Austin Epilepsy Care Center Phone: 512-339-8831 Fax: 512-339-8841

We look forward to meeting you. The attached documents can be printed out for you to complete. Please bring these completed forms with you to your initial appointment.. Please review these forms and complete them carefully. All demographic information and insurance information is required for your initial visit. Please sign and date where indicated.

Please bring your insurance card(s), picture ID and visit payment as required by your insurance.

Please contact your insurance company prior to your appointment to confirm we are listed as a preferred provider on your insurance plans and if a referral is required to see a specialist. (If you have medicare we are providers and a referral is not required.)

Please bring a current list of your medications including dosage information.

Parking information for our office and address information: Our office is located at 2200 Park Bend Drive Bldg 2 Ste 203 Austin, Texas 78758 We are in the Post Oak Centre North Buildings by the St. David's North Austin Medical Center

Parking is free around the building. The parking garage is designated for physicians and staff only. Please do not park under the building as towing is enforced. There are handicap parking spots in the front and the back of the building with one space in the parking garage. The elevator is accessible through the front door and through the parking garage.

AUSTIN EPILEPSY CARE CENTER

Today's Date:	Date of first symptom if known:				
Patient Name: First: MI: Last:	Sex: M F Birth date: Age:				
Address: Apt#	Patient Social Security Number:				
City / Town: State: Zip:	Home Phone: Cell Phone:				
Marital Status: Email Address:	Work Phone: Ext:				
Referring Physician Name /Phone:	For data purposes only, please check one of the following or choose:				
Primary Care Physician Name/Phone:	I choose not to report Race: Asian Native Hawiian: White Hispanic Black or African AmericanOther				
Would you like a copy of your records to go to your Primary? Yes: No:	Ethnicity: Hispanic or Latino Not Hispanic or Latino				
	Primary Language: English Spanish Other:				
Please list any family members, including spouse, parents or friends you authorize us to discuss your personal health information with and list their relationship to you:	Employer name and address: Occupation:				
	Student Status: Full time Part time:				
May we leave medical information on your home phone? _	cell phone? work phone? :				
Emergency Contact person :	Relationship:				
Phone: Address:					
Medical Power or Advanced Directive :					
PRIMARY INSURANCE:	SECONDARY INSURANCE:				
Ins. Carrier:	Ins. Carrier:				
Cardholder's Name:	Cardholder's Name:				
Relationship to Patient:	Relationship to Patient:				
Cardholder's Birthdate:	Cardholder's Birthdate:				
Insured's Address if different than patient:	Insured's Address if different than patient:				
Cardholder's Employer:	Cardholder's Employer:				
	are Center and confirms that the information listed in my medical weledge. I also confirm my insurance listed is effective for services				

Patient / Parent Signature: ______Date: _____

Patient Name: DOB:

Please litted at currout medications, including over the counter preparations, you have taken recently. Please litted at low many mg per done and how many those per day or supply its with your own written list. Please note if Brand Name only or Generic. Dog Allergies (if so, describe type of reaction) Does assysted in your family have any of the following?		ent Name:					DOR	•		
Please indicate how many mg per dose and how many doses per day or supply as with your own written list. Please note if Brand Name only or Generic. Dosg Allergies (if so, describe type of reaction)	Please in	ndicate reason for your	appointme	nt						
Please indicate how many mg per dose and how many doses per day or supply us with your own written list. Please note if Brand Name only or Generic. Dosg Allergies (if so, describe type of reaction)	Please li	ist all current medica	tions, inclu	ding over the counter	r prepar	ations, you have taken	recently.			
No known drug allergies								list. Please note if	Brand Na	ame only or Generic.
No known drug allergies										
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No known drug allergies	Drug Al	lergies (if so, describe	type of read	ction)		Does anyone in your fa	milv have a	nv of the following?		
Any medical conditions/illnesses? Any surgeries, hospitulizations? Any surgeries, hospitulizations? Any precent X-rays or other tests? Beleafing disorder Arrhoits Boyou smoke? How much? Do you sure recreational drugs? Do you carerise? How much? Do you pregnant? Yes No Pharmacy name and phone # Count of last menses: Could you be pregnant? Yes No Pharmacy name and phone # Could you be pregnant? Yes No Pharmacy name and phone # Counter that we will be the pregnant of the	_	-		,					g, childrer	n, etc.)
Any surgeries, hospitalizations? Any surgeries, hospitalizations? Any surgeries, hospitalizations? Any recent X-rays or other tests? Do you smoke? How much? Do you use recreational drugs? Do you smoke? How much? Do you exercise? How much? Do you exercise? How much? Do you exercise? How much? Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Date of last mease: Could you be pregnant? Yes_No_ Age of mother father (if deceased, state cause) Age of mother father	No knov	vn drug allergies				Heart disease		Stroke		
Any surgeries, hospitalizations? Any recent X-rays or other tests? Any recent X-rays or other tests? Any recent X-rays or other tests? Do you use recreational drugs? Do you use recreational drugs? Do you use recreational drugs? Do you exercise? How much? Do you exercise? How much? Do you exercise? How mach? Do you exercise? How mach? Age of mother	Any med	dical conditions/illness	ses?				Blood Pressu		7	
Arthritis Sensory disorder Bleeding disorder Incoordination (Aldney disease Staking Thyroid disease Scarges Headaches Attention deficit/hyperactivity Neuromuscular Disease Brain tumors Headaches Alcoholism Mental filmes Neuromuscular Disease Could you be pregnant? Yes No Pharmacy name and phone # Comments:	A my , gram	namina haamitaligationa	.9							
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Date of last menses: Could you be pregnant? Yes No Pharmacy name and phone # Comments: Age of mother father	Do you	use recreational drugs?	?							
Date of last menses: Could you be pregnant? Yes_No_ Pharmacy name and phone # Mail order Pharmacy name and phone#: Are you right handed or left?	Do you	exercise? How much?	,			Attention deficit/hypo	eractivity	Neurom	uscular D	risease
Could you be pregnant? Yes_ No_	D									
Pharmacy name and phone # Comments: Comments:			No			Age of mother	father _	(if deceased,	, state cau	se)
Mail order Pharmacy name and phone#:										
REVIEW OF SYSTEMS - GENERAL Have you recently experienced any of the following? (please use the back of this page to elaborate when pertinent) Y N Ear / Nose / Throat Y N Skin problem Y N Prostate Problems Y N Sleepiness/Sedati N N High Blood Pressure on the problems Y N Difficulty Y N Heart Attack Seleping Y N Anxiety Y N Heart Attack Seleping Y N Anxiety Y N Pacemaker Y N Allergies Y N Problems Y N Difficulty Y N Pacemaker Y N Anxiety Y N Pacemaker Y N Sore throat Ulcers Y N Neck/low back Pain	Pharma	cy name and phone #	<i>‡</i>			Comments:				
REVIEW OF SYSTEMS – GENERAL Have you recently experienced any of the following? (please use the back of this page to elaborate when pertinent) Y N	Mail or	der Pharmacy name	and phone	#:						
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Y N Shortness of breath brea	$Y \mid N$		Y N	Skin problem	Y N	Prostate Problems	Y N	-	Y N	High Blood Pressure
breath Y N Ashma Y N Hepatitis Y N Joint pain Y N Anxiety Y N Pacemaker	Y N		Y N	Fevers	Y N	Sexual problems	Y N		Y N	Heart Attack
Y N Allergies Y N Problems w/ urination Y N Bone problems Y N Depression Y N Chest pain Y N Sore throat Ulcers Y N Neck/low back pain Y N TB Y N Palpitations Y N Earache Y N Blood in stools Y N Shooting pain/sciatica Y N Abdominal Pain Y N Constipation Y N Muscle pain Y N Anemia Y N Change in appetite Y N Cough Y N Diarrhea Y N Teeth Y N Blood Disorders Y N Black or tarry stools Y N Shaking Y N Other Y N Personality changes (please use the back of this page to elaborate when pertinent) REVIEW OF SYSTEMS – NEUROLOGIC Have you recently experienced any of the following? (please use the back of this page to elaborate when pertinent) Y N Dizziness or vertigo Y N Personality changes Y N Difficulty w/ speech Y N Spells Y N Syncope/blackouts Y N Y N Agitation or confusion Y N Numbness or tingling	***		37.137	**	***		37.137		37.137	D 1
Ulcers Y N Neck/low back pain Y N TB Y N Palpitations	Y N	Asthma	Y N	Hepatitis	Y N	Joint pain	Y N	Anxiety	Y N	Pacemaker
Y N Sore throat Ulcers Y N Neck/low back pain Y N TB Y N Palpitations Y N Earache Y N Blood in stools Y N Shooting pain/sciatica Y N Abdominal Pain Y N Constipation Y N Muscle pain Y N Anemia Y N Weight loss Y N Cough Y N Diarrhea Y N Teeth Y N Blood Disorders Y N Black or tarry stools Y N Shaking Y N Other Teeth Y N Blood Disorders Y N Black or tarry stools Y N Headaches Y N Change in mental acuity Changes Y N Dizziness or vertigo Y N Memory problems Y N Hallucinations Y N Double Vision Y N Visual changes Y N Amaurosis-sudden Loss of vision Y N Agitation or confusion Y N Numbness or tingling or confusion Y N Nausea/vomiting Y N Drooling Y N Difficulty Wallowing / Chewing Y N Difficulty Tasting Y N Ringing in ears Y N Decreased Hearing Y N Distributed Y N Stiffness or slowness Y N Difficulty Tasting Y N Seizures Y N Nounthinence N N Nounthinence N	$Y \mid N$	Allergies	Y N		Y N	Bone problems	Y N	Depression	$Y \mid N$	Chest pain
Y N Earache Y N Blood in stools Y N Shooting pain/sciatica Y N Bleeding/bruising pain/sciatica Y N Change in appetite Y N Abdominal Pain Y N Constipation Y N Muscle pain Y N Anemia Y N Weight loss Y N Cough Y N Diarrhea Y N Teeth Y N Blood Disorders Y N Black or tarry stools Y N Shaking Y N Other Teeth Y N Blood Disorders Y N Black or tarry stools REVIEW OF SYSTEMS - NEUROLOGIC Have you recently experienced any of the following? (please use the back of this page to elaborate when pertinent) Y N Headaches Y N Change in mental acuity Y N Personality Y N Difficulty w/ speech Y N Speech Y N Dizziness or vertigo Y N Memory problems Y N Hallucianos Y N Double Vision Y N Visual changes Y N Syncope/blackouts Y N Agitation or confusion Y N Numbness or tringing Y N Numbness or tri	VIN	Sora throat			VIN	Nack/low back	VIN	TR	VIN	Palnitations
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Reviewed MD Signature Date:				Dowel		Diauder				
Reviewed MD Signature Date:										
	Revie	wed MD Signa	ature _				Date:_			_

Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below.

HIV/AIDS: I consent to the release of any positive or negative infection, antibodies to AIDS, or infection with any other causal									
of my medical records. Initial:Date:									
Release my protected health information to the following personal states of the following personal states are not as a second state of the following personal states are not as a second state of the following personal states are not as a second state of the following personal states are not as a second state of the following personal states are not as a second state of the following personal states are not as a second state of the following personal states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the following person states are not as a second state of the second states are not as a second state of the following person states are not as a second state of the second states are not as a second state of the second states are not as a second state of the second states are not as a second state of the second states are not as a second state of the second states are not as a second state of the second states are not as a second state of t	son(s)/entity:								
Name: Austin Epilepsy Care Center									
Address: 2200 Park Bend Drive Bldg 2 Suite 203 Austin, T	Cexas 78758								
Phone: 512/339-8831 Fascimile: 512/339-8841									
The reasons or purposes for this release of information are as follows:									
Continued Medical Care									
Printed name of patient	DOB:								
Patient signature (or parent, guardian or legal representative): Date:								
I understand that you will provide this information within 15 for preparing and furnishing this information may be charge State Board of Medical Examiners.	·								
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Acknowledgement of Review of Notice of Privacy Practice of Privacy	actices:								
I have been informed of this office's Notice of Privacy I information will be used and disclosed. I understand my dentitled to receive a copy of this document.	, <u> </u>								
Patient signature (or parent, guardian or legal representative): Date:								
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AUSTIN EPILEPSY CARE CENTER

Consent/Patient Financial/Prescription Policy Sheet

We are dedicated to providing the best possible care and service. We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. If you have any questions regarding these policies, please discuss them with our office manager.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept cash, checks, MC, Visa or Discover. A fee of \$40 is charged for returned checks. Any late payments or collections accounts are subject to interest charges and collection fees.

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment/coinsurance/deductibles at the time of service. Our policy is to collect this amount when you arrive for your appointment.
- Our office does not accept third party agreements for payment of services, nor do we file auto insurance or workers compensation claims.
- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send any payment directly to you. Consequently, the charges for your care and treatment are due prior to services being rendered.
- In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services AECC provides in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.
- All minor patients (under 18 years of age) are to be accompanied by an adult to all visits. The adult accompanying the patient is responsible for payment at the time of service.
- There is a \$25 fee for any additional paperwork or forms you request to be completed by our office or physicians. This is due prior to completion of any paperwork. Please allow 5-10 business days for completion after payment is made.

My signature below authorizes payment to be made directly to Austin Epilepsy Care Center by my insurance company, including Medicare, and I authorize the release of my medical information to my insurance carriers for processing of any claims related to services rendered by any healthcare provider for AECC. My signature also authorizes AECC to view my prescription history from external sources and to file prescriptions electronically. By signing this form I consent and authorize my healthcare provider or designees with AECC to examine and treat me.

I have read and understand the financial policy of the practice, and I agree to these terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of the Patient		
Signature of Patient or Responsible Party if a Minor	Date:	