DNS

DALLAS NEUROSCIENCE, P.A.

NEW PATIENT PACKET
DR. RICHARD AHN, MD/YONG HE, MD
1001 ROBBIE MINCE WAY
DESOTO, TEXAS 75115
Office: (214) 622-6300 Fax: (214) 622-6309/ (214) 622-6310

Welcome to Dallas Neuroscience, PA
Thank you for choosing DNS for your neurological care.

PHYSICIAN'S NAME:
APPOINTMENT DATE:
APPOINTMENT TIME:

Please arrive 15 minutes prior to your appointment to complete the registration process. When you arrive for your appointment, please check in at the window showing your physician's name.

PLEASE BRING THE FOLLOWING ITEMS TO YOUR APPOINTMENT:

- Completed New patient packet
- Photo Identification
- Update Insurance ID card
- No copies of ID card are accepted
- Your Co-pay, Deductible or co-insurance amount for the specialist office visit will be collected at the time of service.
- Have your referring physician name, phone number and fax number including any recent lab or reports in regard to your office visit.

OFFICE CANCELLATION POLICY:

If for any reason you are unable to make your schedule appointment, please call the office at (214) 622-6300 at least 24 hours prior to your appointment to cancel or reschedule your appointment.

Not showing up for an appointment without prior notice will result in a $25.00 fee due to the office for **NO SHOW** appointments.

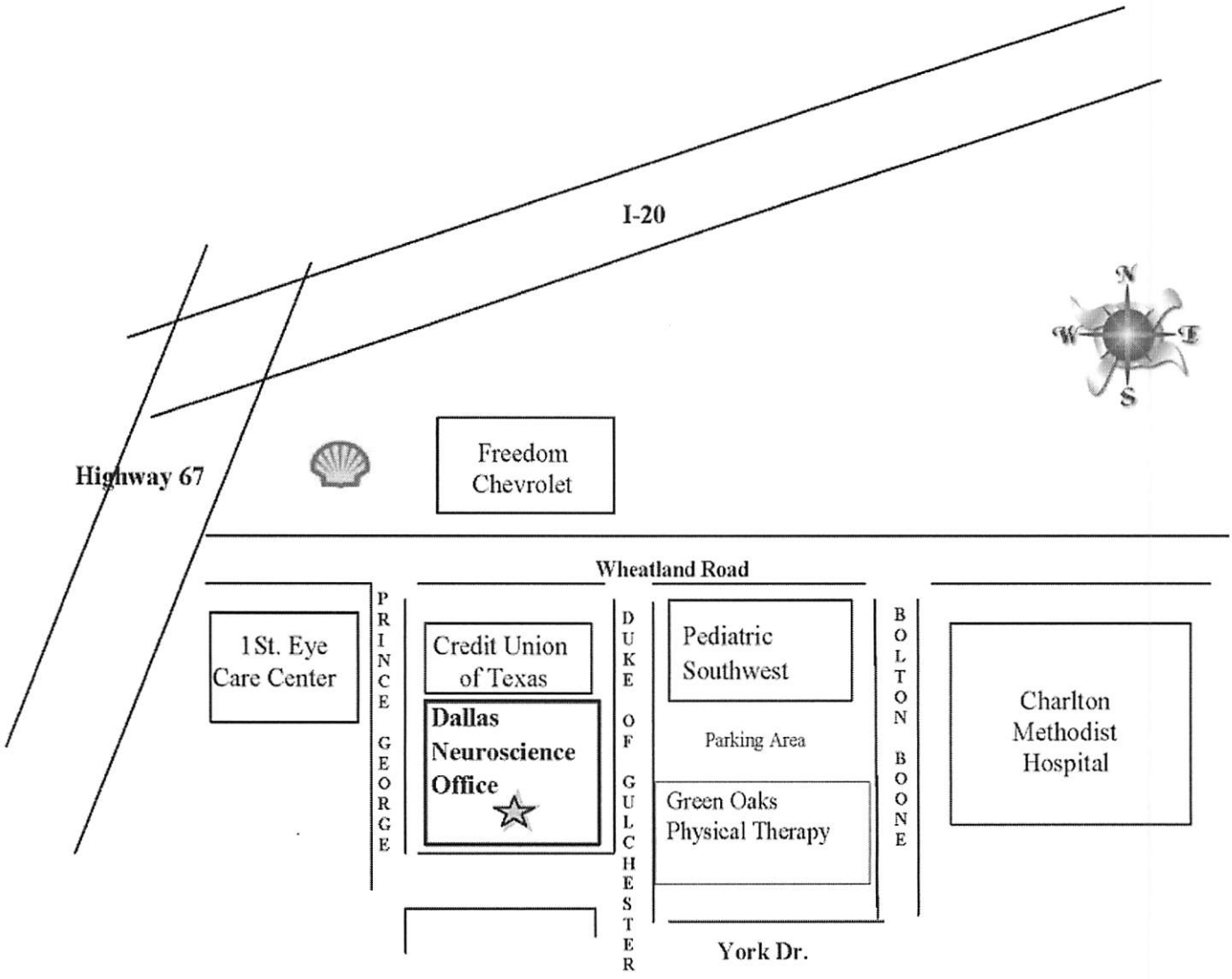
OUR APPOINTMENT POLICY:

All patients must give 24 hours' notice for appointment cancellation and rescheduling your appointment, multiple or 2 consecutive no-show/same day cancellation will result in dismissal from the practice.

DNS

OFFICE LOCATION MAPS: 1001 ROBBIE MINCE WAY, DESOTO, TX 75115

OUR BUILDING HAS A DARK GREEN SHINGLE ROOF, AND WILL SAY "DNS NEUROLOGY" WE ARE DIRECTLY BEHIND THE CREDIT UNION OF TEXAS BANK.



DALLAS NEUROSCIENCE, P.A.

PATIENT INFORMATION FORM

Name (First) _____ (MI)_____ (Last)_____ Date of Birth_____

Street Address_____ Apt #_____ Sex M / F

City_____ State_____ Zip Code_____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____

(Please only list phone numbers where you can be reached)

Contact Preference (circle): Home / Cell For Cell Phones: Consent to TEXT Reminders: Y / N

Social Security #_____ Marital Status S M D W

E-mail _____ Race _____

Are you under the care of a nursing home or inpatient rehab facility? Y/ N ***Preferred Lab Facility** _____
If **YES**, STOP HERE and inform the front desk immediately.

Employer_____ Occupation _____

Referring Physician_____ Phone (_____) _____

Referring Physician Address_____ Fax (_____) _____

Spouse's Name_____ Spouse's Date of Birth_____

Emergency Contact Name _____ Phone (_____) _____

Relationship to Patient _____

Pharmacy _____ Phone (_____) _____

Pharmacy Address / Location_____

PATIENT INSURANCE INFORMATION

Primary Insurance Company_____ Ins. ID # _____

Group #_____ Policy Holder: SELF SPOUSE PARENT

Policy Holder Name_____ Date of Birth _____ SSN_____

Secondary Insurance Company_____ Ins. ID # _____

Group #_____ Policy Holder: SELF SPOUSE PARENT

Policy Holder Name_____ Date of Birth _____ SSN_____

I hereby assign all medical and/or surgical benefits to DNS, P.A. I understand that I am financially responsible for all charges, whether paid or not paid by my insurance company. I also authorize the physician to release any medical information and records, if needed, to assist reimbursement from the insurance company. I authorize DNS, P.A. to provide medical treatment. **We require a 24-hour cancellation/reschedule notice. Not showing up for an appointment without proper notice will result in a $25 fee due to the office before rescheduling. Multiple or consecutive no-shows/same-day cancellations will result in dismissal from the practice. To avoid penalty, please contact the office 24 hours before your scheduled appointment.**

Patient Signature_____ **Date**_____

Responsible Party Signature_____ Date_____

DALLAS NEUROSCIENCE, P.A.
Patient Medical History

Name_____ **Date**_____ **Height**_____ **Weight**_____

Your answers on this form will help your provider understand your medical concerns and conditions better. Best estimates are fine if you cannot remember specific details.

Primary Care Physician – Name/Address/Phone # _____

_____

Your Age_____ How would you rate your general heath? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Hand Dominance (please check): ☐ Right-handed ☐ Left-handed

Present Health Concerns _____

_____

Current Daily Medications (Please include **ALL** medications you take regularly, **including prescribed medication, birth control, supplements and vitamins**):

Medication	Dose	How many times per day	When started

ALLERGIES or Reactions to Medicine: ☐ No known allergies

Medication	Reaction

NAME: _____

Personal Medical History

Please **CIRCLE** any of the following medical problems that you have had, and indicate the year of diagnosis in the field to the left marked "Year." If "Other" please specify in writing.

YEAR	ILLNESS
	Neurological Problems: Stroke – Seizure - Multiple Sclerosis - Sciatica - Headaches - Other:
	Heart Disease: Angina - Heart Attack - Heart Failure - Murmur - Valve Disease - Other:
	High Blood Pressure - High Cholesterol - TIA
	Ulcers - Stomach - Duodenal - Colon
	Diabetes: Type 1 or Type II
	Liver Disease: Hepatitis A - Hepatitis B - Hepatitis C - Cirrhosis - Other:
	Thyroid Problems: Hypothyroid or Hyperthyroid
	Kidney Disease/Failure: Stones – Infection - Dialysis Patient - Other:
	Lung Disease: Asthma - COPD - Cancer - Other:
	Blood Disorders: Anemia - Leukemia - Bleeding Problems - Other:
	Eye Disease: Glaucoma - Blindness - Other:
	Hearing Problems: Deafness - Other:
	Arthritis: Osteoarthritis - Rheumatoid Arthritis - Gout - Other:
	Cancer, Type:
	Psychological Difficulties: Depression - Anxiety - Suicide Attempt - Other:
	Sleeping Problems: Insomnia - Snoring - Sleep Apnea - Daytime Sleepiness - Other:
	Substance Abuse: Alcoholism - Illicit Drug Use - Other:
	Other Major Illnesses / Trauma:

SURGICAL HISTORY

YEAR	SURGERY	YEAR	SURGERY
	Appendectomy		Biopsy (Type & Result):
	Gallbladder		Hernia Repair
	Hysterectomy		Neck (Cervical) Surgery
	Back Surgery (Thoracic or Lumbar)		Prostate Surgery
	Vasectomy		Other:
	Tonsillectomy		

OTHER HOSPITALIZATIONS:

YEAR	REASON

FAMILY HISTORY (Please specify the relation and what side of the family. Ex: Mother, Father, Brother, Sister, Aunt, Uncle, Grandparents): **Not Self**

Medical Condition	Family Member	Medical Condition	Family Member	Medical Condition	Family Member
Alzheimer's		Depression		Seizure	
Anemia		Diabetes		Substance Abuse	
Arthritis		Genetic Disorders		Suicide Attempt	
Asthma		Headaches		Stroke	
Back Problems		Heart Problems		Thyroid Disorder	
Bleeding Disorder		Hearing Problems		Tremors	
High Cholesterol		Kidney Problems		Tuberculosis	
Cancer, Type:		Lung Disease		Other:	
Dementia		Parkinson's			

Check if applies: □ Unknown □ Non-Contributory

NAME: _____

SOCIAL HISTORY

Tobacco Use:

Cigarettes: □ Never; □ Previous, Quit Date _____; □ Current Smoker: Packs per day _____ □ # of Years_____
Other Tobacco: □ Cigars □ Pipe □ Smokeless Tobacco (Snuff or Chew) Age Started _____

Alcohol Use:

Do you drink alcohol? □ No; □ Yes – Please select: □ Beer □ Wine □ Liquor, □ # of drinks per week _____
Alcohol Intake: □ Occasional □ Moderate □Heavy

Drug Use:

Have you used any recreational drugs, ever?
□ Never □ Previously, Please specify: _____ □ Current, Please specify: _____

Sexual Activity:

Are you sexually active? □ Yes □ No □ Not Currently **Are you on birth control medication?** □ Yes □ No
Have you ever had any sexually transmitted diseases or infections? □ No □ Yes, Please specify: _____

OTHER:

Caffeine: □ None; □ Yes – Please select: □ Coffee/Tea _____ cups/day; □ Sodas _____ /day
How would you rate your diet? □ Excellent □ Good □ Fair □ Poor **Do you take supplements?** □ Yes □ No

SOCIOECONOMICS

Occupation: _____ **Employer:** _____
Highest Degree: _____ **Marital Status:** _____
Spouse/Partner's Name: _____ **Number of Children & Ages:** _____
Who lives at home with you? _____

REVIEW OF SYSTEMS (Please select the symptoms you are currently experiencing, or have recently experienced):

Constitutional:
□ Fever, Chills, Sweats
□ Unexplained weight loss, Gain
□ Change in energy, Weakness
□ Excessive thirst or urination
□ Daytime sleepiness
□ Excessive snoring

Eyes:
□ Recent change in vision

Ear, Nose, Throat, Mouth:
□ Difficulty hearing, Ringing in ears
□ Problems with teeth, Gums
□ Difficulty swallowing
□ Hay fever, Allergies

Cardiovascular:
□ Chest pain, Discomfort
□ Palpitations

Respiratory:
□ Cough, Wheeze
□ Difficulty breathing

Gastrointestinal:
□ Abdominal pain
□ Blood in bowel movements
□ Nausea, Vomiting, Diarrhea

Genitourinary:
□ Nighttime urination
□ Incontinence
□ Unusual bleeding
□ Vaginal or Penile Discharge
□ Problems with sexual function

Musculo-Skeletal:
□ Muscle, Joint pain
□ Weakness

Skin:
□ Rash or itch

Neurological:
□ Headaches
□ Dizziness, Light-headedness
□ Numbness, Tingling
□ Memory
□ Loss of coordination

Neurological, cont'd:
□ Seizures
□ Difficulty sleeping
□ Unsteady walking
□ Falling

Psychiatric:
□ Anxiety, stress
□ Depression

Blood, Lymphatic:
□ Unexplained lumps
□ Easy bruising, bleeding

Pain:
□ Currently experiencing pain –
Location of pain (Please also include intensity – Mild, Moderate, or Severe):

_____

_____

Dallas Neuroscience, PA
Dr. Richard Ahn, MD/ Dr. Yong He, MD
1001 Robbie Mince Way
Desoto, TX 75115
Office: 214-622-6300
Fax: 214-622-6310 Fax:214-622-6309

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read, and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions. This notification does not have an expiration dated and will remain in force unless I decide to update or change it.

PATIENT NAME (Please print):_____

DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT (if other than patient):_____

SIGNATURE: _____

DATE: _____

I hereby authorize Dallas Neuroscience, PA to release my personal medical information to the persons listed below. **Please write in *"NONE"* if you do not authorize any other persons to have access to your information.** You may continue on the back if more space is needed.

FULL NAME	**RELATIONSHIP TO PATIENT**	**PHONE NUMBER**

Dr. Richard Ahn, Dr. Yong He
Dallas NeuroScience, PA
FINANCIAL POLICY

Thank you for choosing the offices of Dr. Richard Ahn and Dr. Yong He as your health care provider for neurological services. As part of our professional relationship, it is important you have an understanding of our financial policy.
All patients must read and sign this form before receiving services.

As medical providers, our relationship is with you, the patient, and NOT your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. **It is your responsibility to know and understand the level of services covered by your insurance company.**

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information, your insurance company may deny the claim. **If the claim is denied, you will be financially responsible for the services rendered. That includes office visits, procedures, telemedicine visits and phone calls that are personally returned by the physicians, Dr. Richard Ahn, Dr. Yong He and Rosa Luna, NP.**

Your co-payment, co-insurance, and/or deductible are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, these estimates we receive from your insurance company are estimates alone. You are responsible for paying the full amount determined by your insurance company once they have filed the claim – regardless of the estimation we are given. Please be aware that some or all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.

You must provide us with your most current billing information, including address and telephone numbers. If your information changes, it is your responsibility to provide us with the updated information.

If you have a balance on your account, we will send a statement to you as notification of this balance.
Payment is due in full upon receipt of this statement. If you are not able to pay the balance in full, you must contact our office to discuss a payment schedule. **If you fail to contact our billing office to arrange payment, or do not make payments as agreed upon in your payment schedule, your account may be referred to a professional collection agency. If this occurs, you will no longer be able to receive services from any of the physicians encompassing Dallas NeuroScience, PA until your account is paid in full.**

If you submit payment by check and the bank returns the check unpaid for any reason (e.g. insufficient funds), you will be responsible for a $35.00 returned check charge. This charge must be paid in full plus the amount of the returned check, before any further services will be provided to you. You understand that we will not accept any checks in the future from you; any future payments must be made by cash or credit/debit card.

It is your responsibility to keep your account up to date and not carry a balance. You understand and accept that balances left on your account may affect your ability to see our providers. Failure to keep your account balance current may require us to cancel or reschedule your appointment.

I have read and understand this financial policy. This record of agreement is in effect for the duration of my treatment by these providers.

_____ _____
Patient's Name (Please Print) **Patient's Date of Birth**

_____ _____
Relationship to Patient (if other than patient) **Date**

_____
Signature of Patient or Responsible Party

Dallas NeuroScience, PA

Payment Policy:

I understand that I am required to pay *any* amount my insurance deems my responsibility, including coinsurance, and deductible, at the time services are rendered. If unable to pay at time of service, my appointment may be rescheduled. I am ultimately responsible for my account regardless of insurance. **All patients must read and sign this form before receiving services.**

Charges for Non-Medical Services:

Only **Cash** for these services.

- Medical Records $25
- Billing Records $25
- FMLA Paperwork $30
- Ins Disability Forms(multiple pages) $70
- 1 Page-Disability Form $50
- Disability Parking Placard Form $30
- General Forms $50

All disability forms require a recent office visit and examination within 2 months of the request.

Reminder: If your insurance requires a **referral number**, it is patient's responsibility to acquire one from their primary care physician. **Otherwise, appointment will be rescheduled.**

Appointment Policy: ***We require a 24 hour notice for appointment cancellation/reschedule required* Not showing up for an appointment without proper notice will result in a $25 fee due to the office before rescheduling.***

After **2 *no-shows***, patient will be dismissed from our practice.

Must Provide Insurance Card/Identification for every visit! No Exceptions!*If you do not have your insurance cards with you, your appointment will be rescheduled. **Copies are not accepted!**

Signature_____ **Date**_____

Dr. Richard Ahn, Dr. Yong He
Dallas NeuroScience, PA
1001 Robbie Mince Way, DeSoto, TX 75115
Phone: (214) 622-6300, Fax: (214) 622-6310 (Dr. Ahn) / 6309 (Dr. He)

I, the undersigned patient, hereby affirm that the services received from Dr. Richard Ahn and/or Dr. Yong He will be filed on my medical insurance policy and I will not now, nor in the future, file worker's compensation, an automobile accident claim, or any other accident/injury insurance for **this** service.

If any medical equipment is loaned to me, the undersigned patient or guardian, by Dallas NeuroScience, PA, I agree to return it in the condition it was loaned to me in. Any damage or abuse to the equipment will result in me being held financially responsible for the full cost of the equipment. Additionally, I agree to return any and all equipment loaned to me at the time/date specified by the technician at the time of service. **A $25 per day late fee will be assessed for every day after the agreed-upon date to return the equipment, up to 10 business days (up to $250). After the tenth business day, I understand I will be held responsible for the full cost of the equipment. I understand and agree that any charges due to damage/abuse OR failure to return equipment will be billed directly to me, and that my insurance will not be billed.**

I, the undersigned patient or guardian, hereby affirm that the patient listed below is not under the care of any nursing home facility or inpatient rehab facility at the date of service. If the patient is under the care of a skilled nursing facility, I have informed the office staff of this information.

All patients must read and sign this form before receiving services.

Patient's Name (Please Print)	**Patient's Date of Birth**
Relationship to Patient (If other than patient)	**Date**
Signature	