RIVER CITY neurology PA
personal NEURO HEALTH care

BHS SPECIALTY NETWORK

Patient Registration Form

Date: _____

Patient Information:

Name(last, first MI)_____ Sex: ____Male ____Female

Date of Birth:_____ SS#:_____

Street Address:_____ City:_____

State:_____ Zip Code:_____ Home Phone: _____

Work Phone:_____ Mobile Phone:_____

Patient Referred By:_____

Marital Status: _____Single _____Married _____Other (widow, divorced, separated)

Patient PCP:_____

Spouse's Name:_____ Spouse's Phone #: _____

Spouse's Employer:_____ Spouse's Employer Phone:_____

Guardian Information (If Applicable):

Last Name:_____ First Name:_____ MI:_____

Phone:_____ Street Address:_____

City:_____ State:_____ Zip Code_____

SS#:_____ DOB:_____ Employer Name:_____

Employer Address:_____ Employer Phone:_____

Emergency Contact Information:

Last Name:_____ First Name:_____

Phone:_____ Relationship:_____

Insurance Information:

Primary: Insurance Plan Name:_____Policy Holder: _____

Policy Holder Sex: ___M___F Policy Holder SS#:_____ Policy Holder DOB:_____

Secondary: Insurance Plan Name:_____Policy Holder: _____

Policy Holder Sex: ___M___F Policy Holder SS#:_____ Policy Holder DOB:_____

Tertiary: Insurance Plan Name:_____Policy Holder: _____

Policy Holder Sex: ___M___F Policy Holder SS#:_____ Policy Holder DOB:_____

Please read each of the following statements carefully and sign as your authorization, understanding and agreement to each statement.

ASSIGNMENT AND RELEASE: I hereby assign my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process this claim to my employer, prospective employer and/or insurance carrier.
Signed:_____ Date:_____

MEDICARE BENEFICIARY ASSIGNMENT AND RELEASE: I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by BHS Physicians Network DBA River City Neurology/Dr. Benjamin R. Millar. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services. Signed:_____ Date:_____

FINANCIAL OBLIGATION: I hereby acknowledge that I understand there may be services provided that will not be covered by my insurance carrier, and fully understand that I am fully responsible for any and all charges not covered by my insurance carrier. I understand that payment may be requested at the time of service or I may be billed for such services subsequently.
Signed:_____ Date:_____

CONSENT FOR TREATMENT: I hereby authorize the physician, nurses, medical assistants and staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.
Signed:_____ Date:_____

ADVANCED DIRECTIVE: Do you have an advance directive (living will/power of attorney)? _____Yes _____No If yes, please provide a copy for our records.

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NO SHOW POLICY

Patients who fail to present for a scheduled appointment without contacting the practice to cancel the appointment within 24 hours will be considered a "no-show". Patients who cancel an appointment the day of the appointment will also be considered a "no-show". Patients who consistently fail to present for scheduled appointments will be considered a "chronic no-show".

It is the policy of this practice to assess a $25 "no-show" fee for any appointments missed or cancelled the day of. Patient will not be allowed to re-schedule their appointment until the $25 fee is paid. After the 3rd missed appointment, patient chart will be documented as a "chronic no-show" and may be dismissed from the practice at the provider's discretion.

A chronic "no-show" is defined as having 3 missed appointments in a row or within a rolling 12-month period.

- Patient will be notified of the "no-show" policy at the time of registration.
- Patient appointment status will be updated in system as a "no-show".
- Patient will not be allowed to schedule a new appointment until the $25 fee has been paid. Patient will be reminded of the policy upon attempt to schedule.
- A note will be made in the patients chart stating the patient was a "no-show".

I, _____, have read and understand the above stated policy and agree to abide by it.

_____ _____

Patient Signature Date

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REQUEST FOR MEDICAL RECORDS

Date: _____

Name of patient: _____

Date of birth: _____

Social Security # _____

I _____ **r**equest that all my records be sent to the following physician:

Dr. Kumar Reddy

502 Madison Oak, Suite 320

San Antonio, TX 78258

Office: (210) 490-2581, Fax: (210) 495-0356

If you have any question please call me at: _____ .

Thank you for your prompt attention in this matter.

_____ _____

Signature Date

RIVER CITY neurology PA
personal NEURO HEALTH care

BHS SPECIALTY NETWORK

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 INFORMATON. PLEASE REVIEW IT CAREFULLY.

We are committed to protecting the confidentiality of your medical information, and are required by law to do so. This notice describes how we may use your medical information within the physician's office and how we may disclose it to others outside the physician's office. This notice also describes the rights you have concerning your own medical information. Please review it carefully and let us know if you have questions.

HOW WILL WE USE AND DISCLOSE YOUR MEDICAL INFORMATION?

Treatment: We may use your medical information to provide you with medical services and supplies. We may also disclose your medical information to others who need that information to treat you, such as doctors, physician assistants, nurses, medical and nursing students, technicians, therapists, emergency service and medical transportation providers, medical equipment providers, and others involved in your care. For example, we will allow the hospital to have access to your medical records to assist in your treatment at the hospital for your care. We also may use and disclose your medical information to contact you to remind you of an upcoming appointment, to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you.

Family Members and Others Involved in Your Care: We may disclose your medical information to a family member or friend who is involved in your medical care, or to someone who helps to pay for your care. We also may disclose your medical information to disaster relief organizations to help locate a family member or friend in a disaster. If you do not want the office to disclose your medical information to family members or others who will visit you, **you must talk to the Privacy Official**. You can reach our Privacy Official using contact information listed on the last page of this notice.

Payment: We may use and disclose your medical information to get paid for the medical services and supplies we provide to you. For example, your health plan or health insurance company may ask to see parts of your medical record before they will pay us for your treatment**. Hospital**

Operations: We may use and disclose your medical information if it is necessary to improve the quality of care we provide to patients or to run the Hospital. We may use your medical information to conduct quality improvement activities, to obtain audit, accounting or legal services, or to conduct business management and planning. For example, we may look at your medical record to evaluate whether Hospital personnel, your doctors, or other health care professionals did a good job.

Research: We may use or disclose your medical information for research projects, such as studying the effectiveness of a treatment you received. These research projects must go through a special process that protects the confidentiality of your medical information**.**

Required by Law: Federal, state, or local laws sometimes require us to disclose patients' medical information. For instance, we are required to report child abuse or neglect and must provide certain information to law enforcement officials in domestic violence cases. We also are required to give information to the State Workers' Compensation Program for work-related injuries.

Public Health: We also may report certain medical information for public health purposes. For instance, we are required to report births, deaths, and communicable diseases to the State. We also may need to report patient problems with medications or medical products to the FDA, or may notify patients of recalls of products they are using.

Public Safety: We may disclose medical information for public safety purposes in limited circumstances. We may disclose medical information to law enforcement officials in response to a search warrant or a grand jury subpoena. We also may disclose medical information to assist law enforcement officials in identifying or locating a person, to prosecute a crime of violence, to report deaths that may have resulted from criminal conduct, and to report criminal conduct at the physician's office. We also may disclose your medical information to law enforcement officials and others to prevent a serious threat to health or safety.

Health Oversight Activities: We may disclose medical information to a government agency that oversees the office or its personnel, such as the State Department of Health, the federal agencies that oversee Medicare, the Board of Medical Examiners or the Board of Nursing. These agencies need medical information to monitor the office's compliance with state and federal laws.

CHANGES TO THIS NOTICE Updated 04/08

RIVER CITY neurology PA
personal NEURO HEALTH care

BHS SPECIALTY NETWORK

NOTICE OF PRIVACY PRACTICES

Coroners, Medical Examiners and Funeral Directors: We may disclose medical information concerning deceased patients to coroners, medical examiners and funeral directors to assist them in carrying out their duties.

Organ and Tissue Donation: We may disclose medical information to organizations that handle organ, eye or tissue donation or transplantation.

Military, Veterans, National Security and Other Government Purposes: If you are a member of the armed forces, we may release your medical information as required by military command authorities or to the Department of Veterans Affairs. The office may also disclose medical information to federal officials for intelligence and national security purposes, or for presidential Protective Services.

Judicial Proceedings: The Physician Office may disclose medical information if the office is ordered to do so by a court or if the office receives a subpoena or a search warrant. You will receive advance notice about this disclosure in most situations so that you will have a chance to object to sharing your medical information.

Information with Additional Protection: Certain types of medical information have additional protection under state or federal law. For instance, medical information about communicable disease and HIV/AIDS, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, the office is required to get your permission before disclosing that information to others in many circumstances.

Other Uses and Disclosures: If the office wishes to use or disclose your medical information for a purpose that is not discussed in this Notice, the office will seek your permission. If you give your permission to the office, you may take back that permission any time, unless we have already relied on your permission to use or disclose the information. If you ever would like to revoke your permission, please notify the Privacy Official in writing.

WHAT ARE YOUR RIGHTS?

Right to Request Your Medical Information: You have the right to look at your own medical information and to get a copy of that information. (The law requires us to keep the original record.) This includes your medical record, your billing record, and other records we use to make decisions about your care. To request your medical information, write to the Privacy Official. If you request a copy of your information, we will charge you for our costs to copy the information. We will tell you in advance what this copying will cost. You can look at your record at no cost.

Right to Request Amendment of Medical Information You Believe Is Erroneous or Incomplete: If you examine your medical information and believe that some of the information is wrong or incomplete, you may ask us to amend your record. To ask us to amend your medical information, write to the Privacy Official.

Right to Get a List of Certain Disclosures of Your Medical Information: You have the right to request a list of many of the disclosures we make of your medical information. If you would like to receive such a list, write to the Privacy Official. We will provide the first list to you free, but we may charge you for any additional lists you request during the same year. We will tell you in advance what this list will cost.

Right to Request Restrictions on How the Hospital Will Use or Disclose Your Medical Information for Treatment, Payment, or Health Care Operations: You have the right to request us not to make uses or disclosures of your medical information to treat you, to seek payment for care, or to operate the office. We are not required to agree to your request, but if we do agree, we will comply with that agreement. If you want to request a restriction, write to the Privacy Official and describe your request in detail.

Right to Request Confidential Communications: You have the right to ask us to communicate with you in a way that you feel is more confidential. For example, you can ask us not to call your home, but to communicate only by mail. To do this, write to the Privacy Official. You can also ask to speak with your health care providers in private outside the presence of other patients—just ask them!

Right to a Paper Copy: If you have received this notice electronically, you have the right to a paper copy at any time. You may download a paper copy of the notice from our Web site, at PENDING , or you may obtain a paper copy of the notice from the Privacy Official.

CHANGES TO THIS NOTICE Updated 04/08

RIVER CITY neurology PA
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BHS SPECIALTY NETWORK

NOTICE OF PRIVACY PRACTICES

From time to time, we may change our practices concerning how we use or disclose patient medical information, or how we will implement patient rights concerning their information. We reserve the right to change this Notice and to make the provisions in our new Notice effective for all medical information we maintain. If we change these practices, we will publish a revised Notice of Privacy Practices. You can get a copy of our current notice of Privacy Practices at any time by contacting the Privacy Official.

WHICH HEALTH CARE PROVIDERS ARE COVERED BY THIS NOTICE? This Notice of Privacy Practices applies to the Hospital and its personnel, volunteers, students, and trainees. The Notice also applies to other health care providers that come to the office to care for patients, such as physicians, physician assistants, therapists, other health care providers who are not employed by the office, emergency service providers, medical transportation companies, and medical equipment and suppliers who come to the office. The office may share your medical information with these providers for treatment purposes, to get paid for treatment, or to conduct health care operations. These health care providers will follow this Notice for information they receive about you from the Hospital. These other health care providers may follow different practices at their own offices or facilities. A list of these health care providers is available for your review in the Admissions Office by contacting the Privacy Official.

DO YOU HAVE CONCERNS OR COMPLAINTS Please tell us about any problems or concerns you have with your privacy rights or how the Hospital uses or discloses your medical information. If you have a concern, please contact Local Privacy Official 210-297-1094 Corporate Privacy Official 1-888-895-9945 Corporate Compliance Hotline – Washington DC 1-800-300-9876 If for some reason the Hospital cannot resolve your concern, you may also file a complaint (in writing) with the federal government at the OCR/DHHS regional office. We will not penalize you or retaliate against you in any way for filing a complaint with the federal government.

DO YOU HAVE QUESTIONS? The Hospital is required by law to give you this Notice and to follow the terms of the Notice that is currently in effect. If you have any questions about this Notice, or have further questions about how the Hospital may use and disclose your medical information, please contact the Privacy Official. Effective date: April 14, 2003.

Privacy Official Contact Information:

Name: Baptist Physician Network - HIPAA Privacy Officer
Mailing Address: 8711 Village Drive, Suite 320 San Antonio, TX 78217
Phone: 210-297-2240

CHANGES TO THIS NOTICE Updated 04/08

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BHS SPECIALTY NETWORK

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, DOB, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____Individual refused to _____accept Notice _____ sign Acknowledgement

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

Other (Please specify)
_____

RIVER CITY neurology PA
personal NEURO HEALTH care

BHS SPECIALTY NETWORK

Communication with family & others involved in your care

Patient Information

Name: _____

Date of Birth: _____SS#_____

Please list any family members or others who may be involved in coordinating your care or payment for care. Also, indicate what kinds of information may be shared with each individual.

Name	Relationship to Patient	Type of information			
		All	Schedule	Medical	Billing
_____		Y/N	Y/N	Y/N	Y/N
		All	Schedule	Medical	Billing
_____		Y/N	Y/N	Y/N	Y/N
		All	Schedule	Medical	Billing
_____		Y/N	Y/N	Y/N	Y/N
		All	Schedule	Medical	Billing
_____		Y/N	Y/N	Y/N	Y/N
		All	Schedule	Medical	Billing
_____		Y/N	Y/N	Y/N	Y/N

Specific Instructions or Limitations:

_____
_____
_____
_____

For added security you may add a password to your medical record.
Password: _____ please provide this code to any individual who may be involved in coordinating you care or payment of care. They will be asked for this code (if you provide one here) before information will be released by phone. We will continue to rely on the information in this when communicating with family members or others involved in you care unless you request changes. Please promptly notify you Physician's office if you wish to alter the designations above.

_____ _____
Signature of Patient: Date:

To revoke this authorization, please send a written request with a copy of this form to the Physician's office. If you have any questions please call the Physician's office and ask for the Office Manager.

RIVER CITY neurology PA
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BHS SPECIALTY NETWORK

Office use only

Office visit date: _____ Patient Name: _____

Check In by: _____ Chart #: _____

Pt Intake by: _____ DOB: _____

Check Out by: _____

New Patient Checklist:

Document:	Staff Initials	Notes:
☐ Consult Sheet, Vitals, Blank sheet	_____	_____
☐ New patient worksheet given	_____	_____
☐ Registration information complete	_____	_____
☐ Copy of Insurance card in file	_____	_____
☐ Copy of ID Card in file	_____	_____
☐ Notice of Privacy Practice Ack. Signed	_____	_____
☐ Request for Medical Records Signed	_____	_____
☐ Communication w/family form signed	_____	_____
☐ No show policy form signed	_____	_____
☐ Insurance Auth if needed in file	_____	_____
☐ Copay collected	_____	_____
☐ Collected or notified of balance due	_____	_____
☐ Referring Dr. records in file	_____	_____
☐ Billing slip signed by patient	_____	_____
☐ Charges entered / pt Checked out	_____	_____
☐ Billing Slip scanned	_____	_____
☐ Exit Survey completed	_____	_____

Established Patient:

☐ Registration (Current 1yr)		
If not current – new pt registration req	_____	_____
☐ Verified Pt demo info	_____	_____
☐ Privacy Practice signed (current 1yr)	_____	_____
☐ Follow up Sheet	_____	_____
☐ Copay collected	_____	_____
☐ Collected or notified of balance due	_____	_____
☐ All labs, test, notes needed for visit	_____	_____
☐ Insurance auth if needed in file	_____	_____
☐ Billing slip signed by patient	_____	_____
☐ Charges Entered / pt checked out	_____	_____
☐ Billing Slip scanned	_____	_____
☐ Exit Survey completed	_____	_____

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Allergic to any medications? *circle your response*
Yes No

Please list the medications:_____

Marital Status: *circle your response*
Single Married Widowed
Separated Divorced
Number of children: _____

Work Status: *circle your response*
Full Time Part Time Retired
Unemployed Disabled

Occupation: _____

Education: *circle your highest level completed*

Lower School Grade: 4 5 6 7 8

High School Grade: 9 10 11 12 GED

College Year: 1 2 3 4

College Degree: Associates Bachelors
Masters Doctorate

Do you smoke? *circle your response* Yes No
How much:_____How long:_____
If no, did you smoke previously? Yes No
How much:_____How long:_____

Do you drink alcohol? *circle your response* Yes No
How much:_____How long:_____
If no, did you drink previously? Yes No
How much:_____How long:_____

Family History: *circle appropriate selections*

Adopted

Mother: Alive Deceased Unknown

Father: Alive Deceased Unknown

List any family members with significant health problems:

_____
_____
_____
_____

Review of Systems:
Please circle any selections that you have experienced recently.

Constitutional
- Weight gain
- Weight loss
- Fever
- Sleep difficulty
- Fatigue
- None

Ear, Nose & Throat
- Hearing loss
- Ringing in the ears
- Sinus congestion
- Nose bleeds
- Sore throat
- Swallowing difficulty
- None

Cardiovascular
- Chest pain
- Palpitations
- Swelling of feet
- None

Respiratory
- Cough
- Shortness of breath
- Asthma
- Wheezing
- Spitting up blood
- None

Gastrointestinal
- Abdominal pain
- Heartburn
- Nausea
- Vomiting
- Diarrhea
- Rectal bleeding
- Blood in stool
- None

Genitourinary
- Painful urination
- Blood in urine
- Incontinence
- Frequent urination
- Male erectile difficulty
- None

Musculoskeletal
- Joint pain
- Joint stiffness
- Muscle cramps
- Back pain
- Muscle weakness
- None

Dermatology
- Rash
- Itching
- Change in hair
- Change in nails
- Change in moles
- None

Neurological
- Dizziness
- Loss of consciousness
- Tremor
- Balance difficulty
- Memory loss
- Frequent headaches
- Double vision
- Blurred vision
- Numbness
- None

Psychiatric
- Depression
- Nervousness
- Hallucinations
- Paranoia
- None

Endocrine
- Hot flashes
- Excessive thirst
- Cold intolerance
- None

Heme-Lymph
- Easy bruising
- Bleeding tendency
- Swollen lymph nodes
- Cancer
- Past blood transfusion
- None

NEW PATIENT WORKSHEET

RIVER CITY neurology PA

personal NEURO HEALTH care

BHS SPECIALTY NETWORK

Please complete this two-page form and return it to the front desk prior to your examination today.

This will greatly help Dr. Millar's assessment of your condition. Thank you.

Today's Date:_____

Patient's Name:_____

Age:_____ *circle the appropriate selection below*

Male Female Right Handed Left Handed

Name of referring physician:_____

Any tests that have been performed:_____

_____

_____

Briefly describe the problem for which you are seeking treatment today:_____

_____

_____

_____

Current Medications:

Medication	Dose	How Often?

Circle if you have had problems with any of the following:

Anemia
Anxiety Disorder
Arthritis
Asthma
Atrial Fibrillation
Bleeding Disorder
Cancer (specify which type) _____
Cataracts
Congestive Heart Failure
COPD or Emphysema
Depression
Dementia or Memory Loss
Diabetes
Glaucoma
Heart Attack
High Blood Pressure
High Cholesterol
Kidney Disease (specify type) _____
Liver Disease (specify type) _____
Migraines
Neuropathy
Parkinson's Disease
Seizures
Stomach Problems (specify type) _____
Stroke
Syncope or Passing out
Thyroid Disease (specify type) _____
Other (please specify) _____

Please list any past surgical procedures:

Month & Year	Procedure