Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Cell _____ Work Phone _____ Ext _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address _____

Date of Birth MM _____/DD _____/YYYY _____ Sex ☐ F – Female ☐ M - Male ☐ Transgender

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Declined

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

Language ☐ English ☐ Spanish ☐ Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ French ☐ German ☐ Russian ☐ Other _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Partner

Social Security Number _____-_____-_____ Employer Name _____

Employment Status ☐ 1 - Full-Time ☐ 2 - Part-Time ☐ 3 - Not Employed ☐ 4 - Self-Employed ☐ 5 - Retired ☐ 6 - Active Military

Student Status ☐ F - Full-Time Student ☐ P - Part-Time Student ☐ N – Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ☐ Yes ☐ No

Emergency Contact Relationship to Patient _____ Guardian

Address Line 1 _____

City, State _____ ZIP _____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM _____/DD _____/YYYY _____

Social Security Number _____-_____-_____ Telephone _____

E -Mail Address _____ ☐ Sex ☐ F – Female ☐ M - Male

Address Line 1 _____

City, State _____ ZIP _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Patient Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/DD _____/YYYY _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ ***Date*** _____

TEXAS STROKE INSTITUTE

Saving Lives, One Stroke at a Time

AGREEMENT FOR SERVICES RECEIVED

By executing this agreement, you are agreeing to pay for all services received.

Filing Claims

Please be sure you inform us of any updates or changes to your insurance so we have your current information. If we do not have current information, this will delay payment and possibly cause you to have unexpected expenses. You will be asked to completely fill out a new information profile every year. These profiles expire one year after being signed.

Contracted Insurance

If we are contracted with your insurance company, we must follow our contract and its requirements. If you have a co-payment, co-insurance and/or deductible, you must pay at the time of service.

Non-contracted Insurance

Your insurance is a contract between you and your insurance company. We are NOT a party to this contract between you and your insurance company, in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company who makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

Self-pay Patients

All self-pay patients are required to pay at the time the services are rendered. A payment plan can be arranged if necessary and is requested by the patient.

Insurance Verification

Our verification staff is dedicated to ensuring your visit is covered by your insurance or advising you otherwise prior to your appointment. In some instances, we might not be able to obtain this information. It is always a good idea for you to check with your insurance carrier to verify your specific benefits so there are no unexpected financial surprises at the time or your visit. Payment for services is ultimately your responsibility.

Statements

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued. It will separately show the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Returned Checks

There is a fee (currently $25) for any checks returned by the bank.

Past Due Account

Your account becomes past due 30 days following receipt of your first statement. We will take the necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality

Please understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact you received treatment at our office may become a matter of public record.

Divorce

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, is it the authorizing parent's responsibility to collect from the other parent.

Appointments

It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require that you be on time for your appointments. If you must cancel an appointment, we ask you give us 24 hours' notice whenever possible.

In order to ensure accurate records and true identity of all patients, you will need to present your Driver's License or Identification Card, Insurance Card and Social Security Number at the time of your appointment.

I have read this document and understand the policies and my fiscal responsibility.

(Print): _____

Patient's Name

_____ _____

Patients Signature *Date*

(Print): _____

Guarantor's Name

_____ _____

Guarantor's Signature *Date*

NORTH TEXAS STROKE CENTER, PLLC DBA: TEXAS STROKE INSTITUTE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient initials) **Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Updated: June 12, 2015, replacing November 21, 2013 version

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ **(Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above.** I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Patient Signature _____ Date: _____

Patient Name (Printed): _____ DOB: _____

Updated: June 12, 2015, replacing November 21, 2013 version

TEXAS STROKE INSTITUTE

Saving Lives, One Stroke at a Time

Physician Information Form

Patient Name: _____ **Date:** _____

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

Family Physician: _____

Address: _____

Phone: _____ Fax: _____

Neurologist: _____

Address: _____

Phone: _____ Fax: _____

Cardiologist: _____

Address: _____

Phone: _____ Fax: _____

TEXAS STROKE INSTITUTE

Saving Lives, One Stroke at a Time

Medication & Allergies

Patient Name: _____ **Date:** _____

Medication List

Medication Name *(To include over the counter meds such as vitamins, herbs, diet supplements)*	**Dosage**	**Frequency**	**Date when Medication Began**

Allergies

Drugs / Foods	**Reactions**

TEXAS STROKE INSTITUTE

Saving Lives, One Stroke at a Time

Patient Information Form - Surgeries

Patient Name: _____ **Date:** _____

Prior Surgeries	
Type of Surgery	**Date of Surgery**

Have you had any of these tests?

Yes	No	Test	Date	Where	Results			
		CT Scan			Normal		Abnormal	
		MRI			Normal		Abnormal	
		Carotid Doppler			Normal		Abnormal	
		Echocardiogram			Normal		Abnormal	
		Transcranial Doppler			Normal		Abnormal	
		Cerebral Angiogram			Normal		Abnormal	
		LP (Spinal Tap)			Normal		Abnormal	
		EEG (Brain Wave)			Normal		Abnormal	
		EMG/NCS			Normal		Abnormal	
		Blood Tests (specify)			Normal		Abnormal	
		Other			Normal		Abnormal	

Is there anything else you would like to tell our office?

_____

_____

_____

_____

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Saving Lives, One Stroke at a Time

PATIENT MEDICAL, SOCIAL, FAMILY HISTORY

Patient Name: _____ **Date:** _____

MEDICAL CONDITIONS (any that require(d) medication or monitoring by health care professionals)

Condition	Date Diagnosed	Type of Treatment Received *(For example: Medication, Hospitalization, Chemotherapy, Radiation, etc.)*	Date Resolved

SOCIAL HISTORY

What is your occupation?			
Do you regularly exercise? Type of exercise: _____	Yes	No	Average # of times per week: _____ Average # of minutes per session: _____
Do you regularly drink alcohol?	Yes	No	Average # per day: _____ Circle type: wine / beer / hard liquor Average # per week: _____
Do you drink caffeinated beverages?	Yes	No	Average # per day: _____ Circle type: coffee / tea / soda
Do you currently smoke?	Yes	No	Age Started: _____ Average # of packs per day: _____
Are you a former smoker?	Yes	No	Age Started: _____ Age quite smoking: _____ Average # of packs per day: _____
Ever use recreational drugs?	Yes	No	Type: _____ Circle: current use / past use

FAMILY HISTORY

Relative	Medical Problems/Cause of Death		If deceased, age at death	
Mother				
Father				
Sisters				
Brothers				
Children				
Grandmother	Maternal:	Paternal:	Mat:	Pat:
Grandfather	Maternal:	Paternal:	Mat:	Pat:
Aunts	Maternal:	Paternal:	Mat:	Pat:
Uncles	Maternal:	Paternal:	Mat:	Pat:

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REVIEW OF SYMPTOMS

Patient Name: _____ **Date:** _____

SYMPTOM INVENTORY: Please check the appropriate box below to indicate whether or not you have had the following symptoms **within the past year.**

CONSTITUTIONAL	Yes	No
Fatigue/Lethargy		
Weight gain (unintentional)		
Weight loss (unintentional)		
Unexplained Fever		
Trouble Sleeping		

DERMATALOGICAL/INTEGUMENTARY	Yes	No
Skin rash or lesions		
Easy bruising		

HEENT	Yes	No
Blurred Vision		
Double Vision		
Blindness		
Other Vision Changes		
Trouble Swallowing		
Trouble with smell		
Hoarseness		
Difficulty Chewing		
Pain when Chewing		
Choking		
Drooling		
Ringing in Ears		
Decreased Hearing R / L		

CARDIOLOGY	Yes	No
Chest Pain		
Palpitations		
Difficulty Breathing/Shortness of breath		
Leg Swelling		
Blood Clots		

GI/GU	Yes	No
Nausea/Vomiting		
GI Bleed		
Incontinent Bladder		
Incontinent Bowel		

MUSCULOSKELETAL	Yes	No
Muscle Pain		
Head/Neck Trauma		
Neck Pain		
Chiropractic Therapy		
Leg Pain		
Muscle or Joint Stiffness		

NEUROLOGICAL	Yes	No
Headache		
Dizziness		
Fainting		
Confusion		
Memory Loss		
Poor Concentration		
Weakness in Arms		
Weakness in Legs		
Numbness in Arms		
Numbness in Legs		
Poor Balance		
Poor Coordination		
Trouble Walking		
Facial Numbness or Tingling		
Difficulty with speech		

PSYCHOLOGICAL	Yes	No
Change in Mood or Behavior		
Hallucinations		

OTHER:

_____

Reviewed by Provider: (Initials) _____