



18300 Katy Freeway, Suite 405  
Houston, TX 77094  
Phone: 281-579-6800  
Fax: 281-579-6804

### **Benefit Verification Disclaimer**

Quote of benefits are not a guarantee of payment. Final payment determination will be made upon processing of claims. All claims will be subject to the provisions and exclusions of each individual policy.

As a courtesy, our office verifies coverage details prior to services; however this does not suffice as the sole verification of benefits as it is patient responsibility to know their benefit details according to the patient benefit booklet received from insurance upon initial coverage.

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**Patient Signature**

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**Date**



**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **MI** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Social Security:** \_\_\_\_\_ **Marital Status:**  Married  Divorced  Single  Widowed  Unknown

**Sex:**  Male  Female **Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Best Number for Reminders:**  Home  Cell  Other (Specify): \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Language:** \_\_\_\_\_

**Race:**  American Indian or Alaska Native  Asian  Black or African American

White  Native Hawaiian or Other Pacific Islander  Hispanic  Refused

**Ethnicity:**  Hispanic  Not Hispanic or Latino  Refused

**Pharmacy Name and Number** \_\_\_\_\_ **Referring Physician:** \_\_\_\_\_

**Emergency Contact Information:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Do you have an advance directive plan?**  Yes  No.

**If yes, is it a**  living will  power of attorney  Organ donor  Other, Specify \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Name of insured:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Name of insured:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**I certify that the above information is correct to the best of my knowledge and authorize NeurocarePlus to submit claims to the above insurance companies, and authorize NeurocarePlus to act as an agent on my behalf to appeal any claim denial. I understand that I am responsible for all charges whether or not covered by my insurance. I also understand that a \$25 no show fee will be applied for all missed office visits(\$50 for procedures), not cancelled or rescheduled 24 hrs prior to the scheduled time, and that this charge is not covered by insurance. I also understand that if my insurance requires referral from my PCP, I am responsible to obtain and to send it to NeurocarePlus prior to my appointment. If no not obtained, my appointment will have to be rescheduled. By signing this form, I voluntarily give consent to such medical care, treatment and diagnostic tests that Dr. Nammour and his designated staff believe are necessary.**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



Family History:

<b>Disease</b>	<b>Familv Member (Mother, Father, Grandparent, Etc)</b>
Diabetes	_____
Hypertension	_____
Heart Disease	_____
Mental Illness	_____
Cancer	_____
Seizures	_____
Epilepsy	_____
Parkinson's	_____
Alzheimer's	_____
MS	_____
Neuropathv	_____
ALS	_____
Other:	_____

Social History:

- Are you a **current smoker\_ former smoker\_ nonsmoker\_**
  - If so, how many cigarettes a day? \_\_\_\_\_
  - Have you considered quitting? **Yes / No / Thinking about it**
  - If former how long has it been since you last smoked? \_\_\_\_\_
- Do you use any othertype of Tobacco? Yes\_ No\_ What type? \_\_\_\_\_
- Do you use any recreational drugs? Yes\_ No\_ If so, which drugs? \_\_\_\_\_
- Did you have a drink containing alcohol in the past year? Yes\_ No\_
- If Yes, how often did you have a drink containing alcohol in the past year?
  - **Monthly or less 2-4 times a month 2-3 times a week 4+ times a week**
- How many drinks did you have on a typical day when you were drinking in the past yr?
  - **1-2 drinks 3-4 drinks 5-6 drinks 7-9 drinks 10 or more drinks**
- How often did you have 6 or more drinks on one occasion in the past year?
  - **Never Less than monthly Monthly Weekly Daily or almost daily**
- Do you drink any beverages containing caffeine? (*Coffee, tea, soda, etc*) Yes\_ No\_
- If yes, how many cups per day? **1-2 cups\_ 2-3 cups\_ 3-4 cups\_ More than 4 cups\_**

Neurocareplus

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M: \_\_\_\_\_

DOB: \_\_\_\_\_

**Thinking ability changes**

I have noticed a recent decline in my memory. \_\_ Y \_\_ N

Others ( my friends or family) tell me that I'm forgetting things they tell me \_\_Y \_\_N

My ability to concentrate seems to have declined recently. \_\_Y \_\_N

I have suffered recent losses that might hurt some of my thinking ability \_\_Y \_\_N

I get confused or easily distracted more than I used to. \_\_Y \_\_N

Signature: \_\_\_\_\_

\_\_ Date: \_\_\_\_\_



First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

*Please provide the best phone number and email for our office to contact you.*

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

I, \_\_\_\_\_, hereby give consent to the following persons to discuss my medical records, and/or test result with Dr. Nicolas Nammour and his staff, as needed.

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I understand that I have the right to revoke this authorization, in writing, at any time this may apply to one or more of the above persons.

Patient Printed Name: \_\_\_\_\_

\_\_\_\_\_ Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**Acknowledgement of Review of Notice of Privacy Practices**

I have reviewed this office's notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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Signature of Patient or Legal Guardian

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Name of Patient or Legal Guardian

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Relationship to Patient

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Date



To the patient: You have the right, as a patient to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing or treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request Dr. Nammour and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I also allow Dr. Nammour and his staff to request a copy of any previous or current prescribed medications to be included in my chart.

I certify that I have read and fully understand the above statements and consents fully and voluntarily to its content.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_





## **Policies and Procedures Effective January 1st, 2018**

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following policies. If you have any questions about these policies please discuss them with the office manager or staff. We are dedicated to providing the best possible care and service to you and we regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

### **Missed or Cancelled Appointments/ Late Arrivals**

It is the responsibility of the patient to arrive for appointments on time. Cancellations MUST be received 24 hours in advance. We reserve the right to charge a \$25 fee for missed, cancelled, or no show appointments. If you are more than 15 minutes late, we reserve the right to ask you to reschedule. If you are late we recommend that you call our office to verify that your appointment will still be honored.

**Initial** \_\_\_\_\_

### **Patient Appointment Responsibility**

When you do not keep your agreed upon appointment, three people are affected. Firstly, you do not receive the needed treatment prescribed by your physician. Secondly, another patient could have benefitted by utilizing your appointment time. Finally, the physician now has a gap in his schedule due to time reserved for you. Note that any missed, cancelled, or no show fees are not covered by your insurance.

**Initial** \_\_\_\_\_

### **Insurance Coverage**

Please understand that as your health care provider and healthcare facility, our relationship is primarily with you and not your insurance company. As a courtesy and convenience to you, we will file insurance claims for all of our patients. We cannot bill your insurance company unless you give us current and accurate insurance information.

**Initial** \_\_\_\_\_

### **Patients Without Insurance**

Occasionally, our patients may find themselves without health insurance coverage. Our policy states that 100% of all anticipated charges must be paid at the time of service.

**Initial** \_\_\_\_\_

### **Forms/Copies of Records**

Please be aware as becoming an establish patient per hipaa guidelines we are required to have you sign and fill out yearly forms and to make copies of your picture ID/TDL and Insurance cards.



Completion of any forms that require your provider's input can be very time consuming for both you and your provider. We require an appointment be made to review the requested information. We reserve the right to charge for a follow up visit. We also reserve the rights to charge for the first 20 pages \$ 25.00 and any additional page .50 cents per page for copying medical records and \$ 30 for any forms or documents to be filled out. Please allow 1week for forms and copies to be completed.

**Initial**\_\_\_\_\_

#### **Pre-Certification**

Pre- Certification (prior approval) may be required by your insurance plan before certain procedures or diagnostic testing. Please allow 48-72 hours for this process to be complete. Please make sure that pre-certification has been given before proceeding with any procedure or diagnostic testing. Scheduling is done through the facility. Our office does not coordinate any scheduling for any outgoing diagnostic studies. Once approval from your insurance is obtained, the facility will contact you to schedule.

**Initial**\_\_\_\_\_

#### **Outgoing Referrals**

All referrals given by the physician will be faxed to the facility. We will provide you with a copy of the referral order. The referred physician's office will contact you to schedule your appointment. Please allow 72 hours for them to contact you, pending office procedure. If the physician is out of network with your insurance please contact your insurance for a list in network providers.

**Initial**\_\_\_\_\_