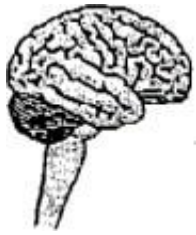


NEUROLOGY CONSULTANTS

1102 Orchard Dr • Arlington, TX 76012 • Phone (817) 299-8100 • Fax (817) 469-6378

D. Chi Nguyen, M.D.
Board Certified in Neurology

Dung Nguyen, M.D.
Board Certified in Neurology

In order to make your first visit a smooth one, please complete the enclosed forms and bring them with you on your appointment date. You also must provide some form of identification and a current insurance card.

Name_____

Appointment date:_____Time:_____

****Please note, if your insurance requires a referral from your primary care physician (PCP), it is your responsibility to acquire this from that provider.**
If a referral is required, and it is not in our office by your appointment time, we will reschedule your time with our physician.

It is important to note that if you have a work related injury, or think you might have a work related injury…we do not handle workers comp. claims nor do we see auto related injuries. We are sorry but we are a small practice and we cannot absorb the litigation demands for these type of medical problems.

PATIENT MEDICAL HISTORY

Name: _____ **Date:** _____
DOB: _____ **Height:** _____ **Weight:** _____

Please summarize your current problem(s) in the space provided: _____
_____

Please list your current medications:

Name	Dosage	Times/Day	Name	Dosage	Times/Day

Please list any allergies to medications: _____
_____
Past medical history: _____
_____
Past surgical history: _____
_____

Family history:

Relation	Living	Deceased	Illnesses
Father			
Mother			

Social History:

What is your marital status? _____

What is your current living arrangement (with whom)? _____
How many children do you have? _____
Smoking: ( ) Non- smoker ( ) Former Smoker ( ) Current Smoker _____ pack/s per day
Alcohol: ( ) Yes ( ) No How often: ( ) rare ( ) weekend ( ) occasional ( ) daily
Working: ( ) Yes ( ) No Occupation: _____

Have you had any of the following symptoms in the past several weeks?

Fever	Yes / No	Blurred vision	Yes / No	Nausea	Yes / No
Chills	Yes / No	Double vision	Yes / No	Vomiting	Yes / No
Loss of appetite	Yes / No	Difficulty with sleep	Yes / No	Diarrhea	Yes / No
Weight gain	Yes / No	Shortness of Breath	Yes / No	Constipation	Yes / No
Night sweats	Yes / No	Chest pain/palpitations	Yes / No	Anxiety/Depression	Yes / No

2025 DEMOGRAPHICS UPDATE

Primary Care Physician: _____ **Referred By:** _____
Emergency Contact: Name, Relationship & Phone #: _____

Name: _____ **Date Of Birth:** _____ **SSN:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home Phone: _____ **Mobile Phone:** _____
Email: _____ **Request appointment reminders by email and text?** ☐ **Yes** ☐ **No**
Marital Status: ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Legally Separated**
Please circle: Male Female Do not wish to report
Race: ☐ **White** ☐ **African American** ☐ **Hispanic** ☐ **American Indian** ☐ **Asian** ☐ **Other**
Ethnicity: ☐ **Hispanic or Latin American** ☐ **Not Hispanic or Latin American** ☐ **Do not wish to report**
Language: ☐ **English** ☐ **Spanish** ☐ **Indian** ☐ **Vietnamese** ☐ **Other**

Employer: _____ ☐ **Retired** ☐ **Unemployed** ☐ **Student**

Address: _____
City: _____ **State:** _____ **Zip:** _____
Business Phone: _____

Primary Cardholder Name: _____ **Date Of Birth:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Primary insurance: _____
Member ID: _____ **Group ID:** _____
Secondary insurance: _____
Member ID: _____ **Group ID:** _____

Pharmacy: Name _____ **Address** _____
Phone _____ **Fax** _____

Is this worker's compensation related? _____**YES**_____**NO**
Is this personal injury/disability related? _____**YES**_____**NO**
Any possible litigation involved? _____**YES**_____**NO**

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Neurology Consultants** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Neurology Consultants**. I understand that diagnosis or treatment of me by **D. Chi Nguyen, MD** or **Dung Nguyen, MD** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Neurology Consultants** is not required to agree to the restrictions that I may request. However, if **Neurology Consultants** agrees to a restriction that I request, the restriction is binding on **Neurology Consultants** and **D. Chi Nguyen, MD** and **Dung Nguyen, MD**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **D. Chi Nguyen, MD** or **Dung Nguyen,** MD or **Neurology Consultants** has taken action in reliance on this consent.

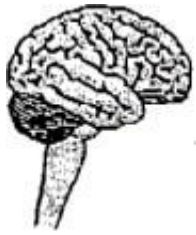
My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Neurology Consultants**' Notice of Privacy Practices prior to signing this document. The **Neurology Consultants**' Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Neurology Consultants**. The Notice of Privacy Practices for **Neurology Consultants** is also provided at the **Front office**. This Notice of Privacy Practices also describes my rights and the **Neurology Consultants** duties with respect to my protected health information.

Neurology Consultants reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____
Print Name of Patient or Personal Representative Relationship of Representative to Patient

_____ _____
Signature of Patient or Personal Representative Date



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"NO SHOW" OR LATE CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations with work or family. However, when you do not call to cancel an appointment, preferably within 24 hours, you are preventing another patient from getting much needed help. We have a long list of patients that have been asked to be placed on a "cancellation list, hoping to be called earlier and it's so difficult for us to see time go unused, time that could have been spent helping someone else but we couldn't because we weren't notified of your inability to come in.

It has **always been** our policy to charge $25 for each 'no show' 15 minute appointment in our office, most offices charge twice the amount, that means:

A routine follow up visit---$25.00

An EMG appointment is----this is $75.00

An EEG is --$100.00

Botox injection is -- $75.00

Neurotrax is $75.00

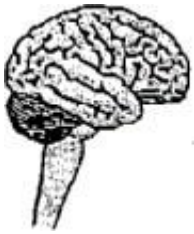
This charge cannot be billed to insurance and will be collected on your next office visit.

We hope you understand this policy and see how it could benefit you if you ever need to be seen right away.

I have read and understand this policy and agree to adhere to it as explained.

_____ _____

(signature) (printed name)



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I hereby authorize the use or disclosure of information from the medical record of:

Patient Name_____ Date of Birth_____ Social Security # _____

I authorize Neurology Consultants, its physicians, and its staff to disclose the following protected health information (example: any appointment details, anything having to do with patient medical concerns, etc.) to person(s) listed below for their use (spouses, children, other doctors aside from primary, caregiver, family members, friends, etc) :

Recipient(s):_____

Please release the following:

☐ Entire record ☐ Medical records and diagnostic studies ☐ Insurance information

☐ Other _____

This protected health information is used or disclosed for the following purposes:

☐ Facilitation of patient care ☐ Insurance purposes ☐ Legal matters

☐ Other _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
☐ ***Yes**, I consent to the release of this information.* ☐ ***No**, I do not consent to the release of this information.*

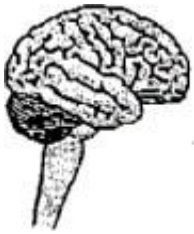
I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date:_____.***

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Neurology Consultants.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient (If Legal Representative) Witness



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STATEMENT OF FINANCIAL OBLIGATION

To our patients;

We are happy to assist you with your insurance and if need be, the filing of your secondary insurance. We work diligently with all carriers to insure your claim is properly submitted and paid.

However, **please understand that statements regarding your insurance benefits come directly from your insurance carrier and always have a disclaimer that this is not a guarantee of payment**. Insurance coverage is becoming more complicated and knowledge of your plan is best served by you.

We check on benefits only and not on the status of your deductible, whether it is met or not.

Also, **it is the responsibility of the patient to obtain a referral**, **if required by your insurance plan**, **from their primary care physician**. If the referral is not in the office at the time of your appointment we will have to reschedule.

I understand that I am ultimately responsible for the medical care I receive from the physicians at Neurology Consultants and will assume full financial responsibility.

Signature_____Date_____