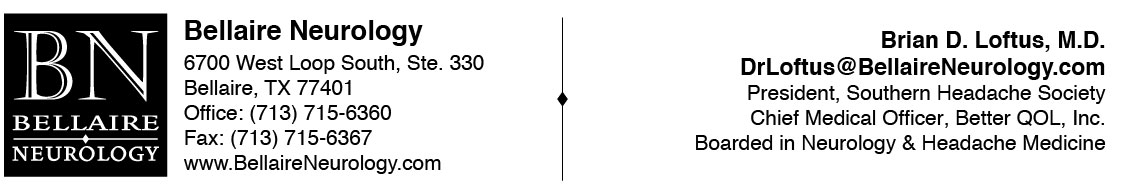
****

Dear New Patient,

My staff and I would like to welcome you to Bellaire Neurology and I look forward to meeting you. If you have questions, please call my office at 713-715-6360.

**New Patient Forms:**

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 having your new patient forms in advance, you only need to arrive 10 to 15 minutes before your scheduled appointment.

**Here are three ways to return the forms.**

1. You may fax the forms to us at 713-715-6367
2. You may email the forms to my medical assistants at [LoftusNurse@BellaireNeurology.com](mailto:LoftusNurse@BellaireNeurology.com).
3. 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 new patient as well as a financial burden on Bellaire Neurology.

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 anytime. 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 when you check-in for your first appointment.

Your future partner in health,

Brian D. Loftus, MD

Boarded in Neurology and Headache Medicine

President, Southern Headache Society

Chief Medical Officer, Better QOL, Inc.

**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:** | |  | | | | | | | | | | | | | | | | | | | | | | |  | **Marital Status:** | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | |  | Married | | | |
| **City:** |  | | | | | | | | | | **State:** | | | | |  | | | **Zip:** | | |  | | |  | Single | | | |
| **Email Address:** | | | | | |  | | | | | | | | | | | | | | | | | | |  | Divorced | | | |
| **Date Of Birth:** | | | | |  | | | | | | | **Sex:**  Male  Female | | | | | | | | | | | | |  | Separated | | | |
| **Social Security Number:** | | | | | | | | |  | | | | | | | | | | | | | | | |  | Widowed | | | |
| **Home Phone #:** | | | | | |  | | | | | | | | | **Cell Phone #:** | | | | | |  | | | | | | | | |
| **Work Phone #:** | | | | | |  | | | | | | | | | **Alt Phone #:** | | | | | |  | | | | | | | | |
| **Employer:** | | | |  | | | | | | | | | | | | | | | | | | | | |  | **Student:** | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | |  | Yes  No | | | |
| **City:** |  | | | | | | | | | | **State:** | | | | |  | | | **Zip:** | | |  | | |  | **Retired:** | | |
| **Drivers License#:** | | | | | | |  | | | | | | **State Of Issue:** | | | | | | |  | | | | |  | Yes  No | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FINANCIAL RESPONSIBILITY** (Section 2) **(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)** | | | | | | | | | | | | | | | | | | | | | |  | | **CHECK HERE IF “SELF” & PROCEED TO SECTION 3** | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | | | | | | | | | | | | | | | | | | | |  | **Relationship:** | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | |  | Spouse | | | |
| **City:** |  | | | | | | | | | | **State:** | | | | |  | | | **Zip:** | | |  | | |  | Parent | | | |
| **Email Address:** | | | | | |  | | | | | | | | | | | | | | | | | | |  | Legal Guardian | | | |
| **Date Of Birth:** | | | | |  | | | | | | | **Sex:**  Male  Female | | | | | | | | | | | | |  | Other (Specify) | | | |
| **Social Security Number:** | | | | | | | | |  | | | | | | | | | | | | | | | |  |  | | | |
| **Home Phone #:** | | | | | |  | | | | | | | | **Cell Phone #:** | | | | | | |  | | | | | | | | |
| **Work Phone #:** | | | | | |  | | | | | | | | **Alt Phone #:** | | | | | | |  | | | | | | | | |
| **Employer:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address:** | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **City:** |  | | | | | | | | | | **State:** | | | | |  | | | | | **Zip:** | |  | | | | | | |
| **Drivers License#:** | | | | | | |  | | | | | | | | | **State Of Issue:** | | | | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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:** | | | |  | | | | | | | | | | | |  | | **Relationship to Insured:** | |
| **Claims Address:** | |  | | | | | | | | | | | | | |  | | Self | |
| **City:** |  | | | | | | | **State:** |  | | **Zip:** | | | |  |  | | Spouse | |
| **Phone # for Providers/Eligibility & Benefits:** | | | | | | | | | |  | | | | | |  | | Parent | |
| **Member Number:** | | |  | | | | | | | | | | | | |  | | Legal Guardian | |
| **Group Number:** | | |  | | | | | | | | | | | | |  | | 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:** | | | |  | | | | | | | | | | | |  | | **Relationship to Insured:** | |
| **Claims Address:** | |  | | | | | | | | | | | | | |  | | Self | |
| **City:** |  | | | | | | | **State:** |  | | **Zip:** | | | |  |  | | Spouse | |
| **Phone # for Providers/Eligibility & Benefits:** | | | | | | | | | |  | | | | | |  | | Parent | |
| **Member Number:** | | |  | | | | | | | | | | | | |  | | Legal Guardian | |
| **Group Number:** | | |  | | | | | | | | | | | | |  | | 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 thru 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) | | | | | | | | | | | | |
| **Principal 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 Previously Tried For Condition But Not Currently Taking (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?** |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | | |

**Bellaire Neurology, PA**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **PATIENT NAME:** |  | | |
| **Treatment Authorization** | | |
|  | | |
| I authorize Bellaire Neurology, PA to examine, diagnose and treat me. (If signed by the patient’s representative - I authorize Bellaire Neurology, PA to examine, diagnose and treat the patient.) I authorize and give Bellaire Neurology, PA consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) 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. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF RESPONSIBLE PARTY DATE | | |
| **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. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE | | |
| **E-Mail Message & Text Message Authorization** | | |
| Bellaire Neurology requires that patients maintain an email account that is checked a minimum of 3 times per week. 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. Lab results are posted to the patient portal account along with a message from Dr. Loftus. You will receive an email notification when lab results are available for viewing. Bellaire Neurology, P.A. sends appointment reminders via email and/or cell phone text message. Bellaire Neurology 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. By signing below, I agree to supply an email address so that I can receive patient portal notifications, appointment reminders, and confirm scheduled appointments. Text message appointment reminders will also be sent to a cell phone if a cell number is provided. If you do not wish to receive text messages, there is an opt out link in the text message. I will immediately notify Bellaire Neurology if my contact information changes. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE | | |
| **Prescription Benefits and Medication History** | | |
| I give consent for Bellaire Neurology to download my prescription benefits and medication history information from Surescripts pharmacy clearinghouse. | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE | | |

|  |
| --- |
| **Insurance Billing Policy Acknowledgement** |
| * I agree to inform Bellaire Neurology about **multiple 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 to keep my insurance information updated at all times and will let Bellaire Neurology know of any changes to my insurances **a minimum of 2 business days before my next appointment.** If my insurance changes and Bellaire Neurology is not given 2 business days to verify my benefits, I agree to pay Bellaire Neurology’s cash pay price(s) and possibly 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, then **I agree to pay Bellaire Neurology’s cash pay price for service and my claim will not be refiled.** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE |
| **Acknowledgement of No Show & Late Cancellation Policy** |
| Patients who fail to show up for their scheduled appointments or fail to give two (2) business days notice when canceling or rescheduling their appointments place an extra burden on the staff of Bellaire Neurology. 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 “no show” or late cancel their first appointment are required to sign our “No Show/Late Cancellation Policy” prior to rescheduling and must guarantee the appointment by providing a credit card or by placing a $100 deposit on their account. A fee is not charged at this time. * Established patients with two (2) or more “no shows“or “late cancellations” in the last ten (10) visits are required to sign our “Multiple No Show/Late Cancellation Policy” prior to scheduling their next appointment. At this time, they must also provide a credit card that will be kept on file or place a $100 deposit on their account. A fee is not charged at this time. * If the patient fails to show for another scheduled appointment or cancels/reschedules an appointment with less than two (2) business days notice, the card on file will be charged $100. If they placed a $100 deposit on their account, it will be used, and a new deposit will need to be provided. If the $100 deposit is not used within 10 visits, then a refund will be issued. It will also be returned upon patient request if they are not returning to our office. |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE |
| **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. | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  SIGNATURE OF PATIENT OR PATIENT REPRESENATIVE DATE | |
|  | |
| **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 whom we may or may not talk to or share medical information about you. Please also list at least one emergency contact.   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Yes** | **No** | **Name of Individual(s):** |  | **Relationship:** |  | **Phone Number:** |  | **Emergency**  **Contact** |  | **Medical Decisions** | |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | | |

|  |
| --- |
| **Bellaire Neurology, PA**  6700 West Loop South, Ste. 330 Bellaire, TX 77401 • 713.715.6360 Phone • 713.715.6367 Fax |

**Clinical Research Trials**

Dr. Loftus does clinical research. There are a lot of exciting new drugs emerging in field of headache and neurology and we want our patients to be able to try them first. He has partnered with the Texas Center for Drug Development (TCDD) to help carry out his research activities. We have a HIPAA agreement with TCDD. A research coordinator from their office may contact you about enrolling in a clinical trial or research study. Please let our office know If you do not want anyone from TCDD to contact you regarding research.

**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, and Sphenopalatine Ganglion Blocks (SPG Blocks). 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 follow guidelines in mind when scheduling a headache rescue procedure:

* You must call and make an appointment for headache rescue. We are not an urgent care clinic and are not able 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 and Dysport Treatment Information**

* 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 it 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 this 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 dose 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 also 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.