ *Cigars* _____ *Pipes* _____
   If you are a former smoker, when did you quit? _____
   How much did you smoke and for how long? _____
7. Do you drink alcoholic beverages? _____
   How many per month? _____ What type of alcohol? _____
   When did you start drinking alcohol? _____
8. Do you use any recreational drugs? _____ It so, what type and for how long? _____
   _____
9. Have your ever had any problems with alcohol, drug or substance abuse? _____
   If yes, please explain: _____
10. Have you ever been diagnosed or treated for sexually transmitted disease? _____
    If yes, please explain: _____
11. Have you been diagnosed with the Human Immunodeficiency Virus (HIV or AIDS)? _____
    Do you have reason to suspect that you have had intimate contact with persons with HIV? _____
12. Please give the date of you last: *HIV Test* _____ *Chest X-Ray* _____ *EKG* _____
    TB Test _____ *Blood Test* _____ *Eye Exam* _____ *Pap Smear* _____
13. Have you ever received a blood transfusion? _____ When? _____
14. Have you recently undergone any other medical tests? Please circle below:

    MRI Scan *CT (CAT) Scan* *Arteriogram or Angiogram*
    EMG or Nerve Conduction *Echocardiogram (sonogram of heart)*
    Carotid Doppler (sonogram of arteries in neck) *EEG*

    Please list any other recent tests not shown above _____
    _____
    _____
15. If you are a female, what was the beginning date of your last menstrual period? _____
    Are you pregnant or do you have reason to suspect that you may be pregnant? _____
    If you are pregnant, what is your approximate due date? _____
16. How many sisters do you have? _____ brothers? _____
17. Do you have any children? (Please list the number of boys and girls and their ages)
    _____
    _____
    _____
18. Do your children have any health problems?
    _____
    _____
    _____
    _____

Medical Information Form
Part Three

19. Please circle below if anyone in your family has suffered from any of the listed medical conditions. Briefly give details as to who in the space provided. Attach additional pages it needed.

Stroke	
Brain aneurysm	
Intellectual disability	
Heart attack	
High blood pressure	
Diabetes	
Muscular dystrophy	
Other muscle disease	
Disease of the peripheral nerves	
Mental illness	
Tuberculosis	
Thyroid disease	
Lung disease	
Anemia	
Stomach problems	
Bleeding tendency	
Kidney disease	

20. If your parents are not living, please give the cause of their death and age at time of death _____

_____

21. What is the highest level of education that you have achieved? _____

_____

22. Please list any other facts about your health that you think the doctor should know _____

_____

Thank you for taking the time to fill out these forms regarding your health and medical history. This information will be of assistance in evaluating your condition and forming a plan of treatment. The physician cannot be responsible for pertinent information that has been omitted.

Patient Symptom Inventory

Please notate below whether you have experienced any of the symptoms within the past year or so.

Headache	
Neck Pain	
Low Back Pain	
Pain in a particular arm or leg	
Sensory loss or tingling in an arm or leg	
Blurred or double vision; blindness	
Ringing in the ears	
Dizziness or vertigo	
Impaired speech	
Difficulty swallowing	
Trouble walking	
Falling down	
Weakness all over	
Passing out	
Spells of altered awareness	
Seizures	
Memory loss	
Hallucinations	
Depression	
Trouble speaking	
Loss of appetite	
Unexplained weight loss	
Nausea or vomiting	
Persistent diarrhea or constipation	
Blood in stool or urine	
Abdominal pain	
Incontinence of urine or stool	
Pain or burning with urination	
Sexual dysfunction	
Chest pain	
Shortness of breath	
Palpitations or rapid heart rate	
Recent cold or flu	
Congestion or sinus problems	
Prolonged or frequent fevers	
Night sweats	
Persistent cough	
Skin Rashes	
Ulcers in mouth or on skin	
Changes in skin moles	
Loud snoring	
Trouble sleeping	
Day time sleepiness	
Joint or bone pain	

ESS: _____
STOP-BANG: _____

Patient Name: _____ Date: _____

Age: _____ Sex: _____ Weight: _____ Height: _____ Neck Circumference: _____

EPWORTH SLEEPINES SCALE

Directions:

1. Please read the list of situations and answer how likely you would be to doze off or fall asleep, and not just tired, at these times.
2. The situations refer to the last three weeks.
3. Even if you have not done or been in these situations recently, please try to guess how they may have affected you.
4. Please use the following scale graded 0,1,2 and 3 for each situation and give the total.

0 = would never dose
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Sitting and reading	_____
Watching Television	_____
Sitting quietly in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon	_____
Sitting and talking with someone	_____
Sitting quietly after lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

THE STOP –Bang Questionnaire

(OSA screening tool)

1.	Do you **S**nore loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
2.	Do you often feel **T**ired, fatigued, or sleepy during the day?	Yes	No
3.	Has anyone **O**bserved you to stop breathing during your sleep?	Yes	No
4.	Do you have or are you being treated for high blood **P**ressure?	Yes	No
5.	**B**ody Mass Index (BMI) more than 35? (BMI = (weight in lbs * 703) / (your height in inches * your height in inches))	Yes	No
6.	**A**ge over 50 yr. old?	Yes	No
7.	**N**eck circumference greater than 40 cm?	Yes	No
8.	**G**ender male?	Yes	No

SNI NEUROLOGY AND SLEEP

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

SNI NEUROLOGY AND SLEEP appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to SNI NEUROLOGY AND SLEEP, for providing medical services to me, the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to the practice, and that I am responsible for any amount due after payment has been made by my insurance carrier.

If I do not have coverage for any of my visits by an insurance carrier, I agree to pay the private pay amounts in full at time of service (see private pay agreement). If I cannot pay in full, I will not receive the discounted rate but can enroll in a 3 payment, payment plan until balance is paid off.

Patient Signature _____ Date_____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment.

If you no-show (do not call and let us know you cannot make the appt PRIOR to your scheduled time), more than one office visit, each no-show will be a **$50** fee. Any no-shows for procedures, including any sleep studies, EEG, EMG, NCV, VEP, BEAP or any other testing performed in the office will result in a **$100** fee. 2 or more no shows may result in your discharge from our practice. We will notify you in writing, via certified mail, if you are discharged from care.

Notice of Privacy Practices

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

YOUR PRIVATE HEALTH INFORMATION (PHI)

Each time you have contact with a healthcare provider for delivery of healthcare, a record of your contact/visit is prepared. This record, maintained in written, oral or electronic format, contains presenting signs/symptoms, results of examination and tests, diagnoses, treatment and future care. Your medical record is the physical property of SNI NEUROLOGY AND SLEEP, but you have certain rights to restrict some of the uses or disclosures of the information in your medical record. SNI NEUROLOGY AND SLEEP, however, has the right to use and disclose the information contained in your medical record in the process of providing treatment, receiving payment and performing other regular healthcare operations such as:

- Documenting and describing the care you received for legal purposes
- Communicating with other healthcare providers who may be involved in your care
- Educating health care professionals
- Medical research
- Providing information for government and public health entities responsible for improving public health and welfare
- Evaluating and improving the care you receive and the outcomes achieved
- Billing and verification of services provided to you
- Conducting other routine healthcare operations such as quality improvement studies and assessing healthcare provider competence

Protecting you privacy and maintaining the security of your health information is one of the most important responsibilities of SNI NEUROLOGY AND SLEEP. SNI NEUROLOGY AND SLEEP is required by law to maintain privacy and confidentiality of your health information, provide you with this *Notice of Privacy Practices,* notify you of your rights to restrict use of this information, notify you if SNI NEUROLOGY AND SLEEP is unable to agree to a requested restriction, and allow you to review the Notice of Privacy Practices prior to granting consent and notifying you of changes/revisions to this notice.

EXAMPLES OF DISCLOSURE OF YOUR PHI

Healthcare delivery and treatment:
Information obtained from you by a physician, nurse or other healthcare professional is documented in your record and used for the assessment, and evaluation, diagnosis and treatment of your medical condition(s). This information is provided to other healthcare professionals, such as other physicians, specialists, physical therapists, hospital based providers and/or other healthcare providers following your treatment by SNI NEUROLOGY AND SLEEP

Billing and payment:
Your PHI is utilized to justify the level of care delivered to you and the charges incurred for the services. This information generally accompanies the bill and is sent to our payers and other third party administrators.

Other healthcare operations:
SNI NEUROLOGY AND SLEEP may disclose your PHI to other individuals and businesses in order for SNI NEUROLOGY AND SLEEP to perform its day-to-day operations. These other individuals and businesses include business associates such as vendors and/or contractors used for credentialing and peer review, patient satisfaction surveys, utilization review/utilization management, billing and claims management, medical research, disease management, and quality improvement initiatives, as well as management services organizations, laboratories free standing diagnostic facilities and legal counsel. SNI NEUROLOGY AND SLEEP requires all its business associates to agree to appropriately protect the confidentiality of your PHI.

Reminders and Treatment:
SNI NEUROLOGY AND SLEEP may contact you to provide you with information that we feel is useful or helpful to you, based on your PHI. For example, SNI NEUROLOGY AND SLEEP may contact you (or instruct a specialist physician to whom you have been referred to contact you) to schedule an appointment or as an appointment reminder, to suggest alternative treatments, or to provide you with information on treatments you are already receiving.

Other Uses and Disclosures:
SNI NEUROLOGY AND SLEEP may also utilize or disclose your PHI in order to communicate with or notify family members, relatives and others responsible for your health, and funeral directors. In addition, SNI NEUROLOGY AND SLEEP may disclose your PHI through other communications and reports required to be made by healthcare professionals such as the public health department, law enforcement, the Food and Drug Administration, organ procurement organizations, correctional institutions and workers compensation where applicable.

Other uses and disclosures of PHI not permitted or required by law will be made only with your written authorization. You may revoke your authorization at any time provided that the revocation is in writing, except to the extent that SNI NEUROLOGY AND SLEEP has already taken action in reliance on your prior authorization.

YOUR RIGHTS CONCERNING PHI

Except as otherwise provided by law, you have the right to: receive a paper copy of this Notice of Privacy Practices if you have agreed to receive it electronically, receive confidential communications of PHI if a request is submitted to SNI NEUROLOGY AND SLEEP in writing; inspect and copy PHI or records about you in a designated record set as long as the PHI is maintained in the record set;

Ask SNI NEUROLOGY AND SLEEP to amend PHI or records about you in a designated record set as long as the PHI or record is maintained in the record set (SNI NEUROLOGY AND SLEEP is not required to change the information if it deems it to be accurate);

Receive an accounting disclosures of PHI (a list of the disclosures made by SNI NEUROLOGY AND SLEEP about you for reasons other than for treatment, payment or health care operations); and

Request that SNI NEUROLOGY AND SLEEP restrict uses or disclosures of your PHI. Though SNI NEUROLOGY AND SLEEP is not required to agree to a restriction, to the extent that is does agree with your request, SNI NEUROLOGY AND SLEEP may not use or disclose the protected PHI in violation of the restriction unless the information is needed to provide emergency treatment, or is otherwise permitted or required by law.

SNI NEUROLOGY AND SLEEP is required by law to abide by the terms of this Notice of Privacy Practices, allow you to review this Notice prior to granting consent, and notify you of changes/revisions to this Notice. If you believe your privacy right have been violated, you may submit a written complaint to SNI NEUROLOGY AND SLEEP or the Secretary of Health and Human Services describing in detail the manner in which you feel your privacy rights have been violated. SNI NEUROLOGY AND SLEEP will not retaliate against you in any way for filing a complaint with SNI NEUROLOGY AND SLEEP, or with the Secretary.

For further information regarding PHI, please contact Jennifer Brown, Privacy Officer of SNI NEUROLOGY AND SLEEP, at 214-496-0500.

PATIENT CONSENT FORM

I understand that as part of my healthcare, SNI NEUROLOGY AND SLEEP, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

This Notice of Privacy Practices provides specific information and complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that I have the right to review the notice prior to signing this consent. I understand that SNI NEUROLOGY AND SLEEP reserves the right to change the Notice of Privacy Practices. Prior to implementation of the revised Notice of Privacy Practices, the revised Notice will be mailed to me if I provide my address below. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that my physician is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent that SNI NEUROLOGY AND SLEEP has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

☐ I request the following restrictions on the use and/or disclosure of my personal health information.

_____

_____

I further understand that 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.

I have been provided and have reviewed SNI NEUROLOGY AND SLEEP's Notice of Privacy Practices dated January 30, 2017.

_____ _____

Signature of Patient or Legal Representative Date

_____

Print Name of Patient or Legal Representative

*I request that changes to the Notice of Privacy Practices be sent to me at this address:

Name: _____

Address _____

_____

City: _____ State: _____ Zip:_____

SNI NEUROLOGY AND SLEEP

Release of PHI

Please list persons we may speak to regarding your care, on your behalf. (ie. Spouse, child, friend):

_____

_____

_____

_____

_____

_____ _____

Printed Name DOB

_____ _____

Date Signature