Kevin E. Conner M.D., P.A
800 West Arbrook BLVD. Suite 100
Arlington, TX 76015

PATIENT INFORMATION

Please Fill Out Clearly and <u>Completely</u>

Date _____ /_____ /_____

Patient's Name _____ Sex _____M _____ F

Patient's Address _____ Apt. _____

City_____State_____Zip_____

Home Phone _____- _____-_____ Work _____-_____-_____ Cell _____-_____-_____

Which Phone do you want us to use as primary contact _____Home _____ Work_____ Cell

Date of Birth _____ /_____ /_____ Social Security _____-_____-_____ Email _____

Spouse's Name _____

Insurance and Responsible Party Information
MUST BE COMPLETED IN ITS ENTIRETY

Primary Insurance:

Name of Insurance_____

Policy Holder's Name_____

Policy Holder's Address _____

City _____ St . _____Zip_____

Policy Holder's Date of Birth _____/ _____ /_____ Social Security # _____-_____-_____

Insured's Employment_____

Secondary Insurance:

Name of Insurance_____

Policy Holder's Name_____

Policy Holder's Address _____

City _____ St . _____Zip_____

Policy Holder's Date of Birth _____/ _____ /_____ Social Security # _____-_____-_____

Insured's Employment_____

In Case of Emergency Please Contact:

Name _____Relationship to you_____

Address: _____

City_____State_____Zip_____

Phone #_____-_____-_____

_____ _____

Name of Primary Care Physician Referred By

Kevin E. Conner M.D., P.A
800 West Arbrook BLVD. Suite 100
Arlington, TX 76015

PATIENT QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

_____
_____
____

Please print the address of where you would like your billing statements and / or correspondence from our office to be sent if other than your home.

_____
_____
____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": Yes_____ No_____

Please print the telephone number, if any, where you want to receive calls about your appointments pathology and lab results, or any other healthcare information if other than your home phone number: { ____ } _____

Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? Yes ____ No ____

On your work machine or voicemail? Yes _____ No ____

On your cell phone voicemail? Yes_____ No_____

PATIENT NAME _____ (guardian if under 18 years)

PATIENT / GUARDIAN SIGNATURE_____DATE_____

Kevin E. Conner M.D., P.A
800 West Arbrook BLVD. Suite 100
Arlington, TX 76015

Office Policies

Welcome to the office of Dr. Kevin Conner. It is our wish to make your experience in our office as pleasant as possible. We are furnishing the following information to you in an effort to make our relationship run as smoothly as possible.

1. **WE DO NOT SEE PATIENTS FOR ANY TYPE OF MOTOR VEHICLE ACCIDENT OR WORKER'S COMPENSATION INJURIES.**

2. Current insurance card and picture ID is required at every visit, NO EXCEPTIONS! Any change in insurance information is the patient's responsibility to inform the receptionist. If correct information is not received from the patient, the patient will be responsible for the balance in full.

3. Patients are responsible for obtaining and being aware of their need for referrals. The office staff cannot be responsible to obtain these for you.

4. Co-payments are due at the time of service. We accept cash; check, Visa or Mastercard

5. If you need a prescription refill, **please call your pharmacy** and they will fax the request to us. Please allow 48 hours for your prescription to be filled.

6. Please allow 30 days for medical record requests. This needs to be done in writing by the patient or person with power of attorney.

7. If you need the physician to fill out any forms for you, please allow 10 days after payment for these to be completed.

8. If you are having lab work done, your requisition will need to be signed at the lab for them to be able to file your insurance. We are not responsible for non-covered lab expenses.

9. If you have call block on your telephone, we will be unable to reach you by phone. When anyone from our office calls, it will show up on your Caller ID as unavailable.

10. If you arrive 15 minutes late for your appointment, **you will have to reschedule**.

11. 24 hour notice is required for cancellations. If you fail to do so, a $25.00 fee will be accessed and may result in termination from practice.

12. If you provide inaccurate information regarding your medical and/or prescription history, you will be immediately terminated from the practice.

We greatly appreciate your understanding of these policies, and look forward to a long lasting relationship with you.

Signature:_____ Date:_____

Kevin E. Conner M.D., P.A
800 West Arbrook BLVD. Suite 100
Arlington, TX 76015

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

The right to request restrictions on uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to receive of accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written cop' of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights 200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257 Toll Free- 1-877-696-6775

Kevin E. Conner M.D., P.A
800 West Arbrook BLVD. Suite 100
Arlington, TX 76015

Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Kevin E Conner M.D., P. A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Kevin *E* Conner M.D., P. A..

I understand that diagnosis or treatment of me by Kevin E. Conner M.D., P. A. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Kevin E Conner M.D. P.A. is not required to agree to the restrictions that I may request. However, if Kevin E Conner M.D., *P.A* agrees to a restriction that I request, the restriction is binding on Kevin E Conner M.D., P.A.

I have the right to revoke this consent, in writing, at any time, except to the extent that Kevin E Conner M.D., P.A. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Kevin E Conner M.D., P.A.'s Notice of Privacy Practices prior to signing this document.

Kevin E Conner M.D., P.A.'s Notice of Privacy Practices has been provided to me.
The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Kevin E Conner M.D., P.A..

The Notice of Privacy Practices is also posted in the reception area of Kevin E Conner M.D., P.A.

Kevin E Conner M.D., P.A. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment or is available at any time at www.kevinconnermd.com.

Name of Patient: _____ Relationship to Patient *(if different)*_____

Signature: _____ Date:_____

Kevin E. Conner M.D., P.A
501 Rita Lane ,Suite 105
Arlington, TX 76014 817-417-6141
Fax:817-417-6261

NEW PATIENT QUESTIONNAIRE

Date: _____/_____/_____

Name: _____

Birth Date: _____

Referred By: _____

HISTORY OF PRESENT ILLNESS:

1) What is your reason for seeing the doctor?_____

_____

2) How long have you had this problem? _____

3) Have you ever seen a neurologist before? _____

Name & Address: _____

If you have seen a neurologist in the past it is helpful if we can determine what diagnostic procedures you have had and the results of those tests:

TEST	DATE	RESULT AND WHERE TEST WAS PERFORMED
MRI		
EMG		
CAT SCAN		
EEG		

PAST MEDICAL & SURGICAL HISTORY:

	Circle Once	If yes, please explain
Fever	Y / N	
Weight Loss	Y / N	
Rash	Y / N	
Headache	Y / N	
Dizziness	Y / N	
Loss of Consciousness	Y / N	
Vision Changes	Y / N	
Speech Change	Y / N	
Hearing Change	Y / N	
Difficulty Swallowing	Y / N	
Shortness of Breath	Y / N	
Chest Pain	Y / N	
Heart Flutters	Y / N	
Heartburn	Y / N	
Urinary Difficulties	Y / N	
Neck Pain	Y / N	
Back Pain	Y / N	
Joint Pain or Swelling	Y / N	
Numbness or Tingling	Y / N	
High Blood Pressure	Y / N	
Diabetes	Y / N	
High Cholesterol	Y / N	

Please list any other medical issues you have now or had in the past:

_____

_____

Please list any surgical procedures and approximate date:

_____

_____

FAMILY HISTORY:

Please list any diseases/medical conditions in your family history (provide family member, when possible)

_____

_____

Name_____ Date_____

MEDICATION HISTORY:

Are you currently taking any medications? _____ Yes _____ No. If yes, please list below. Please include dosage, frequency and how long you have been taking the medication.

DRUG	DOSAGE AND FREQUENCY	DATE STARTED

Do you have any drug allergies? _____ Yes _____No If yes, please list below and include adverse reaction experienced.

DRUG	REACTION

Please provide us with the name and phone number of the pharmacy you fill at.

_____

I understand that Kevin Conner M.D. will routinely review my refill history with all physicians/pharmacies to ensure my safety and wellbeing.

Signature:_____ Date:_____

PERSONAL HISTORY:

1) Are you married? _____

2) Do you have any children? _____

3) Occupation? _____

4) Are you on a special diet? _____

5) Do you drink alcohol? _____

If yes, how much and how often? _____

6) Caffeine intake (coffee, tea, soft drinks, chocolate, etc.) _____

_____

7) Do you smoke? _____

If yes, how many per day? _____

For how long? _____

8) Did you ever smoke? _____

If yes, how much did you smoke?_____

When did you quit? _____

Please list any other personal/ medical information relevant to your current condition or treatment:

_____

_____

_____

Name_____ Date_____