Ahmad Saeed Ata, M.D.
Greenville Phone # (903) 450-8122

NEUROCARE of TEXAS

Also known as Greenville Neurology Associates

NAME: _____ DOB: _____ AGE: _____ SS#: _____-_____-_____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE (____) _____ - _____ 2nd (____) _____ - _____ WORK (____) _____ - _____

OK TO LEAVE DETAILED MESSAGE? YES _____ NO _____ EMAIL: _____

MALE / FEMALE MARITAL STATUS: MARRIED _____ WIDOWED _____ DIVORCED _____ SINGLE _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: (_____) _____ - _____

PERMISSION TO GIVE CONFIDENCIAL INFORMATION TO EMERGENCY CONTACT: YES NO

MEDICAL HISTORY

___ DIABETES ___ HIGH BLOOD PRESSURE ___ HIGH CHOLESTEROL ___ HEART DISEASE ___ THYROID

OTHER(s): _____

SURGERIES

SPINE SURGERY: YES NO LEVEL(s): _____ HYSTERECTOMY: YES NO YEAR: _____

PACEMAKER/DEFIBRILLATOR: YES NO CARD: _____

PAIN PUMP: YES NO CARD: _____ STIMULATOR: YES NO CARD: _____

BRAIN SURGERY: YES NO TYPE: _____ YEAR: _____ DOCTOR: _____

OTHER(s): _____

PRIMARY CARE DOCTOR: _____ PHONE#: _____

REFERRING DOCTOR: _____ PHONE#: _____

DO YOU HAVE A: CARDIOLOGIST: YES NO DOCTOR: _____ PHONE#: _____

PAIN MANAGEMENT: YES NO DOCTOR: _____ PHONE#: _____

SOCIAL HISTORY

CAFFEINE? _____ HOW MUCH DAY? _____ ***DRINK ALCOHOL?*** _____ HOW OFTEN? _____

CIGARETTES? _____ PAST: _____ HOW MUCH DAY?_____ ***DRUG USE?*** _____ HOW OFTEN? _____

IS ILLNESS OR INJURY WORK RELATED? YES_____ NO_____

PHARMACY

LOCAL PHARMACY: _____ LOCATION: _____ CITY & ZIP: _____

MAIL ORDER: _____

SIGNATURE: _____ DATE: _____

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PATIENT NAME: _____ DATE:_____

MAIN REASON FOR TODAYS VISIT: _____

ARE YOU CLAUSTROPHOBIC? YES ___ NO ___ HISTORY OF KIDNEY DISEASE? YES ___ NO ___

ARE YOU PREGNANT OR CAN YOU BE? YES ___ NO ___ IF YES, DUE DATE: _____/_____/_____

HOW DID YOU HEAR ABOUT US? _____

IDENTIFY ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING

NEURO

___ HEADACHE
___ NECK PAIN
___ BACK PAIN
___ NUMBNESS
WHERE:_____
___ WEAKNESS
WHERE:_____
___ SEIZURES
___ DIZZINESS
___ VERTIGO
___ CONFUSION
___ MEMORY LOSS
___ TREMORS
___ INVOLUNTARY MOVEMENT
___ BLACK OUT SPELLS

VISION

___ DOUBLE VISION
___ BLURRED VISION

PULMONARY

___ DIFFICULTY BREATHING
___ SNORING

GASTRO

___ ABDOMINAL PAIN
___ NAUSEA
___ DIARRHEA

HEMOTOLOGY

___ ABNORMAL BLEEDING
___ ANEMIA
___ BRUISING

CARDIAC

___ CHEST PAIN
___ STROKE
___ IRREGUALR HEART BEAT
___ LEG PAIN/SWELLING

SKIN

___ RASH
___ ITCHING
___ HAIR LOSS

MENTAL

___ DEPRESSION
___ MOOD DEPRESSION
___ ANXIETY
___ LACK OF CONCENTRATION

GENERAL

___ FEVER
___ WEIGHT LOSS 10LBS+
___ WEIGHT GAIN 10LBS-
___ SINUS PAIN
___ COUGH
___ HOARSENESS
___ RINGING IN EARS
___ HEARING LOSS
___ EXCESSIVE DAYTIME SLEEPINESS
___ FATIGUE
___ JOINT PAIN
___ MUSCLE CRAMPS

SIGNATURE: _____ DATE: _____

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Financial Agreement

GUANRANTEE OF PAYMENT:

Medical care has been or will be provided to the patient whose name appears below. I/We both jointly and individually, shall be fully responsible for payment for the patient's bill, based upon the physician's posted charges, which I/We agree are fair and reasonable. The physician may demand full payment of the patient's bill at anytime, but the physician is not required to do so. Even if the physician does not demand immediate payment, your obligation to make such payments remain the same. **I understand that failure to abide to this agreement can result in termination of care from this practice.**

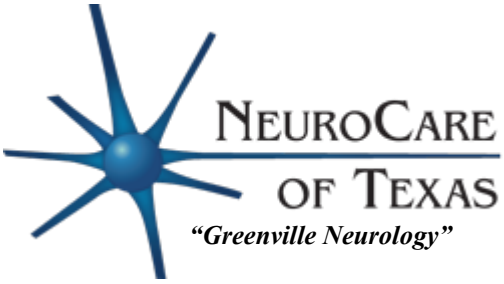
- **____PLEASE INITIAL**
  - You must pay any co-payment or deductible at the time of service, unless other arrangements have been made with our office, prior to your appointment date.
  - The remainder of your bill will be sent to your insurance company for direct payment to our office.
  - If by mistake your insurance company remits this payment to you, please send it to us along with all paperwork sent to you at the time. Please do not send it back to the insurance company, for this will only delay financial payment that you will be required to pay to our office.

Sometimes your insurance company will refuse payment of a claim to us for some of the following reasons:

1) This is a pre-existing illness, which they do not cover.
2) You have not met your full calendar year deductible or it is your coinsurance (percentage you owe).
3) The type of medical service required is not covered by your insurance (Botox/injections).
4) The insurance was not in effect at the time of service.
5) You have other insurance which must be filed first.
6) Your insurance plan changed and you failed to inform our office of such change.

- If your insurance company denies the claim for any of the above reasons, or any other reason, our office cannot be responsible for the bill. It is the responsibility of the patient to pay the amount due to our office in full.
- We charge a flat rate fee of $25 to complete insurance forms for life insurance, disability insurance, and other forms related to your treatment or care, that may be requested by your insurer. **We do request that payment of $25 upfront.**
- If for any reason you cannot keep your appointment with our office, you **must** call to cancel or reschedule within 24hrs of your appointment; if you do not, there will be a $25 no show charge billed to your account and this must be paid before your next appointment.
- I have read and understand my financial obligations and will be fully responsible for payment and all medical services denied by my insurance company.

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** ____/____/_____



A. Saeed Ata, M.D.
Board Certified in Neurology and Neurophysiology (EEG and EMG)

******NOTICE******

Please be advised that our office does not take LOP's (Letter of Protection), under any circumstances. It will be your responsibility and you are held accountable for any unpaid charges that you may have from NeuroCare of Texas. If any charges are processed through your insurance then refunded back to them at anytime, you will be liable for the unpaid charges. We are sorry for any inconvenience this may cause.

Patients Signature **Date**

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4501 Joe Ramsey Blvd Ste. 200
Greenville, Texas 75401

Notice of Privacy Practices Acknowledgement

I understand that, under the *Health Insurance Portability & Accountability Act of 1996 (HIPPA),* I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization, at the address above, at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature of Patient: _____

Date: _____

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4501 Joe Ramsey Blvd. Ste. 200

Greenville, Texas 75401

Phone # (903) 450-8122 Fax # (903) 454-2785

»PLEASE SIGN ONLY«

»DO NOT DATE THIS FORM«

Authorization to Release Protected Health Information

Patient Name: _____ **DOB:** _____

I authorize: _____ **To release to:** _____

Address: _____ **Address:** _____

_____ _____

Phone #: _____ **Phone #:** _____

Fax #: _____ **Fax #:** _____

This information is needed for the purpose of: at the request of the individual_____

Medical Care _____ **Insurance** _____ **Litigation** _____ **Other** _____

Date information needed: _____ ****STAT** _____ **YES** _____ **NO****

Information is to be sent via: Patient to pick-up _____ **Send by mail** _____ **Fax to:** _____

Treatment Dates to be Included: _____ to _____

All marked needs to be included in the sent records:

History and Physical _____ **Discharge Summary** _____ **ER Reports** _____ **Lab Reports** _____

Consultation Reports _____ **Progress Notes** _____**EKG/ECHO** _____ **X-ray/CT/MRI/MRA** _____

EEG/EMG/VNG Reports _____ **Other:** _____

I understand that the information to be released may include information regarding a medical condition which is protected by Federal Law. Unless you indicate otherwise, this information will not be released (if present) to the organization, agency, or individual named on this request.

I, _____, authorize the release of information regarding:

Drug Abuse/Dependence _____ **HIV test results** _____ **Psychiatric Conditions** _____

Alcohol Abuse/Dependence _____ **Hep/HIV/AIDS/ARC infection** _____

I request and authorize that above names health care provider to release the information specified to the organization, agency, or individual name on this request. This authorization is subject to revocation at any time except to the extent that action has been taken and expired 180 days from the date signed. The facility to which this authorization is directed, its employees and authorized representatives are hereby released from legal responsibility or liability for the provision of information as authorized above. I understand that the information that is being released is subject to re-disclosure by the recipient and is no longer protected.

_____	_____	_____
Signature of Patient	**Date**	**Witness Initial**
_____	_____	_____
Signature of Authorized Party	**Date**	**Witness Initial**

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Patient Disclosure

To All Medicare Patients

As of January 1st, 2011, NeuroCare of Texas would like to make you aware of other Imaging Services within 25 miles of our office.

- ***Open Imaging: 3003 Joe Ramsey Blvd. Greenville, Texas 75401 (903) 455-3330***
- ***Lake Pointe Imaging: 4101 Wesley St. F Greenville, Texas 75401 (903) 259-3128***
- ***Hunt Regional: 4001 Ridgecrest Rd. Greenville, Texas 75401 (903) 408-5000***

Patient Signature: _____ ***Date: _____***

NeuroCare of Texas

Dr. Ahmad Saeed Ata
Phone (903) 450-8122
Fax (903) 454-2785

MEDICATION LIST

Name: _____ DOB: _____/_____/_____

- ☐ NKDA or Medication Allergies: _____

Medication Name?	mg?	How do you take it?
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		
11)		
12)		
13)		
14)		
15)		
16)		
17)		
18)		
19)		
20)		