Austin Epilepsy Care Center

Sami Aboumatar, M.D.
Jeanne Beattie, M.D.
Daniel Schere, M.D.
Diego Tovar Quiroga, M.D.
Phone: 512-339-8831 Fax: 512-339-8841
www.austinepilepsy.com

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

Parking information
North office location: 2200 Park Bend Dr Bldg 2 Ste 203 Austin, TX 78758
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.

South office location: 4316 James Casey St Bldg E Ste 201 Austin, TX 78745
Parking is free around the building. Parking spots with Suite 201 are open to our patients as are spots that do not have reserved suite numbers. There are handicap parking spots in the front of the building. The elevator is accessible through the front door.

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: Primary Care Physician Name/Phone: Would you like a copy of your records to go to your Primary? Yes: _____ No:_____	**For data purposes only, please check one of the following or choose:** **I choose not to report ____** **Race:** Asian __ Native Hawiian: __ White __ Hispanic __ Black or African American __Other __ **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:

Ins. Carrier: _____

Cardholder's Name: _____

Relationship to Patient: _____

Cardholder's Birthdate: _____

Insured's Address if different than patient:

_____

Cardholder's Employer: _____

SECONDARY INSURANCE:

Ins. Carrier: _____

Cardholder's Name: _____

Relationship to Patient: _____

Cardholder's Birthdate: _____

Insured's Address if different than patient:

_____

Cardholder's Employer: _____

My signature below is consent to treatment by Austin Epilepsy Care Center and confirms that the information listed in my medical and financial file today is accurate and true to the best of my knowledge. I also confirm my insurance listed is effective for services and I understand to assure accurate records, I will update any of this information when necessary.

Patient / Parent Signature: _____Date: _____

Patient Name: DOB:

Please indicate reason for your appointment

Please list all current medications, including over the counter preparations, you have taken recently.
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.

Drug Allergies (if so, describe type of reaction)

No known drug allergies _____

Any medical conditions/illnesses?

Any surgeries, hospitalizations?

Any recent X-rays or other tests?

Do you smoke? How much?

Do you use recreational drugs?

Do you exercise? How much?

Date of last menses:
Could you be pregnant? Yes __ No __

Pharmacy name and phone #

Mail order Pharmacy name and phone#:

Does anyone in your family have any of the following?
If so, specify which family member (e.g. mother, sibling, children, etc.)

Heart disease	Stroke
Hypertension (High Blood Pressure)	Epilepsy
Diabetes	Dementia
Cancer (what organ)	Muscle disorder
Arthritis	Sensory disorder
Bleeding disorder	Incoordination
Kidney disease	Shaking
Thyroid disease	Seizures
Brain tumors	Headaches
Alcoholism	Mental illness
Attention deficit/hyperactivity	Neuromuscular Disease

Age of mother _____ father _____ (if deceased, state cause)

Comments:

Are you right handed or left? □ Right □ Left Height Weight

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/Sedation	Y | N	High Blood Pressure
Y | N	Shortness of breath	Y | N	Fevers	Y | N	Sexual problems	Y | N	Difficulty sleeping	Y | N	Heart Attack
Y | N	Asthma	Y | N	Hepatitis	Y | N	Joint pain	Y | N	Anxiety	Y | N	Pacemaker
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	Bleeding/bruising	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						

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 changes	Y | N	Difficulty w/ speech	Y | N	Spells
Y | N	Dizziness or vertigo	Y | N	Memory problems	Y | N	Hallucinations	Y | N	Double Vision	Y | N	Visual changes
Y | N	Syncope/blackouts	Y | N	Lethargy/Fatigue	Y | N	Nausea/vomiting	Y | N	Change in smell	Y | N	TIA- mini strokes
Y | N	Amaurosis-sudden Loss of vision	Y | N	Agitation or confusion	Y | N	Numbness or tingling	Y | N	Drooling	Y | N	Difficulty swallowing / chewing
Y | N	Difficulty Tasting	Y | N	Ringing in ears	Y | N	Decreased Hearing	Y | N	Hoarseness	Y | N	Choking
Y | N	Stroke	Y | N	Weakness R Arm	Y | N	Weakness L Arm	Y | N	Weakness R Leg	Y | N	Weakness L Leg
Y | N	Unsteadiness	Y | N	Seizures	Y | N	Clumsiness	Y | N	Pain	Y | N	Stiffness or slowness
Y | N	Trouble Walking	Y | N	Incontinence Bowel	Y | N	Incontinence Bladder				

Reviewed MD Signature _____ 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 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:** _____

Release my protected health information to the following person(s)/entity:

Name: **Austin Epilepsy Care Center**

Address: **2200 Park Bend Drive Bldg 2 Suite 203 Austin, Texas 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 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

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Acknowledgement of Review of Notice of Privacy Practices:

I have been informed of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand my documents may be sent electronically. I am entitled to receive a copy of this document.

_____ _____

Patient signature (or parent, guardian or legal representative): Date:

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: