CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

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Please read and complete these forms, press the "PRINT" tab, and then sign at the designated locations. Bring this to your initial evaluation.

PATIENT INFORMATION

Today's Date:	Referring MD:	PCP: (if different)	Diagnosis:
Last Name:	First Name:	Middle:	○ Sin ○ Mar ○ Div ○ Sep ○ Wid
Birth Date: ○ Male ○ Female	Social Security Number:	Driver's License:	
Home Phone Number:	Cell Phone Number:	Work Phone Number:	
Home Address:	City:	State:	Zip:
Employer:	Occupation:	Injury Due To:	
Emergency Contact:	Emergency Number:	Relationship:	

FINANCIAL AGREEMENT

As a courtesy, C.T.N.C. will contact your insurance company for a verification of benefits. All patients are encouraged to call their insurance company for further verification or clarification of benefits. C.T.N.C. will not be held responsible for inaccurate information obtained during the verification process. In most cases, C.T.N.C. will bill your insurance. However, any account balance incurred with C.T.N.C. is legally the responsibility of the patient. The adult, parent, or legal guardian accompanying a minor is responsible financially for all services provided by C.T.N.C. and agrees to all terms listed in this agreement.

TERMS OF AGREEMENT

1. C.T.N.C. requires a 24 hour notification on all cancellations. Missed appointments and late cancellations will result in a $25.00 charge to the patient.
2. Attendance agreement – after three missed appointments C.T.N.C. will discharge you from therapy and your doctor and/or case manager will be notified.
3. I have reviewed my insurance benefits with a C.T.N.C. representative (as provided by your insurance company), and have been notified of any co-pays, insurances, or deductibles.
4. All co-pays, co-insurances, and deductibles are due prior to treatment.
5. Verification of benefits is not a guarantee of payment by the insurance company and I am responsible for any dates of services or procedures not covered by my insurance plan.
6. I will notify a C.T.N.C. representative of any changes in my information; including, but not limited to, address, phone number, or insurance coverage.
7. I, the undersigned certify that I (or my dependent) have insurance coverage as provided by C.T.N.C. and assign directly to C.T.N.C. all insurance benefits, otherwise payable to me for services.
8. I hereby authorize the release of all information necessary to secure the payment of benefits.
9. I authorize the use of this signature on all insurance submissions.

_______________ **Patient or Guardian Initials**

___ - __ - ____ **Social Security Number**

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by C.T.N.C., our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of use and disclosure for these purposes, please review our Notice of Information Practices. You have the right to review our Notice of Information Practices prior to signing this consent form.

Please give the name(s) of person(s) that may obtain verbal information regarding your medical history if any:

Name: _______________ Relationship: _______________

Name: _______________ Relationship: _______________

_______________ **Patient or Guardian Initials**

CONSENT FOR CARE AND TREATMENT

As the patient or patient's legal representative, I hereby consent to necessary examination, procedures and/or treatments prescribed by my referring physician and recommended by therapists at C.T.N.C. as is necessary in his/her judgment. I understand that I am under the care and supervision on treating at C.T.N.C.

_______________ **Patient or Guardian Initials**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, _______________, have received a copy of Central Texas Neurology Consultants, P.A.'s Notice of Privacy Practices.

_______________ **Patient or Guardian Initials**

I certify that the information on this form is to be true to the best of my knowledge, and C.T.N.C. has explained my benefits as quoted by the insurance company.

_______________ **Patient or Guardian Initials** _______________ **Date**

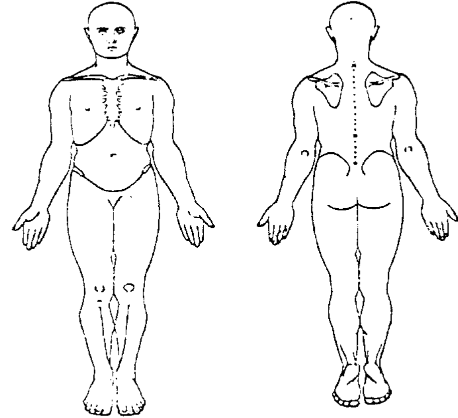
MEDICAL HISTORY REVIEW

Name: ______________________ Age: __________ Preferred Name: ____________________

Have you ever been told that you have any of the conditions listed below, and list your specific type for that condition if it applies?

- ☐ Angina
- ☐ Arthritis: ______________
- ☐ Asthma
- ☐ Cancer: ______________
- ☐ Chronic Bronchitis
- ☐ Cirrhosis
- ☐ Congestive Heart Failure
- ☐ Diabetes: ______________
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Heart Disease: ______________
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disease: ______________
- ☐ Liver Disease: ______________
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Myofascial Pain Syndrome
- ☐ Osteoporosis
- ☐ Polio
- ☐ Shortness of Breath
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Problems:
- ☐ Ulcers: ______________
- ☐ Others: ______________

Please use the figures below to mark where your pain is



Yes	No	
☐	☐	Are you pregnant?
☐	☐	Do you have a Visual Impairment?
☐	☐	Do you have a Hearing Impairment?
☐	☐	Have you been discharged from a Hospital or Skilled Nursing Facility within the past 30 days?
☐	☐	Have you had Home Health Care within the past 30 days?
☐	☐	Have you had Physical Therapy this year? If YES, where were you treated?

PLEASE LIST ALL SURGICAL OPERATIONS AND THE DATES PERFORMED

PLEASE LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU ARE CURRENTLY TAKING

WHAT IS YOUR GOAL IN THERAPY?

______________________ ______________
Patient Signature **Date**