Smart Neuro Health & Wellness Centers

PEDIATRIC NEW PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Date of Birth: ____/____/____ Sex: ○ Male ○ Female SS # (optional): _____

Main Contact:

Parent/Guardian Name: _____ Relationship: _____

Occupation: _____ Home Phone #: _____ Work Phone #: _____

Parent/Guardian Name: _____ Relationship: _____

Occupation: _____ Home Phone #: _____ Work Phone #: _____

○ Divorced ○ Separated

Are there any special custody arrangements we should be aware of ? ○ Yes ○ No

Siblings: _____ DOB: ____/____/____ Other Siblings: _____ DOB: ____/____/____

If Yes, please describe: _____

_____

_____

Living Arrangements: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

OTHER PATIENT INFORMATION

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____ (Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____ (Please Specify)

Smart Neuro Health & Wellness Centers

PEDIATRIC NEW PATIENT INFORMATION

Patient Name:_____ Date of Birth:_____/_____/_____

INSURANCE INFORMATION

Primary Insurance:_____ Policy/ID # _____

Name of Policy Holder:_____ DOB:_____/_____/_____ Group/Acct #:_____

Employer:_____ Employer Address: _____

City: _____ State: _____ Zip Code:_____ Work #: _____

Secondary Insurance:_____ Policy/ID #: _____

Name of Policy Holder:_____ DOB:_____/_____/_____ Group/Acct #:_____

Employer:_____ Employer Address: _____

City: _____ State: _____ Zip Code:_____ Work #: _____

Smart Neuro Health & Wellness Center

GENERAL CONSENT FORM

Patient Name:_____ **Date of Birth:**_____/_____/_____

Assignment of Benefits. I authorize Smart Neuro Health & Wellness Centers, ("SNHWC") to submit claims on my behalf directly to Medicare/Medicaid/my private health insurance carrier. This means that SNHWC will collect payment for supplies and services provided. I understand that I am financially responsible to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and treatment to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: _____

Consent for Treatment. I consent for SNHWC to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical procedure could expose another individual to my/the patient's BBF, SNHWC may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at SNHWC's expense.

Patient Initials: _____

Electronic Prescription. I understand SNHWC utilizes electronic prescribing technology which facilitates the electronic transmission of prescription information between providers and pharmacists. All triplicate refills between appointments will be charged $20.

Phone Calls. By providing contact information, I authorize SNHWC, its assignees, and third party collection agents to use the contact information I have provided to communicate with me and to place calls to my home/cellular/ employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Involvement of Others in Care. I authorize SNHWC to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #:_____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)

I consent for SNHWC to photograph the minor patient for identification purposes only. **Patient Initials:** _____

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

Smart Neuro Health & Wellness Center

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

Patient Name: _____ DOB ____/____/____
First M.I. Last

☐ M ☐ F

REASON FOR VISIT TODAY: _____

_____

_____

ALLERGIES (Include medications, foods, x-ray dyes) or ☐ NONE KNOWN

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ NONE

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____

Address: _____ City: _____ State/Zip: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. List any additional information on back of sheet) or ☐ NONE

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ NONE

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

FAMILY HISTORY – Is there a family history of:

Is there a family history of:	YES	NO	Relationship	Onset Age	Cause of Death?
ADD/ADHD					
Allergies					
Asthma					
Birth Defects					
Cancer					
Cardiovascular Disease					
Coronary Artery Disease					
Deafness					
Depression					
Developmental Delay					
Developmental Dislocation of Hip					
Diabetes					
Eczema					
Elevated Lipids / Cholesterol					
Eye Problems					

Is there a family history of:	YES	NO	Relationship	Onset Age	Cause of Death?
Genetic Disease					
Heart Attack - at less than 55					
Hemoglobinopathy/Sickle cell					
High Blood Pressure					
Kidney Disease					
Learning Disability					
Mental Disability					
Migraines					
Obesity/Overweight					
Scoliosis					
Seizure Disorder					
Stroke < 55					
Sudden Infant Death Syndrome					
Thyroid Disease					
Other: _____					

Smart Neuro Health & Wellness Center

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____ DOB_____/_____/_____
First M.I. Last

MEDICAL HISTORY

Please write an "X" next to the complaint(s) or ailment(s) that apply to the patient. If you are unsure, place a question mark (?)

Abdominal Pain	☐Yes	☐No	Overweight / Obesity	☐Yes	☐No	Seizure Disorder	☐Yes	☐No
Acne	☐Yes	☐No	Pneumonia	☐Yes	☐No	Sickle Cell	☐Yes	☐No
ADD/ADHD	☐Yes	☐No	Prematurity	☐Yes	☐No	Speech Delay	☐Yes	☐No
Anemia	☐Yes	☐No	Psychiatric / Mental Health Problems	☐Yes	☐No	Stomach Ache / GERD	☐Yes	☐No
Allergies	☐Yes	☐No	Pyelonephritis	☐Yes	☐No	Strabismus / Eye Problems	☐Yes	☐No
Allergic Rhinitis	☐Yes	☐No	Renal Disease / Kidney Problems	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Asthma	☐Yes	☐No	Scoliosis	☐Yes	☐No	Underweight	☐Yes	☐No
Autism	☐Yes	☐No	Seizures, Febrile	☐Yes	☐No	Urinary Tract Infection	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No				Vision Problems	☐Yes	☐No
Bronchitis	☐Yes	☐No						
Cancer	☐Yes	☐No						
Cadiovascular Disease	☐Yes	☐No						
Chickenpox	☐Yes	☐No						
Congenital Heart Disease	☐Yes	☐No						
Concussion	☐Yes	☐No						
Constipation	☐Yes	☐No						
Coronary Artery Disease	☐Yes	☐No						
Deafness	☐Yes	☐No						
Depression	☐Yes	☐No						
Developmental Delay	☐Yes	☐No						
Developmental Dislocation of Hip	☐Yes	☐No						
Diabetes	☐Yes	☐No						
Eating Disorder	☐Yes	☐No						
Eczema	☐Yes	☐No						
Elevated Lipids / Cholesterol Disease	☐Yes	☐No						
Fainting	☐Yes	☐No						
Food Allergy	☐Yes	☐No						
Fracture	☐Yes	☐No						
Genetic Disorder	☐Yes	☐No						
Growth / Weight Problems	☐Yes	☐No						
Headaches	☐Yes	☐No						
Head Injury	☐Yes	☐No						
Hearing Problems	☐Yes	☐No						
Heart Murmur	☐Yes	☐No						
History of Wheezing	☐Yes	☐No						
High Blood Pressure	☐Yes	☐No						
Inhaler/Neb Use	☐Yes	☐No						
Learning Disability	☐Yes	☐No						
Migraines	☐Yes	☐No						
Otitis Media, Recurrent	☐Yes	☐No						

Other?_____

_____

_____

_____

_____

BIRTH HISTORY

Place of birth: _____

Child's birth weight: ___lb.____oz.

Duration of pregnancy:_____

Mom's Age_____Dad's Age _____

Problems with pregnancy? ☐Yes ☐No

(if Yes please specify) _____

Prenatal care given? ☐Yes ☐No

(if Yes please specify) _____

Type of delivery: ☐ Vaginal ☐ C-Section ☐ Forceps / Vacuum

If C-Section, why? _____

_____

Was baby breech? ☐Yes ☐No

Any medications/smoking during pregnancy? ☐Yes ☐No

(if Yes please specify) _____

Problems with labor/delivery? ☐Yes ☐No

(if Yes please specify) _____

Length of stay in nursery:_____

Any nursery complications? ☐Yes ☐No

(if Yes please specify) _____

Birth Defects? ☐Yes ☐No

(if Yes please specify) _____

Child's discharge weight: ___lb.____oz.

Is the baby circumcised? ☐Yes ☐No

HepB given? ☐Yes ☐No Date_____

Passed Hearing Test? ☐Yes ☐No

PEDIATRIC NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____DOB_____/____/_____
First M.I. Last

ADOLESCENT HISTORY

OB/GYN HISTORY (females only)

Has your period started? ☐ Yes ☐ No Last Menstrual cycle:_____duration (days)____No. of Pregnancies:_____No. of Deliveries: _____

TOBACCO HISTORY

Is child an active cigarette smoker? ☐ Yes ☐ No

Has child ever been a cigarette smoker? ☐ Yes ☐ No *If Yes, smoked average of____packs/day for_____years. Quit in_____(yr)

Does child use other tobacco products? ☐ Yes ☐ No *If yes, please specify _____

Does anyone smoke inside/outside house? ☐ Yes ☐ No

ALCOHOL AND DRUG HISTORY

Has child ever been diagnosed with alcoholism? ☐ Yes ☐ No Does child currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Has child ever used: Alcohol ☐ Yes ☐ No Marijuana ☐ Yes ☐ No Recreational drugs ☐ Yes ☐ No

Metabolic Steroids ☐ Yes ☐ No Abused prescription drugs ☐ Yes ☐ No

---

Signature_____ Date_____
Patient/Legal Representative

_____ Date_____
Relationship to Patient

_____ Date_____
Witness

Smart Neuro Health & Wellness Center

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO SNHWC

Name of Patient:_____ D.O.B._____ Age:_____
LAST FIRST M.I.

I,_____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)

to release the following information by mail, fax, electronically or orally to SNHWC:

Address: _____

_____

Phone: _____

Fax: _____

Information is for:

☐ Dr. _____

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. SNHWC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness Signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual Date

Smart Neuro Health & Wellness Center

FINANCIAL POLICY NOTICE

Name: _____
Date of Birth: _____

Thank you for choosing SNHWC. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that
they fully understand their benefits and coverage. We accept cash, MasterCard, Visa and Discover.

Please review and sign after reading each policy listed below

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify SNHWC of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect my coverage. I understand that I am responsible for any amounts not covered by my insurer. Routine in-office procedures, including but not limited to, biopsies, injections, destruction of precancerous and non-cancerous growths are billed separately from my office visit and may be subject to my deductible or coinsurance. I agree to fulfill all policy provisions which my insurance companies may require for payment.

Copayments: I understand that all copays are due at the time of my appointment.

Deductibles: I understand that if it is determined that my insurance policy has an unmet deductible, payment for services at the contracted rate between SNHWC and my insurer will be due at the time of service.

Benefit Representation: I understand that the staff of SNHWC will make every effort to accurately verify my insurance benefits but I will not solely rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at SNHWC all insurance benefits, if any, otherwise payable to me for services rendered. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for all charges whether or not paid by insurance or Medicare. I further agree to pay for any items or services not covered by insurance or Medicare, as applicable. I hereby authorize the SNHWC to release all information necessary to secure all payments or approvals of benefits.

Payment for Ancillary Services (Laboratory/Pathology): I understand that SNHWC utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill for services separately from SNHWC. I acknowledge that payments made to SNHWC are for services rendered by SNHWC and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that SNHWC does not accept Worker's Compensation cases.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. I acknowledge that I must contact SNHWC before this time if I wish to make other payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

_____ _____
Signature of Patient or Guardian/Guarantor **Date**

_____
Relationship

Smart Neuro Health & Wellness Center

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO SNHWC

Name of Patient:_____ D.O.B._____ Age:_____
LAST FIRST M.I.

I,_____, hereby authorize
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person/entity who should release records)
to release the following information by mail, fax, electronically or orally to SNHWC:

Address: _____ **Information is for:**

_____ ☐ Dr. _____

Phone: _____

Fax: _____

For the purpose of: _____

- ☐ All Health Information
- ☐ Statements of Charges or Payments
- ☐ AIDS or HIV Information *Initials* _____
- ☐ History and Physical Examination
- ☐ Copies of Records of Reports Provided to the Above Named (i.e. Hospital, Lab, Clinic, etc.)
- ☐ Mental Health and/or Alcohol & Drug Abuse Treatment *Initials* _____
- ☐ Progress Notes
- ☐ Substance Abuse Records *Initials* _____
- ☐ Genetic Information (inc. genetic test results) *Initials* _____
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Hepatitis Information
- ☐ Photographs, Videotapes, Digital, or Other Images

☐ Record of visit for a specific date(s). Specific dates include or are limited to:

_____

☐ Other (must be specific):

_____

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2. A photocopy or fax of this authorization is as valid as this original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. SNHWC, its employees, officers, and physicians are hereby released from any legal responsibility or liability for receipt of the above information to the extent indicated and authorized herein.
5. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
6. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient Expiration Date of Authorization
unless otherwise noted, authorization expires 1 year from date of signature above

_____ _____
Witness Signature Date

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

_____ _____
Signature of Minor Individual Date

New Patient Intake Forms - Patient Name:_____

Depression Assessment (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
1	2	3	4

ATTRIBUTION: Dr. Kurt Kroenke MD, Robert L. Spitzer MD, Janet B. W. Williams DSW (2001)

New Patient Intake Forms - Patient Name:_____

Anxiety Assessment (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at All	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

It you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3