ALAMO NEUROLOGY CONSULTANTS
9730 WESTOVER HILLS, STE 105
SAN ANTONIO,TX 78251

APPT DATE/TIME : _____
REFERRING PHYSICIAN : _____

Full Name: _____ Date of Birth: _____ Sex: ____

Address: _____ City, State, Zip: _____

Home #: _____ Cell #: _____ Email: _____

Race/Ethnicity: _____ Language: _____ Marital Status (circle): Single, Married, Divorced, Separated, Widowed

Employer Name: _____ Work #: _____

Emergency Contact: _____ Phone #: _____ Relation: _____

PHARMACY & Location: _____ Phone #: _____

Please list name and relation of individuals we could provide information to, for HIPPA release of information:

1. _____ 2. _____

PLEASE NOTE: IT IS PATIENT RESPONSIBILITY TO CONFIRM THAT WE ARE PARTICIPATING PROVIDERS FOR YOUR PLAN
CALL THE PHONE NUMBER IN BACK OF YOUR CARD AND PROVIDE YOUR INSURANCE WITH OUR TAX ID: 264-73-3435

PROVIDERS: Dr. Qingxuan Wu Dr. Jennifer Sharron

PRIMARY INSURANCE: _____

Name of Insured: _____ DOB: _____

Member ID: _____ Group #: _____ In-network confirmed? _____

SECONDARY INSURANCE: _____

Name of Insured: _____ DOB: _____

Member ID: _____ Group #: _____ In-network confirmed? _____

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN and/or SPECIALISTS:

Name	Specialty	Phone number	Name	Specialty	Phone number

PLEASE LIST YOUR CURRENT MEDICATIONS AND BRING YOUR MED BOTTLES TO APPT:

Name	Form (pill, capsule, solution)	Strength	Frequency

MEDICAL HISTORY ***(please circle and describe)*** ◯ **Check if you do not have any medical problems**

Diabetes: type 1 / type 2	Spinal problems: *describe:*
High blood pressure / high cholesterol	Thyroid: *hypothyroidism / Graves / Hashimoto's / other:*
Heart disease / Heart failure / Heart valve / pacemaker	Autoimmune: *Lupus / Sjogren's / Fibromyalgia / other:*
Heart rhythm: atrial fibrillation / bradycardia	Arthritis: *rheumatoid / osteoarthritis / other:*
Stroke / TIA	Anemia/blood problems: *describe:*
Headaches	Cancer: *type(s):*
Seizures	Prostate: *enlarged / other:*
Dementia	Sexual problems: *describe:*
Lung: *COPD / asthma / sleep apnea / other:*	Venereal disease: *type(s):*
Birth defects/inherited diseases: describe:	Eye: *glaucoma /macular degeneration / cataracts / other:*
Gastrointestinal: describe:	Ear: hearing loss / vertigo / Meniere's / other:
Kidney / Urinary tract: describe:	Traumatic brain injury: *year and description:*
Liver: hepatitis / fatty liver / other:	Chronic pain: *describe*:
Skin: *eczema / psoriasis / acne / other:*	Depression / anxiety / PTSD / bipolar / other*:*

SURGICAL HISTORY: ***List all surgeries*** **HOSPITALIZATIONS:** ***List all admissions to a hospital***

Date	**Surgery**	**Date**	**Reason for admission**
	◯ *Check if you have never had any surgeries*		◯ *Check if you have never been hospitalized*

SOCIAL HISTORY: ***please circle and fill out*** **MEDICATION ALLERGIES:**

Tobacco: **NO** | **YES** (# packs per day: _____ # yrs: _____) | **QUIT** (yr quit:____ ____)	◯ *Check if no medication allergies*
Alcohol: **NO** | **YES** (# drinks ___ per day/week/month/yr) | **QUIT** (yr quit: _____)	
Caffeine: **NO** | **YES** coffee / tea / soda / other:_____ (# cups _____ per day / week)	
Street/Illegal drugs: **NO** | **YES** (type(s): _____) | **QUIT** (yr quit:_____)	
Occupation: _____ (current / retired / disabled)	
Highest grade level (high school, college, etc.):	

FAMILY HISTORY: ***please list medical problems or cause of death***

Father:	Siblings:
Mother:	Grandparents

The above information is true to the best of my knowledge. I authorize Alamo Neurology Consultants, PA or insurance company to release any information required to process my claims, which are payable to Alamo Neurology Consultants, PA. I also acknowledge receiving a copy and understanding the Notice of Privacy Practices. I understand that it is my responsibility to confirm I am being treated by an in-network provider and am financially responsible for any balance the insurance does not cover.

Patient (or Responsible Party Signature

Date

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WWW.ALAMONEUROLOGY.COM

MEDICAL RECORDS RELEASE
AND AUTHORIZATION
FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

I authorize the custodian of my records to release the following information* (check all applicable):

- ☒ All records
- ☐ X-ray/radiology records
- ☐ Laboratory/pathology records
- ☐ Abstract/Summary

The information may be used for each of the following purposes:

- ☐ At my request
- ☐ For payment/insurance
- ☐ For my health care
- ☐ For employment purposes

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

Please send the records listed above to:

Alamo Neurology Consultants, PA
9730 Westover Hills Blvd, Ste 105
San Antonio, Texas 78245-6359
Fax: 360-462-6496

This authorization shall expire no later than one year from the date of signature. I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e parent guardian, power of attorney, executor)*

ANC Office Policies and Fees

Insurance: Please provide us with updated insurance cards with a Photo ID. Copayments/deductibles are due at time of visit. If you have not met your deductible, we will collect $200 for the first visit and $125 for the follow up.

Balances: Outstanding balances may result in rescheduling appointments.

In-Network Participation: please call your insurance to confirm provider participation with your plan, by calling the number in the back of your card and providing them with our Tax ID or NPI:

Alamo Neurology	Dr. Qingxuan Wu	Dr. Jennifer Sharron
TaxID: 264733435	NPI: 1548440340	NPI: 1093033698

Patient Poral: We recommend the use of our patient portal for fast, secure messaging with our staff and providers. Ask our front desk for registration details.

Refills: Please plan ahead! ANC requires 48 hour notice for RX refills.

Medical Records: Patient records available upon request with ID. Transferring records by fax to another office requires a signed medical release from the receiving office. For paper copies, Printing fees may apply.

Third Party requests for Records or Letter requests are subject to a $50.00 fee.

FMLA forms: At the provider's discretion for established patients, an appointment is required for FMLA documentation. Patient must bring in copy of forms to be filled.

EEG/EMG appts: For these one hour appointments, our office requires a $50 scheduling fee which is REFUNDABLE once the claim has processed, unless, patient is a no show or cancels within 24 hrs.

NO call, NO show: Please allow 24 hour notice for rescheduling appointments. We do not double book our providers, if a patient is a NO SHOW, you will not be rescheduled.

Please sign below if you have read and understand our office policies and fees. Thank you.

_____ _____

Patient/ Responsible Party Signature Date

ALAMO NEUROLOGY CONSULTANTS, PA

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.

Updated: June 20, 2018

I. **OUR OBLIGATIONS.** We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information.

A. **For Treatment.** For coordinating and managing your health care with physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. **For Payment.** To bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan.

C. **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers

D. **Other reasons include, but not limited to**: Quality Assurance, Utilization Review, Credentialing and Peer Review, Treatment Alternatives, Appointment Reminders and Health Related Benefits and Services, Individuals Involved in Your Care or Payment for Your Care, As Required by Law, To Avert an Imminent Threat of Injury to Health or Safety, Public Health Risks, Health Oversight Activities, and Legal Matters.

III. **OTHER USES OF MEDICAL INFORMATION**

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization.

B. **Right to Revoke Authorization**. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time.

IV. **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.**

A. **Right to Inspect and Copy.** Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing.

B. **Right to Amend.** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

C. **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

D. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

F. **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time.

G. **Right to Breach Notification.** In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services and with the Practice at the address below:

Alamo Neurology Consultants, PA
Attn: HIPAA Officer
9730 Westover HIlls Blvd, Ste 105
San Antonio, Texas 78245-6359
210-520-7160

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative: _____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____Date:_____