



Eric J. Pappert, 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.



## FINANCIAL INFORMATION

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: \_\_\_\_\_



## 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.



## 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

HIPAA Notice of Privacy Practices—This form does not constitute legal advice, and it covers only federal, not state, law.



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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

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 check the symptoms you are experiencing:

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

**Other:** \_\_\_\_\_

Please indicate whether you have a history of any of the conditions noted below:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Glasses            | <input type="checkbox"/> Ear/Nose Problems                     | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Valve Problems                  | <input type="checkbox"/> Heart Rhythm Problems   |
| <input type="checkbox"/> Seizures           | <input type="checkbox"/> Stomach Ulcers                        | <input type="checkbox"/> Liver Problems          |
| <input type="checkbox"/> Kidney Problems    | <input type="checkbox"/> Arthritis                             | <input type="checkbox"/> Back Trouble            |
| <input type="checkbox"/> Rash               | <input type="checkbox"/> Migraine                              | <input type="checkbox"/> High Cholesterol        |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> High Blood Pressure                   | <input type="checkbox"/> Mental Disease          |
| <input type="checkbox"/> Lung Problems      | <input type="checkbox"/> Poor Circulation                      | <input type="checkbox"/> Heart Attack/Chest Pain |
| <input type="checkbox"/> Stroke             | <input type="checkbox"/> Eye Problems                          |  |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> 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: \_\_\_\_\_

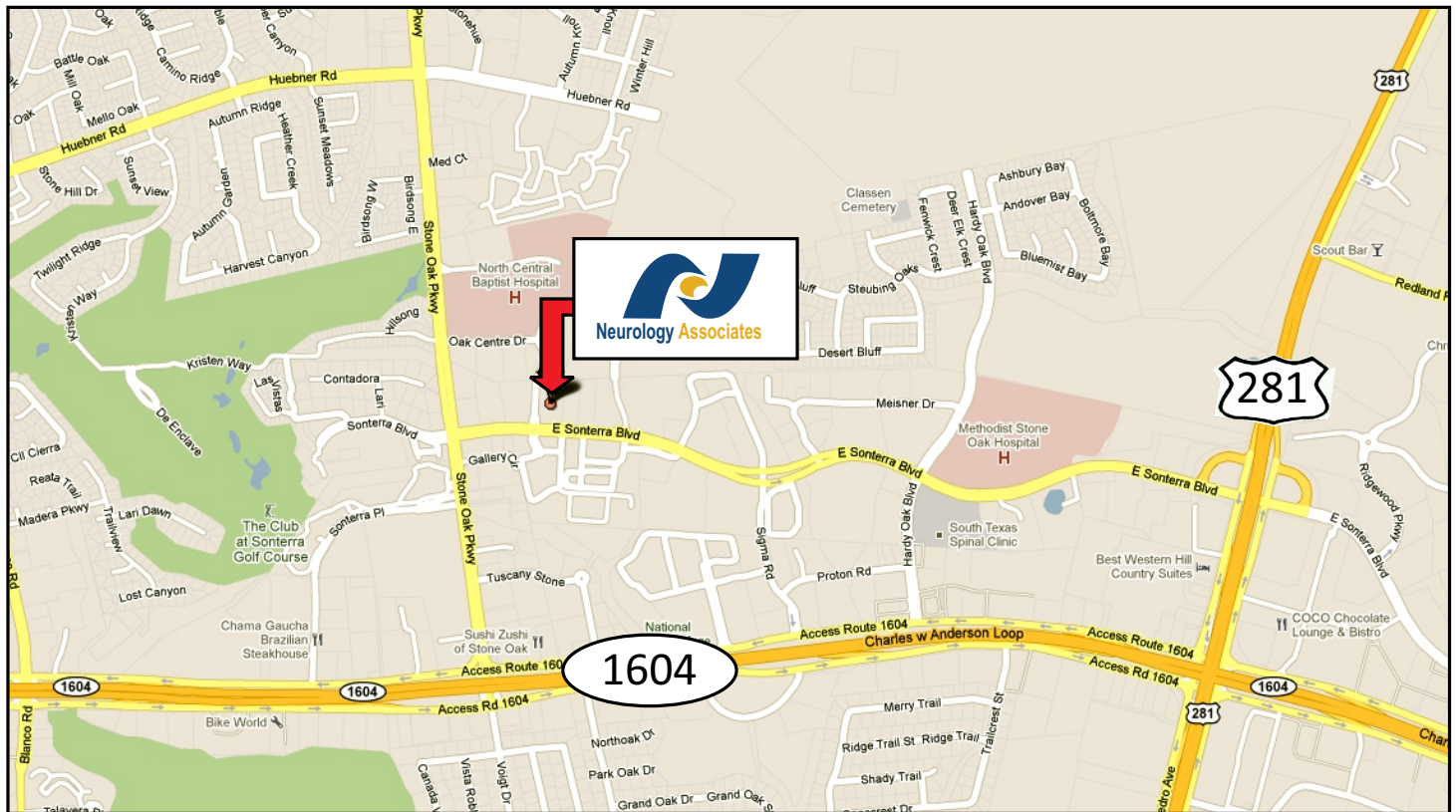
**RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS:** I hereby authorize Neurology Associates to Release my medical records to my Insurance carrier or similar organization for verification of the validity of my medical claim(s). I hereby authorize my insurance benefits be paid to San Marcos Neurology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

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.