Bellaire Neurology
6700 West Loop South, Ste. 330
Bellaire, TX 77401
Office: (713) 715-6360
Fax: (713) 715-6367
www.BellaireNeurology.com

Brian D. Loftus, M.D.
DrLoftus@BellaireNeurology.com
President, Southern Headache Society
Chief Medical Officer, Better QOL, Inc.
Boarded in Neurology & Headache Medicine

Dear New Patient,
My staff and I would like to welcome you to Bellaire Neurology. I look forward to meeting you at your appointment. If you have questions please call my office at 713-715-6360. Having your forms in our office before your appointment allows my staff ample time to enter your medical history, insurance info, pharmacy info and other data into our computer system before your first appointment with me. By sending your new patient forms in advance, you only need to arrive 15 minutes before your scheduled appointment.

Filling out the Forms:
If you are not seeing me for headache or head pain - you may skip pages 7, 8, and 10. The Virtual Visit form on page 14 is optional unless you plan on doing your first visit virtually. If you are interested in having a virtual visit please let us know so we can make sure this is appropriate for your condition and medical history.

These forms are designed so they may be filled out and signed electronically if you chose to do so. We recommend that you use Adobe Acrobat Reader (or Acrobat Standard if you already have it). Acrobat Reader is a free tool that will allow you to fill out and sign this document. To sign your forms please use the "Fill & Sign" tool within Acrobat Reader - it will enable you to sign in all the required areas. Please save your form frequently as you fill it out so you do not lose any data should you have a computer issue. If you are using a computer (Mac or PC), download Acrobat Reader at https://get.adobe.com/reader/. If using a mobile device (iPhone, Android, iPad or other tablet), download the Adobe Fill & Sign App at https://acrobat.adobe.com/us/en/mobile/fill-sign-pdfs.html.

Once you save the PDF with your electronic signature you will not be able to edit it. Sign the form after you have completely filled everything out. I recommend you save your form unsigned, then do a "Save As" to save a new copy and then begin signing it.

Here are four ways to return the forms.

1. You may email the forms to my medical assistants at Practice@BellaireNeurology.com. Make sure a copy is saved on your computer before emailing it back to us.
2. You can send the forms via encrypted email by visiting https://app.protectedtrust.com/Pickup/bKr3j5nWoLWg
3. You may fax the forms to us at 713-715-6367
4. If time permits you may mail the forms to the address above.

Cancellation and No Show Policy: I spend approximately 40 minutes with new patients. I don't believe in double-booking appointments and my office typically runs on-time. Since I spend so much time with new patients, an extra burden is placed on my staff and other patients when a new patient fails to show for their appointment or cancels/reschedules with less than 2 business days-notice. The appointment usually goes unfilled and this represents a delay to see another patient as well as a financial burden on Bellaire Neurology. Therefore if a new patient fails to show for their first scheduled appointment or cancels/reschedules their appointment with less than two (2) business days' notice, they will need to sign our "No Show/Late Cancellation Policy" and secure their rescheduled appointment with a credit card or deposit.

Patient Portal: We have a patient portal where you can access your lab results, treatment plans and even download your medical records at any time. You can also use our portal to request refills, update your demographic information and send messages directly to me or my staff. You will be given a username and password to the patient portal at check-out after your first appointment. The portal is our preferred way to communicate between appointments.

Your future partner in health,

Brian D. Loftus, M.D.

Bellaire Neurology, PA

6700 West Loop South, Ste. 330 Bellaire, TX 77401 • 713.715.6360 Phone • 713.715.6367 Fax

PATIENT INFORMATION (Section 1)

Name: ______________________

Address: ______________________

City: __________ **State:** ______ **Zip:** ______

Email Address: ______________________

Date Of Birth: __________ **Sex:** Male Female

Social Security Number: ______________________

Home Phone #: __________ **Cell Phone #:** __________

Work Phone #: __________ **Alt Phone #:** __________

Employer: ______________________

Address: ______________________

City: __________ **State:** ______ **Zip:** ______

Drivers License#: __________ **State Of Issue:** __________

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Student: ☐ Yes ☐ No

Retired: ☐ Yes ☐ No

FINANCIAL RESPONSIBILITY (Section 2)

(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

☐ **CHECK HERE IF “SELF” & PROCEED TO SECTION 3**

Name: ______________________

Address: ______________________

City: __________ **State:** ______ **Zip:** ______

Email Address: ______________________

Date Of Birth: __________ **Sex:** ☐ Male ☐ Female

Social Security Number: ______________________

Home Phone #: __________ **Cell Phone #:** __________

Work Phone #: __________ **Alt Phone #:** __________

Employer: ______________________

Address: ______________________

City: __________ **State:** ______ **Zip:** ______

Drivers License#: __________ **State Of Issue:** __________

Relationship:
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other (Enter below)

PHARMACY INFORMATION (Section 3)

Name Of Pharmacy:	Zip Code or Street Address:	Pharmacy Phone:	Pharmacy Fax:

FOR OFFICE USE ONLY:

Appointment Date:__________ Demos Rec’vd On:__________ ☐ Insurance Setup ☐ Patient History Entered

PRIMARY INSURANCE INFORMATION (Section 4)

(PLEASE FILL OUT ALL INSURANCE INFORMATION EVEN IF INSURANCE CARD HAS BEEN ATTACHED)

Insurance Company: ______________________

Claims Address: ______________________

City: ____________ **State:** ________ **Zip:** ________

Phone # for Providers/Eligibility & Benefits: ______________________

Member Number: ______________________

Group Number: ______________________

Relationship to Insured:

- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other: ____________

Insured's Full Name: ______________________

Insured's Social Security No.: ____________ **Insured's Date Of Birth:** ____________

SECONDARY INSURANCE INFORMATION (Section 5)

(PLEASE FILL OUT ALL INSURANCE INFORMATION EVEN IF INSURANCE CARD HAS BEEN ATTACHED)

Insurance Company: ______________________

Claims Address: ______________________

City: ____________ **State:** ________ **Zip:** ________

Phone # for Providers/Eligibility & Benefits: ______________________

Member Number: ______________________

Group Number: ______________________

Relationship to Insured:

- ☐ Self
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other: ____________

Insured's Full Name: ______________________

Insured's Social Security No.: ____________ **Insured's Date Of Birth:** ____________

HOW DID YOU HEAR ABOUT US? (Section 6)

☐ Referred by Physician - Physician's Name: ______________________

Phone: ______________________

Fax: ______________________

☐ Internet Website or Search Engine – Which site did you initially find us on? ____________

☐ Newspaper/Magazine Article Or Ad – Which publication? ____________

☐ Insurance Plan (Check here if you found us through your insurance plan's website or in their provider directory.)

☐ Friend or Family Member: ______________________

☐ Other – Please describe: ______________________

OTHER PHYSICIANS (Section 7)

Physician Name:	Physician Phone:	Physician Fax:

PATIENT HISTORY (Section 8)

Principle reason for seeing Dr. Loftus? ______________________

How long have you had this problem? ______________________

Any other neurological issues? ______________________

Please check either yes or no to the following questions:

	Yes	No
Do you feel excessive fatigue, tiredness, or bad in general?	☐	☐
Have you had a recent change in weight?	☐	☐
Have you had a recent fever?	☐	☐
Do you have headaches?	☐	☐
Do you have double vision or a change in your vision?	☐	☐
Do you have shortness of breath at rest?	☐	☐
Do you have shortness of breath with exercise?	☐	☐
Do you have a regular exercise routine?	☐	☐
Do you have chest pain at rest (not exercise related?)	☐	☐
Do you have chest pain with exercise?	☐	☐
Have you been diagnosed with cardiac disease?	☐	☐
Do you have problems with nausea?	☐	☐
Do you have problems with inability to control stools (incontinence)?	☐	☐
Do you have problems with inability to control urine (incontinence)?	☐	☐
Do you have problems with sexual activity (if currently sexually active)?	☐	☐
Do you have problems with neck pain or arm pain?	☐	☐
Do you have problems with low back pain or leg pain?	☐	☐
Do you feel that you are depressed?	☐	☐
Do you feel that you are overly anxious?	☐	☐
Do you wake up feeling refreshed?	☐	☐
Do you snore?	☐	☐
If female, do you have regular menstrual cycles?	☐	☐
Do you currently smoke or use any tobacco product?	☐	☐
Have you smoked greater than 100 cigarettes in your lifetime?	☐	☐
Have you used, or currently use any illegal substances?	☐	☐

How much alcohol do you typically drink? ______________________

How much caffeine do you typically drink? ______________________

MEDICATION & MEDICATION HISTORY (Section 9)

Current Medications (Attach Another Page If Needed)

Name, Dose and Frequency:	Reason For Medication:	Prescribing Physician:

Drugs <u>Previously</u> Tried For Condition But <u>Not Currently Taking</u> (Attach Another Page If Needed)

Name, Dose and Frequency:	Reason For Stopping:	Prescribing Physician:

Drug Allergies And Adverse Reactions

☐ No Known Drug Allergies

Drug and Dose:	Description of Adverse Reaction:

PAST MEDICAL HISTORY

(Section 10)

(ATTACH ADDITIONAL PAGE IF NEEDED)

Other Medical Conditions:	Date Of Onset:	Treating Physician:

Past Surgeries:	Date Performed:	Operating Physician:

List any diseases that run in your immediate family (Parents, Brother, Sisters, Children):

____

____

____

Does anyone in your immediate or extended family have the same condition or symptoms for which you are seeing Dr. Loftus? If so, who?

____

____

Is there any other information you would like to tell us?

____

____

____

____

HEADACHE HISTORY (Section 11)

Do you have recurrent, separate headaches OR one continuous headache? ______

Age at first significant headache OR if continuous headache, date the continuous headache started? ______

Have you ever seen a neurologist for your headaches? If yes, who? ______

What prompted you to come see to Dr. Loftus? ______

Answer the following for your **most severe headaches**:

What is your headache severity at its worst? ☐ Mild ☐ Moderate ☐ Severe

Describe your headache pain: ☐ Throbbing ☐ Pulsating ☐ Stabbing ☐ Constant ☐ Even

Is your pain primarily on one side of your head? ☐ Yes ☐ No

Does exertion (such as walking up a flight of stairs) make your headache worse? ☐ Yes ☐ No

Does light make your headache worse? ☐ Yes ☐ No

Does noise make your headache worse? ☐ Yes ☐ No

Do certain smells make your headache worse? ☐ Yes ☐ No

Do you have nausea? ☐ Yes ☐ No

Do you vomit with your headaches? ☐ Yes ☐ No If yes, how quickly does it start? ______

How long does your headache pain last? ______

Answer the following for the **last 30 days** or a **typical month**:

How many days were you **headache free**?
(You did not even have a mild headache) ______

How many days did you have a **severe headache**?
(Went to bed/stopped what you were doing for at least part of the day) ______

How many days did you have a **moderate headache**?
(Headache interferes but still able to function, maybe just not as effectively) ______

How many days did you have a **mild headache**?
(Headache is there if you think about it but not interfering) ______

Have you taken any of the following medications **when you have a headache**?

If you currently take the medication, place a ☑ or ☒ in 'Current Med'. If you used to take or tried the medication in the past but aren't taking it now, then place a ☑ or ☒ in the "Took in Past" box. If you never took the medication leave both boxes blank.

FDA Approved Acute Headache Medications	Current Med	Took in Past	Other Medications Commonly Used for Headaches	Current Med	Took in Past
Amerge (naratriptan)	☐	☐	Advil, Aleve, other NSAIDs	☐	☐
Axert (almotriptan)	☐	☐	Aspirin	☐	☐
Frova (frovatriptan)	☐	☐	Tylenol/Excedrin Migraine	☐	☐
Imitrex/Onzetra/Toysmrna (sumatriptan)	☐	☐	Cambia (diclofenac potassium)	☐	☐
Maxalt (rizatriptan)	☐	☐	Torodol IM injection (ketorolac)	☐	☐
Relpax (eletriptan)	☐	☐	Fioricet, Esgic (butalbital)	☐	☐
Zomig (zolmitriptan)	☐	☐	**Other medications taken for a headache**		
DHE IM/SQ injection (dihydroergotamine)	☐	☐		☐	☐
Migranal (Nasal dihydroergotamine)	☐	☐		☐	☐
Nurtec ODT (rimegepant)	☐	☐		☐	☐
Reyvow (lasmiditan)	☐	☐		☐	☐
Ubrelvy (ubrogepant)	☐	☐		☐	☐

Have you taken any of the following medications to **prevent headaches**?	Currently Taking ☑ = Yes ☐ = No	Took in Past ☑ = Yes ☐ = No	Dates Taken (mm/yyyy – mm/yyyy)	Highest **Daily** Dose	Impact medication had on your headaches? (no better, less than 50% better, more than 50% better, more than 75% better)	Adverse Effects or reasons for stopping the medication
ANTIDEPRESSANTS						
Amitriptyline (Elavil, Endep)	☐	☐				
Duloxetine (Cymbalta)	☐	☐				
Desvenlafaxine (Pristiq)	☐	☐				
Milnacipran (Savella)	☐	☐				
Mirtazapine (Remeron)	☐	☐				
Nortriptyline (Pamelor, Aventyl)	☐	☐				
Venlafaxine (Effexor)	☐	☐				
BETA-BLOCKERS						
Atenolol (Tenormin)	☐	☐				
Metoprolol (Lopressor, Toprol)	☐	☐				
Nadolol (Corgard)	☐	☐				
Nebivolol (Bystolic)	☐	☐				
Propranolol (Inderal)	☐	☐				
ARB/ACE/CCB						
Candesartan (Atacand)	☐	☐				
Lisinopril (Zestril, Prinivil, Qbrelis)	☐	☐				
Valsartan (Diovan)	☐	☐				
Verapamil (Calan, Isoptin)	☐	☐				
ANTI-EPILEPTIC/ANTI-CONVULSANT						
Gabapentin (Neurontin)	☐	☐				
Pregabalin (Lyrica)	☐	☐				
Topiramate (Topamax, Qudexy, Trokendi)	☐	☐				
Valproic acid, Divalproex (Depakote)	☐	☐				
Zonisamide (Zonegran)	☐	☐				
INJECTIONS/INFUSIONS						
Aimovig (erenumab)	☐	☐				
Ajovy (fremanezumab)	☐	☐				
Emgality (galcanezumab)	☐	☐				
Vyepti (eptinezumab)	☐	☐				
Botox for Migraine, At least 155 units every 12 weeks	☐	☐				

Patient Name: ______________________________________ Date: ________________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please make a ✓ or X in the appropriate box	**Not at all** *Score: 0*	**Several days** *Score: 1*	**More than half the days** *Score: 2*	**Nearly everyday** *Score: 3*
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless than you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
Add Columns (Office Use Only)				
			Sum of Total Scores	

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people? ***(This question only applies to items 1-9 above only)***

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult

ANXIETY ASSESSMENT (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please make a ✓ or X in the appropriate box	**Not at all** *Score: 0*	**Several days** *Score: 1*	**More than half the days** *Score: 2*	**Nearly everyday** *Score: 3*
10. Feeling nervous, anxious or on edge	☐	☐	☐	☐
11. Not being able to stop or control worrying	☐	☐	☐	☐
12. Worrying too much about different things	☐	☐	☐	☐
13. Trouble relaxing	☐	☐	☐	☐
14. Being so restless that it is hard to sit still	☐	☐	☐	☐
15. Becoming easily annoyed or irritable	☐	☐	☐	☐
16. Feeling afraid as if something awful might happen	☐	☐	☐	☐
Add Columns (Office Use Only)				
			Sum of Total Scores	

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people? ***(This question only applies to questions 10-16 above)***

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult

Patient Name: ____ Date: ________________________

MIGRAINE DISABILITY ASSESSMENT (MIDAS)

This questionnaire is used to determine the level of pain and disability caused by your headaches and helps your doctor find the best treatment for you.

INSTRUCTIONS*:* Please answer the following questions about all your headaches over the last **3 months**. Write your answer- **it must be one number, not a word or a range** - in the box next to each question. Write zero if you did not do the activity in the past **3 months**. If you don't keep a headache calendar, provide your best estimate.

	# of **DAYS**
1. On how many days in the last 3 months did you miss work or school because of your headaches? (If you did not attend work or school enter zero in the box.)	Days
2. How many days in the last 3 months was your productivity at work or school reduced by half or more because of your headaches? *(Do not include days you counted in question 1 where you missed work or school. If you do not attend work or school enter zero in the box.)*	Days
3. On how many days in the last 3 months did you not do household work because of your headaches?	Days
4. How many days in the last 3 months was your productivity in household work reduced by half or more because of your headaches? *(Do not include days counted in question 3, where you did not do household work.)*	Days
5. On how many days in the last 3 months did you miss family, social, or leisure activities because of your headaches?	Days
Total Score (Questions 1-5)	
A. On how many days in the last 3 months did you have a headache? (If headache lasted more than one day, count each day.)	Days
B. On a scale of 0-10, on average, how painful were these headaches? (Where 0=no pain at all, and 10=pain which is as bad as it can be.)	

MIGRAINE TREATMENT EFFICACY QUESTIONNAIRE (mTOQ-4)

This questionnaire is used to determine how well acute medications work when you have a migraine. ***Please answer each question with one of the following responses:***

Never *Rarely*
Less than half the time *Half the time or more*

Please answer the following questions about the medication(s) that you currently use to treat headaches.	***Answer***	*Numerical Score (Office Use)*
6. After taking your migraine medication, are you pain free within 2 hours for most attacks?		
7. Does one dose of your migraine medication usually relieve your headache and keep it away for at least 24 hours?		
8. Are you comfortable enough with your migraine medication to be able to plan your daily activities?		
9. After taking your migraine medication, do you feel in control of your migraines enough so that you feel there will be no disruption to your daily activities?		
	Score:	

Bellaire Neurology, PA

6700 West Loop South, Ste. 330 Bellaire, TX 77401 • 713.715.6360 Phone • 713.715.6367 Fax

PATIENT NAME: ______________________________ **DOB:** ______________________

Treatment Authorization

I authorize Bellaire Neurology, PA to examine, diagnose and treat ______________________ (name of patient). I authorize and give Bellaire Neurology, PA consent to submit specimens (blood, urine, tissue, etc.) to the Quest Diagnostics (or lab of choice) for analysis and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

____ ______________________

SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE

Responsible Party Agreement:

I do hereby acknowledge that I am the guarantor of this account and agree to pay for services rendered, including any supplies or pharmaceuticals that are provided to me in my treatment. If any charges are submitted to my insurance carrier by either Bellaire Neurology, PA or by a provider of healthcare services/products/ equipment which are ordered by my physician for the care of the named patient and these services are not covered medical services. I hereby agree that I am responsible for the payment of any co-payment, deductible and co-insurance and that I agree to make payment for these amounts at the time of service. If I do not have insurance coverage, I agree to pay for services rendered at the time of service.

________ (INITIAL)

Authorization for Release of Information:

I hereby authorize Bellaire Neurology, PA to release any information necessary to my insurance company (ies), including governmental health care insurers (such as Medicare) or other health care practitioners involved in the care of the above-named patient. I understand that I am giving this authorization to determine insurance benefits, for the payment of any claims, in the event of a subpoena or for the release of information necessary for the provision of continuity of care, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care. Dr. Loftus also performs clinical research. You may be contacted by a research coordinator regarding participating in research study. If you do not wish to be contacted about clinical research, please let our office know.

________ (INITIAL)

E-Mail Message & Text Message Authorization:

Bellaire Neurology, PA requires patients to maintain an email account that is checked a minimum of 3 times per week to ensure patients receive notification of new information on their patient portal account. Established patients should contact Dr. Loftus with medical questions through our HIPAA compliant online patient portal. He does not accept direct emails from patients as this is unsecure. You will receive an email notification when you have a message or new information, including lab results, are available for viewing. Bellaire Neurology, PA sends appointment reminders via email and/or cell phone text message. Bellaire Neurology, PA also sends patient satisfaction surveys via email and text messaging no more often than every 6 months. These messages are not encrypted and do not contain any personal medical information.

I agree to supply an email address to receive patient portal notifications, appointment reminders, and confirm my scheduled appointments. I understand if I provide a cell phone number then text message appointment reminders will also be sent. If I do not wish to receive appointment reminder emails I can unsubscribe. I can also opt out of text messages. I will immediately notify Bellaire Neurology if my contact information changes.

________ (INITIAL)

Prescription Benefits and Medication History:

I give consent for Bellaire Neurology to download my prescription benefits and medication history information from Surescripts pharmacy clearinghouse.

________ (INITIAL)

Acknowledgement of Review of Notice of Privacy Practices:

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. It can be downloaded from our website and is attached to emails with our new patient forms.

________ (INITIAL)

Insurance Billing Policy Acknowledgement:

- I agree to inform Bellaire Neurology if I have multiple health insurance policies because both policies may be required for billing purposes. I understand that I cannot choose which insurance will be primary and standard insurance rules will be followed to determine which policy is my primary and secondary insurance.
- I agree notify Bellaire Neurology about any changes to my insurance a minimum of 2 business days before my next appointment. If my insurance changes and Bellaire Neurology is not given at least 2 business days to verify my benefits, I agree to pay Bellaire Neurology's cash pay price(s) and understand I will receive a credit when the claim is processed.
- If I fail to notify Bellaire Neurology prior to my appointment about a change in insurance or about a secondary policy, and it is discovered after the appointment, I agree to pay Bellaire Neurology's cash pay price for services and my claim will not be refiled.

________ (INITIAL)

Acknowledgement of No Show & Late Cancellation Policy:

Patients who "no show" for their scheduled appointments or fail to give two (2) business days notice when canceling/rescheduling their appointments place an extra burden on the staff of Bellaire Neurology, PA. Furthermore, since the appointment goes unfilled, this represents either a delay to see another patient or a financial burden to Bellaire Neurology. Therefore, Bellaire Neurology has implemented the following policy:

- *New Patients who either cancel their first appointment without proper notice or "no show" are required to sign our "No Show/Late Cancellation Agreement" prior to rescheduling and must guarantee their next appointment by providing a credit card or $100 cash/check deposit. The credit card will be validated but a fee will not be incurred.*
- *Established Patients with two or more "no shows" or "late cancellations" within in the last ten (10) visits on Dr. Loftus schedule are required to sign our "Multiple No Show/Late Cancellation Policy" prior to scheduling their next appointment. They must also provide a credit card that will be kept on file or place a $100 deposit on their account. The credit card will be validated but a fee will not be incurred.*
- *Once the "No Show/Late Cancelation Agreement" has been signed, if the new or established patient fails to show for another scheduled appointment or cancels/reschedules an appointment with Dr. Loftus without proper notice, the credit card on file will be charged $100. If a $100 cash/check deposit was left, it will be used, and a new deposit will need to be provided. After 10 visits with Dr. Loftus without any late cancelations or no shows, the agreement will no longer be in effect. If the $100 cash/check deposit was not used, a refund will be issued. It will also be returned upon patient request if the patient is not returning to our office.*

________ (INITIAL) I acknowledge your "Late Cancelation and No Show Policy". I understand I must provide two (2) business day notice when canceling or rescheduling an appointment with Dr. Loftus otherwise the appointment will either be considered a late cancelation or no show.

Prior Authorization and Appeal Policy:

A prior authorization (PA) is a requirement that a physician obtain approval from your health insurance plan to prescribe a specific medication for you. Having to obtain a PA is a technique for minimizing costs, wherein benefits are only paid if the medical care has been pre-approved by your insurance company. PAs used to only be required for very expensive medications but there has been an increase in medications that are requiring prior authorization including some that are generic and cost less than $1 per pill on goodrx.com (without insurance). The frequency of re-authorizations has also increased. Some plans grant approval for 1 year, but others will only approve as little as 3 months at a time.

________ (INITIAL) When a PA is needed, I understand Dr. Loftus now requires an office visit so that he can gather all the relevant data at a single visit. There is also a $25 charge to cover the time for a medical assistant to find the necessary form online, fill it out, and attach the office visit note. Dr. Loftus also reviews the form and answers any unanticipated questions prior to submission.

If my PA is denied by my insurance and requires an appeal for which Dr. Loftus must write a letter of medical necessity or have a phone call with a medical director at my insurance company, I understand there will be an additional $100 charge. If the appeal just entails filling out another form and re-submitting the same information already provided, then there is not an additional charge. Dr. Loftus will consider waiving this $100 appeal fee on case-by-case basis if someone has a financial hardship. I understand Bellaire Neurology will contact me on the patient portal to notify me about the denial and ask for my approval to proceed with an appeal before any work is done. My insurance company will also likely notify me of the denial via mail. I understand I have the option to appeal my denied PAs on my own if I prefer.

Authorized Contacts

Many times, family members will call and ask or give medically related information about the patient. So that we may properly protect your privacy, please indicate with whom we may (or may not) talk to or share medical information about you. If you want to limit what we can share, only check emergency contact. **Existing patients: the contacts specified below will replace any previous authorized contacts*.

Yes	No	Name of Individual(s):	Relationship:	Phone Number:	Emergency Contact	Medical Decisions
☐	☐				☐	☐
☐	☐				☐	☐
☐	☐				☐	☐

My initials next to each section confirm I have read, and understand the information provided in that section. My signature below confirms my authorization and acknowledgement of all sections and policies.

PRINT NAME ____________________ DATE ____________________

SIGNATURE OF PATIENT (OR PATIENT REPRESENTATIVE) ____________________ RELATIONSHIP TO PATIENT (IF APPLICABLE) ____________________

Bellaire Neurology
6700 West Loop South, Ste. 330
Bellaire, TX 77401
Office: (713) 715-6360
Fax: (713) 715-6367
www.BellaireNeurology.com

Brian D. Loftus, M.D.
DrLoftus@BellaireNeurology.com
President, Southern Headache Society
Chief Medical Officer, Better QOL, Inc.
Boarded in Neurology & Headache Medicine

Patient Portal Consent Form

The patient portal can be reached at https://portal.BellaireNeurology.com. Credentials will be assigned after your first appointment. The Texas Medical Board has adopted a list of disclosures required for medical internet sites. The following statements are designed to fully comply with the current TMB requirements on internet medicine.

Bellaire Neurology provides this site for the exclusive use of established patients, to enhance patient - physician communications. All users must be established by an office visit. We strive to keep all the information in your records correct and complete. If you identify a part of your record that is incorrect, you agree to notify us immediately. In addition, by use of this portal you agree to not provide false or misleading information. All portal messages become part of the permanent medical record.

Bellaire Neurology maintains the information on this site. Our mailing address is 6700 West Loop South Ste 330 Bellaire, Texas. For questions about this site you may contact us at 713-715-6360. The site itself is operated by Aprima, Inc, the company that produces our medical software. All the doctors in our group are licensed in the State of Texas.

We provide limited internet based medical services, primarily related to reviewing lab results, medications, and sending our staff messages. We do not provide any emergency services for users of our site. If you have an emergency or other urgent matter you should contact your personal physician by telephone or proceed immediately to an emergency room. For established patients, we have doctors on call for us nights and weekends who may be contacted by calling the office.

The Texas Medical Board requires that we inform you that:

1) All internet communication with our staff is required by the Texas Medical Board to be recorded in your medical record.
2) Staff members other than your physician will be involved in receiving your messages, and routing them to the doctor, nurse, or front desk as necessary.
3) Our hours of operation are 9:00 am – 5:30 pm on Monday thru Thursday and 9:00 am to 5:00 pm on Friday. We encourage you to use the web site at any time, however messages are held for us until we return the next business day. Messages are typically handled within 1 business day. If your doctor is out of the office that day, your request will typically wait until the doctor returns. If you do not get a response within 1 business day, please call our office as necessary.
4) The types of transactions available online are:
   a) Messaging to medical office staff
   b) Review of scheduled appointments
   c) Review of medication list
   d) Update of medical history & contact information
   e) Review of laboratory results
   f) Prescription medication refill requests

Please read our HIPAA Privacy Policy for information on how private health information is handled in our office. For complaints to the Texas Medical Board, contact: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information, the TSBME website is at www.tsbme.state.tx.us

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, as well as any other instructions that my physician may impose to communicate with patients via online communications. I have had a chance to ask any questions that I had and to receive answers. I have been proactive about asking questions related to this consent agreement. All of my questions have been answered and I understand and concur with the information provided in the answers.

By signing below, I acknowledge that I agree to maintain an email account that I check at least three (3) times per week. I understand that I will receive notifications via email that information (i.e. lab results, messages, etc) has been uploaded to my patient portal account that I need to read. I understand that it is a requirement that I use the portal to send non-urgent messages & requests and check my portal account to remain a patient at Bellaire Neurology.

____________________________ SIGNER'S NAME

____________________________ DATE

____________________________ SIGNATURE OF PATIENT (OR PATIENT REPRESENTATIVE)

____________________________ RELATIONSHIP TO PATIENT (If Applicable)

Bellaire Neurology
6700 West Loop South, Ste. 330 Bellaire, TX 77401
713.715.6360 Phone ● 713.715.6367 Fax

Bellaire Neurology Telephone/Virtual Visit Authorization

Bellaire Neurology offers Telephone Visits and Virtual Video Appointments. A virtual visit allows you and Dr. Loftus to see and hear each other during the visit using a mobile device or a webcam and speakers on your computer. Your insurance will probably not cover a phone visit, but they may cover a virtual visit. If you would like your virtual visits filed to your insurance, please let us know by checking the box below. Even if the visit is not covered, you will save on your travel expenses and time. The patient must be in Texas when a virtual visit takes place.

By signing this form, you agree for your credit card to be charged for the telephone or virtual visit fee and other balances on your account. This authorization will be used until you cancel the authorization. Telephone and Virtual visits will take place at scheduled appointment times (Dr. Loftus will try to be prompt). Portal messages and brief phone calls are still provided at no charge at this time. The fees below are after a 20% same day payment discount. Please ensure we always have a valid credit card on file prior to the visit to take advantage of this "same day payment discount". [1]

20-minute Follow-Up Telephone/Virtual Visit (**During Normal Business Hours** M-Th 9am -5pm)	$170
20-minute Follow-Up Telephone/Virtual Visit (**After Hours** – 7-10pm on Wednesday)	$220
40-minute New Patient Virtual Visit (Offered During Normal Business Hours Only-Requires Referral)	$340

Please fill in all your information below and we will keep this on file for future phone & virtual appointments. If you would like to pay by check, we must receive your payment 3 business days prior to the scheduled appointment. Failure to receive a check may cause rescheduling or cancellation of your appointment. Your receipt will be sent to the email address below. Please remember to update the information should your credit card expire or change.

Note: Patients who only want to have telephone visits must be seen in the office at least once every 12 months or have a virtual visit once every 12 months. Patients who have online virtual visits are required to see Dr. Loftus in the office every 24 months. Texas law requires an in-office face-to-face visit for Dr. Loftus to prescribe opioids therefore they cannot be prescribed during a telephone visit or virtual video visit.

Patient Name: ____

Name on Credit Card: ____

Payment Type: ☐ Visa ☐ Master Card ☐ Amex ☐ Discover

If either of the following are applicable, please let us know:

This is a DEBIT Card for a Health Savings Account/Flexible Spending Account ☐ Yes ☐ No

This is a DEBIT card for Checking/Savings Account ☐ Yes ☐ No

Credit Card #: ____

Expiration Date: _____/_____ CVC#: ____________[2]

Billing Address & Zip Code: ____

Email for Receipts: ____

I authorize Bellaire Neurology, PA to charge the amount due. I will keep this card on file until the card expires or I cancel this agreement. I agree to keep this card updated with Bellaire Neurology and understand a same day discount will not be applied if my card cannot be charged on the day of my telephone or virtual visit.

Signature: ______________________________ Date Signed: ______________________

I would like Virtual Visits filed to my insurance. Bellaire Neurology does not file claims for telephone visits and we do not file to HMO plans or Medicare Advantage Plans.

I authorize you to use this card for my No Show/Late Cancel Agreement if I have an active one on file. I understand HSA and Flex Spending Funds may not be used for No Show/Late Cancel Fees under current IRS Guidelines.

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[1] If the credit card on file declines or expires and a valid credit card cannot be charged for your visit, a 20% same day payment discount will not be applied. The billed charges are $212.50 for a Telephone/Virtual Visit during regular business hours, $275 for an after-hours Telephone/Virtual Visit and $425 for a New Patient Virtual Visit during normal office hours.

[2] The CVC is the 3-digit code on back of card or 4 digits on front of American Express Cards

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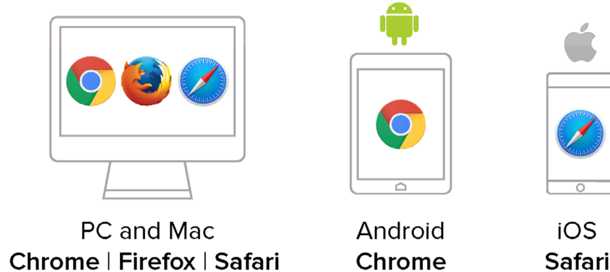
How to check-in for your video visit

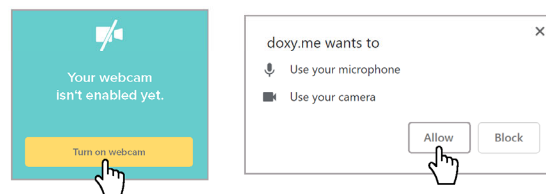
1 Use a computer or device with camera/microphone



2 Enter https://BN.doxy.me/HeadacheDoc in your web browser

3 Type in your name and click check in

4 Allow your browser to use your webcam and microphone



5 Dr. Loftus will start your visit. He is notified that you checked-in and are waiting.

Call Tips

- Have a good internet connection
- Restart your device before the visit
- Use the Start Test button in the waiting room
- Need help? Send us a message https://doxy.me

Powered by doxy.me

Bellaire Neurology, PA

6700 West Loop South, Ste. 330 Bellaire, TX 77401 • 713.715.6360 Phone • 713.715.6367 Fax

Headache Rescue Guidelines

Our office offers headache rescue treatments for patients having acute migraines and frequent cluster headaches. Treatments include a variety of IV push injections, IV infusions, Pericranial Nerve Blocks (PNB), and Sphenopalatine Ganglion Blocks (SPG). You can learn more about these treatments on the Bellaire Neurology website. Not all insurance plans cover every single treatment option but they all typically cover some of them. Your expected financial responsibility will be explained in advance of having any procedure.

Please keep the following guidelines in mind when scheduling a headache rescue or procedure:

- You must call and make an appointment for headache rescue. We are not an urgent care clinic and are not in a position to accept walk-in appointments.
- Morning Rescue Procedures: Patients must arrive by 11 am to receive treatment before we close for lunch at 12:20 pm. If you arrive after 11 am you may have to wait until 1:40 pm when our office reopens after lunch.
- Afternoon Rescue Procedures: Patients must arrive by 4 pm (Monday-Thursday) and 3:30 pm (Friday) to be treated before we close for the evening.
- Some IV infusions (such as haloperidol and solumedrol) require earlier arrival times.
- If you call in the morning, then you will be seen in the afternoon unless Dr. Loftus is not in the office that day or needs to leave at a specific time. If you desire to be treated in the morning, you need to call early and plan to arrive before 11 am. When you do call, please mention that you are calling for “rescue” treatment to help avoid confusion.
- If you are past due to see Dr. Loftus and you need medication refills or to discuss ongoing care, you will need to have an office visit with Dr. Loftus. This may be an abbreviated appointment but you and/or your insurance will be charged for a lower level office visit. (Not typically a level 4 visit which is much more in depth).

Botox/Dysport Treatment Information (If we are obtaining the drug through your specialty pharmacy)

- If we are obtaining your Botox or Dysport from your **specialty pharmacy provider (SPP)**, then you must **schedule your appointment a minimum of 4 weeks before you are due for your treatment** to allow our office time to obtain the drug. We recommend you schedule your next treatment when you check out. If you do not schedule at least 4 weeks before you are due for your next treatment, then your treatment will likely be delayed.
- If we have **not received** your Botox/Dysport from your specialty pharmacy **1 week before your appointment**, your appointment will have to be canceled and will be rescheduled when the drug has arrived. To avoid this, we ask you to do the following:
    1. IMPORTANT: To ensure that your prescription is filled promptly and shipped to our office, you must speak with the Specialty Pharmacy when they call you. They may call from an unidentified phone number. Please answer their call.
    2. Tell your SPP you would like to give your consent to ship the drug to our office for the rest of the year. Ask them to make a note of your consent in your file. Also call our office or send a portal message and tell us you have done this, so we also know you gave consent for the rest of the year. Then when we order the next vial, we can remind the SPP your consent is already on file.
    3. The SPP will want to collect your co-payment for the drug. This may require a credit card. Please consider leaving a credit card on file with your SPP for your future doses of Botox/Dysport later this year. This makes the process go even faster. Please tell our office if you have left a credit card on file with your SPP so we can remind them when we order your drug.
    4. REMEMBER: It is also your responsibility to make sure your Botox/Dysport has arrived at our office 1 week before your appointment. We sometimes must make 4-5 phone calls to get a single dose shipped to our office. You need to take responsibility by being proactive and doing your part to get your drug shipped to our office.

Miscellaneous Fees

- Filling Out Disability Forms: $50 Note: The patient may also need to schedule an appointment with Dr. Loftus for an exam.
- Medical Records: $25 for the first 20 pages and $0.50 for each additional page.
    - Note: Requests for recent office visit notes will be sent to other physicians for no charge as a courtesy but requests for complete charts or extensive records will be charged at the rates listed above. The patient will be responsible for any charges incurred for their medical records.
    - Patients can download a PDF format of their chart from the patient portal, but it will not include scanned attachments. It includes the following: office visit notes, messages, patient history, Rx history, lab results from Quest Diagnostics (but not LabCorp).
- Specialty Pharmacy Coordination Fee: You will be charged a $50 coordination fee per dose for a drug administered in our office when it is obtained from your specialty pharmacy. This fee is to partially cover our expenses related coordinating this service.
- Prior Authorization for Prescription Medication: $25; Appeal of Denied Prior Authorization: $100