New Patient Form

Patient Demographics

Patient Name		Date of Birth	Gender
Address	City	State	Zip Code
Home Phone	Mobile Phone	Email Address	
Language	SSN	Race	Ethnicity

Marital Status & Employment

Marital Status □ Single □ Married □ Divorced □ Widowed □ Partner		
Employment Status	Employer	Employer Phone

Emergency Contact

Name	Relationship	Phone

Primary Insurance

Insurance Name		Phone
Policy Holder	Relationship	Date of Birth
Subscriber / ID #		Group #

Secondary Insurance

Insurance Name		Phone
Policy Holder	Relationship	Date of Birth
Subscriber / ID #		Group #

Person Responsible for Bill (if not patient)

Name	Relationship / Phone

SECTION 1: OFFICE POLICY

- **Patient Identification:** To enhance identity protection in compliance with the Federal Trade Commission's "Red Flag" rule, which mandates healthcare providers to establish anti-identity theft programs, our office has implemented a patient identification policy. Our Office will require valid photo identification from all patients upon check-in. This also ensures that we can correctly match patient information with their medical records, safeguarding their privacy and enhancing the quality of care provided. If, at the time of your visit, you are unable to provide proper identification, we regret to inform you that we will need to reschedule your appointment.
- **Minors:** It is mandatory for the parent(s) or guardian(s) to be present during the visit, and they are responsible for the full payment of services, as well as the receipt of billing statements.
- **Treatment Authorization:** I hereby authorize Central Texas Neurology Consultants to examine, diagnose and treat me. I authorize Central Texas Neurology Consultants consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analysis and study and to include diagnosis for submission for payment to the insurance carrier for the named patient. I hereby voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being. If I request or initiate a telehealth visit (a "virtual visit'), I hereby consent to participate in such telehealth visit and its recording and I understand I may terminate such visit at any time. My consent shall cover medical examinations and diagnostic testing, including, but not limited to, minor surgical procedures (injections) and vaccine administration. My consent shall also cover the carrying out of the orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.
- **Assignment of Benefits and Authorization to Release Medical Information:** I hereby certify that the insurance information I have provided is accurate, complete, and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the provider or supplier of any services furnished to me by that provider or supplier. I authorize my provider to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.
- **Prescription Refills**: Patients must contact their pharmacies directly to request any prescription refills for medications that our provider prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.
- **Consent to Call, Email & Text:** I understand and agree that my provider may contact me using automated calls, emails, and/or text messaging sent to my landline and/or mobile device. These communications may notify me of appointments, reminders, preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt out of receiving all such communications from my provider by notifying my provider's staff or by visiting "My Profile" on my Patient Portal. By providing a telephone number and submitting this form, I am consenting to be contacted by SMS text message. Message & data rates may apply. You can reply STOP to opt-out of further messaging.
- **Marketing Communications**: I acknowledge and consent to receive marketing text/emails including information regarding goods/services/events/promotions etc. that we believe may be of interest to you.

You may opt out of these messages at any time. Your care will not be affected if you choose to opt out of marketing communications; you will continue to receive healthcare-related messages.

- **Acknowledgement of Review of Privacy Practices**: I have reviewed this office's Notice of Privacy Practices, outlined on our clinic's website under Privacy Policy or by request from the front desk, which explains how my medical information will be used and disclosed. I acknowledge that I have received a copy of Central Texas Neurology Consultants' "Notices of Privacy Practices".
- **Prescription Benefits and Medication History:** I hereby authorize Central Texas Neurology Consultants to download my prescription benefits and medication history information from Surescripts pharmacy clearinghouse.

SECTION 2: FINANCIAL POLICY

We do not accept any cash. We offer contactless payment options through the online portal, self-check-in, and in-office. We accept checks and all major cards: Visa, MasterCard, Amex, and Discover Card.

- **No-Show and Late Cancellation Policy Consent**: To ensure timely access to care for all patients and respect the time of our providers and staff, our practice has established a formal policy regarding appointment cancellations and missed visits. Appointments are reserved specifically for you, and failure to attend or cancel within the required window prevents us from offering that time to another patient. This form outlines our standard no-show and cancellation fees, the defined cancellation window, applicable exceptions, and how these fees will be billed and collected. We strive to be fair and consistent while balancing clinical operations and patient accountability. Please review the details below and sign to acknowledge your understanding of this policy.
    - *Cancellation Window:* Patients must cancel or reschedule by 10:00 AM the business day prior to the scheduled appointment to avoid a fee. Cancellations made after this time, or failure to attend the appointment, will result in the applicable no-show or late cancellation fee being charged.
    - *The following fees will be applied:*

Appointment Type	Fee
Established Patient	$50
New Patient	$100
NCV	$150

      These fees are not covered by insurance and are the responsibility of the patient. Frequent violations (3 or more within a 12-month period) may result in limited scheduling options or internal review from the practice.
    - *First Time Waiver & Grace Period:* While this policy is not proactively communicated for each appointment, first-time offenses may be waived at the practice's discretion. Exceptions may be granted by the Practice Manager in cases of medical emergencies, family emergencies, or other unforeseen circumstances.
    - *Acknowledgment:* I understand and agree to the terms outlined in this No-Show and Late Cancellation Policy. I acknowledge that I am responsible for any applicable fees.
- **Cost Estimates**: We are committed to understanding your benefits and providing you with a cost estimate for your care before your appointment. Estimates are just that – estimates. Things can, and do,

sometimes turn out differently. While we do our best to provide cost estimates as a courtesy, please inform us of any changes to your information such as name, address, phone numbers, and/or insurance information before your appointment. If you have any questions, please call us before your appointment so there are no surprises when you check-in. You are aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You may be asked to pay for these services in full at the time of the visit and/or be responsible for any amounts uncovered by the insurance payor.

- **Self-Pay**: If you are uninsured, you will be responsible for payment in full at the time of service. Upon request, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, healthcare providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.
- **Out-of-Network Service Agreement:** This form provides important information about receiving care from a provider or facility that is not contracted with your health insurance plan ("out-of-network"). By signing below, you acknowledge your understanding that out-of-network services may not be covered at the same benefit level as in network care, and that you may be responsible for additional out-of-pocket costs. We are committed to providing transparent information about the financial implications of your care. This agreement confirms your informed consent to proceed with out-of-network services and outlines your responsibility for payment based on the terms of your health plan and the provider's billing policies. I acknowledge that the services I am receiving may be considered out-of-network by my insurance provider. I understand that my insurance may issue payment directly to me. I agree to forward any insurance payments I receive to the practice immediately. Failure to do so may result in my account being sent to collections. I understand I am financially responsible for charges not covered by insurance.

ACKNOWLEDGEMENT FORM

By signing below, you:

- Agree to all sections (1&2) outlined in these pages of Patient Policy Rev. 05022025
- Agree to receive electronic documents accessible via our patient portal or website. A paper copy is available upon request.
- Central Texas Neurology Consultants' Notice of Privacy Practices
- Central Texas Neurology Consultants' Financial Policy
- Central Texas Neurology Consultants' General Office Policy
- Agree that this form applies and extends to subsequent visits and appointments with any Central Texas Neurology Consultants' providers.
- Have carefully read and agree to the terms above and understand that any failure to comply with any of these terms may result in discharge from Central Texas Neurology Consultants.

_____ _____

Patient Name Patient Signature

_____ _____

Legal Guardian Name (*if applicable*) Legal Guardian Signature (*if applicable*)

_____

Date

Authorization to Discuss Health Information

I hereby authorize Central Texas Neurology Consultants to discuss the following specific health information with the individuals I designate below: 1) scheduling/appointment information, 2) medical information including symptoms, diagnosis, medications, and treatment plan, 3) laboratory test results, 4) MRI results, and 5) billing information. I understand that I have the right to revoke my permission at any time, except where Central Texas Neurology Consultants has already made disclosures in reliance upon this request. The authorization may be revoked at any time by contacting Central Texas Neurology Consultants in writing. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPPA.

Designee	Relationship	Phone Number

Medical Histories

Current Medications ☐ None

Medication	Dose	Frequency	Reason/Notes

Drug & Environmental Allergies ☐ No known allergies

Allergen	Reaction	Approx. Year

Past Medical History – check all that apply ☐ No significant past medical history

Neurological Medical History	
☐ Stroke / TIA	☐ Epilepsy / Seizures
☐ Migraine	☐ Multiple sclerosis
☐ Parkinson's disease	☐ Dementia / Memory loss
☐ Peripheral neuropathy	☐ Other _____
General Medical History	
☐ Hypertension	☐ Heart disease
☐ High cholesterol	☐ Thyroid disorder
☐ Kidney disease	☐ Liver disease
☐ Cancer (*type*:_____)	☐ Autoimmune disease (*type*:_____)
☐ Diabetes	☐ Lung disease (e.g. COPD/asthma)
☐ GI disease (e.g. stomach/reflux/colon problems)	☐ Depression or anxiety

Social History

Education Level	
Occupation	
Retired	☐ No | ☐ Yes (*year retired*:_____)
Tobacco Use	☐ Never ☐ Former (*year quit*:_____) ☐ Current smoker (*packs/day*: ☐ <½ | ☐ ½–1 | ☐ >1) ☐ Current e-cigarette or vape use (*frequency/day:*_____)

	☐ Current tobacco chewer (*frequency/day:*_____*)* *Has tobacco cessation counseling been provided?* ☐ No | ☐ Yes (*date*:_____)
Alcohol Use	☐ None ☐ 1–6 drinks/week ☐ 7–14 drinks/week ☐ >14 drinks/week
Caffeine Use	☐ None ☐ Uses (*type/frequency*:_____)
Activities of Daily Living	*Are you able to care for yourself?* ☐ Yes | ☐ No *Are you able to walk?* ☐ Yes | ☐ No | ☐ Other: _____
Exercise	*# days / week of at least 30 minutes per day*: ☐ 0 | ☐ 1-2 | ☐ 3-4 | ☐ ≥5 *Type(s) of exercise*: ☐ Walking | ☐ Running | ☐ Swimming | ☐ Yoga | ☐ Weights
Living Situation	☐ Alone ☐ Family/partner ☐ Assisted living ☐ Other: _____
Driving	☐ Drives ☐ Does not drive (*reason*:_____)
Hand Dominance	☐ Right ☐ Left ☐ Bilateral
Advance Directive	*Do you have an advance directive?* ☐ Yes | ☐ No *Do you have a medical power of attorney?* ☐ Yes | ☐ No

Family History – check box and note family relation to you ☐ No relevant family history

Neurological Family Medical History	
☐ Stroke *Relation*: _____	☐ Epilepsy / Seizures *Relation*: _____
☐ Parkinson's disease *Relation*: _____	☐ Multiple sclerosis *Relation*: _____
☐ Migraine *Relation*: _____	☐ Dementia / Alzheimer's disease *Relation*: _____
☐ Peripheral neuropathy *Relation*: _____	☐ Amyotrophic lateral sclerosis (ALS) *Relation*: _____
☐ Huntington's disease *Relation*: _____	☐ Cerebral aneurysm / AVM *Relation*: _____
☐ Sleep apnea *Relation*: _____	☐ Narcolepsy *Relation*: _____
☐ Other neurological disorder: _____ *Relation*: _____	
General Family Medical History	
☐ Diabetes *Relation*: _____	☐ Hypertension *Relation*: _____
☐ Heart disease *Relation*: _____	☐ Cancer (*type*:_____) *Relation*: _____
☐ Autoimmune disease (*type*:_____) *Relation*: _____	