Neurology Associates

Eric J. Pappert, M.D.
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Patrick Grogan, M.D.
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Welcome...

Welcome to Neurology Associates... we value your confidence in our ability to address your specialized health care needs. Neurology Associates offers comprehensive neurological health care services including expert clinical diagnostics, specialized neurological testing, and up-to-date treatment of diverse disorders affecting the brain, spinal cord, peripheral nerves and muscles.

The staff of Neurology Associates is dedicated to providing you with compassionate, comprehensive specialty care.

Enclosed in this packet is the information you need to create the necessary partnership between us. This packet is designed to assist you in maximizing the benefits of the services you receive from us.

For your visit we will need the following information:

1) Completed Patient Registration form *(enclosed)*
2) Completed Patient Medical Information form *(enclosed)*
3) Medical insurance cards *(New Medicare Card)*
4) Drug Coverage Card
5) Completed Release of Medical Records form
6) Copies of pertinent medical records, x-rays and the list of medications
7) Texas Drivers License or US Photo ID *(i.e.. Passport or State ID)*

We look forward to being of service to you.

Thank you for choosing Neurology Associates.

Neurology Associates

FINANCIAL INFORMATION

This letter is to confirm your appointment on: _____

Thank you for choosing us as your health care providers. We are committed to your treatment being successful. Your clear understanding of our Financial Policy is important to our professional relationship. All patients must complete our *"Patient Registration Forms"* prior to your arrival to our office. You will find this form attached for your convenience. Our business office policy requires payment at the time of each visit.

We will confirm your insurance benefits with us prior to your first visit. New patient, neurology, specialty consultations / examinations are approximately $250-370. The cost of follow-up visits are $80-200. If you do not have insurance, you are responsible for payment in full, prior to scheduling your visit with the doctor. We will accept credit cards, check, or cash to hold your appointment time.

If you have commercial, indemnity policy, you are responsible for payment in full, regardless of your insurance company's arbitrary determination of what they consider *"usual"* and *"customary"* rates. Insurance is a contract between you and your insurance company. We are not a party to this contract.

If you are a member of a Managed Care, PPO, POS, or HMO plan with whom we contract, you will be responsible for only your co-pay and/or the fulfillment of your deductible, prior to your visit with the doctor. HMO members are responsible for the receipt of referral forms from their primary care physicians for new and follow-up visits. If you do not have a referral, you will be responsible for the entire cost of the visit or will have to reschedule the visit when you have a valid referral.

Medicare patients *(who do not have a supplement or secondary insurance)* are responsible for their annual deductible and co-pay at the time of visit. After Medicare pays its component, we will submit the remaining balance on your behalf to your supplement only twice. Thereafter, you will be responsible for payment of this component.

We accept checks, Visa, MasterCard, Discover and American Express. If you have any questions regarding this policy please call our San Antonio Office: **210-656-2333**. If you have questions regarding the billing process or status, please call our billing service: **512-282-2455**. Your insurance statement for your bill may list the doctor's name or our central main billing office **San Marcos Neurology Associates, P.A.** as the payee.

IF YOU NEED TO CANCEL A FOLLOW-UP APPOINTMENT: Please notify us at least 24 hours In advance. We will assess a $50.00 no show fee for failure to present without a 24-hour notice and $75.00 no show fee for Neuropsychological Assessments appointments.

Returned Checks: The office will assess a $50 return check fee for insufficient funds.

Forms and Letters: The office will assess a $25 fee for each page of a form or $150 for a letter requiring the attention of staff or physician *(e.g., disability, handicapped sticker, attorney or employer)*. We charge $25 for copies of medical records for your use.

Unpaid Balances: Unpaid balances are subject to collection fees and attorney fees.

Signature:_____

Printed Name:_____

Neurology Associates

HIPAA NOTICE OF PRIVACY PRACTICES
NEUROLOGY ASSOCIATES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS FORM DOES NOT CONSTITUTE LEGAL ADVICE, AND IT COVERS ONLY FEDERAL, NOT STATE, LAW.

State and Federal laws require us to maintain the privacy of your information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *April 14, 2003* and will remain in effect until it is amended by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes, and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices, and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Janis Adkins. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members access to your health information according to their primary job functions. Every staff member is required to sign our confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Your health information may also be disclosed to your family, friends, and/or other persons you choose to involve in you care only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify or assist in the notification of a family member or anyone responsible for your care in case of an emergency involving your care, your location, your general condition or death. If at all possible, we will provide you with an opportunity to object ***to*** this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose ***only*** that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up files, prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to our medical records staff, outside health or management reviewers, and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law (Court or administrative orders, subpoena, discovery request, or other lawful process). We will use and disclose your information ***when*** requested by national security, intelligence, other State and Federal officials, and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of airier crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Neurology Associates

HIPAA NOTICE OF PRIVACY PRACTICES
NEUROLOGY ASSOCIATES - continued

Public Health Responsibilities: We will disclose your healthcare information to report problems with products, reactions to medications, produce recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.

Marketing Health Related Services: We will **not** use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders including, but not limited to voicemail messages, postcards, or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $25 for the first 20 pages and 15¢ for each page thereafter and the staff time charged will be $75 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information (When we make a routine disclosure of you information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore, these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons ***other than*** treatment, payment, or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003, do not have to be made available).

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Please request a complaint form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Neurology Associates
Phone Number: (210)656-2333

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Dear Neurology Associates Patients,

We are committed to providing you with the highest level of medical care. We understand that in today's healthcare environment you may require the assistance of our office with items that are not part of covered services by Medicare or your private insurance.

In order to provide these non-covered services, we have added multiple staff members to our offices. As a result, we need to institute a charge for these non-covered services, in order to cover these added personnel costs.

Please note the following charges that will be applied to your account for the respective services not paid for by Medicare or your private insurance:

$25/per page for any documents requiring the physician's signature (examples, FMLA, Disability Forms, Life Insurance, etc) and Refills Outside Clinic Hours (Monday through Thursday 9am to 4pm and Friday 9am to 12noon).

$50 for Missed Appointments, Physician Letters, Prior Authorizations for Medications, and Phone Consultations.

$75 for Missed Neuropsychological Assessment Appointments.

$75 for all Toxin Prior Authorizations (Botox, Dysport, Myobloc and Xeomin).

RECORDING DEVICES: TO ENSURE CONFIDENTIALITY AND PRIVACY, ANY TYPE OF ELECTRONIC RECORDING IS STRICTLY PROHIBITED WITHIN THE OFFICE.

I acknowledge the receipt of this document and have been provided with a copy:

Patient Name: _____

Signature: _____

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I have been informed that Neurology Associates **DOES NOT** accept Worker's Compensation insurance cases.

I confirm that my visits with Neurology Associates are not related to ANY work injuries or illnesses.

I HAVE ALSO RECEIVED A COPY OF NEUROLOGY ASSOCIATES NOTICE OF PRIVACY PRACTICES.

_____

Print Patient Name

_____

Patient Signature

_____

Witness Signature

Date: _____/_____/_____

Patient Registration Form

Neurology Associates

Patient Name (First, MI, Last): _____ Date of Birth: ___/___/___

Age: _____ Gender: ☐ M ☐ F Social Security # _____

Street Address: _____

Apartment/Unit: _____ City: _____ State:_____ Zip:_____

Home Phone:: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Driver's License Number: _____ Employer: _____ Occupation:_____

Employer's Street Address: _____

Apartment/Unit: _____ City: _____ State:_____ Zip:_____

Guarantor/Guardian Name (if patient is a minor): _____

Date of Birth: _____ Age: _____ Gender: _____ Marital Status: _____

Street Address: _____

Apartment/Unit: _____ City: _____ State:_____ Zip:_____

Home Phone:: _____ Work Phone: _____ Cell pPhone: _____

Employer: _____ Relationship to Patient: _____

Employer's Street Address: _____ City: _____ State: ___ Zip: _____

Spouse Name: _____ Date of Birth: _____ Social Security #: _____

Employer: _____ City: _____ State:____ Zip: _____ Work Phone: _____

Please list a person living outside your home who should be notified in case of emergency:

Name: _____ Relationship: _____

Home Phone:: _____ Work Phone: _____ Cell Phone: _____

Referring Physician/Primary Care Physician: _____

Physician Address: _____

Unit: _____ City: _____ State:_____ Zip:_____

Phone Number: _____ Fax Number: _____

Primary Insurance Company Name: _____

Insurance Company Address: _____Phone: #_____

City;_____ State: _____ Zip: _____ Name of Insured: _____

Relationship to Patient:_____ ID#: _____ Group #:_____

Secondary Insurance Company Name: _____

Insurance Company Address: _____Phone: #_____

City;_____ State: _____ Zip: _____ Name of Insured: _____

Relationship to Patient:_____ ID#: _____ Group #:_____

Drug Coverage Insurance Name: _____

Insurance Company Address: _____Phone: #_____

City;_____ State: _____ Zip: _____ Name of Insured: _____

RxBIN #: _____ RxPCN #:_____ RxGROUP#: _____

I agree that (regardless of my insurance policy) I am responsible for the entire balance on my account resulting from professional services rendered to the patient (or myself). I will be responsible for all payments denied by my HMO, PPO, or insurance company. I have read the information in the Financial Policy and completed the above answers. To the best of my knowledge this information is correct and true. I will notify this office in case of any changes to my health insurance status, or any of the above information.

Signature:_____ Date:_____

Please mark **YES** or **NO** on the symptoms you are experiencing:

	Y N	Y N	Y N
Constitutional	❑ ❑ Weight Gain	❑ ❑ Weight Loss	❑ ❑ Fatigue
	❑ ❑ Trouble Sleeping	❑ ❑ Sleepiness	❑ ❑ Fever
Cardiac	❑ ❑ Chest Pain	❑ ❑ Palpitations	
Cognitive	❑ ❑ Forgetfulness	❑ ❑ Confusion	❑ ❑ Loss of Consciousness
Eyes	❑ ❑ Double Vision	❑ ❑ Blurry Vision	❑ ❑ Trouble Reading
	❑ ❑ Loss of Vision		
Ears	❑ ❑ Trouble Hearing	❑ ❑ Ringing in Ears	❑ ❑ Vertigo
	❑ ❑ Ear Pain	❑ ❑ Blisters	❑ ❑ Discharge
Respiratory	❑ ❑ Cough	❑ ❑ Shortness of Breath	❑ ❑ Wheezing
Mouth/Throat	❑ ❑ Dry Mouth	❑ ❑ Trouble Swallowing	❑ ❑ Trouble Chewing
	❑ ❑ Throat Pain	❑ ❑ Blisters	❑ ❑ Abnormal Taste
Stomach/Bowel	❑ ❑ Nausea	❑ ❑ Vomiting	❑ ❑ Diarrhea
	❑ ❑ Constipation	❑ ❑ Bloating	❑ ❑ Pain
Bladder/Genital	❑ ❑ Frequent Urination	❑ ❑ Loss of Urine	❑ ❑ Impotence
	❑ ❑ Loss of Stool	❑ ❑ Urine Retention	
Neurological	❑ ❑ Headache	❑ ❑ Passing Out	❑ ❑ Dizziness
	❑ ❑ Weakness	❑ ❑ Numbness	❑ ❑ Tingling
	❑ ❑ Shaking	❑ ❑ Slowness	❑ ❑ Poor Balance
	❑ ❑ Twitching	❑ ❑ Confusion	
Musculoskeletal	❑ ❑ Back Pain	❑ ❑ Leg Pain	❑ ❑ Arm Pain
	❑ ❑ Neck Pain	❑ ❑ Spasms	
Skin	❑ ❑ Dryness	❑ ❑ Itchiness	❑ ❑ Rash
Do You Feel/Have	❑ ❑ Down/Sad	❑ ❑ Anxious	❑ ❑ Nervous
	❑ ❑ Suspicious	❑ ❑ Hallucinations	

Other: _____

Please indicate whether you have a past history of any of the conditions noted below **YES** or **NO**:

Y N	Y N	Y N
❑ ❑ Glasses	❑ ❑ Ear/Nose Problems	❑ ❑ Thyroid Disease
❑ ❑ Diabetes	❑ ❑ Heart Valve Problems	❑ ❑ Heart Rhythm Problems
❑ ❑ Seizures	❑ ❑ Stomach Ulcers	❑ ❑ Liver Problems
❑ ❑ Kidney Problems	❑ ❑ Arthritis	❑ ❑ Back Trouble
❑ ❑ Rash	❑ ❑ Migraine	❑ ❑ High Cholesterol
❑ ❑ Drug/Alcohol Abuse	❑ ❑ High Blood Pressure	❑ ❑ Mental Disease
❑ ❑ Lung Problems	❑ ❑ Poor Circulation	❑ ❑ Heart Attack/Chest Pain
❑ ❑ Stroke	❑ ❑ Eye Problems	
❑ ❑ Cancer	❑ ❑ If yes what type and treatment:_____	

List any other medical illnesses not mentioned above: _____

_____

List surgeries:_____

Have you smoked in the past: ❑ Yes ❑ No Do you smoke now? ❑ Yes ❑ No Packs/day:_____ How many years ?_____

Do you use alcohol: ❑ Yes ❑ No What kind?:_____ How much a week?: _____ Did you drink heavily in the past?: ❑ Yes ❑ No

Do you use illegal drugs: ❑ Yes ❑ No What type: _____

Past Medical History of Family Members:

Father/Mother:_____

Sister(s) / Brother(s):_____

Are you: ❑ Single ❑ Partnered ❑ Married ❑ Divorced ❑ Widowed ❑ Separated Any Children?: ❑ Yes ❑ No Number:_____

Your present and past occupation:_____ Highest schooling level:. _____

RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS: I hereby authorize Neurology Associates to Release my medical records to my Insurance carrier or similar organization for verification of the validity of my medical c1aim{s). 1 hereby authorize my insurance benefits be paid to San Marcos Neurology Associates P.A.

Print Your Name:_____ Birth Date:__/__/__ Signature: _____

Physician Signature:_____ Date: ___/___/____

Neurology Associates

Please "PRINT" your current list of medications

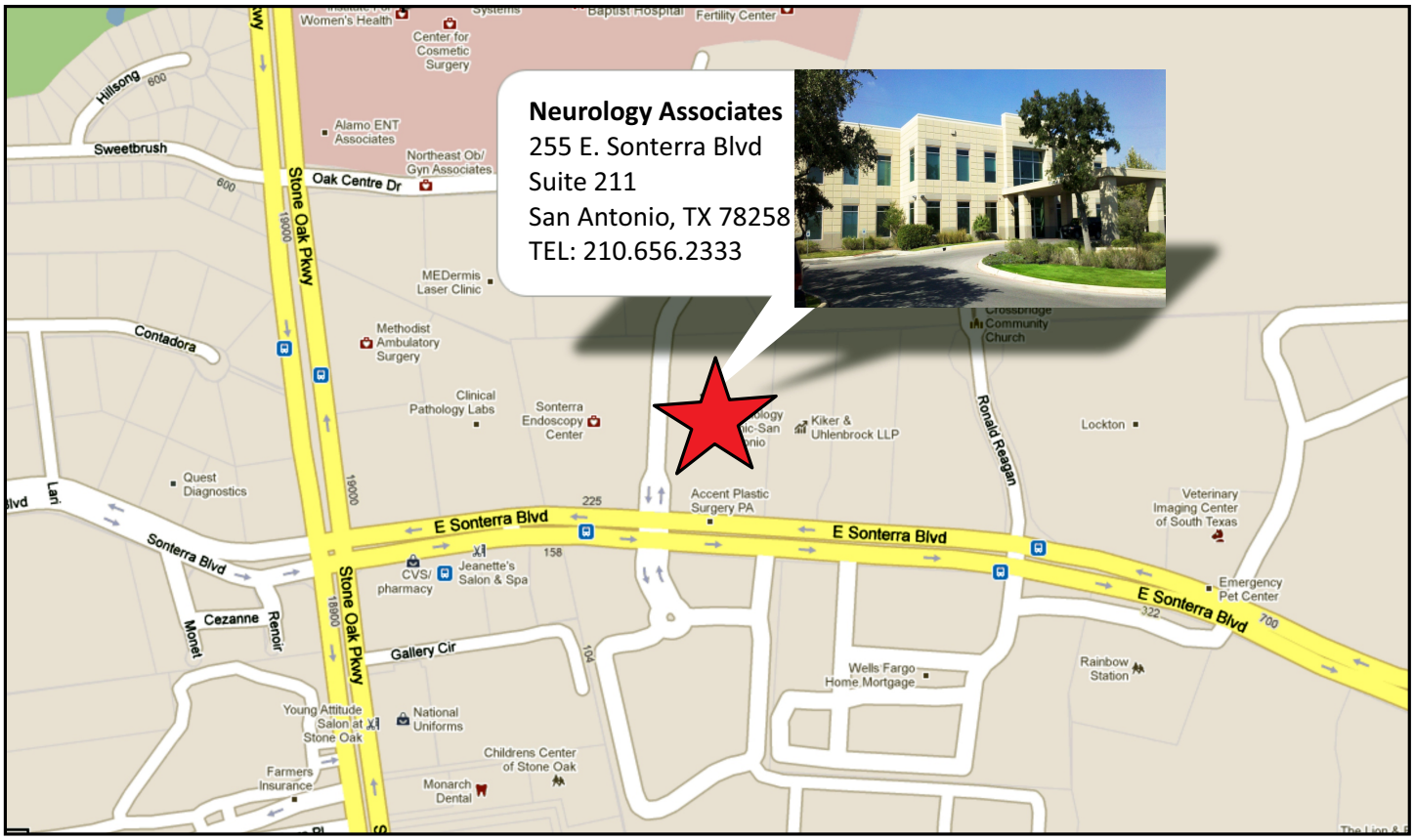
MEDICATION	MILLIGRAM	# OF PILLS A DAY	REASON FOR MEDICATION

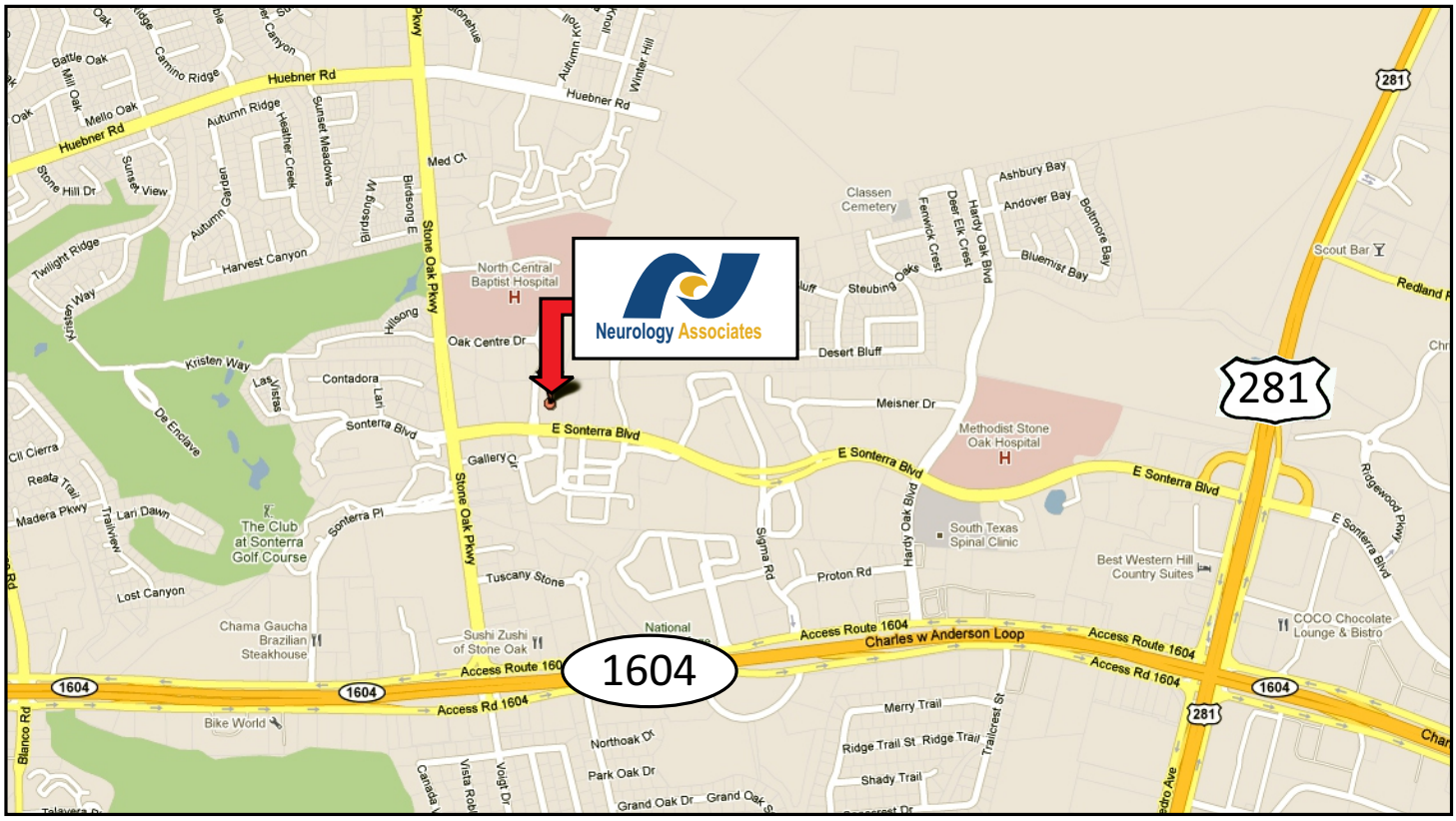
List medication allergies: _____

_____

Print Your Name:_____ Birth Date:__/__/__ Signature: _____

Neurology Associates, P.A. - San Antonio, TX





Note: There are three bldgs in Sonterra Medical Park that look identical (Bldg 155, 225 and our Bldg 255). We are in Bldg 255 in Suites 210 and 211.