Houston Neurology & Sleep Center

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PH: (713) 465-9282
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Katy, Texas 77450
PH: (832) 200-1273
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21216 Northwest Fwy. #510
Cypress, TX. 77429
PH: (832) 678-2971
FAX: (281) 640-8954

Dear Patient:

Your appointment is scheduled for _________________________@ ________________at:

- ❑ Our main location at 7500 San Felipe, Suite 525
- ❑ Our Katy location at 21703 Kingsland Blvd, Suite 101
- ❑ Our Cypress location at 21216 Northwest Fwy, Suite 510

Please arrive 15 minutes prior to your appointment time to complete any paperwork that may be necessary. Remember that if your insurance is an HMO, you need to bring your referral with you. If your insurance requires a co-pay or you need to pay your deductible, we will accept credit cards, check or exact change.

We have enclosed some questionnaires and patient paperwork for you to complete and bring with you to your appointment.

Please remember that if you do not show up for your appointment or cancel with less that 24 hour notice, you will be charged a fee of up to $50.00. If you need to reschedule your appointment, please try to give us at least 1-2 days notice.

Please feel free to visit our web page at www.houstonsleepcenter.com.

Houston Neurology and Sleep Center
Todd J. Swick, MD, PA

Patient Information Sheet

Referring Physician: ______________________________ **Address:** ______________________

Physician Phone: ______________________________ **Fax:** ______________________

Patient Last Name: ______________________ **First Name:** ________________ **Middle Initial:** ______

SSN #: ____________________ **Date of Birth:** ____________ **Age:** ______ **Male / Female (Married: M S D)**

Telephone #: H (____) ______________ **W (______)** ______________ **Cell (______)** __________

Home Address: ______________________________ **City, State, Zip:** ________________

Your Employer: ______________________________ **Occupation:** ________________

Employer Address: ______________________________ **City, State, Zip:** ________________

Spouse Last Name: ______________________ **First Name:** ________________ **Middle Initial:** ______

SSN #: ______________________ **Date of Birth:** ______________ **Age:** ______

Telephone #: H (____) ______________ **W (______)** ______________ **Cell (______)** __________

Spouse's Employer: ______________________________ **Occupation:** ________________

Employer Address: ______________________________ **City, State, Zip:** ________________

Emergency Contact Name: ______________________________ **Relationship:** ______________

Telephone #: H (____) ______________ **W (______)** ______________ **Cell (______)** __________

Insurance Information: **PPO** **HMO** **POS** **EPO** **Medicare** **Medicaid** **Other:** __________

Primary Insurance Company: ______________________ **Insured Name:** ________________

Telephone #: ____________________ **ID #:** ________________________ **Group #:** __________

Secondary Insurance Company: ______________________ **Insured Name:** ________________

Telephone #: ____________________ **ID #:** ________________________ **Group #:** __________

AUTHORIZATION TO PAY BENEFITS AND RELEASE INFORMATION TO FILE INSURANCE

I hereby authorize Houston Neurology and Sleep Center to receive payment of insurance benefits for the procedures performed and for services provided. I also understand that a photocopy of this authorization can be used and will be valid as my original signature. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Houston Neurology and Sleep Center to release any information to the insurance and or referring physician acquired in the course of my examination or treatment.

______________________________ ______________________________

Signed (Patient / Responsible Party) **Date**

WE NEED A COPY OF YOUR INSURANCE CARDS AND YOUR DRIVER LICENSE. Thank you.

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem Date of onset Treatment Resolved/Current

____
____
____
____

2. List prescription and over-the-counter medications/drugs you are taking or recently have taken:
Name Dosage How often Reason

____
____
____
____
____
____
____

3. Your weight? ______________Your height? _____________
4. Do you smoke? ____________ If yes, how long? _____________ How much? _________/ day
5. Do you drink alcohol? _______ If yes, how long? _____________ How much? ____/ day/wk/mo
6. Do you drink caffeinated beverages (coffee, tea, cola)? _______ How much? ____/ day/wk/mo

General History
1. Have you had any recent problems with your memory or concentration? _____________________
   If yes, explain: ____
   ____
2. Have you noticed any changes in your mood or irritability lately? __________________________
   If yes, explain: ____
   ____
3. Are you having any other problems (e.g. stress, anxiety, or pressures)? ______________________
   If yes, explain: ____
   ____
4. Have you been depressed lately? ____
   If yes, explain: ____
   ____
5. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)?____
   If yes, explain: ____
   ____
6. How did you hear about us? Physician referral/Friend/Web Page/Phone Book
   or advertisement in the ____

INFECTION CONTROL QUESTIONNAIRE

NAME: ____DATE:__________________________________

In order to protect all of our patients, including yourself please review the list below and complete this brief questionnaire.

Have you had yourself or been in contact with anyone that had the below diseases over the past 60 days? ________________yes ________________no. If you answered YES, please circle the ones that you were exposed to. Thank you for your cooperation in completing our Infection Control Questionnaire.

DISEASES USUALLY CONSIDERED REPORTABLE:

- Aids
- Amoebiasis
- Anthrax
- Botulism
- Campyrobactra
- Chancroid
- Chickenpox (Varicella)
- Chlamydia
- Cholera
- Influenza
- Leprosy (Hansen's Disease)
- Leptospirosis
- Lyme's Disease
- Malaria
- Measles (Rubeola)
- Meningitis (Aseptic)
- Meningitis (Bacterial)
- Mumps
- Non-gonococcal Urethritis
- Pertussis (whooping cough)
- Plague
- Poliomyelitis
- Psittacosis (Omithosis)

- Rabies
- Reyes Syndrome
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Salmonella Infections
- Shigellios
- Smallpox
- Syphilis
- Tetanus
- Toxic Shock Syndrome
- Trichinosis
- Tuberculosis

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Sleep Medicine/ Neurology

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, acknowledge that I have read and reviewed a copy of Houston Neurology & Sleep Center's Notice of Privacy Practice. This Notice describes how Houston Neurology & Sleep Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information , and rights I may have regarding my protected health information.

_______________________________________ _______________________

Signature of Patient, or Personal Representative Date

____

If Personal Representative, relationship to Patient

Houston Neurology & Sleep Center

Dear Valued Patient:

Thank you for choosing us to participate in your health care. Our main concern is that you receive the proper and optimal treatment. In order to prevent any misunderstandings and to serve you better, we ask that all patients read and sign our financial policy in addition to completing our patient information form. If you have any questions or concerns about our financial policy, please do not hesitate to contact the office.

PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, AMERICAN EXPRESS, VISA, MASTERCARD, DISCOVER CARD AND PERSONAL CHECKS.

In **special instances**, we may file your insurance for you.

1. We will file your insurance if you are a member of an insurance plan with which we are contracted. We will make every attempt to verify coverage prior to your visit. FIXED COPAYS, DEDUCTIBLES, AND NON-COVERED SERVICES WILL BE COLLECTED AT THE TIME OF CHECK IN. Inability to make payment at the time may require us to reschedule your appointment.

2. MEDICARE PATIENTS: It can be considered Medicare fraud to waive deductibles and co-payments. Therefore, you will be asked to pay these amounts at the time the service is rendered.

3. If your insurance plan requires you to have a referral to see us, it is your responsibility, **not ours**, to ensure that the referral is in our office no later than the day of your appointment. You will need to hand-carry this to us on the day of your appointment, you may also fax us a copy prior to your appointment.

In the event that you arrive in our office without a valid referral, you have the following options:

a. Reschedule your appointment to allow you time to obtain the referral.
b. You may call your physician to obtain the referral. If it can be faxed to us within 30 minutes will we work you into the schedule. Verbal approvals are not sufficient.

c. You can be seen as a **fee-for-service** patient for this visit. If you elect this option, you must pay for our full billed charges at the time of service and your insurance company **will not** reimburse you for this visit.

RETURNED CHECKS will incur a $50.00 fee. The amount of the check plus fee must be paid within ten (10) days of notification via either mail or telephone to prevent further action. **WE DO PROSECUTE THEFT BY CHECK. Payment** will be by money order, cash, or credit card. No partial payments will be accepted. Once a check is returned on your account, we will no longer be able to accept personal checks as payment.

MISSED APPOINTMENTS

Physician appointments are subject to a $50.00 missed appointment charge. These charges are not covered by your insurance company.

ACCOUNTS TURNED OVER FOR COLLECTION

1. Should my account be turned over for collection, I agree to pay any and all applicable collection agency fees in addition to my principle balance.
2. And, if the account is referred for litigation, additional attorney's fees will be accessed in addition to the principal balance.

The collection agency that we use **DOES** report bad debt to the three national credit bureaus. You may also be given notice legally dismissing you from our practice and asked to find another physician.

Situations do occur that result in overpayments on your account. When overpayments are identified your account will be audited to determine if the overpayment was made by you or the insurance company. Overpayments made by the insurance company will be reimbursed directly to them by us. If there is an overpayment due you, our policy is to apply this overpayment to future visits. Refunds will not be processed until the claim has cleared for the dates of service involved. Special situations warranting a refund check will normally be processed approximately 30 days after final verification.

We understand that temporary financial problems may affect your timely payments of your balances. We encourage you to communicate such problems with our office, so that your account can be properly managed. Again, thank you for choosing us as your health provider. We appreciate your trust in us and we look forward to serving you.

______________________________________ _______________

Patient Signature/Responsible Party Signature Date