TRINITY NORTH DALLAS NEUROLOGY
Elizabeth Samuel, M.D.
Diplomate, American Board Of Psychiatry & Neurology
4325 N. Josey Lane, Plaza III, Suite 211
Carrollton, TX 75010
Phone: 214-483-5665, Fax: 214-483-5684

PATIENT REGISTRATION

Last Name: _____ First Name: _____ DOB: _____
Soc. Sec. #: _____ Age _____ Sex: M F
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Patient Employed by _____
Address _____ Business Phone _____
Whom may we thank for referring you? _____ Phone _____
Primary Care Doctor (PCP) _____ Phone _____
Other Doctor Listing _____ Phone _____
In case of an emergency, who should be notified? _____
Relation to patient _____ Phone _____
In your own words, please explain the reason for today's appointment:
_____
_____

PHARMACY INFORMATION – *Please notify us with your preferred pharmacy to your most convenience*

Pharmacy Name: _____ Phone: _____
Address/Crossroads: _____ Fax #: _____

PRIMARY INSURANCE

Person Responsible for Account: Last Name _____ First _____
Relationship to Patient _____ DOB _____ SS # _____
Address (If different from patient) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Insurance Company _____
Policy/ID # _____ Group # _____
Customer Service Phone Number _____
Address _____

ADDITIONAL INSURANCE

Is Patient covered by additional insurance? ☐Yes ☐No
Subscriber Name _____ Relationship to Patient _____ DOB: _____
Address (If different from patient's) _____
Insurance Company _____ Policy # _____
Group # _____ Address/Customer Service # _____

ASSIGNMENT AND RELEASE

I hereby assign all medical benefits including major benefits to which I am entitled for medical services rendered to myself or my dependents, to Elizabeth Samuel M.D. and Trinity North Dallas Neurology this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid and original. I understand that I am financially responsible for all charges whether or not paid by said insurance company. I hereby authorize said assignee to release all information necessary to secure payment on my behalf.
I authorize Trinity North Dallas Neurology, PLCC to obtain/have access to my medication history.

_____ _____ _____
Signature of Patient or Parent of Mino **Relationship** **Date**

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Welcome to the ***Trinity North Dallas Neurology*** clinic in Carrollton, Texas. The purpose of this letter is to answer some questions regarding neurology and explain clinic policies that are in place to provide the best and most efficient patient care possible.

Neurologists are medical sub-specialists who diagnose and treat disorders of the brain, spinal cord, nerves and muscles. Diagnostic tests such as Electroencephalography (EEG), Electromyography (EMG), Sleep studies, MRI/CT scans, angiography and lumbar puncture are employed. Neurologic problems include conditions such as stroke, seizures/epilepsy, headache/migraine, dystonia, dementia/memory problems (Alzheimer's disease), multiple sclerosis, Parkinson's disease, back/neck pain, numbness/pinched nerves, neuropathy to name a few.
Dr. Samuel is dedicated to providing you with advanced and comprehensive neurological care and the information you need.

- **Appointment Confirmation**: We call our patients *2 working days* before each scheduled appointment. If you have not heard from us, please call us to confirm your appointment.
- **Referrals**: If your insurance plan requires an authorized referral from you primary care doctor in order to see us, please check with your doctor to be sure that your visit has been approved, before your visit. If appointment is made and we have not received a required referral from you PCP office please note appointment will have to be rescheduled.
- *Please plan to arrive 30 minutes prior to your first scheduled appointment, IF you DO NOT have all your New Patient Paperwork filled out already. Late arrivals will necessitate the need to reschedule your appointment. Please bring with you all pertinent medical records: brain & spine scans, EMG/ EEG reports, carotid Doppler studies, cerebral angiogram, recent laboratory studies. Please call your primary care physician in advance to fax all pertinent records to our office.*
- *Fill out the attached patient information forms prior to your appointment and bring all of these forms to your appointment along with your insurance card(s), DL or picture ID. Please be very specific and thorough when filling out these forms.*
- **Medication list**: For all visits, please bring an updated medications list with dose.
- **Co-Payments**: Please be prepared to pay a co-payment (if required by your plan) at the time of your visit. We accept cash, credit cards as well as personal checks. *Please note, if you are a CASH or SELF PAY patient, the office visit charge will be collected up-front before your appointment.*
- **Notify us 24 hours in advance if you need to cancel or reschedule an appointment**. *A $35 charge will be incurred if you cancel without 24 hour notice. If you do not show up for EEG or EMG appointment you will be charged a $100 no show fee. If you miss more than two appointments without 24 hours notice, you may be discharged from the clinic*. If you are a new patient and you "No Show" you may be subject to not being rescheduled again.
- *For prescription refills*, please call your pharmacy at least 72 hours in advance for the refill. The pharmacist will fax us a form for your refill. *Refills will be called in within 48 hours after receiving the request.*

Thank you for your understanding. Our staff is here to help. If there are ever any questions or concerns, please do not hesitate to call us.

PATIENT AGREEMENT TO CONDITIONS OF CARE
I have read and agree to the above conditions

Patient Name (please print) Patient Signature Date

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FINANCIAL RESPONSIBILITY AGREEMENT

Patient Name: _____ Date of Birth: _____
Last Name First Name

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventative exam or physical, lab testing, x-ray, EEG, EMG, BOTOX and any other screening service or diagnostic test ordered by the physician or the physician's staff.

I understand and agree it is my responsibility and not the responsibility of the Physician or Office to know if my insurance will pay for my medical service or visit, preventative exam or physical, lab testing, x-ray, EEG, EMG, BOTOX or any other screening service or diagnostic testing ordered by the physician or physician's staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out of network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.

I understand and agree it is my responsibility to know if my PCP (primary care physician) choice has been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.

I understand that the physician may charge a $35.00 fee if I do not show up for my follow up appointment, or if I cancel without a 24 hour notice. I understand that the physician may charge $100.00 fee if I do not show up for my EMG/EEG/BOTOX appointment. If I am a new patient and "no show" or do not "cancel" my appointment within 24 hours I may be subject to being discharged from physician office.

Signature: _____ Date: _____
(Please sign here-Patient or Responsible Party)

Responsible Party Name: _____
(Please print name of Responsible Party if different from Patient)

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PATIENT REGISTRATION FORM
DISCLOSURES & CONSENTS

Patient Last Name: _____ First: _____
Date of Birth: _____

ASSIGMENT OF INSURANCE BENEFITS:
I hereby authorize direct payment of my insurance benefits to Trinity North Dallas Neurology, or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Trinity North Dallas Neurology, is unable to collect from my insurance carrier for whatever reasons.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of any of my or my dependent's records that these programs may request. I hereby direct that payments of my or my dependent's authorized benefits be made directly to Trinity North Dallas Neurology, or the physician on my behalf.

AUTHORIZED TO RELEASE NON-PUBLIC PERSONAL INFORAMATION:
I certify and I have read and been offered a copy of Trinity North Dallas Neurology "HIPAA Notice of Privacy Practices". I hereby authorize Trinity North Dallas Neurology or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR EMAIL:
I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Trinity North Dallas Neurology representative or my physician to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointments reminders, referral arrangements, and diagnostics test results. I understand that I have the right to resign this authorization at any time by notifying Trinity North Dallas Neurology to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes labs, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay/deductibles/co-ins, or balances due for these services if they are not reimbursed by my insurance or whatever reason.

CONSENT TO TREATMENT
I hereby consent to evaluation, testing, and treatment as directed by my Trinity North Dallas Neurology or those under his/her supervision.

PATIENT SIGNATURE: _____ DATE: _____
GURANTOR SIGNATURE: _____ DATE: _____
(If different from patient)
GURANTOR NAME (Please print): _____

AUTHORIZATION

Patient and/or guarantor are responsible for charges incurred. It is a courtesy for our office to file your insurance; however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. In the event that your insurance company has not paid within 60 days, you are responsible for the balance due. It is also the patient's responsibility to obtain referrals from your primary care physicians when required. If the referral is not obtained before the visit, the patient is liable for payment in full on the date of service. If we are unable to obtain payment within a reasonable amount of time from the patient and/or guarantor we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I _____ have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf, to be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

I authorize this facility to release information to (Please check all that apply):

- ☐ Spouse: (List full name of spouse)_____
- ☐ Children: (List full names & phone numbers)_____
  _____
- ☐ Others: (List complete name & phone number)_____
  _____
- ☐ No One

_____ _____

Signature Date

MEDICARE PATIENTS

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished me by the provider. I authorize any holder of medical information about me to release Medigap Insurer _____ any information needed to determine those benefits payable for related services.

_____ _____

Signature Date

MEDICARE LIFETIME AUTHORIZATION

HIC#:_____

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct and authorize any holder of the medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physicians' services to the physician or organization furnishing the services or authorized such physician or organization to submit a claim to Medicare for payment to me. I request that this authorization also apply to all other insurances.

Sign: _____ Date: _____

Print name:_____ Title/Relationship:_____

Witnessed by: _____Address:_____

If signed by someone other than the beneficiary, state the reason the patient was unable to sign:

_____

TRINITY NORTH DALLAS NEUROLOGY

MEDICAL HISTORY QUESTIONAIRE FORM

MEDICATIONS – *List all current medications. Include prescribed and over-the-counter drugs, such as vitamins and inhalers.*

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

_____

_____

ALLERGIES – *List all known allergies.*

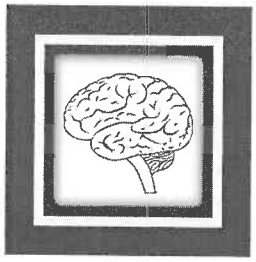
Allergy	Reaction(s)	Date of First Reaction (approx.)
_____	_____	____/____
_____	_____	____/____
_____	_____	____/____
_____	_____	____/____

MEDICAL HISTORY – *Check all diseases and conditions that apply.*

- Aneurysm
- Anxiety Disorder
- Arthritis
- Asthma
- Atrial fibrillation
- Back Problems
- Bleeding Disorder
- COPD
- Cancer
- Cardiac arrhythmia
- Coronary Artery Disease
- Depression
- Diabetes
- Epilepsy
- Fibromyalgia
- GERD
- Head Trauma/Injury
- Headaches
- Heart Attach (MI)
- Heart Problems
- Hepatitis
- Hyperlipidemia
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Kidney Disease
- Liver Disease
- Lupus
- Migraines
- Multiple Sclerosis
- Neck Injury
- Neuropathy
- Osteopenia
- Osteoporosis
- Seizures
- Sleep Disorder
- Sleep apnea
- Stroke
- Thyroid Problems
- Ulcers
- _____
- _____
- _____
- _____

SURGICAL HISTORY – *Check all surgeries that apply.* ***(Please indicate approx. year of the surgery)***

- Appendectomy
- Brain Surgery
- Breast Surgery
- CABG
- Caesarean Section
- Carotid endarterectomy
- Cataract Surgery
- Cerebral aneurysm
- Cervical Spine Surgery
- Cholecystectomy
- Colectomy
- Craniotomy
- Dilation and Curettage
- Gastric Bypass
- Heart Surgery
- Hemorrhoidecto my
- Hernia Repair
- Hip Surgery
- Hysterectomy
- Knee Surgery
- Lumbar Spine
- Shoulder
- Spinal
- Thyroid
- Tonsillectomy
- Tubal Ligation
- _____



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MEDICAL HISTORY QUESTIONAIRE FORM (Page 2)
FAMILY HISTORY
Check all diseases and conditions that apply.

(Please add relation to family member; if Grandparent/ Aunt/ Uncle, indicate Paternal or Maternal)

☐ Alzheimer's Disease _____
☐ Anxiety Disorder _____
☐ Bleeding Disorders _____
☐ CAD _____
☐ Cancer _____
☐ Dementia _____
☐ Depression _____
☐ Diabetes _____
☐ Headaches _____
☐ Heart Attacks _____
☐ Heart Problem _____
☐ Hyperlipidemia/high cholesterol _____
☐ Hypertension _____
☐ Mental Illness _____
☐ Migraines _____
☐ Multiple Sclerosis _____
☐ Neuropathy _____
☐ Parkinson's Disease _____
☐ Seizures _____
☐ Stroke _____
☐ Tremors _____
☐ Other _____

SOCIAL HISTORY – *Please complete and/or circle all correct answer choices.*

1. Hand Dominance - ☐ Right Hand ☐ Left Hand ☐ Bilateral (Both Hands)
2. Occupation - _____
3. Highest Level of Education - ☐Less than 8 ☐9 ☐10 ☐11 ☐12 ☐2-Year College ☐4-Year College+
4. Marital status - ☐Ukwn ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Domestic Partner
5. Number of Children - _____ # Adopted - _____
6. Smoking Status - ☐Never smoker ☐Former smoker ☐Current every day smoker ☐Current some day smoker
   Has smoked since age - _____
   Smoking- How much? - ☐None ☐1PPW ☐2PPW ☐1/4PPD ☐1/2PPD ☐1PPD ☐11/2PPD ☐2PPD ☐3+PPD
7. Chewing Tobacco Status – ☐Never Used ☐Former Use ☐Current every day use ☐Current some day use
   Has chewed Tobacco since age - _____
   Chewing tobacco – How much? - ☐None ☐1/day ☐2-4/day ☐5+/day
8. Passive smoke exposure? ☐Yes ☐No
9. Alcohol intake ☐None ☐Occasional ☐Moderate ☐Heavy
   Alcohol years of use _____
10. Illicit drugs _____
11. Caffeine intake - ☐None ☐Occasional ☐Moderate ☐Heavy
12. Exercise Level - ☐None ☐Occasional ☐Moderate ☐Heavy
13. Diet - ☐Regular ☐Vegetarian ☐Vegan ☐Gluten free ☐Specific ☐Carbohydrate ☐Cardiac
14. Are you able to care of yourself? - ☐Yes ☐No
15. Exposure to insect bites? - ☐Yes ☐No
16. Exposure to heavy metals? - ☐No ☐Lead ☐Mercury ☐Arsenic ☐Other_____
17. Exposure to chemicals or toxins? - _____
18. HIV risk factors? O No O Blood transfusion O Sexual exposure O Needle stick O Tattoo

TRINITY NORTH DALLAS NEUROLOGY

REVIEW OF SYSTEMS

Constitutional:

- Weight loss/weight gain (lbs?)
- Loss of appetite
- Prolonged fever
- Night sweats
- Trouble sleeping

Neurological

- Spells of altered awareness
- Impairment of speech
- Trouble walking
- Falling down
- Weakness in a specific are or leg
- Weakness allover
- Numbness or tingling in hands or feet
- Intermittent shooting pain in arms/legs
- Memory loss
- Headache
- Tremor

Eyes:

- Blurred vision
- Double vision
- Blindness (one or both eyes)
- Droopy eyelids
- Tearing/discharge
- Dry eyes

Ear/Nose/Throat:

- Hearing loss
- Ringing in ears
- Dizziness or vertigo
- Nasal congestion/sinus problems
- Smell or taste impairment

Cardiovascular/Heart:

- Chest pain or tightness
- Palpitation/irregular heart beat
- Heart murmur
- Enlarged heart
- Shortness of breath
- Swelling of feet/ankles

Respiratory/Lungs:

- Recent cold/flu
- Chronic cough
- Blood in sputum
- Tuberculosis
- Emphysema/COPD
- Asthma
- Seasonal allergies

Gastrointestinal:

- Mouth sores
- Dry mouth
- Frequent heart burn/ulcers
- Difficulty swallowing
- Nausea/vomiting
- Persistent diarrhea
- Persistent constipation
- Change in bowel habits
- Change in stool character
- Jaundice/liver disease

Kidney/Bladder/Genital:

- Recurrent urinary tract infection
- Kidney stones
- Urination at night more than once
- Burning/frequency/difficulty starting stream
- Urinary incontinence
- Brown or cola colored urine
- Bloody urine
- Sexual dysfunction
- Genital ulcers/sores

Muscle/Bone/Joint/skin:

- Fatigue
- Muscle pain/aches/cramps/spasms
- Muscle wasting/thinning
- Joint pain/swelling
- Skin rashes
- Dry skin

Psychiatric:

- Frequent crying spells
- Hallucination or Delusions
- Suicidal thoughts/attempts
- Family or work related stress or anxiety