



NEUROLOGY
 2800 Garth Road, Baytown, TX 77521
 Tel: (281) 428-1141 Fax: (281) 425-3992

REGISTRATION INFORMATION

Date _____ Referred By _____

PATIENT DETAILS

Name _____
Last First Middle
 Address _____
Street City State Zip
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____ Age _____ Birth date _____ Sex: Male Female
 Driver License # _____ Marital Status: Single Married Widowed Separated Divorced
 Employer _____ Occupation _____
 Employer Address _____ Phone _____

SPOUSE / GUARDIAN DETAILS

Name _____ Birth date _____
Last First Middle
 Home Phone _____ Work Phone _____ Cell Phone _____
 Social Security # _____
 Employer _____ Occupation _____
 Employer Address _____ Phone _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relation to Patient _____
 Address _____ Home Phone _____ Work Phone _____

INSURANCE & PAYMENT DETAILS

Method of Payment Cash Check Credit Card
 Do you have medical Insurance? Yes No
 If Yes, Name of Primary Insurance _____ HMO POS PPO Other
 Policy # _____ Group # _____ Insured's SSN _____
 Name of Insured _____ Insured's DOB _____
 Name of Secondary Insurance _____ HMO POS PPO Other
 Policy # _____ Group # _____ Insured's SSN _____
 Name of Insured _____ Insured's DOB _____

I authorize the release of any medical information necessary to process claims on my behalf. I also authorize the payment of medical benefits to Dr. Ricardo Pardo, Stephanie Schwartz, and/or Hemant Pandey who will be filing my insurance claims. This authorization is to include any and all insurance policies that I am covered under.

 Signature

 Date



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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION
ANOTHER FACILITY TO JACINTO MEDICAL GROUP

Patient's Name: _____ DOB: _____

SSN: _____

I REQUEST AND AUTHORIZE

NAME OF CLINIC/DOCTOR: _____

ADDRESS: _____

PHONE No: _____

Fax No: _____

TO RELEASE THE MEDICAL RECORDS OF THE PATIENT NAMED ABOVE TO:

(1) RICARDO PARDO M.D., (2) PRITI PALVADI M.D., (3) STEPHANIE SCHWARTZ M.D.
2800 Garth Road
Baytown
Tx 77521
Phone: (281) 428-1141 Fax: (281) 425-3993

The request and authorization applies to following treatment, conditions or dates of treatment.

_____ All Healthcare information

Other: _____

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorder/mental health, drugs and/ or alcohol use. You are specifically authorized to release all healthcare information relating to such diagnosis, testing, or treatment.

Signature of Patient or Authorized Representative

Date Signed

Relationship or status if signed by anyone other than Patient
(Parent, Legal guardian, Personal representative, etc)

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE SIGNED



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FINANCIAL POLICY

In order, for our office to be able to continue to deliver the quality of care that you are accustomed to, it has become necessary to make some changes in our financial policies. The following list contains guidelines that have become part of making your visit to The Neurology Center as pleasant as possible, while providing you with the highest quality of care.

ALL PATIENTS ARE REQUIRED TO READ AND SIGN A COPY TO BE RETAINED IN YOUR CHART.

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us with ALL the correct information to ensure proper billing to your insurance company(ies).
2. If you have a change in address, telephone numbers, or employer, please notify the receptionist and we will be happy to update your records.
3. We will collect your deductible, co-payment, co-insurance, or charges for non-covered services **at the time of your visit**. If you have a balance after insurance payment from a previous visit, we will also ask for that payment. We accept cash, checks, money orders, Visa, MasterCard, and American Express.
4. If we do not participate with your insurance, we will file your claim(s) as a courtesy, however, you will be expected to pay for your services **at the time of your visit**.
5. If your insurance company denies our charge, or does not pay us in a timely manner, you will be billed for the entire balance. You will be expected to pay your balance in full within 30 days or call our billing department to make payment arrangements. If payment is not received in a timely manner, your account may be subject to more aggressive collection methods.
6. **MEDICARE PATIENTS:** The Jacinto Neurology is a participating provider with Medicare Part B and we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we will bill you for the balance due. If you do not have a supplemental insurance, the 20% Medicare does not cover will be collected from you at the time of service. Each year you will be expected to pay the allowed amount of your charges until your Medicare annual deductible has been met.
7. **MANAGED CARE (HMO, PPO) PATIENTS:** If we participate with your plan, we will bill your insurance for you, however, your co-pay will be collected up front, no exceptions. If your plan requires you to choose a primary care physician, it is your responsibility to make sure your insurance company has your physician on file. If your plan requires prior authorization, you must provide The Neurology Center with a current referral or you will be responsible for payment of services provided. If we do not participate with your plan, we will verify your **out of network** benefits and file your charges. Your payment of the portion of the bill the insurance will not cover will be expected from you at the time of service.
8. **SELF-PAY PATIENTS:** Patients without medical coverage will be expected to pay at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing The Jacinto Neurology Group to make payment arrangements.

Remember, whether you do or do not have any medical insurance, you are ultimately responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department.

SIGNATURE: _____

DATE: _____



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Patient Consent and Acknowledgment Form for Use and Disclosure of Protected Health Information

I hereby give my consent for Jacinto Medical Group, P.A. (JMG) , Jacinto Medical Corporation (JMC), and /or Baytown Urgent Care, Ltd.(BUC) to use and disclose protected health information (PHI) about me to carry out treatment, payment, and health care operations (TPO). (The Notice of Privacy Practices provided to me by JMG, JMC, and/or BUC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. JMG, JMC, and/or BUC reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Cathy Rouse, Office Manager at 2800 Garth Road, Baytown, Texas or by calling (281) 425-3800** for further information.

With this consent, JMG, JMC, and/or BUC may call my home or other alternative location and leave a message on voice mail or in person in reference to my items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, JMG and/or JMC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, JMG, JMC, and/or BUC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that JMG and/or JMC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am acknowledging receipt of the Notice of Privacy Practices and consenting to allow JMG, JMC, and/or BUC to use and disclose my PHI to carry out TPO.

Furthermore, I understand that JMG, JMC, and/or BUC have an electronic medical records system, which entails all of my private healthcare information. Within this electronic system, there is a function to include a digital photograph on each patient's chart. This photograph is solely used as to identify the patient upon reviewing the patient's chart. I hereby consent to JMG, JMC, and/or BUC and his or her assistants as necessary to photograph myself as the patient on record and to download onto my electronic medical chart.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my consent. If you do not sign this consent, or later revoke it, JMG and/or JMC may decline to provide treatment to me. I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Signed by: _____
Signature of Patient or Legal Guardian Date Relationship to Patient

Printed Patient's Name Print Name of Legal Guardian, if applicable

Signature of JMG/JMC Authorized Representative Date

Consent to Treat

I hereby authorize and direct JMG, JMC, and/or BUC and his or her assistants as necessary to perform quality care, to perform the following procedures/treatment upon me:

Medical Care Visits Procedure/Treatment: _____

The nature and purpose of this procedure, alternative methods of treatment, and potential risks and complications listed below have been fully explained to me, including the following: _____ procedure/ treatment(s) upon me.

I acknowledge that the practice of medicine is not an exact science and no guarantees have been made to me as to the outcome of this procedure and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or his or her staff, associates, or colleagues.

Print Name _____ **Date of Birth** _____
Signature _____ **Date** _____
Witness _____ **Date** _____

If the patient is a minor or has a legally designated representative:

Print Patient Name _____ **Date** _____
Representative Signature _____



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PAST MEDICAL HISTORY

Date _____ Referring Physician _____

PATIENT DETAILS

Name _____ Birth date _____
Last First Middle
 Address _____
Street City State Zip
 Home Phone _____ Work Phone _____ Email _____

SURGICAL HISTORY *(Check boxes that apply to your past medical history)*

- Tonsillectomy Appendectomy Gyn Surgery Hernia
- Gallbladder Heart Surgery Cataract
- Other Surgeries _____

MEDICAL HISTORY *(Check boxes that apply to your past medical history)*

- High Blood Pressure Diabetes Seizures Low Back Pain
- Stroke Migraine Heart Disease Neck Pain
- Cancer (Type of Cancer) _____
- Other Medical or Neurological Problems _____

ALLERGIES TO MEDICATIONS _____

SOCIAL HISTORY

Smoking? No Yes (If Yes, please list how many packs/day & for how many years you have smoked?)
 _____ Packs per day for _____ year(s). Date Quit Smoking: _____
 Alcohol? No Yes (If Yes, please indicate the number of drinks/day, number of years, and type(s) of alcohol used)
 _____ drink(s) per day for _____ year(s).
 Type(s) of Drinks: Beer Wine Mixed Drinks Never Used Alcohol Hospitalized for Alcohol Use

EMPLOYMENT

Job Title _____ Level of Stress: High Medium Low
 Exposures: Noise Chemicals Toxins Fumes Gases Other: _____

EDUCATION Highest Level Achieved _____

FAMILY HISTORY (Please list those people in your family with the following illnesses):

High Blood Pressure _____ Heart Disease _____
 Diabetes _____ Cancer _____
 Stroke _____ Migraine _____
 Seizures _____ Parkinson's _____
 Alzheimer's _____ Other Neurologic Problems _____

My Primary Care Physician: _____



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	Medication Name	mg Dose	How many times a day
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			



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REVIEW OF SYMPTOMS

Name: _____ Account: _____ Date: _____

Please check if you have currently or recently had any of the following:

GENERAL

- Fever
- Chills
- Night Sweats
- Weight gain
- Weight
- Loss of Appetite
- Hot Flashes

HEAD AND NECK

- Blurred Vision
- Double Vision
- Sleeping Spots
- Poor Hearing
- Nasal Congestion
- Sinus Congestion
- Nose Bleeds
- Mouth Sores/Fever Blisters
- Sore Throat
- Dental Problems
- Other _____

RESPIRATION

- Cough
- Sputum Production
- Coughing Up Blood
- Shortness of Breath
- Shortness of Breath with Exertion
- Wheezing
- Other _____

CIRCULATION

- Chest Pain
- Heart Pounding, Racing, or Skipping
- Swollen Feet
- Other _____

DIGESTION

- Trouble Swallowing
- Nausea
- Vomiting
- Heartburn
- Diarrhea
- Constipation
- Hemorrhoids
- Blood in Stool
- Black Stools
- Colonoscopy or Flex Sig
- Other _____

URINARY

- Burning with Urination
- Increased Frequency
- Up at night to Urinate
Number of Times _____
- Dark or Bloody Urine
- Kidney Stones
- Bladder Infection
- Incontinence
- Other _____

PROSTATE

- Difficulty Urinating
- Prostate Problems
- Last Prostate Exam _____
- Other _____

SLEEP

- Snoring
- # of Awakening at Night _____
- Unrefreshing Sleep
- Insomnia
- Daytime Somnolence/Fatigue
- Feel Drowsy Driving or at Work
- Only for Family Member/Bed Partner*
- Does He or She:*
- Snore
- Restless Sleep
- Breathing pauses during sleep
- Mood or Behavior Changes

MUSCULOSKELETAL

- Arthritis
- Bone or Joint Pain
Which Ones? _____
- Back Pain
- Swollen Joints
- Other _____

NEUROLOGIC

- Headaches
- Dizzy Spells
- Numbness
- Weakness
- Forgetfulness
- Confusion
- Balance
- Visual Changes
- Speech Difficulties
- Other _____

SKIN

- Rash
- Change in a Mole
- Lumps or Bumps
- Itching
- Change in Color
- Bruising or Bleeding
- Other _____

EMOTIONS

- Nervousness
- Depression
- Anxiety
- Trouble Sleeping
- Other _____

PAIN

- Location
- Severity (Rank from 1 to 10, If 10 is the worst) _____
- How long does it last? _____
- What makes it better or Worse?

Physician's Signature: _____