Bob Bower, MD, PA

Board Certified Adult Neurology

Date: _____

Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____ **Marital Status:** Single Married Widowed Divorced

City/State/Zip: _____ **Home Phone #:** _____

E-Mail: _____ **Cell Phone #:** _____

Preferred Contact Method: □ Home Phone □ Cell Phone □ E-Mail

Ethnicity: □ Hispanic/Latino **Race:** □ White □ Black/African American □ Asian

□ Not Hispanic/Latino □ Native Hawaiian/Pacific Islander □ American Indian/Alaskan Native

□ Other: _____

Preferred Language: □ English □ Spanish □ Other: _____

PRIMARY INSURANCE ****Does this policy replace your Medicare policy? YES NO**

Insurance Name: _____ Phone #: _____

Subscribers Name: _____ Relationship to Patient: _____

Subscribers Date of Birth: _____

SECONDARY INSURANCE ****Does this policy replace your Medicare policy? YES NO**

Insurance Name: _____ Phone #: _____

Subscribers Name: _____ Relationship to Patient: _____

ADDITIONAL INFORMATION

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

30 Cascade Caverns Road • Boerne, TX 78015
Phone: 830-816-5518 • Fax: 830-331-1042

NAME:_____Date:_____

Your present/past occupation(s):_____Highest schooling level_____

Which hand do you use for writing? Right Left

Please circle any symptoms you are currently experiencing and mark thru symptoms you do not have

GEN:	weight loss/gain	fatigue	trouble sleeping	sleepiness	snoring
	forgetfulness	confusion	dizziness	fevers	decrease appetite
Eyes:	blurred vision	double vision	loss of vision	trouble hearing	ear/eye pain
ENT:	ringing in the ears	sinus drainage	sinus allergies	problems swallowing	problems chewing
CV:	chest pain	palpations	swelling of the legs		
Resp:	shortness of breath	cough			
GI:	nausea/vomiting	diarrhea	constipation	blood in stool	abdominal pain
GU:	urine incontinence	increase frequency	blood in urine	pain with urination	sexual problems
Derm:	Rashes	dry skin	itchy skin		
Heme/endo:	bruising	bleeding	hot/cold intolerance	blood transfusions	
Muscle:	muscle pain	muscle weakness	muscle cramps	joint pain	
Neuro:	headaches	weakness	numbness/tingling	balance problems	loss of consciousness
	Head injury	tremor	neck pain	low back pain	speech problems
Psych:	depression	anxiety	mood swings	suicidal thoughts	hallucinations

Please indicate if you or your family have a history of any of the conditions noted below:

	You	Family			You	Family		You	Family
Anemia	____	____		Arthritis	____	____	Asthma	____	____
Bleeding Disorders	____	____		Cancer	____	____	High Cholesterol	____	____
Diabetes, Type 1	____	____	Controlled ____ Uncontrolled____	Depression	____	____	Heart Disease	____	____
Diabetes, Type 2	____	____	Controlled ____ Uncontrolled____	Hypertension	____	____	Liver problems	____	____
Heart rhythm problems	____	____		Kidney problems	____	____	Kidney stones	____	____
Lung Problems	____	____		Nerve disorders	____	____	Migraines	____	____
Muscle disorders	____	____		Strokes	____	____	Seizures/Convulsion	____	____
Poor circulation	____	____		Infections	____	____	Venereal Disease	____	____
Glaucoma	____	____		Fibromyalgia	____	____	Blood transfusion	____	____
Thyroid problems	____	____					HIV	____	____

Other Medical illnesses not mentioned above:_____

List Surgeries:_____

Do you smoke:_____no_____yes: previously, but quit_____pack per day:_____how many years_____

Do you drink alcohol:_____no_____yes: what kind_____how much a week_____

Did you drink heavily in the past:_____no_____yes Have you used street drugs:_____no_____yes: type_____

Please list any allergies to any medications: _____

_____

Please list medications and strengths: _____

_____

_____

Bob Bower, MD, PA

Neurology Clinic

Record of Disclosures

The HIPAA privacy law gives individuals the right to request a restriction on uses and disclosures of your Personal Health Information (PHI). The individual is also provided the right to request confidential communications and disclosures of PHI through alternate means.

□ Home Telephone #: _____
- □ Leave voicemail with detailed information
- □ Leave voicemail with call-back number only

□ Work Telephone #: _____
- □ Leave voicemail with detailed information
- □ Leave voicemail with call-back number only

□ Written Communication:
- □ Mail to my home address
- □ Mail to my work/office
- □ Fax to this number: _____

□ Other people you may speak to on my behalf:

_____

_____

_____

_____

_____ _____
Printed Patient Name Date

_____ _____
Signature of Patient/Representative Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosures for PHI to the minimum necessary to accomplish the intended purpose. These provisions do apply to uses made pursuant to an authorized request by the individual.

Healthcare entities must keep record of PHI disclosures. Information provided below, if completed properly will serve as an adequate record.

NOTE: Disclosures may be made without consent in the case of an emergency.

****************FOR OFFICE USE ONLY****************

Date of Disclosure & Staff Name	Disclosure to	Type of Disclosure

30 Cascade Caverns Road • Boerne, TX 78015
Phone: 830-816-5518 • Fax: 830-331-1042

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General Medical Records Release & Authorization for Use/Disclosure of Protected Health Information

Patient Name: _____

Address: _____

_____

Phone Number: _____

Last four of SSN: _____ Date of Birth: _____

I authorize the custodian of records: _____

Address: _____

Phone/Fax: _____

To disclose/release the following information:

□ All records □ Billing Records □ Office notes □ Radiology records

□ Pharmacy/Prescriptions □ Lab/pathology records □ _____

Please send the records to: Bob Bower, MD

Address: 30 Cascade Caverns Road, Boerne, TX 78015

Phone/Fax: 830-816-5518 830-331-1042

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/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 Representative/Guardian Date

_____ _____

Printed Name of Patient Representative's Authority to Sign for patient (i.e. parent, guardian, POA, executor)

_____

Witness Signature

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Neurology Clinic

Patient Consent Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- ► Conduct, plan and direct my treatment and follow-up among the multiple heatlhcare providers who may be involved in that treatment directly and indirectly.

- ► Obtain payment from insurance payors.

- ► Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Printed Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____

Provider Name: Bob Bower, MD

30 Cascade Caverns Road • Boerne, TX 78015
Phone: 830-816-5518 • Fax: 830-331-1042

Bob Bower, M.D., P.A.

Board Certified Adult Neurology

NPI: 1659478303 • TAX ID: 74-2776427

FINANCIAL POLICY

Charges for medical services are due at each office visit. Payments may be made by cash, check or credit card. The office will file medical claims for patients who have current health insurance coverage with which the doctor is contracted. **The patient/responsible party are responsible for any deductible, co-pay or amounts designated by your insurance contract at the time of your office visit.** If your policy requires a referral from your primary care physician, it is your responsibility to ensure that the referral has been made and received by this office. Benefits must be assigned to the doctor/clinic on all claims that are filed by this office.

MEDICARE PART B: Assignment is accepted by our providers. We will file your claims for all covered services and Medicare will pay benefits directly to the provider. Each year you are responsible for a deductible of $198.00 for Medicare Part B. If you have a supplemental insurance, please check on the policy for payment of your deductible/20 co-insurance. If you do not have supplemental coverage you will be asked to pay your deductible/20% co-insurance of the Medicare allowed amount at the time of your appointment.

SELF PAY: Payment for all services is due at the time the services are rendered.

The initial self-pay office visit is $125.00, subsequent office visits are $75.00. If you have additional tests/procedures performed they will be an additional fee.

RETURNED/NSF CHECKS: There will be an immediate charge of $25.00 for each returned check. Payment of the $25.00 along with the amount of the returned check is due before the next office visit.

I have read and understand the financial policies presented to me in this document.

_____ _____

Printed Patient Name Date

_____

Patient/Responsible Party Signature

30 Cascade Caverns Road • Boerne, TX 78006

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