NEURO-OPHTHALMOLOGY OF TEXAS, P.L.L.C. Phone: 713-942-2187 Fax: 713-942-0265 Web: www.neuroeye.com

FOR OFFICE USE ONLY	Date	Doctor	Chart #

»»»» **PATIENT INFORMATION** Please print legibly. Please give your name as it appears on your insurance card.

Last name	First name	Middle name

Street address	City	State	Zip code

Home phone	Cell phone	E-mail address

Date of birth (mmddyy)	Social security #	Age	Male ☐	Female ☐	Single ☐	Married ☐	Other ☐

Employer	Street address

City	State	Zip code	Employer phone	Extension

»»»» **If patient is under the age of 18**, give name and phone of responsible parent | Phone

WHO IS SENDING YOU TO SEE US? Please print legibly. Please fill in information to the best of your knowledge.

Full name of sending physician/attorney/person	MD ☐	OD ☐	DO ☐	Other

Street address	City	State	Zip code

Office phone	Fax number	Specialty

INSURANCE INFORMATION Please print legibly. Please fill in information as accuratly as possible. Information on front and back of your card.

Insurance provider	Insurance ID #	Insurance group #

Insurance claims address (located on the back of your insurance card)

City	State	Zip code	Provider phone (usually on the back of your card)

»»»» **Insurance Subscriber (if not above patient)** Last name | First name | Middle name

Street address	City	State	Zip code

Home phone	Work phone	Cell phone

Date of birth (mmddyy)	Social security #	Relationship to above patient

PLEASE READ THE INFORMATION BELOW CAREFULLY, THEN SIGN AT THE BOTTOM OF THE PAGE.

PAYMENT POLICY: It is customary to pay for professional services when rendered. For your convenience we accept traveler checks, money orders, cashier checks, personal checks, cash and MOST BUT NOT ALL major credit cards.

INSURANCE: Please read and sign below if you have insurance with HMO/PPO/POS/EPO and the physician is contracted with your carrier. Present your insurance card along with any required referrals or authorizations to the receptionist.

MEDICAL/SURGICAL BENEFITS ASSIGNMENT AND RELEASE OF MEDICAL INFORMATION AGREEMENT: I request payment of my authorized insurance benefits be made for charges on my behalf to Neuro-Ophthalmology of Texas, P.L.L.C. for unpaid medical/surgical procedures performed now or in the future. I also authorize Neuro-Ophthalmology of Texas, P.L.L.C. to release medical information to my insurance company (ies) or agent, now or in the future, for claim consideration purposes.

ADVANCE BENEFICIARY NOTICE (ABN) FOR NON-COVERED SERVICES: During your visit there may be procedures (refraction, prisms, etc.) performed which could possibly be considered NON-COVERED by your insurance company (depending on your policy). If this is the case and you decide to have these tests (and agree to pay for them at the time of your appointment), you will be asked to sign an ABN form.

THE CONTENTS OF THIS DOCUMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

»»»» **Patient / Legal Guardian Signature** (Form is not valid unless it is signed) | Date | **Witness**

1/12/2010

FINANCIAL POLICY FOR NEURO-OPHTHALMOLOGY OF TEXAS, P.L.L.C. 2014

Neuro-Ophthalmology of Texas believes that part of good eye healthcare is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

Payment

Payment is expected at the time of your visit. If you are a cash paying patient, and have no insurance coverage, payment in full is expected at the time of visit. We accept cash, check or credit card. If you have insurance coverage for your visit you will be asked to pay your copayment, deductible, and any coinsurance due to the practice at the time of your visit. We do ask for a copy of your insurance ID and your driver's license or ID card.

Insurance

We are participating providers with several insurance plans both vision and medical. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.

If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim for you. If we later receive payment from your insurer, we will refund any overpayment to you.

If your plan requires a referral from your primary care physician to our providers, please advise us at the time of appointment, supply us with the name and phone number so that we can call and acquire the referral before your appointment. If we are not prior advised and find this information at the time of verifications, it may cause your appointment to be reset to give us adequate time to acquire the referral.

If your provider at Neuro-Ophthalmology of Texas prescribes any procedure that needs an authorization from your insurer, we will call and secure this authorization to the best of our ability. However, it may require your participation and inquiry to your insurer to obtain this authorization before the procedure can be performed.

Not all insurance plans cover all services. Any non-covered services will be the patient responsibility.

Payment is due on day of the visit or upon receipt of a statement from our office. All procedures billed in our office are considered covered unless limited by your specific insurance policy. After appointment, we verify your insurance coverage with your insurer and secure as much payment information on services made available during the call, but that is not a guarantee that all services will be paid. If your insurance explanation of benefit forms stipulates that you owe additional deductible or coinsurance, we will send you a statement requesting payment in full, you will be expected to pay the amount due on the statement.

Medicare;Medicaid; DARS; Workman's Comp; Letters of protection

We are ***not*** participating providers with Medicare; Medicare advantage plans;

Medicaid; DARS or Workman's comp. We don't accept letters of protection from legal firms

Prisms

We will collect the cost of the Fresnel prisms which is $80.00 for each one prism at the time of service and have the patient sign a form stating that they are aware of this out of pocket expense.

In addition the placement of the prism may require measurement and that procedure called Orthoptics [92065] has a cost of $60.00 which patient is also expected to pay if needed at the time of prism dispensing.

Returned Checks

Returned checks will incur a $30.00 service charge. You will be asked to pay in cash, certified funds, or a money order to cover the amount of the check plus the $30 service charge. Funds are payable upon receipt of notice from the clinic.

Cancellations or Missed Appointments

Neuro-Ophthalmology of Texas attempts to call every appointed patient prior to their expected visit day and time, if you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee, send you a statement which is payable upon receipt.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.
I have read and agree to this Financial Policy:

_____

Patient Name

_____

Signature of Patient or Responsible Party

Date: _____

NEURO-OPHTHALMOLOGY OF TEXAS, P.L.L.C. **DR. ROSA ANA TANG, M.D., M.P.H., M.B.A.**

✚ AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION ✚

REQUEST BEING MADE TO: _____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT MAILING ADDRESS (LINE 1): _____

PATIENT MAILING ADDRESS (LINE 2): _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

✚ FOR OFFICE US ONLY! PLEASE LEAVE THIS SECTION BLANK UNLESS OTHERWISE SPECIFIED. ✚

RELEASE INFORMATION FROM:

☐ DR. ROSA ANA TANG, M.D., M.P.H., M.B.A.
2617C WEST HOLCOMBE BLVD PMB #575
HOUSTON, TEXAS 77025
TELEPHONE: 713 942-2187 **FAX:** 713 942-0265

☐ OTHER (SPECIFY ADDRESS BELOW: PHONE / FAX IF KNOWN)

_____

_____

_____

RELEASE INFORMATION TO:

☐ DR. ROSA ANA TANG, M.D., M.P.H., M.B.A.
2617C WEST HOLCOMBE BLVD PMB #575
HOUSTON, TEXAS 77025
TELEPHONE: 713 942-2187 **FAX:** 713 942-0265

☐ OTHER (SPECIFY ADDRESS BELOW: PHONE / FAX IF KNOWN)

_____

_____

_____

✚ PURPOSE OF RELEASE:

☐ TREATMENT/CONTINUED CARE ☐ PERSONAL ☐ PAYMENT OF INSURANCE ☐ OTHER

✚ INFORMATION TO BE RELEASED:

☐ ENTIRE RECORD ☐ OUTPATIENT CLINIC RECORDS ☐ BILLING RECORDS ☐ FILMS

☐ PICTURES ☐ OTHER _____

INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION FORM MAY INCLUDE INFORMATION RELATING TO HUMAN IMMUNODEFICIENCY VIRUS (HIV), OR AQUIRED IMMUNODEFICIENCY SYNDROME (AIDS); TREATMENT FOR OR HISTORY OF DRUG OR ALCOHOL ABUSE; OR MENTAL OR BEHAVIORAL HEALTH OR PSYCHIATRIC CARE. IF YOU WANT TO EXCLUDE THIS INFORMATION, PLEASE CHECK BELOW.

✚ DO NOT RELEASE INFORMATION REGARDING:

☐ HIV / AIDS / STDs ☐ MENTAL / BEHAVIORAL / PSYCHIATRIC CARE ☐ DRUG / ALCOHOL ABUSE

- THIS AUTHORIZATION IS VALID FOR 180 DAYS UNLESS OTHERWISE STATED HERE: _____
- A PHOTOCOPY OR FAX OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.
- I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY SUBMITTING A REVOCATION IN WRITING TO THE RECIPIENT ABOVE.
- IF I REVOKE THIS AUTHORIZATION, THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN GOOD FAITH ACCORDING TO THIS DISCLOSURE BEFORE THE REVOCATION WAS RECEIVED.
- TREATMENT OR PAYMENT MAY NOT BE CONDITIONED ON MY COMPLETION OF THIS AUTHORIZATION FORM.
- IF THE RECIPIENT INDENTIFIED ABOVE IS NOT COVERED BY FEDERAL OR TEXAS PRIVACY LAWS, THE INFORMATION MAY NOT BE PROTECTED UNDER THESE LAWS ONCE IT IS DISCLOSED TO THE RECIPIENT AND MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT.
- I MAY BE ASKED TO PROVIDE PROOF OF MY IDENTITY/GUARDIANSHIP WITH THIS AUTHORIZATION.
- FEES/CHARGES WILL COMPLY WITH ALL LAWS AND REGULATIONS APPLICABLE TO RELEASE OF PROTECTED HEALTH INFORMATION. PAYMENT IS DUE AT THE TIME OF RELEASE OF INFORMATION.

_____

✚ SIGNATURE OF PATIENT OR QUALIFIED PERSONAL REPRESENTATIVE * **DATE**

* IF SIGNED BY A QUALIFIED PERSONAL REPRESENTATIVE, THE FOLLOWING MUST BE COMPLETED:

PRINTED NAME OF QUALIFIED PERSONAL REPRESENTATIVE: _____

✚ LEGAL DOCUMENTATION SHOWING AUTHORITY TO ACT ON BEHALF OF THE PATIENT:

(EXAMPLE: GUARDIAN OF PATIENT, EXECUTOR OF ESTATE): _____

NEURO-OPHTHALMOLOGY OF TEXAS
DR. ROSA ANA TANG, M.D., M.P.H., M.B.A.

NAME:_____
DATE OF BIRTH: _____

INITIALS

1. PERMISSION TO LEAVE A MESSAGE

I GIVE MY PERMISSION FOR THE STAFF OF NEURO-OPHTHALMOLOGY OF TEXAS TO LEAVE MESSAGES CONCERNING LAB WORK, BIOPSY RESULTS, MEDICATIONS, OR ANY OTHER MEDICAL INFORMATION RELATED TO MY CONDITION WITH THE FOLLOWING:

☐ HOME ANSWERING MACHINE TELEPHONE ☐ CELL PHONE ☐ WORK VOICE MAIL/ANSWERING MACHINE

☐ FAMILY MEMBER (PLEASE CIRCLE): SPOUSE CHILDREN PARENTS BROTHER SISTER

NAME: _____ TELEPHONE #: _____

☐ OTHER
NAME: _____ TELEPHONE #: _____

INITIALS

2. IMPORTANT NOTICE TO THE PATIENT

PAYMENT FOR ALL MEDICAL SERVICES RENDERED IS THE RESPONSIBILITY OF THE PATIENT.
NEURO-OPHTHALMOLOGY OF TEXAS, PLLC WILL SUBMIT CLAIMSTO THE PATIENT'S INSURANCE AS A **COURTESY.** IF NOT PROMPTLY PAID BY THE INSURER, PAYMENT WILL BE SOUGHT DIRECTLY FROM THE PATIENT. ANY AMOUNT *NOT PAID* BY THE PATIENT'S INSURANCE IS STILL THE RESONSIBILITY OF THE PATIENT TO PAY.

INITIALS

3. FAX AND ENCRYPTED EMAIL PRIVACY WAIVER

I GIVE MY CONSENT TO FAX MY MEDICAL RECORDS OR TO SEND THEM BY ENCRYPTED EMAIL PASSWORD PROTECTED (I WILL BE GIVEN PASSWORD) AND MAY BE RECEIVED IN ERROR BY A THIRD PARTY. IN THE EVENT THAT THIS SHOULD OCCUR I ABSOLVE NEURO-OPHTHALMOLOGY OF TEXAS, PLLC OF ALL LIABILITY. I GIVE MY CONSENT TO FAX MY RECORDS FOR THE PURPOSE OF TREATMENT, PAYMENT OF HEALTHCARE OPERATIONS AND UNDERSTAND THAT I MAY WITHDRAW THIS CONSENT AT ANY TIME IN WRITING.

INITIALS

4. I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF NEURO-OPHTHALMOLOGY OF TEXAS, PLLC.

I HAVE INITIALED EACH BOX TO ACKNOWLEDGE THAT I UNDERSTAND EACH OF THE CLAUSES EXPLAINED ABOVE.

_____

✚ SIGNATURE OF PATIENT OR QUALIFIED PERSONAL REPRESENTATIVE * **DATE**

* IF SIGNED BY A QUALIFIED PERSONAL REPRESENTATIVE, THE FOLLOWING MUST BE COMPLETED:

PRINTED NAME OF QUALIFIED PERSONAL REPRESENTATIVE: _____

✚ LEGAL DOCUMENTATION SHOWING AUTHORITY TO ACT ON BEHALF OF THE PATIENT:

(EXAMPLE: GUARDIAN OF PATIENT, EXECUTOR OF ESTATE): _____

FOR INTERNAL USE ONLY

_____

VERIFICATION OF SIGNATURE/AUTHORITY **DATE**

Neuro-Ophthalmology OF TEXAS, P.L.L.C.
DR. ROSA ANA TANG, M.D., M.P.H., M.B.A.

IMAGING CONSENT FORM

I, **[PRINT]** _____ , DO HEREBY CONSENT TO PHOTOGRAPHIC, VIDEOGRAPHIC OR ANY OTHER FORM OF IMAGING TO DOCUMENT ANY OCULAR OR NEURO-OCULAR CONDITION. I UNDERSTAND THAT THESE IMAGES MAY BE USED TO DOCUMENT MY STATUS FOR CLINICAL AND TREATMENT PURPOSES AS WELL AS FOR FUTURE USE IN SCHOLARLY PUBLICATION, EDUCATIONAL MATERIAL OR ANY OTHER OPERATION OF NEURO-OPHTHALMOLOGY OF TEXAS, PLLC. I ALSO UNDERSTAND THAT ANY CLINICAL DATA FROM MY MEDICAL RECORD MAY BE USED WITH THESE IMAGES AND THAT ALL INFORMATION USED FOR PUBLICATION, EDUCATIONAL MATERIAL OR ANY OTHER OPERATION WILL BE DE-IDENTIFIED OF PROTECTED HEALTH INFORMATION AS REQUIRED BY PRIVACY REGULATIONS CONTAINED WITHIN THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT OF 1997. IF A "FULL FACE" IS REQUIRED TO DEMONSTRATE THE CONDITION, THEN THAT MAY BE INCLUDED FOR PURPOSES OF PUBLICATION, EDUCATIONAL MATERIAL OR ANY OTHER OPERATION.

I WAIVE ALL RIGHTS THAT I MAY HAVE TO CLAIMS FOR PAYMENTS OF ROYALTIES OR OTHER COMPENSATION IN CONNECTION WITH THE PUBLICATION OF THESE IMAGES AND/OR WITH THE EXHIBITION AND SHOWING OF THESE DE- IDENTIFIED IMAGES AND THE CLINICAL DATA.

✚ SIGNED _____ DATE _____

✚ WITNESSED BY _____ DATE _____

IF PATIENT IS A MINOR:

✚ GUARDIAN NAME (PRINT) _____ SIGNATURE _____ DATE _____

✚ SLIDE	✚ DIGITAL	✚ VIDEO	✚ OTHER	✚ IMAGING
☐ HAND HELD	☐ RETINA/ONH	☐ BIO	☐ CONFOCAL	☐ X-RAY
☐ SLIT LAMP	☐ SLIT LAMP	☐ SLIT LAMP	☐ NFL TOMOGRAPHY	☐ CT
☐ RETINA/ONH (FLAT)	☐ RETINA/ONH	☐ HAND HELD	☐ OCT	☐ MRI / MRA
☐ RETINA/ONH (STEREO)				

PHOTOGRAPHER _____

NEURO-OPHTHALMOLOGY OF TEXAS NAME:_____DATE: _____
DR. ROSA ANA TANG, M.D., M.P.H., M.B.A. CHART#: _____

REVIEW OF SYSTEMS PLEASE COMPLETE EACH SECTION AND FILL OUT NAME/DATE ON EACH PAGE. BE SURE TO SIGN LAST PAGE.

CURRENT MEDICATION: (INCL OTC, VITAMINS, BP, INJECT)

PILLS	STRENGTH	FREQUENCY

EYE DROPS / OINTMENTS	R	L	LAST USED	FREQUENCY

PAST MEDICATIONS (12 MONTHS) (INCL VITAMINS/ANTIBIOTICS)

PILLS	STRENGTH	FREQUENCY

EYE DROPS / OINTMENTS	R	L	LAST USED	FREQUENCY

✚ PAST MEDICAL AND FAMILY HISTORY

OCULAR HISTORY	SELF (PATIENT)	FAMILY
BLINDNESS	☐	☐
DIABETIC RETINOPATHY	☐	☐
EYE TRAUMA	☐	☐
EYE / LID / ORBITAL SURGERY	☐	☐
GLAUCOMA	☐	☐
MACULAR DEGENERATION	☐	☐
MISALIGNED EYES	☐	☐
OPTIC NEURITIS	☐	☐
RETINITIS PIGMENTOSA	☐	☐
UVEITIS (IRITIS)	☐	☐
WEAK / LAZY EYE	☐	☐

MEDICAL HISTORY	SELF (PATIENT)	FAMILY
ALZHEIMER'S	☐	☐
ASTHMA / COPD	☐	☐
BLOOD CLOTS / PHLEBITIS	☐	☐
CANCER	☐	☐
CAROTID ARTERY / BRUITS	☐	☐
COLLAGEN DISEASE / LUPUS	☐	☐
DIABETES	☐	☐
GOUT	☐	☐
HEMOPHILIAC	☐	☐
HEART DISEASE (ASCVD, CHF)	☐	☐
HEART SURGERY	☐	☐
HEPATITIS / LIVER DISEASE	☐	☐
HYPERTENSION	☐	☐
KIDNEY DISEASE / STONES	☐	☐
MENINGITIS	☐	☐
MIGRAINE	☐	☐
MULTIPLE SCLEROSIS	☐	☐
MYASTHENIA	☐	☐
RHEUMATIC FEVER	☐	☐
SEIZURES	☐	☐
SICKLE CELL	☐	☐
STROKE / TIA	☐	☐
THYROID / GOITER	☐	☐
TUBERCULOSIS	☐	☐
ULCER	☐	☐

FAMILY HISTORY	ALIVE	HEALTH STATUS	DEAD	CAUSE OF DEATH ANY OTHER ILLNESS
MOTHER	☐	_____	☐	_____
FATHER	☐	_____	☐	_____
BROTHER	☐	_____	☐	_____
SISTER	☐	_____	☐	_____
SON	☐	_____	☐	_____
DAUGHTER	☐	_____	☐	_____

✚ I. CONSTITUTIONAL

☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ Muscle aches
☐ Night sweats

Height _____ Weight _____

REVIEW OF SYSTEMS PLEASE COMPLETE EACH SECTION AND FILL OUT NAME/DATE ON EACH PAGE. BE SURE TO SIGN LAST PAGE.

✚ II. EYES

☐ Blind Spots in either eye
☐ Blurred vision
☐ Vision distorted
☐ Double vision
☐ Eyelids droopy
☐ Dry eyes
☐ Eyes Bulge
☐ Discharge from eyes
☐ Itching / crusting
☐ Eyelid twitching/spasms
☐ Eyelids close shut off & on
☐ Flashes of light
☐ Floaters
☐ Halos around light
☐ Light sensitivity
☐ Pain
☐ Redness
☐ Decreased peripheral vision
☐ Vision loss
☐ Glasses
☐ Contacts
☐ Last eye exam

_____

✚ III. NEUROLOGIC

☐ Balance problems
☐ Difficulty comprehending
☐ Coordination problems
☐ Fainting spells
☐ Headaches
☐ Loss of awareness
☐ Loss of consciousness
☐ Loss of memory
☐ Numbness / tingling of arm, hand, fingers
☐ Numbness / tingling of face, jaw, mouth?
☐ Numbness / tingling of head, neck, back
☐ Numbness / tingling of leg, foot, toes
☐ Seizures
☐ Smelling difficulties
☐ Speech disorder
☐ Problems swallowing
☐ Change in taste
☐ Tremors or shake
☐Twitching / spasms of arm, hand, fingers
☐Twitching / spasms of face, jaw, mouth
☐Twitching / spasms of head, neck, back
☐Twitching / spasms of leg, foot, toes
☐ Dizziness / Vertigo
☐ Walking problems
☐ Weakness of your arm, hand, fingers
☐ Weakness of your face, jaw, mouth
☐ Weakness of your head, neck, back
☐ Weakness of your leg, foot, toes

✚ IV. ALLERGIC/IMMUNOLOGIC

☐ Drug allergies_____

☐ Environmental allergies _____

✚ V. CARDIOVASCULAR

☐ Chest pain or discomfort
☐ Tightness
☐ Palpitations
☐ Shortness of breath with activity
☐ Difficulty breathing lying down
☐ Swelling (edema)
☐ Calf pain with walking
☐ Leg cramping

✚ VI. EAR, NOSE, MOUTH, THROAT

Skin

☐ Rashes
☐ Lumps
☐ Itching
☐ Dryness
☐ Color changes
☐ Hair and nail changes

Ears

☐ Decreased hearing
☐ Ringing in ears (tinnitus)
☐ Earache
☐ Drainage

REVIEW OF SYSTEMS PLEASE COMPLETE EACH SECTION AND FILL OUT NAME/DATE ON EACH PAGE. BE SURE TO SIGN LAST PAGE.

✚ VI. EAR, NOSE, MOUTH, THROAT (CONTINUED)

Nose

☐ Stuffiness ☐ Itching ☐ Nosebleeds
☐ Discharge ☐ Hay fever ☐ Sinus pain

Throat

☐ Teeth ☐ Sore tongue ☐ Thrush
☐ Gums ☐ Dry mouth ☐ Non-healing sores
☐ Bleeding ☐ Sore throat ☐ Last dental exam
☐ Dentures ☐ Hoarseness _____

✚ VII. ENDOCRINE

☐ Head or cold intolerance ☐ Frequent urination ☐ Change in appetite
☐ Sweating ☐ Thirst

✚ VIII. GASTROINTESTINAL

☐ Swallowing difficulties ☐ Nausea ☐ Constipation
☐ Heartburn ☐ Change in bowel habits ☐ Diarrhea
☐ Change in appetite ☐ Rectal bleeding ☐Yellow eyes or skin

✚ IX. GENITOURINARY

☐ Frequency ☐ Burning or pain ☐ Incontinence
☐ Urgency ☐ Blood in urine ☐ Change in urinary strength

Male

☐ Hernia ☐ Sores ☐ Erectile dysfunction
☐ Penile discharge ☐ Masses or pain

Female

☐ Vaginal dryness ☐ Vaginal discharge
☐ Hot flashes ☐ Itching or rash

Breasts

☐ Lumps ☐ Pain ☐ Discharge

✚ X. OB GYN

☐ Experiencing menopause ☐ Currently pregnant
☐ Miscarriages ☐ Past abortions

✚ XI. HEMATOLOGIC

☐ Ease of bruising ☐ Ease of bleeding

✚ XII. MUSCULOSKELETAL

☐ Muscle or joint pain ☐ Back pain ☐ Swelling of joints
☐ Stiffness ☐ Redness of joints ☐ Trauma

Neck

☐ Lumps ☐ Pain ☐ Stiffness

✚ XIII. RESPIRATORY

☐ Cough ☐ Coughing up blood ☐ Wheezing
☐ Sputum ☐ Shortness of breath ☐ Painful breathing

✚ XIV. PAIN

NEURO-OPHTHALMOLOGY OF TEXAS NAME:_____DATE: _____
DR. ROSA ANA TANG, M.D., M.P.H., M.B.A. CHART#: _____

REVIEW OF SYSTEMS PLEASE COMPLETE EACH SECTION AND FILL OUT NAME/DATE ON EACH PAGE. BE SURE TO SIGN LAST PAGE.

☐ None ☐ Mild ☐ Moderate ☐ Severe

✚ SOCIAL HISTORY:

OCCUPATION: _____ **EDUCATION:** _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ OTHER

PETS (CATS?): _____ **RECENT SCRATCH?** ☐ NO ☐ YES **TRAVELS:** _____

TOBACCO: CURRENT USE? ☐ NO ☐ YES **PAST USE?** ☐ NO ☐ YES: ☐ CIGARETTES ☐ CIGARS ☐ PIPE ☐ CHEW

✚ HOSPITALIZATIONS/SURGERY:

DATE **PLACE & REASON**

_____ _____

_____ _____

_____ _____

✚ INJURIES (SPECIFY IF OCULAR):

DATE **PLACE & REASON**

_____ _____

_____ _____

✚ WHAT OTHER DOCTORS HAVE YOU SEEN IN THE PAST 5 YEARS AND FOR WHAT REASONS? ✚

(IF POSSIBLE, PLEASE LIST ADDRESS, PHONE NUMBER AND MEDICAL SPECIALTY)

_____

_____

_____

_____

++++++++++++++++ IMPORTANT! PLEASE READ AND SIGN THIS PART ++++++++++++++++

☐ I UNDERSTAND THAT DR. _____ MY _____ IS ATTENDING TO ALL POSITIVELY MARKED PROBLEMS ADDRESSED HERE IN THIS REVIEW OF SYSTEM THAT ARE NOT OCULAR IN NATURE.

☐ I WILL MAKE AN APPOINTMENT WITH DR. _____ MY _____ TO ATTEND ALL POSTIVE MEDICAL PROBLEMS ADDRESSD HERE IN THIS REVIEW OF SYSTEMS THAT ARE NOT OCULAR IN NATURE.

_____

✚ PATIENT'S SIGNATURE **DATE**

DO NOT COMPLETE THIS SHADED AREA

COMMENT FROM INTERVIEWER:

RELIABILITY: ☐☐ ☐ ☐ ☐ ☐ ☐ **SPOKE DIRECTLY WITH:** PATIENT ☐ FAMILY ☐ OTHER _____

ALL OF THE 14 REVIEW OF SYSTEMS SUBJECTS WERE REVIEWED BY: _____ **DATE:** _____

ALL OF THE 14 REVIEW OF SYSTEMS SUBJECTS WERE REVIEWED BY: _____ **DATE:** _____

NEURO-OPHTHALMOLOGY OF TEXAS NAME:_____DATE: _____
DR. ROSA ANA TANG, M.D., M.P.H., M.B.A. CHART#: _____

REVIEW OF SYSTEMS PLEASE COMPLETE EACH SECTION AND FILL OUT NAME/DATE ON EACH PAGE. BE SURE TO SIGN LAST PAGE.

✚ SEXUALLY TRANSMITTED DISEASES (STDs) MEDICAL HISTORY

	YES	NO
HIV	☐	☐
AIDS	☐	☐
OTHER	☐	☐

✚ PSYCHIATRIC

☐ Nervousness ☐ Stress ☐ Other: _____
☐ Depression ☐ Anxiety
☐ Memory loss ☐ Bipolar disorder

PSYCHIATRIC HOSPITALIZATION / TREATMENTS

DATE PLACE & REASON

_____ _____

_____ _____

_____ _____

✚ ALCOHOL AND DRUG USE PERSONAL HISTORY

ALCOHOL: CURRENT USE? ☐ NO ☐ YES **PAST USE?** ☐ NO ☐ YES

☐ BEER ☐ WINE ☐ WHISKEY ☐ OCCASIONALLY

RECREATIONAL DRUGS: CURRENT USE? ☐ NO ☐ YES **PAST USE?** ☐ NO ☐ YES:

TYPE _____

_____

_____

TREATMENTS

DATE PLACE & REASON

_____ _____

_____ _____

_____ _____

---------- **PLEASE SIGN BELOW**----------

I CERTIFY THAT THE INFORMATION GIVEN ON THIS FORM IS TRUE AND CORRECT.

_____

✚ PATIENT'S SIGNATURE **DATE**

NEURO-OPHTHALMOLOGY OF TEXAS, P.L.L.C.

ROSA TANG, M.D., M.P.H., M.B.A

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. PLEASE REVIEW IT CAREFULLY.

THE NEURO-OPHTHALMOLOGY OF TEXAS USES HEALTH INFORMATION ABOUT YOU FOR TREATMENT, TO OBTAIN PAYMENT FOR TREATMENT, FOR ADMINISTRATIVE PURPOSES, AND TO EVALUATE THE QUALITY OF CARE THAT YOU RECEIVE. YOUR HEALTH INFORMATION IS CONTAINED IN A MEDICAL RECORD THAT IS THE PHYSICAL PROPERTY OF THE NEURO-OPHTHALMOLOGY OF TEXAS.

HOW NEURO-OPHTHALMOLOGY OF TEXAS MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

✚ **FOR TREATMENT.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE YOUR HEALTH INFORMATION TO PROVIDE YOU WITH MEDICAL TREATMENT OR SERVICES. FOR EXAMPLE, INFORMATION OBTAINED BY A HEALTH CARE PROVIDER, SUCH AS AN OPTOMETRIST, PHYSICIAN, NURSE, OR OTHER PERSON PROVIDING HEALTH SERVICES TO YOU, WILL RECORD INFORMATION IN YOUR RECORD THAT IS RELATED TO YOUR TREATMENT. THIS INFORMATION IS NECESSARY FOR HEALTH CARE PROVIDERS TO DETERMINE WHAT TREATMENT YOU SHOULD RECEIVE. HEALTH CARE PROVIDERS WILL ALSO RECORD ACTIONS TAKEN BY THEM IN THE COURSE OF YOUR TREATMENT AND NOTE HOW YOU RESPOND TO THE ACTIONS. IF YOU HAVE BEEN REFERRED INTO OUR FACILITY FROM A HEALTHCARE PROVIDER OUTSIDE OF THE NEURO-OPHTHALMOLOGY OF TEXAS, THAT REFERRING DOCTOR MAY HAVE SENT INFORMATION ABOUT YOU IN ADVANCE TO HELP IN OUR TREATMENT OF YOU. WE WILL PROVIDE YOUR REFERRING HEALTHCARE PROVIDER WITH COPIES OF YOUR RECORD OR REPORTS THAT WILL ASSIST HIM/HER IN YOUR TREATMENT AND HEALTH CARE AFTER YOU HAVE COMPLETED YOUR MANAGEMENT FROM OUR FACILITY.

✚ **FOR PAYMENT.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE AND DISCLOSE YOUR HEALTH INFORMATION TO OTHERS FOR PURPOSES OF RECEIVING PAYMENT FOR TREATMENT AND SERVICES THAT YOU RECEIVE. FOR EXAMPLE, A BILL MAY BE SENT TO YOU OR A THIRD-PARTY PAYOR, SUCH AS AN INSURANCE COMPANY OR HEALTH PLAN. THE INFORMATION ON THE BILL MAY CONTAIN INFORMATION THAT IDENTIFIES YOU, YOUR DIAGNOSIS, AND TREATMENT OR SUPPLIES USED IN THE COURSE OF TREATMENT.

✚ **FOR HEALTH CARE OPERATIONS.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR OPERATIONAL PURPOSES. FOR EXAMPLE, YOUR HEALTH INFORMATION MAY BE DISCLOSED TO MEMBERS OF THE MEDICAL STAFF, RISK OR QUALITY IMPROVEMENT PERSONNEL, AND OTHERS TO:

- EVALUATE THE PERFORMANCE OF OURSTAFF;
- ASSESS THE QUALITY OF CARE AND OUTCOMES IN YOUR CASES AND SIMILAR CASES;
- LEARN HOW TO IMPROVE OUR FACILITIES AND SERVICES; AND
- DETERMINE HOW TO CONTINUALLY IMPROVE THE QUALITY AND EFFECTIVENESS OF THE HEALTH CARE WE PROVIDE.

✚ **APPOINTMENTS.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE YOUR INFORMATION TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU. YOU OR A FAMILY MEMBER MAY BE CONTACTED BY POSTCARD AND/OR BY AN AUTOMATED TELEPHONE VOICE SYSTEM AT THE NUMBER YOU HAVE PROVIDED, AND ENCRYPTED EMAIL AND FAX AS ALTERNATIVE METHODS FOR CONTACT TO REMIND YOU OF AN UPCOMING APPOINTMENT.

✚**NOTIFICATION.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE OR DISCLOSE INFORMATION TO NOTIFY OR ASSIST IN NOTIFYING A FAMILY MEMBER, PERSONAL REPRESENTATIVE, OR ANOTHER PERSON RESPONSIBLE FOR YOUR CARE OF YOUR GENERAL CONDITION. YOU HAVE THE RIGHT TO RESTRICT WHO WE MAY DISCLOSE INFORMATION TO.

✚**MARKETING.** THE NEURO-OPHTHALMOLOGY OF TEXAS IN COMPLIANCE WITH BOTH FEDERAL AND STATE RESTRICTIONS CANNOT DISCLOSE YOUR HEALTH INFORMATION TO 3RD PARTIES FOR MARKETING PURPOSES UNLESS AN AUTHORIZATION TO DO SO IS OBTAINED FROM YOU IN ADVANCE. HOWEVER, THE NEURO-OPHTHALMOLOGY OF TEXAS MAY DIRECTLY MARKET TO YOU BY FACE-TO-FACE OR BY MAIL FOR RESEARCH OPPORTUNITIES, SERVICES, PROCEDURES OR MATERIALS OFFERED BY THE NEURO-OPHTHALMOLOGY OF TEXAS THAT MAY BE OF BENEFIT TO YOU. IF YOU DO NOT WISH TO RECEIVE THIS INFORMATION, YOU HAVE THE RIGHT TO BE REMOVED FROM OUR MAILING LIST.

✚**REQUIRED BY LAW.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE AND DISCLOSE INFORMATION ABOUT YOU AS REQUIRED BY LAW. FOR EXAMPLE, THE NEURO-OPHTHALMOLOGY OF TEXAS MAY DISCLOSE INFORMATION FOR THE FOLLOWING PURPOSES:

- FOR JUDICIAL AND ADMINISTRATIVE PROCEEDINGS PURSUANT TO LEGAL AUTHORITY;
- TO REPORT INFORMATION RELATED TO VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE; AND
- TO ASSIST LAW ENFORCEMENT OFFICIALS IN THEIR LAW ENFORCEMENT DUTIES;

✚**PUBLIC HEALTH.** YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED FOR PUBLIC HEALTH ACTIVITIES SUCH AS ASSISTING PUBLIC HEALTH AUTHORITIES OR OTHER LEGAL AUTHORITIES TO PREVENT OR CONTROL DISEASE, INJURY, OR DISABILITY, OR FOR OTHER HEALTH OVERSIGHT ACTIVITIES.

✚**DECEDENTS.** HEALTH INFORMATION MAY BE DISCLOSED TO FUNERAL DIRECTORS OR CORONERS TO ENABLE THEM TO CARRY OUT THEIR LAWFUL DUTIES.

✚**RESEARCH.** THE NEURO-OPHTHALMOLOGY OF TEXAS MAY USE YOUR HEALTH INFORMATION FOR RESEARCH PURPOSES WHEN AN INSTITUTIONAL REVIEW BOARD OR PRIVACY BOARD THAT HAS REVIEWED THE RESEARCH PROPOSAL AND ESTABLISHED PROTOCOLS TO ENSURE THE PRIVACY OF YOUR HEALTH INFORMATION HAS APPROVED THE RESEARCH. YOU MAY BE CONTACTED BY TELEPHONE OR BY MAIL ASKING TO PARTICIPATE IN SPECIFIC STUDIES HERE AT THE NEURO-OPHTHALMOLOGY OF TEXAS OR RECEIVE GENERAL INFORMATION ABOUT RESEARCH OPPORTUNITIES.

✚**HEALTH AND SAFETY.** YOUR HEALTH INFORMATION MAY BE DISCLOSED TO AVERT A SERIOUS THREAT TO THE HEALTH OR SAFETY OF YOU OR ANY OTHER PERSON PURSUANT TO APPLICABLE LAW.

✚**GOVERNMENT FUNCTIONS.** YOUR HEALTH INFORMATION MAY BE DISCLOSED FOR SPECIALIZED GOVERNMENT FUNCTIONS SUCH AS PROTECTION OF PUBLIC OFFICIALS OR REPORTING TO VARIOUS BRANCHES OF THE ARMED SERVICES.

✚**WORKERS' COMPENSATION.** YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED IN ORDER TO COMPLY WITH LAWS AND REGULATIONS RELATED TO WORKERS' COMPENSATION.

✚**OTHER USES.** OTHER USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION AND YOU MAY REVOKE THE AUTHORIZATION EXCEPT TO THE EXTENT THE NEURO-OPHTHALMOLOGY OF TEXAS HAS TAKEN ACTION IN RELIANCE ON SUCH.

✚ YOUR HEALTH INFORMATION RIGHTS

YOU HAVE THE RIGHT TO:

- RESTRICT THE RELEASE OF "SENSITIVE HEALTH INFORMATION (SHI)" SUCH AS GENETIC TEST RESULTS, SUBSTANCE ABUSE TREATMENT, HIV/AIDS TEST RESULTS AND MENTAL HEALTH RECORDS. IN ORDER FOR SHI TO BE RELEASED, WE MUST OBTAIN YOUR AUTHORIZATION TO DO SO.
- REQUEST A RESTRICTION ON CERTAIN USES AND DISCLOSURES OR YOUR INFORMATION AS PROVIDED BY
- 45 C.F.R. §164.522; HOWEVER, THE NEURO-OPHTHALMOLOGY OF TEXAS IS NOT REQUIRED TO AGREE TO A REQUESTED RESTRICTION;
- OBTAIN A PAPER COPY OF THE NOTICE OF INFORMATION PRACTICES UPON REQUEST;
- INSPECT AND OBTAIN A COPY OF YOUR HEALTH RECORD AS PROVIDED FOR IN 45 C.F.R. §164.524;
- REQUEST THAT YOUR HEALTH RECORD BE AMENDED AS PROVIDED IN 45 C.F.R. §164.526;
- REQUEST COMMUNICATIONS OF YOUR HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS; AND
- RECEIVE AN ACCOUNTING OF DISCLOSURES MADE OF YOUR HEALTH INFORMATION AS PROVIDED BY 45
- C.F.R. §164.528.

✚ADDITIONAL SECURITY PROTECTION:

- SALE OF YOUR PHI AS A USE OR DISCLOSURE REQUIRES YOUR EXPRESS AUTHORIZATION TO DO SO;
- ADVANCE NOTICE TO YOU IF THE NEURO-OPHTHALMOLOGY OF TEXAS RECEIVES PAYMENT FROM THIRD PARTY TO SEND TREATMENT COMMUNICATIONS AND INFORMATION TO YOU ABOUT PRODUCTS OR SERVICES; AND
- YOU MAY RESTRICT DISCLOSURES OF YOUR PHI TO A HEALTH PLAN WITH RESPECT TO TREATMENT SERVICES FOR WHICH YOU HAVE PAID OUT-OF-POCKET.

✚COMPLAINTS

YOU MAY COMPLAIN TO THE NEURO-OPHTHALMOLOGY OF TEXAS AND TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (OFFICE OF CIVIL RIGHTS) IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED. YOU WILL NOT BE RETALIATED AGAINST FOR FILING A COMPLAINT.

✚OBLIGATIONS OF THE NEURO-OPHTHALMOLOGY OF TEXAS

THE NEURO-OPHTHALMOLOGY OF TEXAS IS REQUIRED BY LAW TO:

- MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION;
- PROVIDE YOU WITH THIS NOTICE OF ITS LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR HEALTH INFORMATION;
- ABIDE BY THE TERMS OF THIS NOTICE;
- NOTIFY YOU IF WE ARE UNABLE TO AGREE TO A REQUESTED RESTRICTION ON HOW YOUR INFORMATION IS USED OR DISCLOSED;
- ACCOMMODATE REASONABLE REQUESTS YOU MAY MAKE TO COMMUNICATE HEALTH INFORMATION BY ALTERNATIVE MEANS OR AT ALTERNATIVE LOCATIONS; AND

THE NEURO-OPHTHALMOLOGY OF TEXAS RESERVES THE RIGHT TO CHANGE ITS INFORMATION PRACTICES AND TO MAKE THE NEW PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION IT MAINTAINS. REVISED NOTICES WILL BE MADE AVAILABLE TO YOU BY UPON YOUR NEXT VISIT. YOU MAY ALWAYS VIEW AND DOWNLOAD ANY UPDATED VERSION BY ACCESSING OUR WEBSITE AT: HTTP://WWW.NEUROEYE.COM/

✚CONTACT INFORMATION

IF YOU HAVE ANY QUESTIONS OR COMPLAINTS, PLEASE CONTACT:

CHIEF PRIVACY OFFICER
DIRECTOR; HIPAA COMPLIANCE AND OVERSIGHT
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