HASHWANI NEUROLOGY & NEUROPHYSIOLOGY CLINIC

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Arafat Ali Hashwani, M.D

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Phone: (281) 313-0337 Fax: (281) 980-0321

www.hnnclinic.com

Dear New Patient,

Welcome to Hashwani Neurology & Neurophysiology Clinic (HNNC). We are delighted to have you as our new patient. We extend our sincere thanks for the opportunity to meet your medical health needs.

We look forward to a continued relationship with you. Welcome to our practice!

New Patients:

All new patients must bring, have faxed (281-980-0321), or email (info@hnnclinc.com) all results of any prior tests (lab work, MRI, MRA, CT Scans) that have been performed within the last 12 months, or any imaging pertaining to their visit.

Late Cancellation and No-Show

Our goal is to provide quality individualized medical care in a timely manner. This policy is to bring self awareness to our patients to help reduce late cancellations and no-shows. This policy enables us to better utilize available appointments for patients that are in need of medical care. Late cancellations (less than 24 hours) and no-shows will incur a $50 fee for follow-up appointments and $75 for office testing (EEG, EMG). The charge is not billable to insurance, you will be responsible for payment out of pocket. Please review our Appointment Policy.

Patient Portal:

We provide services for our patients through our patient portal, and we urge you to sign up with our front desk. The patient portal will allow you to access your lab results, update your patient demographic information and send messages to my staff and myself. Please provide our staff with a valid email address so that they can begin the process of signing you up for this service.

Email: _____

Again, welcome to our office!

PATIENT INFORMATION (Section 1)

Name: _____

Date of Birth: _____ **Social Security #:**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Employer: _____ **Work Phone #:** _____

Workman's Comp: ◯ Yes ◯ No **Related to Any Type of Accident:** ◯ Yes ◯ No

Status:

Legal Sex

Language

Race

Marital Statu

FINANCIAL RESPONSIBILITY (Section 2)

(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

☐ **CHECK HERE IF "SELF" & PROCEED TO SECTION 3**

Guarantor Name: _____

Date of Birth: _____ **Sex:** ◯ Male ◯ Female

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____

Relationship:

◯ Spouse
◯ Widowed
◯ Parent
◯ Legal Guardian
◯ Other (Specify)

_____

PRIMARY INSURANCE INFORMATION (Section 3)

Insured Name: _____

Insured ID#: _____

Group/Policy #: _____

Insurance Company: _____

Insured's Date of Birth: _____

Relationship to Insured:

◯ Self
◯ Spouse
◯ Parent
◯ Other: _____

SECONDARY INSURANCE INFORMATION (Section 4)

Insured Name: _____

Insured ID#: _____

Group/Policy #: _____

Insurance Company: _____

Insured's Date of Birth: _____

Relationship to Insured:

◯ Self
◯ Spouse
◯ Parent
◯ Other: _____

Authorized Contacts (Section 5)

To fully protect your privacy, please indicate who we may talk to or share medical information about you. Please also list at least one emergency contact.

Name of Individual(s):	Relationship:	Phone Number:	Emergency Contact	Medical Decisions
			☐	☐
			☐	☐
			☐	☐
			☐	☐

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 CURRENTLY SEEING (Section 7)

Physician Name:	Physician Phone:	Physician Fax:

PHARMACY INFORMATION (Section 8)

Name of Pharmacy:	Pharmacy Address:	Pharmacy Phone:	Pharmacy Fax:

PATIENT HISTORY (Section 9)

Chief complaint for seeing Dr. Hashwani? _____

How long have you had this problem? _____

Any other neurological issues? _____

MEDICATION & MEDICATION HISTORY (Section 10)

Drug Allergies and Adverse Reactions ☐ **No Known Drug Allergies**

Name and Dose:	Description of Adverse Reaction:

Current Medications (Additional space section 17)

Name:	Dosage (e.g. 250 mg):	Frequency (e.g. once a day):	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:

MEDICAL HISTORY (Section 11)

Other Medical Conditions:	Date of Onset:	Treating Physician:

FAMILY HISTORY (Section 12)

List any diseases and the relationship to the family member that run in your immediate family:

Diseases:	Relationships:

SOCIAL HISTORY (Section 13)

1. Are you a current smoker? If yes, how much? _____ ☐ Yes ☐ No
2. Are you a former smoker? If yes, when did you quit? _____ ☐ Yes ☐ No
3. Do you live alone or with others? If with others, whom _____ ☐ Alone ☐ With Others
4. Are you right-handed, left-handed, or both? ☐ Right-handed ☐ Left-handed ☐ Both
5. Do you drink alcohol? If yes, how much? _____ ☐ Yes ☐ No
6. Do you drink caffeine? If yes, how much? _____ ☐ Yes ☐ No
7. Have you used, or currently use any illegal substances? If yes, which ones? ☐ Yes ☐ No
   _____
8. Do you have an advanced directive like living will or power of attorney? ☐ Yes ☐ No
9. If female, are you pregnant? ☐ Yes ☐ No

SURGICAL HISTORY (Section 14)

Past Surgeries:	Date Performed:	Operating Physician:

IMPORTANT MEDICAL QUESTIONS (Section 15)

If you are coming in for EMG/NCS testing, these questions are important to fill out for your own safety!

1. Are you on any blood thinners (e.g. Aspirin, Plavix, Eliquis, Xarelto, Warfarin (Coumadin), Brilinta, etc.)? ☐ ☐ No
2. Do you currently have or had a history of HIV? ☐ ☐ No
3. Do you currently have or had a history of Hepatitis? ☐ ☐ No
4. Do you currently have or had a history of any STDs (Sexually Transmitted Diseases)? ☐ ☐ No

PAST MEDICAL HISTORY (Section 16)

Past Medical Systems No to All ◯

Dizziness/ Vertigo: ◯ Yes ◯ No
Memory Difficulty: ◯ Yes ◯ No
Hyperlipidemia: ◯ Yes ◯ No
Hypertension: ◯ Yes ◯ No
Epilepsy/ Seizures: ◯ Yes ◯ No
Stroke/TIA: ◯ Yes ◯ No
Headaches: ◯ Yes ◯ No

ADDITIONAL INFORMATION (Section 17)

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

REVIEW OF SYSTEMS (Section 18)

Please check either yes or no to the following questions:

Constitutional Symptoms
Fever: ◯ Yes ◯ No

Eyes
Blurred Vision: ◯ Yes ◯ No

ENT
Ringing of the Ears: ◯ Yes ◯ No

Cardiovascular
Chest pain: ◯ Yes ◯ No
Palpitations: ◯ Yes ◯ No

Respiratory
Asthma: ◯ Yes ◯ No

Gastrointestinal
Nausea or vomiting: ◯ Yes ◯ No

Genitourinary
History of kidney stones: ◯ Yes ◯ No

Musculoskeletal
Joint stiffness: ◯ Yes ◯ No
Neck Pain: ◯ Yes ◯ No
Back Pain: ◯ Yes ◯ No

Integumentary (skin)
Rash: ◯ Yes ◯ No

Neurological
Frequent headaches: ◯ Yes ◯ No
Lightheaded or dizzy: ◯ Yes ◯ No
Convulsions or seizures: ◯ Yes ◯ No
Numbness or tingling sensations: ◯ Yes ◯ No
Memory difficulty: ◯ Yes ◯ No

Psychiatric
History of anxiety: ◯ Yes ◯ No
History of depression: ◯ Yes ◯ No

Endocrine
History of diabetes: ◯ Yes ◯ No
History of thyroid disorder: ◯ Yes ◯ No

Hematologic/ Lymphatic
History of anemia: ◯ Yes ◯ No

TREATMENT AUTHORIZATION

PATIENT NAME: _____

_____ INITIAL

I (i.e., ◯ self / ◯ patient representative) authorize HNNC to examine, diagnose, and treat the patient. I authorize and give HNNC consent to order any test needed to treat the patient, such as (but not limited to) EEG, EMG, MRI, MRA, CT scans, etc. and to include diagnosis for submission for payment to the insurance carrier.

E-Mail Message & Text Message Authorization

_____ INITIAL

Established patients should contact Dr. Hashwani with medical questions through our HIPAA compliant online patient portal through Athena Health. Dr. Hashwani does not accept direct emails from patients, as this is unsecure. HNNC sends appointment reminders via phone call and/or cell phone text message. 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. **I will immediately notify HNNC if my contact information changes.**

Insurance Billing Policy Acknowledgement

_____ INITIAL

- I agree to inform HNNC about all of my insurance (insurances) information. I understand that if multiple insurances are involved, I cannot choose which insurance will be primary. Standard insurance rules will be followed to determine primary or secondary insurance order.
- I agree to keep my insurance information always updated and will let HNNC know of any changes to my insurances **a minimum of 5 business days before my next appointment.**
- **If I fail to notify HNNC prior to my appointment about any changes to my insurance status, then I agree to pay HNNC's cash pay price for service, and my claim will not be refiled.**

Acknowledgment of Appointment Policy

_____ INITIAL

If you are unable to attend an appointment, please let us know as soon as possible so that we can assign your time slot to someone else. We ask for at least **two business days'** cancellation notice for all appointments. If you do not do so, we reserve the right to charge the following "late cancellation or no-show fee." Your card on file will be charged the day of your no-show or late cancellation.

*__$50.00__ for an office visit

*__$75.00__ for a diagnostic procedure visit

As a courtesy, we make every effort to call and text to confirm appointments in advance; however, it remains YOUR responsibility to know and to keep your appointment. We realize that emergencies arise and will be considered on an individual basis.

After three no-show appointments/reschedules, the office reserves the right to discharge the patient from the practice or collect payment in advance for future services.

Authorization for Release of Information

_____ INITIAL

I hereby authorize HNNC to release any information necessary to my insurance company/companies, including governmental health care insurers (such as Medicare) or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the case to determine insurance benefits and 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.

☐ By signing below, I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ SIGNATURE OF PATIENT OR REPRESENATIVE

_____ DATE

FINANCIAL POLICY - ACCEPTANCE OF LIABILITY WAIVER

Thank you for choosing Hashwani Neurology and Neurophysiology Clinic as your health care provider. It is our goal to meet patient needs and address patient concerns effectively. Areas of primary concern for all patients are the financial policies of the practice, especially those pertaining to insurance billing and patient payment requirements. We expect our patients to take an active role in their healthcare management, including the area of finances. Upon your arrival, your benefits will be explained to you, to the best of our understanding and you will be asked to authorize a credit on file. In an effort to keep patients informed about such policies, we ask that all patients read and sign a copy of our Financial Policy prior to receiving treatment.

_____ **CREDIT CARDS** are accepted for payment. We accept all major credit cards. I authorize HNNC to store my credit card in a secure electronic format that is PCI-DSS compliant. I understand that my credit card will be kept on file for all future appointments and patient responsible balances.

_____**PAYMENTS** are expected at the time services are rendered. This includes all deductibles, co-insurance, co-payments and any non-covered services. Patients who have an insurance carrier with whom the practice has a valid contract will be responsible for all fees as outlined in the patients' contract agreement. I understand the services rendered may not be covered by my health plan. If it is later determined that my coverage was not active on the day of the service, I will be responsible for the charges.

_____**INSURANCE** is filed for all insurance carriers for whom the practice has a valid contract. The patient is responsible for filing claims for carriers for whom the practice does not have a valid contract. This includes all carriers who are secondary to Medicare. It is the insured's responsibility to verify that the services requested, and the physician is covered by the terms of your insurance plan. If there are any questions, the insured is to call his/ her insurance carrier to confirm coverage. If any services are denied as out of network, not covered by the terms of the policy, policy not in force, not medically necessary, or have a deductible/co-pay issue, the patient or responsible party will be responsible for any unpaid balances.

_____**REFERRALS** are patients responsibility to know if their insurance requires one from their primary care physician and that is up to the patient to obtain the referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

_____**STATEMENTS AND BILLING CORRESPONDENCE** are sent to update you of any pending amounts that have not been covered by your insurance. Please call immediately to speak with billing if you have any questions as your credit card will be charged WITHIN 3 BUSINESS DAY of the statement.

_____**DELINQUENT ACCOUNTS** are placed for collection 90 days from the date of service or from the date of the first billing statement, whichever applies. Patients having financial difficulties are encouraged to discuss them frankly with our billing coordinator before the account becomes delinquent.

_____**REQUESTS FOR MEDICAL RECORDS**: A fee of $10.00 up to 30 pages and after $.50 per page will be incurred. Upon receipt of payment, the requested documentation will be available or can be picked up within 3-5 business days unless otherwise notified. If you are not able to pick up the medical records, we can send them certified mail that will be an additional fee of $10. Medical records requested directly from a medical provider for continuity of care will be faxed at no charge.

_____**FMLA/DISABILITY FORMS/MEDICAL LETTER:** A fee of $25.00 will be due before we start completing any forms. We will NOT complete any WORKERS COMP/MOTOR VEHICLE forms. We will not fill out any forms that require PERMANENT disability. Each form will be assessed prior to any fee as we reserve the right to decline any forms.

I have read the Financial Policy of Hashwani Neurology and Neurophysiology Clinic and understand and agree to adhere to the policies as outlined. I further agree to be responsible for all charges not covered by the terms of my insurance plan or in the case of cosmetic treatments for all charged incurred.

_____ _____

Signature of Responsible Party **Date**

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 uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

1) Treatment, Payment, Health Care Operations

a) Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, your care may require the involvement of a specialist. When we refer you to that physician, we will share some or all of your medical information with that physician to facilitate the delivery of care.

b) Payment
We are permitted to use and disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

c) Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law. We may ask another physician to review this practice's charts and medical records to evaluate our performance so that we may ensure that this practice provides only the best health care.

Other examples are:

2) Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

a) Public Health, Abuse or Neglect, and Health Oversight
We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to 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 medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.
Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.
We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

b) Legal Proceedings and Law Enforcement
We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.
If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:
i) The information is released pursuant to legal process, such as a warrant or subpoena;
ii) The information pertains to a victim of crime and you are incapacitated;
iii) The information pertains to a person who has died under circumstances that may be related to criminal conduct;
iv) The information is about a victim of crime and we are unable to obtain the person's agreement;
v) The information is released because of a crime that has occurred on these premises; or
vi) The information is released to locate a fugitive, missing person, or suspect.

3) We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

a) Workers' Compensation
We may disclose your medical information as required by workers' compensation law.

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

c) Military, National Security and Intelligence Activities, Protection of the President
We may disclose your medical information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

d) Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors
When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

e) Required by Law
We may release your medical information when the disclosure is required by law.

i) Your Rights Under Federal Law-The U. S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

f) Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involved in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

g) Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

h) Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed at the end of this document. We may ask that a narrative of that information be provided rather than
copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to be copied for the following reasons:

i) The information is psychotherapy notes.
ii) The information reveals the identity of a person who provided information under a promise of confidentiality.
iii) The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
iv) The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee for copies.

i) Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

i) The information wasn't created by this practice or the physicians in this practice.
ii) The information is not part of the designated record set.
iii) The information is not available for inspection because of an appropriate denial.
iv) The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the incorrect information.

j) Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

4) Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

5) Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U. S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with the government or us.

6) Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

7) Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Acknowledgment 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.

SIGNATURE OF PATIENT OR REPRESENATIVE **DATE**

Ilene Urquiza Privacy Officer
Hashwani Neurology & Neurophysiology Clinic (HNNC)
2743 Imperia Drive, Suite #105
Sugar Land, TX 77479