Southlake Neurology and Neurophysiology Clinic, PLLC
321 W. SOUTHLAKE BLVD, SUITE 180 SOUTHLAKE, TX 76092
PH: 817-421-2905 FAX:817-416-7284

New Patient:_____ Hospital/ Follow-up:_____

Patient Information:

PatientName:(Last):_____(First)_____(Middle):_____

Date of Birth:_____ SS#:_____ Marital Status: _____

Address:_____City:_____State:_____Zip code:_____

Home#:_____Cell#:_____Work#:_____Email:_____

Driver's License #:_____Exp. Date: ____State:_____

Occupation:_____Employer:_____

Preferred Contact Method: (circle one): HOME CELL WORK

In order to protect your privacy, let us know if we can leave a voicemail on the following: **Home Cell Work**

Can we leave a message with a person who answers your phone: **YES NO**

Name of referring doctor: _____Phone#_____

Spouse or Guardian (if minor child is patient):

Spouse/GuardianName(Last):_____(First):_____(Middle):_____

Date of Birth:_____SS#_____ Relationship to Patient:_____

Address:_____City:_____State:_____Zipcode:_____

Home#:_____Cell#:_____Work#_____

Is this person also your Emergency Contact? Yes No

- **Is this person authorized to receive information regarding your medical condition or your diagnosis? (treatment, payment, and healthcare operations) Yes No**

If Emergency contact is someone else other than spouse:

Name:_____Phone#:_____Relationship:_____

Name:_____Phone#:_____Relationship:_____

List names of family members or other persons, if any, whom we may inform about your medical condition and diagnosis other than your spouse:

Name:_____Phone#:_____Relationship:_____

Name:_____Phone#:_____Relationship:_____

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Insurance Information:

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME:	INSURANCE NAME:
POLICY ID #:	POLICY ID #:
POLICY GROUP #:	POLICY GROUP #:
POLICY HOLDER NAME:	POLICY HOLDER NAME:
POLICY HOLDER DOB:	POLICY HOLDER DOB:
RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD	RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD
CLAIMS ADDRESS:	CLAIMS ADDRESS:

Consent for Medical Treatment:

I hereby give permission to Southlake Neurology and Neurophysiology Clinic, PLLC its providers and employees for medical treatment for myself or for the patient (if I am the patient's representative, e.g. parent, guardian, or medical power of attorney). I understand that this will involve taking a medical history, performing a physical examination, possibly removing articles of clothing for the examination, forming a clinical impression, making a treatment plan, ordering or performing diagnostic studies, communicating with other persons involved in the medical care, prescribing medications, and ordering medical treatments.

Patient/RepresentativeName:_____Patient/RepresentativeSignature:_____

Acknowledgement of Notice of Privacy Practices:

Federal law requires us to ask you to sign this statement to confirm that we provided you with our Notice of Privacy Practices. Southlake Neurology and Neurophysiology Clinic, PLLC has provided its Notice of Privacy Practices to me.

Patient/RepresentativeName:_____Patient/RepresentativeSignature:_____

Assignment of Benefits:

I hereby assign Medicare, Medicaid, and insurance benefits to Southlake Neurology and Neurophysiology Clinic, PLLC . In the event my insurance does not pay the amount billed or there is a balance on my account, I will be financially responsible for the amount or any other outstanding balance.

Patient/RepresentativeName:_____Patient/RepresentativeSignature:_____Date:_____

NO SHOW/NO CALL OFFICE POLICY:

As a courtesy we ask for our patients to cancel any upcoming appointments within 12 hours. Please be aware that failure to call and cancel within the 12 hours will constitute as a NO SHOW/NO CALL and a fee of $25 will be charged to your account. Same day cancellations will also be considered NO SHOW. A total of three (3) no shows and cancellations will be considered grounds for automatic termination from the practice.

Patient/RepresentativeName:_____Patient/RepresentativeSignature:_____Date:_____