NEUROPATHY
TREATMENT CLINICS OF TEXAS

Date of Consult: _____

Referring Doctor: _____

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

DOB:_____ SS#: _____ Email:_____

Occupation: _____ Employer: _____

Ethnicity: _____

INSURANCE

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

How did you hear about us?: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

EMERGENCY CONTACT

Contact Name: _____ Relationship: _____

Phone: _____ Patient Signature: _____

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NEUROPATHY HISTORY

Where is the location of your pain **AND** when did it begin?

_____
_____

When does this complaint bother you the most: (circle all that apply to your pain)?

AM / PM Comes and goes Pain with activity Constant

What makes the concern better? _____ Worse? _____

What is your concern with respect to nerve pain: (circle all that apply)?

Pain	Numbness		Tingling Pain with Touch	Shooting Shocks
Burning	Aching	Sensitivity	Pins and needles	Tightness

Is your neuropathy associated with: (circle all that apply)?

Poor Balance Weakness Swelling Slow healing wounds Insomnia secondary to the pain

What therapies have you tried to obtain relief? (Example of failed therapies: Physical Therapy, Chiropractor, Acupuncture, injections, medications, NSAIDS, bracing, etc.)

_____
_____
_____

Please rate your overall pain on a scale from 0-10 over the 1-2 weeks. (0 no pain 10 severe pain)

Pain	Numbness	Tingling	Burning	Tightness

What limitations do you have because of your neuropathy? What daily activities do you have difficulty performing?

_____
_____
_____

Have you seen other specialty providers, and what have they offered to help with your concern? When?

_____
_____
_____
_____

Have you had any diagnostic studies concerning the reason for your pain? (Examples: Lumbar MRI, Nerve Conduction study, vascular studies, pseudoscan?) **WHEN?**

_____
_____

Are you diabetic? If yes, what was your last A1C?

_____
_____

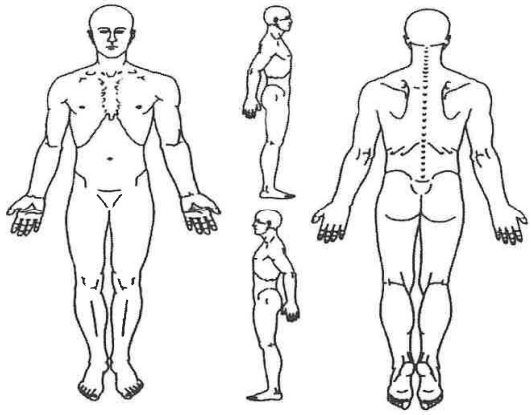
What else is important for us to know?

_____
_____

Please mark an "x" on the region of your pain and describe how this complaint feels.

Aching	Progressive	Stinging
Cramping	Dull	Sharp
Throbbing	Numbness	Burning

Other: _____



SOCIAL HISTORY

Tobacco use? YES / NO / FORMER If YES what is your typical
Alcohol use? YES / NO If YES, Beer / Wine / Liquo
Illegal drug use? YES / NO / FORMER If YES what substance? _____
Do you take NSAIDS (Motrin, Aleve, Advil, Naproxen, etc.) regularly? YES / NO _____

IMPLANTS

Do you have Pacemaker? YES / NO
Do you have a Defibrillator? YES / NO
Pacemaker/ Defibrillator dependent? YES / NO
Do you have a Spinal Cord Stimulator or other nervous system implant? YES / NO
Do you have a seizure disorder? YES / NO

FUNCTIONAL ASSESSMENT

Are you able to walk, stand, sit unassisted?	YES / NO
Assistive devises used for walking?	YES / NO
Can you get up out of a chair unassisted?	YES / NO
Do you have difficulty with your balance?	YES / NO

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MEDICAL HISTORY

Circle all that apply

HEAD:
Trauma

EYES:
Blindness
Cataracts
Glaucoma
glasses/contacts

EARS:
Hearing aids

NOSE/SINUSES:
Allergic Rhinitis
Sinus infections

MOUTH/THROAT:
Dentures

CARDIOVASCULAR:
Aneurysm
Angina
DVT (thrombosis)
Dysrhythmia
Hypertension
Murmur
Myocardial Infarction (heart attack)

RESPIRATORY:
Asthma
Bronchitis
COPD
Emphysema
Pleuritis
Pneumonia

GASTROINTESTINAL:
Cirrhosis
GERD
Gallbladder disease
Heartburn
Hemorrhoids
Hepatitis
Hiatal hernia
Jaundice
Ulcers

GENITOURINARY:
Hernia
Incontinence
Kidney Stones
Other Kidney Disease:
UTI (s)

MUSCULOSKELETAL:
Arthritis
Gout
Injury

DERMATOLOGICAL:
Dermatitis
Mole(s)
Other skin conditions
Psoriasis

NEUROLOGICAL:
Epilepsy
Seizures
Severe headaches/ Migraine
Stroke
TIA

PSYCHIATRIC:
Bipolar disorder
Depression
Hallucinations/ delusions
Suicidal Ideation
Suicide attempts

ENDOCRINE:
Goiter
Hyperlipidemia/cholesterol
Hypothyroidism
Thyroid disease
Thyroiditis
Type I DM
Type II DM

HEMATOLOGY/ONCOLOGY:
Anemia
Cancer: _____

INFECTIOUS DISEASE:
HIV
STD
Tuberculosis (dz)
Tuberculosis (exposure)

AUTOIMMUNE/CUSTOM:
Amputation
Osteoporosis
Dialysis
Prostate (BPH):
Chronic Pain Syndrome
Fibromyalgia
Poor Circulation
Memory loss
Parkinson's
Neuropathy
Lupus
Bleeding disorders

Other Conditions:

_____
_____
_____
_____
_____

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SURGICAL HISTORY

Provide history for the past 5 years. **Include any distant surgeries relevant to current nerve pain**.

Procedure	Date of Surgery	Complications?

FAMILY HISTORY

(check all that apply)

	FATHER	MOTHER	BROTHER	SISTER
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Please Circle	Alive/Deceased	Alive/Deceased	Alive/Deceased	Alive/Deceased
	Age _____	Age _____	Age _____	Age _____

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ALLERGIES

_____

_____

_____

_____

MEDICATIONS

Name: **Dosage:**

_____

_____

_____

_____

_____

_____

_____

_____

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Do I Need a Test for PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys become narrowed or clogged. It affects over 8 Million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Circle YES or NO:

1. Do you have foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest?	**YES**	**NO**
2. Do you experience ongoing pain at rest in your lower legs or feet?	**YES**	**NO**
3. Do you experience foot or toe pain that often disturbs your sleep?	**YES**	**NO**
4. Do your toes or feet become pale, discolored, or bluish easily?	**YES**	**NO**
5. Do have you had skin wounds or ulcers on your feet or toes that are slow to heal?	**YES**	**NO**
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	**YES**	**NO**
7. Have you suffered a severe injury to the leg(s) or feet?	**YES**	**NO**
8. Do you have persistent infection of the leg(s) or feet that have become complicated (gangrenous/black skin tissue)?	**YES**	**NO**

Patient Signature: _____

Physician Signature: _____ Date: _____

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COVID-19 SCREENING ASSESSMENT TOOL

General Questions:

1. **Have you had a COVID VACCINE? YES_____ NO_____ When _____.**
   PLESE NOTE, IF YOU HAVE BEEN VACCINATED YOU MAY SKIP REMAINING QUESTIONS.

COVID-19 Specific Screening:

1. Have you, your primary caregiver, or anyone in your household traveled outside the United States within the last 30 days? If so, provide the locations. YES____ NO_____
   _____

2. Are you, your primary caregiver, or anyone in your household experiencing any respiratory symptoms such as cough or shortness of breath, chest tightness, runny nose, or sore throat?
   YES____ NO_____
3. Have you, your primary caregiver or anyone in your household had a fever of 100.4 F or greater in the last 24 hours? YES____ NO_____
4. Have you been in contact with a person under investigation for COVID-19 or who has tested positive for COVID-19? YES____ NO_____

Patient Authorization

PLEASE NOTE THAT NEUROPATHY TREATMENT CLINICS OF TEXAS DOES NOT DISCLOSE OR SELL ANY PATIENT PROTECTED HEALTH INFORMATION TO ANY THIRD-PARTY BUSINESS OR ONLINE DATABASE.

I authorize Neuropathy Treatment Clinics of Texas ("**NTCOT**") to contact me according the policies of NTCOT regarding facets of my care, including requests for information, verification of payment or benefits, or reminders for appointments. I understand and accept that NTCOT may leave messages on home or cell phone answering system or send reminder cards by U.S. mail, email, or text message according to the policies of NTCOT.

If NTCOT needs to communicate with me regarding my treatment, my preferred method of communication is as follows (check one):

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

☐ Mailed Letter ☐ Text Message ☐ Via Guardian (if selected, also select method of communication)

I understand that if I have chosen home, work, or cell phone as my preferred method of communication, NTCOT may be required to leave a voicemail for me regarding my treatment. In such an event, NTCOT should (check one):

☐ Leave a message with detailed information regarding my treatment.

☐ Leave a message requesting that I call NTCOT at a specified phone number.

I understand that from time to time NTCOT may utilize email or text messages to communicate with me both about my treatment and for marketing purposes. I understand that these emails or text messages may include appointment reminders, general health reminders, feedback requests, newsletters, and other information relating to NTCOT. Accordingly, I (check one):

☐ Authorize NTCOT to email or text me for both treatment and marketing purposes.

☐ Authorize NTCOT to email or text me appointment and health reminders only.

☐ Do not authorize NTCOT to email or text me.

I understand that from time to time NTCOT may take pictures or videos of treatments being performed for training and marketing purposes. I understand that the pictures or videos could be used on NTCOT's social media platform for marketing and informational purposes.

☐ Authorize NTCOT to take and use my pictures or videos for training and marketing purposes.

☐ Do not authorize NTCOT to take or use pictures or videos of me.

I understand that this authorization will remain in effect until I either submit a subsequent Patient Contact Authorization changing my above stated preferences or I revoke or withdraw this authorization in writing. To do so, I must send written notice to NTCOT at 16300 Addison Road, Suite 300, Addison, Texas 75001.

I acknowledge and agree that NTCOT, its employees, officers, and physician are released from any legal responsibility of liability for or resulting from the authorized disclosure of my health or billing information.

Printed Patient Name	**Signature of Patient/Personal Representative**
Relationship to Patient	**Date**
Practice Representative Name	**Signature of Practice Representative/Witness**

Statement of Patient Financial Responsibility

Neuropathy Treatment Clinics of Texas ("**NTCOT**") appreciates the confidence you have shown in choosing us to provide for your health care needs. The services you have elected to participate in imply a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/s on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know their coverage and benefits. The patient authorizes NTCOT to furnish information to insurance carriers concerning their care. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at NTCOT.

If any tests are performed by the lab you may receive a separate bill from their offices that you are financially responsible for. Full payment for NTCOT services provided is due at the time of services rendered; fees and interest may be charged.

If payment is denied for lack of authorization, the patient is responsible for payment in full.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Some health insurance carriers require that the patient is to pay a co-pay for services rendered. This is a contract between you and your insurance carrier. Payment of all co-pays is expected at the time the service is rendered for the patients.

I understand that I am responsible for co-payment and deductible/co-insurance as dictated by my insurance carrier.

Initial_____

CANCELLATION/NO SHOW POLICY

Please Cancel and Reschedule in the event of potentially contagious illness (to include fever, nausea, vomiting, diarrhea).

We understand there may be times when you miss an appointment due to emergencies, illnesses, or obligations to work or family. However, we ask that you call the office 24 hours prior to your appointment time to cancel or reschedule your appointment.

I understand if I miss an appointment without canceling 24-hours in advance, I will be charged a $50 no-show fee and I will not be allowed to schedule another appointment until that fee is paid in full.

Initial_____

I UNDERSTAND THAT AFTER THREE MISSED APPOINTMENTS WITH NO CONTACT TO NTCOT TO CANCEL OR RESCHEDULE APPOINTMENT, I WILL BE DISMISSED FROM MY TREATMENT PROGRAM AT NTCOT.

Initial_____

I UNDERSTAND THAT AFTER FIVE CANCELED APPOINTMENTS, I WILL BE DISMISSED FROM MY TREATMENT PROGRAM AT NTCOT.

Initial_____

I have read the above policy regarding my financial responsibility to NTCOT, for providing medical services to me or the patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to NTCOT. I understand that any amount remaining after such payment has been paid by my insurer carrier becomes the patient's responsibility.

_____
(Signature of patient OR parent/guardian if under the age of 18)

_____ _____
(Print Name) (Date)

Acknowledgment of Receipt of Notice of Privacy Practices

I may refuse to sign this acknowledgement

I, _____, acknowledge that I have received a copy of Neuropathy Treatment Clinics of Texas's Notice of Privacy Practices.

Patient Signature: _____

Date: _____

Witness: _____

Office Use Only

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

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency prohibited obtaining the acknowledgment
Other: _____

HIPAA PRIVACY POLICIES & PROCEDURES

GENERAL RULE: NO USE OR DISCLOSURE

The office of the Neuropathy Treatment Clinics of Texas must not use or disclose protected health information ("**PHI**"), except as these Privacy Policies and Procedures permit or require.

ACKNOWLEDGMENT AND OPTIONAL CONSENT

The office of the Neuropathy Treatment Clinics of Texas will make a good-faith effort to obtain a written acknowledgment of receipt ("**Acknowledgement**") of our Notice of Privacy Practices from a patient before we use or disclose his or her PHI for treatment, to obtain payment for that treatment, or for our healthcare operation ("**TPO**").

Our office's use or disclosure of PHI for our payment activities and healthcare operations may be subject to the minimum necessary requirements.

Our office will stay familiar with Texas's privacy law. If required by state or law, or as directed by the Neuropathy Treatment Clinics of Texas, we will also seek consent from a patient before we use or disclose PHI for TPO purposes in addition to obtaining an Acknowledgment for our Notice of Privacy Practices.

A) Obtaining consent - If consent is to be obtained, upon the individual's first visit as a patient (or next visit is already a patient), our office will request and obtain the patient's written consent for use and disclosure of the patient's PHI for treatment, payment and healthcare operations. Any consent we obtain must be on our consent form, which we may not alter in any way. Our office will include the signed consent form in the patient's chart.

B) Exceptions - Our office does not have to obtain the patient's consent in emergency treatment situations; when treatment is required by law; or when communications barriers prevent consent.

C) Consent Revocation - A patient from whom we obtain consent may revoke it at any time by written notice. Our office includes the revocation in the patient's chart. There is a space at the bottom of our consent form where the patient can revoke the consent.

D) Applicability - Consent for use or disclosure of PHI should not be confused with information consent for treatment. The section applies to our practice.

AUTHORIZATION

In some cases, we must have proper, written authorization from the patient or patient's personal representative before we use or disclose a patient's PHI for any purpose, except TPO or as required or permitted without consent or authorization.

The office of Neuropathy Treatment Clinics of Texas will use the authorization form and will act in strict accordance with the authorization, meaning:

a) A patient may revoke authorization at any time by written notice.

b) The office of the Neuropathy Treatment Clinics of Texas will use or disclose PHI as permitted by a valid authorization we receive from another healthcare provider.

ORAL AGREEMENT

Our office may use or disclose a patient's protected PHI with the patient's oral agreement. We may use professional judgment with common practice for the patient's best interest in allowing a person to act on behalf of the patient's best interest in allowing a person to act on behalf of the patient to pick up supplies, x-rays, etc. We will do all we can possible to verify the identity of the person that this information is released to. Our office does not do marketing that would involve the release of any information about a patient. An exemption to the oral or written agreement would be for coroners, medical examiners, and funeral directors, reporting of neglect or abuse to law enforcement if required by law, etc.

MINIMUM NECESSARY

Our office will make reasonable efforts to disclose, or request of another covered entity, only the minimum necessary PHI to accomplish the intended purpose.

NOTICE OF PRIVACY PRACTICES

The Neuropathy Treatment Clinics of Texas will maintain a Notice of Privacy Practices as required by Privacy Rules. We will use and disclose PHI in conformance with the contents of Notice of Privacy Practices and will revise them whenever there is a material change to our legal duties, the patient's rights, etc. The Neuropathy Clinics of Texas will provide a Notice of Privacy Practices to any person who requests it. This notice will be posted and will be available for patients to take with them. The Neuropathy Treatment Clinics of Texas will make a good-faith effort to obtain from the patient a written Acknowledgment of Receipt of our Notice of Privacy Practices.

PATIENTS RIGHTS

Our office will honor the rights of the patient regarding their PHI. With rare, exceptions, we will permit patients to request access to the PHI we hold. We may offer to provide a summary of the information in the chart. Patients have a right to amend their PHI and other records for as long as we maintain them. We may deny a request to amend PHI or other records if we did not create the information, if we believe the information is accurate and complete, or we do not have the information. We will not physically alter or delete existing notes in a patient's chart. We will inform the patient when we agree to make the amendment. Patients have a right to an accounting of certain disclosures we made (a) before September 1, 2019; (b) to the patient; (c) to or for notification of persons involved in a patient's healthcare or payment for healthcare; (d) for treatment or payment; (e) national security or intelligence purposes; (f) to correctional facilities or law enforcement officials regarding inmates; or (g) according to an Authorization signed by the patient or the patient's representative. Our patients have the right to request our office to restrict use or disclosure of their PHI, including for TPO. We may terminate an agreement restricting use of disclosure of PHI by a written notice of termination to the patient. We will document in the patient's chart any such agreed to restrictions. Our office will be aware of and respect the patient's rights regarding their PHI.

STAFF TRAINING AND MANAGEMENT

The Neuropathy Treatment Clinics of Texas will train all staff members in our office in these Privacy Policies and Procedures, as necessary and appropriate for them to carry out their functions. We will complete the privacy training of our existing workforce by September 1, 2019; and we will train each new staff member within a reasonable time after they begin their job. Our office will develop, document, disseminate, and implement appropriate discipline policies for staff members who violate our Privacy Policies and Procedures, the Privacy Rules, or other applicable federal or state privacy law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Neuropathy Treatment Clinics of Texas at (972) 920-6968.

If you believe your privacy rights have been violated, you can send a complaint to Neuropathy Treatment Clinics of Texas at 16300 Addison Road, Suite 300, Addison, Texas 75001 or the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

We may change our policies and this notice at any time and have those revised policies apply to all the PHI we maintain. If or when we change our notice, we will post the new notice at the office of each practice location where it can be seen.