PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME: ____________________________ FIRST NAME: _____________________________ MIDDLE: _______________

ADDRESS:_______________________________ CITY:_________________________ ST:____________ ZIP:________________

SEX: ☐ MALE ☐ FEMALE DOB:_____________ AGE:__________ SS#: ______________________

HOME #: ____________________ CELL #:_____________________________________ WORK #: ____________________________

MARTIAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MINOR

EMPLOYER INFORMATION:
NAME:
CITY, ST & ZIP:
PHONE:

REFERRING PHYSICIAN:

DID A PHYSICIAN REFER YOU TO SEE DR. GURRU? ☐ YES ☐ NO REFERRING PHYSICIANS NAME:____________________________

WHAT IS THE REASON FOR YOUR VISIT TODAY? ____

PATIENT INSURANCE INFORMATION:

INSURANCE NAME________________________________ POLICY #: _______________________ GROUP #: _______________

(IF different from the patient)

CARD HOLDER'S NAME: DOB: SS#

SECONDARY INSURANCE INFORMATION:

INSURANCE NAME_____________________________________ POLICY #: __________________ GROUP #: ___________________

(IF different from the patient)

CARD HOLDER'S NAME: DOB: SS#

PHARMACY INFORMATION:

PHARMACY NAME: _____________________________________ PHONE: _________________________ CITY: ___________________

WORKERS' COMPENSATION:

WORK RELATED? ☐ YES ☐ NO

DATE OF INJURY:____________________

LIABILITY: (Please complete this section if your illness/injury results from an accident, auto or otherwise - BUT not work related)

DATE OF ACCIDENT:_________________ INSURANCE NAME:__________________

GUARANTOR -RESPONSIBLE PARTY INFORMATION:

FIRST NAME: ____________________________ MIDDLE: _____________ LAST NAME: __________________________________

SS:_________________________________

RELATIONSHIP:_______________________ DOB_____________ SEX: ☐ MALE ☐ FEMALE

ADDRESS:_______________________________ CITY:_________________________ ST:_____________ ZIP:_________________

EMPLOYER: ____ PHONE #: ___________________________________

ADDRESS: CITY: ST: ZIP:

EMERGENCY CONTACT (If different from above):

NAME: ____ RELATIONSHIP:____

HOME #: CELL #: WORK #:

I, the undersigned, a patient in this office, herby authorize the treating doctor, to administer such treatment as necessary. I agree to pay all charges for me and members of my family, shown by statement ,promptly upon presentation here of, unless credit arrangements have been agreed upon, prior to care. I also herby authorize payment of insurance benefits otherwise payable to me directly, to the doctor. I authorize release of any information concerning my(or my child's) health care, advice provided for the purpose of evaluation claims for insurance benefits.

As a parent of legal guardian, I authorize the treating doctor and whomever he designates as his assistant to administer treatment to this minor child. I am financially responsible for the minor child.WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES. THE BEST HEALTH SERVICES ARE BASED ON FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.

Manoher L. Gurru, M.D., is an investor in Odessa Regional Medical Center and Basin Health Care Hospital. At times, Dr. Gurru refers patients to ORMC and BHC in connection with their care and treatment.

Signature (Patient or Parent of Minor): ____________________________________ **Date:** _______________

ADVANCED NEUROSCIENCE CLINIC, P.A.

MANOHER L. GURRU, M.D.

PO Box 4100, Midland, TX 79704

601 E. 2nd Street, Suite E — **Odessa, TX 79761**

702 Andrews Hwy. — **Midland, TX 79701**

(432) 570-9991 ▪ FAX: (432) 570-9998

MEDICAL RECORD REQUEST FORM

In accordance with the Health Insurance Portability and Accountability Act of 1996 you are giving permission to release Protected Health Information as defined herein. Understanding that this authorization may be re-disclosed to additional parties and will no longer be protected by HIPAA. Further understanding that this may be revoked at any time by contacting the below Medical Records Officer, and that such a revocation does not apply to the extent that persons authorized to use or disclose the health information have already acted in reliance on this authorization.

Name: ______________________________ **Date:** ______________________

Date of Birth: ______________ **SSN:** __________________ **Phone:** ________________

I hereby request and authorize: (Doctor's Name) ______________________________

(Clinic Name) ______________________________

To release my personal medical information to: Manoher L. Gurru, M.D.

Purpose of the Release: ____

Treatment Dates to be Released: ____________________________________
As required by HIPAA any release of Protected Health Information may only be strictly "minimum necessary" except when defined as to date and substance. (Complete Chart is Unacceptable when not defined by date etc.)

<u>Information Requested in the above time period:</u> (please check requested areas)

- ___**Physician Office Notes**
- ___**Lab Reports**
- ___**X-Ray Reports**
- ___**Other Diagnostic Studies**
- ___**Pathology Reports**
- ___**Surgical Reports**
- ___**Consult Notes**
- ___**Physical Therapy Notes**
- ___**Psychiatric Notes** *(see restrictions for release)*
- ___**Billing/Collections**
- ___**Other:** ______________________
  ____

HIV / AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical records.
Initial: **Date:**

In requesting the medical records I understand there maybe fees for preparing and furnishing the information, per TEXAS State Board of Medical Examiners regulations as follows: $25.00 for pages 1-20 and $0.50 per page for each page there after. This will include postage to send if necessary. The request will be completed within 15 business days following full payment of required amount for each record.
I understand this information release is for the specific purpose above and may not be provided in whole or in part to any other agency, organization or person. I understand this correspondence and records from other health care providers will not be released. I may revoke this authorization at any time and this authorization expires 180 days from the date of signature unless otherwise specified.

______________________________ ______________________________
Patient Signature or Legal Representative **Date**

______________________________ ______________________________
Relationship to Patient **Witness**

____
Authorization withdrawn - Signature & Date

Patient's Name:___________________________________ **Advanced Neuroscience Clinic, P. A.**

DOB:_____/_____/_________ Appointment Date:_____/_____/_________ **Nanette Paredes, PA-C / Manoher L. Gurru, M.D.**

HISTORY QUESTIONNAIRE

What are you being seen for today?____
How long have you had this symptom?____
Have you been seen by Dr. Gurru before? Y/N
When_________________________ Where? _____________________ What for? _______________________

Please CIRCLE all that apply:

Headaches	Dizziness	Difficulty Walking	In coordination	Memory Loss	Slurred Speech	Difficulty Swallowing
Blurred/Double Vision	Ringing in Ears	Urinating Urgency/Frequency	Incontinence of Urination/Bowel	Paralysis	Numbness/Tingling	
Neck Pain	Mid/Low Back Pain	Other ______________________________				

Please CIRCLE the symptoms you are having TODAY.

Fever	Weight Gain/Loss	Tiredness	Chest Pain	Palpitations	Cough	Shortness of Breath	Abdominal Pain	Blood in Stool
Nausea/Vomiting	Pain Urinating	Blood in Urine	Frequency/Urgency Urinating	Anxiety	Depression			
Earache	Runny Nose	Nasal Congestion	Sore Throat	Blurred/Double Vision/Vision Loss (R or L)				
Muscle aches	Joint Pain	Snoring	Gasping for Air	Snorting	Daytime Sleepiness	Napping During the Day		
Excessive Thirst/Hunger/Urination	Easy Bruising/Bleeding	Hives	Wheezing	Other ______________________				

During sleep have you been told that you: (CIRCLE all that apply) Snore? Pause in Breathing? Gasp for Air? Choke?
During the day do you: Feel Tired During the Day? Feel Sleepy? Take Naps?

Past Medical History:

Have you **had** or do you **currently have** any of the following? (Please **CIRCLE** all that apply)

Diabetes	Atrial Fibrillation	Seizures/Epilepsy	Migraines/Headache	Stroke/Mini Stroke (TIA)	Parkinson's	
High/Low Thyroid	Asthma	Cancer Where:______	Hepatitis	High Cholesterol	High Blood Pressure	Heart Failure (CHF)
Heart Attack	Hardening or Blockage of Coronary Arteries	Heart Stent	Heart Burn	Stomach Ulcer	Irritable Bowel Syndrome	
Kidney Stones /Kidney Failure/Dialysis	Substance Abuse	Rheumatoid Arthritis	Other: ____________________			

Past Surgeries: Please **CIRCLE** the following Surgeries you have had.

Carotid Artery Surgery (R or L)	Low Back Surgery	Neck Surgery	Carpal Tunnel Surgery (R or L)	Cataract/Glaucoma			
Heart Bypass	Heart Attack	Pacemaker	Defibrillator	Hysterectomy	Appendix	Gall Bladder	Bladder Suspension
Breast Biopsy/Surgery (R or L)	Colon	Prostate	Cesarean Section	Joint Surgery (Hip/Knee/Ankle/Shoulder) (R/L or Both)			
Tonsils/Adenoid	Gastric Bypass	Lap Band	Other: ______________________________				

Social History: **CIRCLE One**

How many years of school have you completed? 5 6 7 8 9 10 11 12 College 1 2 3 4
Employment status: Student Employed Unemployed Retired Legally Disabled
Marital Status: S M D W Number of Children?___________

Have you ever used any of the following?

Substance	Previous Use	Current Use	Amount/Frequency
Alcohol	Y / N	Y / N	Social / Moderate / Heavy
Sodas, coffee, tea	Y / N	Y / N	Social / Moderate / Heavy
Tobacco	Y / N	Y / N	Social / Moderate / Heavy
Illegal Drugs	Y / N	Y / N	

Family History: Please **CIRCLE** the health conditions/diseases that the below relatives have had or currently have.

Father	High Blood Pressure	Diabetes	High Cholesterol	Low Thyroid	Parkinson's	Alzheimer's	Stroke	Seizure/Epilepsy	Other:
Mother	High Blood Pressure	Diabetes	High Cholesterol	Low Thyroid	Parkinson's	Alzheimer's	Stroke	Seizure/Epilepsy	Other:
Siblings	High Blood Pressure	Diabetes	High Cholesterol	Low Thyroid	Parkinson's	Alzheimer's	Stroke	Seizure/Epilepsy	Other:

Continues on Back → **Continues on Back →** **Continues on Back →**

Patient's Name: ___________________________________

<u>Are you allergic to any medications</u>? ____

<u>Current Medications</u>

Please list or bring a list of your current medications including Prescriptions, Over-the-Counter, and Vitamins.

Medication Name	Dose (Mg)	Frequency	Reason

****PLEASE BRING ALL OF YOUR MEDICATIONS IN THEIR ORIGINAL BOTTLES WITH YOU TO YOUR APPOINTMENT!****

<u>Please Do Not Write Below this Line.</u> ____

History	Exam	A/P

AUTHORIZATION TO DISCLOSE INFORMATION TO FAMILY AND/OR OTHER AUTHORIZED INDIVIDUALS

I, ________________________, give authorization to release all my protected health information to the person(s) named below. I understand this office is not responsible for re-disclosure upon release under this authorization. I further understand this authorization is voluntary, and not a requirement for obtaining treatment. However, if not signed, information will only be disclosed to the patient.

1. Name: _________________________________ Relationship to patient:__________________________

   Phone #_________________________________Alternate #___________________________________

2. Name: _________________________________ Relationship to patient:__________________________

   Phone #_________________________________Alternate #___________________________________

3. Name: _________________________________ Relationship to patient:__________________________

   Phone #_________________________________Alternate #___________________________________

☐ I do not give authorization for my protected health information to be released to anyone other than myself

_________________________________ ______________

Signature of patient or patient's Representative Date

____

Representative's Authority

This Authorization is valid until revoked in writing by patient or authorized representative.

___ A copy of this signed Authorization has been given to the patient.

__________ ______________

Date Employee Initial.

Advanced Neuroscience Clinic, P.A.

IMPORTANT PATIENT POLICIES

Financial Policies:

Payment is due at the time of service unless other arrangements have been made in advance.

As a courtesy to our patients, we participate with many of the heath plans. However, you are ultimately responsible for payment of services. Please be aware of your specific plan benefits. If your insurance carrier fails to pay in a timely manner, you will be responsible to pay.

Copays/Deductibles/Past due balances are collected prior to each visit. These will be collected in full prior to seeing the physician. Patients will be rescheduled if balances are not paid in full or prior arrangements are not made for a payment plan.

There will be a $25 charge on all returned checks. All visits thereafter will be on a cash basis only, payable prior to being seen. Returned checks not paid within 10 days will be referred to the District/County Clerk for collection.

Policy Regarding Completion of Forms and Medical Records:

All forms including Disability, FMLA, Drug Assistance, etc. are only accepted during your regular appointment, and completed on the 3rd Friday of the month. There is a $35 charge due prior to completion of these forms. Your insurance company does not cover this fee.

A fee of $25 will apply to medical records requests for the first twenty pages and an additional $0.50 per page thereafter.

Appointment Policies:

As with any medical office, delays may occur due to unforeseen emergency situations. Please be patient with us as we work through these times. The same care and dedication will be given to you during your appointment. We will keep you informed of the anticipated delay time, however please feel free to reschedule your appointment if necessary.

If you are not able to make your scheduled appointment, please provide our office with a 24 hour cancellation notice. Appointments not cancelled within 24 hours will be considered a “No Show”. Patients who “No Show” for a second time will be billed a $25 “No Show” fee that must be paid prior to being re-scheduled. The 3rd “No Show” will result in the patient being discharged from the clinic.

Please allow 3-5 business days for all Lab and Radiology results, including CT, MRI, MRA, etc. Only patients with abnormal results will be routinely notified. Please feel free to contact our office after this time.

Please bring all medications in their original bottles to each visit. Please notify us during your appointment if refills are needed. All other refill requests are handled within 48 hours of receipt by this office. Please keep in mind that we are not open on Saturday and Sunday.

Dr. Gurru is a specialist and does not treat problems not associated with Neurology. Please maintain a primary care physician at all times to evaluate and treat these issues.

Dr. Gurru is an investor in Basin Health Care Hospital and Odessa Regional Medical Center. At times, he refers patients to these hospitals in connection with their care and treatment.

I have read all the above policies and understood clearly.

Date: __________

Patient/Guardian Name: ______________________ Signature: ______________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This practice understands that medical information about you and your health is personal. We are committed to protecting this information. This practice will create a record of care and services you receive as a basis for planning your care and treatment, for communicating with the many healthcare professionals involved in your care, to obtain payment for services provided, as a source of information for public health officials, and to provide you with quality care while complying with certain legal requirements.

By law, this office is required to provide you with our Notice of Privacy Practices. If you should have any questions about this Notice or to submit requests pursuant to this Notice, please contact the Practice Manager at (432) 570-9991. A copy of this Notice is available upon request.

<u>Methods Medical Information may be Used and Disclosed</u>

The following information describes different ways this office may use and disclose your medical information. Although examples are given, it is impossible to list every use or disclosure.

For Treatment We are permitted to use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes coordination or management with other physicians of facilities. For example, the physicians in this practice are specialists. When we provide treatment, we may request information from your referring physician as well as provide information about your diagnosis and treatment so that he may appropriately treat you for other medical conditions.

For Payment We may use and disclose information about you to bill and collect payment for services provided to you from your insurance company, Medicare, you, or other payer. For example, we may need to disclose information about you to a healthy plan in order for the health play to pay for your physician for the services you received. We may also need to inform your health plan about a treatment of procedure you are going to receive in order to obtain prior approval or to determine whether your plan will cover these services.

For Health Care Operations We are permitted to use and disclose medical information about you in order to efficiently operate our office and ensure all patients receive quality care. For example, your medical records or health information may be used to evaluate health care services, and the quality of your treatment. In addition, medical and billing records are audited to ensure we maintain our compliance with federal and state regulations.

Appointment Reminders and Other Health Related Benefits We may use and disclose medical information about you as a reminder of an upcoming appointment, or to inform you of treatment alternatives or other health related benefits. For example, we may provide a reminder of your next appointment by telephone, voicemail/answering machine, or written notice.

Research of Other Qualified Personnel We may use and disclose medical information about you for research or for management audit, financial audit, or program evaluation. You will not be directly or indirectly identified in any report of the research, audit, or evaluation. Your identity will not be disclosed in any manner.

Organ and Tissue Transplants If you have formally indicated your desire to be an organ donor or recipient, we may release medical information to organizations who handle procurement of organ, eye, or tissue transplantation.

Coroners, Medical Examiners, and Funeral Directors We are permitted to release information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release information to funeral directors in order for the director to carry out his duties.

Military, Veterans, and National Security If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may disclose your medical information for specialized governmental functions, authorized national security and intelligence activities, and for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

As Required by Law We will disclose medical information about you when required by federal or Texas law regulations.

Public Health Risks and Health Oversight We may disclose your medical information for public health activities which may include the prevention or control of disease, injury or disability, to report births and deaths, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your information to report reactions to medications or problems with products, or to notify individuals or recalls of product they may be using.

Medical information about you may be disclosed to health oversight agencies for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. They may include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor government programs, eligibility or compliance, and to enforce civil rights and criminal laws.

Abuse or Neglect We will disclose medical information in order to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report the abuse or neglect of elders or the disabled.

Worker's Compensation Medical information about you may be disclosed to provide benefits to you for work-related injuries or illnesses.

Lawsuits and Disputes If you are involved in certain lawsuits or administrative disputes, we are permitted to disclose medical information about you in response to a court order or administrative order.

Law Enforcement If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided the information:

- Is in response to a court order, warrant, or subpoena;
- Pertains to a victim or crime, whether living or deceased, and we are unable to obtain the person's agreement;
- Is released because a crime has occurred on these premises;
- Is released to locate a fugitive, missing person, or suspect.

We may also release medical information about you when necessary to prevent a serious threat to your health and safety, including mental and emotional injury to you, or the health and safety of the public or another person.

Inmates If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional facility or law enforcement official. This release is permitted to allow the institution to provide you the medical treatment, to protect your health or the health and safety of others, or for the safety or security of the correctional facility.

YOUR RIGHTS REGARDING MEDICAL INFORMATION

The U.S. Department of Health and Human Services created regulations intended to protect your rights as a patient as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following are rights regarding your medical information which this office collects and maintains. We will not retaliate against a patient who exercises their rights under the HIPAA.

Right to Request Restrictions You have the right to request a restriction or limitation on the medical information this office uses or discloses about your treatment, payment, health care operations. You also have the right to request a limit on the medical information disclosed to someone who is not involved in your care or the payment for your care. *We are not required to agree to your request*. However, if we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

To request restrictions you must make your request in writing to the Practice Manager. Include the following in your request: (1) what information you want to limit; (2) what kind of restriction you are requesting; (3) to whom the limits apply. For example, you may request we limit disclosure to your spouse, family members or other relatives, or close personal friends who may or may not be involved in your care.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask to be contacted only at work or by mail. This request must be made in writing and submitted to the Practice Manager. We are required to accommodate only reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Inspect and Copy You have the right to inspect and copy medical information that may be used to make decisions about your care. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Practice Manager. We may refuse to provide you with certain information you request to inspect or copy if the information:

- Includes psychotherapy notes;
- Has been complied in anticipation for use in civil, criminal, or administrative proceedings;
- Is subject to or exempt from the Clinical Laboratory Improvements Amendments of 1988;
- Identifies a person whom information was obtained under a promise of confidentiality.

If you request a copy of your medical information, we are permitted to charge a fee. The Texas State Board of Medical Examiners has established these fees for the costs of copying, mailing, or summarizing your records. Texas law requites we provide these copies or a narrative within 15 days of your request. We will inform you of when the records will be ready or if we believe access should be limited or denied. If access is denied, we will notify you in writing of this decision.

We may deny your request to inspect and copy records in certain limited circumstances. If you are denied access to medical information, including psychotherapy notes, you may request this denial be reviewed. Another licensed health care professional who was not involved in the original decision to deny access will perform this review.

Right to Amend You have the right to request and amendment of your medical information for as along as the information is maintained by this office. To request an amendment you must submit you request in writing along with a reason that supports your request to the Practice Manager.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by this office, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by this office;
- Is part of the information you would not be permitted to inspect or copy;
- Is accurate and complete.

We will respond to your request in writing within 60 days. However, if we refuse to allow an amendment, you are permitted to include a statement about the information in a medical record. If your amendment is accepted, we will work with you to notify other designated individuals of this amendment.

Right to an Accounting of Disclosures You have the right to request an accounting of disclosures. This is a list of disclosures made of your medical information for purposes other than treatment, payment, or health care operations, or disclosures made per a signed authorization by you or you representative. Other limitations may apply as well.

You must submit your request in writing to the Practice Manager. The first accounting of disclosures within any 12-month period will be free of charge. We are permitted to charge a reasonable fee for any additional requests within that same period. You will be notified of the cost involved so that you may withdraw or modify you request before any charge is incurred.

Complaints If you believe your privacy rights have been violated, you may file a complaint with the Practice Manager. You may also send written complaints to the Office for Civil Rights, U.S. Department of Health and Human Services. The Office for Civil Rights may be contacted at:

Region VI, Office for Civil Rights
US Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202

Changes to Our Notices This office reserves the right to change our practices, policies, and procedures and to make the new provisions effective for all protected health information we maintain. Should any change be made, a revised Notice of Privacy Practices will be posted in the office, and made available to you upon your request. *This Notice of Privacy Practices is effective June 8, 2009.*

Facility Referral Disclosure: Manoher L. Gurru, M.D., is an investor in Odessa Regional Medical Center and Basin Health Care Hospital. At times, Dr. Gurru refers patients to ORMC and BHC in connection with their care and treatment. If you should have any questions regarding referrals to ORMC or BHC please contact the Practice Manager at (432) 570-9991.

We strive to provide quality health to all our patients.

____________________	____________________	____________
Signature of Patient or Representative	**Relationship/Authority of Representative**	**Date**
____________________	____________	
Witness	**Date**	