Gill Eye & Neuroscience

Paul Gill, M.D. *Bobby Gill, M.D.*
Jose R. Labault, M.D. *Mary Lou Alonso, CNRN, NP-C*

Phone: 832/912-7777
Fax: 832/912-7776

PATIENT DEMOGRAPHICS SHEET

Patient Name:_____ **DOB:**_____ **DATE:**_____

Sex: [ ]Male [ ]Female **Marital Status:** [ ]Single [ ]Married [ ]Divorced [ ]Widow [ ]Seperated SSN:____-____-____

Ethnicity: [ ]Hispanic/Latino [ ]Non-Hispanic **Primary Language Spoken:** [ ]English [ ]Spanish [ ]Other:_____

Race: [ ]Caucasian [ ]African American [ ]Native Hawaiian [ ]Asian [ ]American Indian [ ] Other Race: _____ [ ] **Decline to Answer**

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Best Contact #:_____ **Second #:**_____ **Email:** _____

Employment Status: [ ]Employed [ ]Student [ ]Retired [ ]Self-Employed [ ]Unemployed [ ]Disabled

Occupation: _____ **Business #:** _____ **Employer:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Emergency Contact: _____ **Contact #:** _____ **Relationship:** _____

Primary Care Doctor: _____ **PH:** _____ **Fax:** _____

Referring Doctor: _____ **PH:** _____ **Fax:** _____

I found out about Gill Eye & Neuroscience by: [ ]PCP [ ]Relative [ ]Friend [ ] Insurance [ ]Internet [ ]Hospital:_____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Policy or ID#:_____ Group #:_____

Policy Holder Name:_____ DOB:_____ SSN: ____-____-____

Secondary Insurance: _____ Phone: _____

Policy or ID#:_____ Group #:_____

Policy Holder Name:_____ DOB:_____ SSN: ____-____-____

CONSENT TO MEDICAL TREATMENT
I hereby authorize Gill Eye & Neuroscience & its employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the physical may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not and exact science and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or physician as to the result of the treatments, examination or otherwise that may be obtained.

ASSIGNMENT OF INSURANCE BENEFITS TO PROVIDER
I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XVIII of the Social Security Act that may cover professional services rendered to the above name mentioned assignee.

FINANCIAL AGREEMENT
I agree to pay any balance of the charges over & above the mentioned benefits. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

AUTHORIZATION TO RELEASE INFORMATION
I authorize the release of any information to any insurance company or third party payer for the purpose of obtaining payment for services provided. I authorize release of any information to any physician, skilled facility or other.

Patient/Responsible Party Signature: _____

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REVIEW OF SYSTEMS

Patient Name: _____ **DOB:** _____ **DATE:** _____

FORM COMPLETED BY: [ ] Patient [ ] Other/Name: _____ Relationship: _____

◯ CHECK HERE IF NONE OF THE FOLLOWING APPLY: _____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING: (Check all that apply)

GENERAL:
- ◯ Weight Change
- ◯ Loss of Weight
- ◯ Fatigue
- ◯ Fever
- ◯ Chills
- ◯ Night Sweats
- ◯ Swollen Lymph Glands

RESPIRATORY:
- ◯ Cough
- ◯ Shortness of Breath
- ◯ Wheezing
- ◯ Coughing up blood or Sputum

ENDOCRINE:
- ◯ Heat Intolerance
- ◯ Cold Intolerance
- ◯ Excessive Thirst
- ◯ Excessive Hunger

GASTRO-INTESTINAL:
- ◯ Nausea
- ◯ Vomiting
- ◯ Change in Bowel Habit
- ◯ Bloody Stools

IMMUNOLOGIC:
- ◯ Seasonal Allergies
- ◯ Hives
- ◯ Rash

GENITOURINARY:
- ◯ Frequency
- ◯ Hesitation
- ◯ Urgency
- ◯ Inability to Empty Bladder
- ◯ Lack of Sexual Drive

CARDIOVASCULAR:
- ◯ Chest pain/discomfort
- ◯ Shortness of Breath
- ◯ Palpitations

NEUROLOGIC:
- ◯ Headache
- ◯ Dizziness
- ◯ Vertigo
- ◯ Fainting
- ◯ Difficulty with Speech
- ◯ Weakness
- ◯ Tingling
- ◯ Numbness
- ◯ Difficulty with Concentration
- ◯ Memory Problems
- ◯ Abnormal Sleep Habit
- ◯ Brief loss of Responsiveness

MUSCULOSKELETAL:
- ◯ Muscle Aches
- ◯ Joint Pain
- ◯ Muscle Cramps
- ◯ Neck Pain
- ◯ Back Pain
- ◯ Weakness

PSYCHIATRIC:
- ◯ Depressed mood
- ◯ Thoughts of Suicide
- ◯ Anxiety
- ◯ Visual Hallucinations
- ◯ Auditory Hallucinations

SKIN:
- ◯ Rashes
- ◯ Suspicious Lesions
- ◯ Change in Moles

EAR, NOSE & THROAT:
- ◯ Altered Hearing
- ◯ Earache
- ◯ Ringing
- ◯ Hoarseness
- ◯ Sore Throat
- ◯ Nasal Congestion
- ◯ Facial Pain

EYES:
- ◯ Blurred Vision
- ◯ Double Vision
- ◯ Light Sensitivity
- ◯ Eye Pain
- ◯ Brief loss of Vision

SOCIAL HISTORY:

- ◯ Refuse to answer

Do you smoke?
- ◯ No, never
- ◯ No, quit/Date: _____
- ◯ Yes

If yes, how often do you smoke?
- ◯ Every day
- ◯ Some days, but not every day

Number of cigarettes per day:
- ◯ Less than 5
- ◯ 6-10
- ◯ 11-20
- ◯ 21-30
- ◯ 31 or more

How soon after you wake up do you smoke?
- ◯ Within 5 minutes
- ◯ 6 – 30 minutes
- ◯ 31 – 60 minutes
- ◯ After 60 minutes

Are you interested in quitting?
- ◯ Ready to quite
- ◯ Thinking about quitting
- ◯ Not ready to quite

Do you drink alcohol?
- ◯ No, never
- ◯ No, quit/Date: _____

If yes, how often do you drink alcohol?
- ◯ Every day
- ◯ Some days
- ◯ Socially
- ◯ Rarely

Type of drinks:
- ◯ Beer, # _____
- ◯ Wine, # _____
- ◯ Whiskey, # _____
- ◯ Scotch, # _____
- ◯ Rum, # _____
- ◯ Vodka, # _____
- ◯ Mixed drinks, # _____

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Patient Name: _____ **DATE:** _____ **Referring Doctor:** _____

PAST MEDICAL HISTORY:

(Check all that apply)

- ◯ **No significant medical history**
- ◯ High blood pressure
- ◯ Elevated Cholesterol
- ◯ Elevated Triglycerides
- ◯ Coronary Artery Disease
- ◯ Heart Attack
- ◯ Heart Disease
- ◯ Atrial Fibrillation
- ◯ Congestive Heart Failure
- ◯ Aortic Stenosis
- ◯ Mitral Stenosis
- ◯ Cardiac Murmur
- ◯ Patent Foramen Ovale
- ◯ Abdominal Aneurysm
- ◯ Chronic Neck Pain
- ◯ Chronic Back Pain
- ◯ Arthritis
- ◯ Rheumatoid Arthritis
- ◯ Fibromyalgia
- ◯ Carpal Tunnel Syndrome
- ◯ Migraine Headaches
- ◯ Cluster Headaches
- ◯ Dizziness
- ◯ Vertigo
- ◯ Stroke
- ◯ TIA/Transient Ischemic Attack
- ◯ Cerebral Aneurysm
- ◯ Seizure Disorder
- ◯ Dementia
- ◯ Parkinson's Disease
- ◯ Multiple Sclerosis
- ◯ Peripheral Neuropathy
- ◯ Autism
- ◯ Down Syndrome
- ◯ Mental Retardation
- ◯ Anxiety
- ◯ Depression
- ◯ Panic Disorder
- ◯ Bipolar Disorder
- ◯ Schizophrenia
- ◯ Asthma
- ◯ COPD
- ◯ Emphysema
- ◯ Pneumonia
- ◯ Pulmonary Embolism
- ◯ Sleep Apnea
- ◯ Previous Intubation
- ◯ Anemia
- ◯ Diabetes
- ◯ Thyroid Disorder
- ◯ Renal Failure
- ◯ Renal insufficiency
- ◯ Kidney stones
- ◯ Chronic UTI's
- ◯ Constipation
- ◯ Diarrhea
- ◯ Acid Reflux
- ◯ Gastric Ulcers
- ◯ Diverticulosis
- ◯ Blurred Vision
- ◯ Double Vision
- ◯ Light Sensitivity
- ◯ Eye Pain
- ◯ Blindness
- ◯ Tunnel Vision
- ◯ Cancer, Type:

_____

- ◯ OTHER:

_____

_____

SURGICAL HISTORY:

(Check all that apply and provide a year)

- ◯ **No Surgery**
- ◯ Cardiac Pacemaker
- ◯ Angioplasty
- ◯ Angioplasty with stent
- ◯ Aneurysm, [ ]clipping [ ]coiling [ ]embolization
- ◯ Craniotomy, Reason:_____
- ◯ Appendectomy
- ◯ Arthroscopy knee, [ ]R [ ]L
- ◯ Neck surgery
- ◯ Thoracic back surgery
- ◯ Lumbar back surgery
- ◯ CABG (open heart surgery)
- ◯ Carpal Tunnel Release,- [ ]R [ ]L
- ◯ Cataract
- ◯ Cholecystectomy (Gallbladder)
- ◯ Cholectomy (Colon removed)
- ◯ Colostomy
- ◯ Gastric Bypass
- ◯ Hernia Repair
- ◯ Hip Replacement, [ ]R [ ]L
- ◯ Knee Replacement, [ ]R [ ]L
- ◯ Lasik
- ◯ Liver Biopsy
- ◯ Small Bowel Resection
- ◯ Thyroidectomy
- ◯ Tonsillectomy

Gender Specific Male:

- ◯ Prostatectomy
- ◯ TURP
- ◯ Vasectomy

Gender Specific Females:

- ◯ Breast Augmentation
- ◯ Tubal Ligation
- ◯ Hysterectomy
- ◯ Breast Biopsy, [ ]R [ ]L
- ◯ C-Section
- ◯ D & C
- ◯ Mastectomy, [ ]R [ ]L

OTHER:_____

_____

FAMILY HISTORY: (Please circle all that apply, and relation to family member)

Diabetes: _____ Migraine headaches: _____
High blood pressure: _____ Alzheimer's disease: _____
High cholesterol: _____ Parkinson's disease: _____
Stroke: _____ Arthritis: _____
Heart disease: _____ Asthma: _____
Coronary artery disease: _____ Glaucoma: _____
Seizure disorder: _____ Macular disease: _____
Cancer, Type: _____

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Patient Name: _____ **DOB:** _____ **DATE:** _____

CURRENT MEDICATIONS: (Please include strength and frequency)

◯ Check if NO Medications

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGIES:

◯ Check if NO Know Drug Allergies. If yes, please list below:

_____ _____ _____
_____ _____ _____
_____ _____ _____

PHARMACY INFORMATION:

Pharmacy name: _____

Pharmacy number: _____

MISC. INFORMATION:

Who currently lives with you? _____

If you live in a facility or group home, please provide the name: _____

Current occupation: _____ Do you work FT or PT: _____

Are you under the care of a pain management specialist? If, yes please provide the name and phone number:

_____

Do you smoke? (see ROS for details)
◯ YES
◯ NO
Do you drink alcohol? (see ROS for details)
◯ YES
◯ NO
Do you use illicit drugs
◯ YES
◯ NO
If yes, what type and how often?_____

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Acknowledgment of Review of Notice of Privacy Practice

I have reviewed Gill Eye and Neuroscience's Notice of Privacy Practices which explains how my information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative _____ Date _____

Name of Patient or Personal Representative _____ Description of Personal Representative's Authority _____

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Gill Eye and Neurosciences cares about protecting all patients' privacy. In the process of providing services requested we will collect, use and share certain information provided by the patient. The "Notice of Privacy Practices" explains in detail what information is collected and how information may be used.

TREATMENT – We are permitted to use and disclose your medical information to those involved in your treatment including, but not limited to, hospital staff, primary care physicians and specialist.

PAYMENT – we are permitted to use and disclose your medical information to bill and collect payment of services provided to you. This includes correspondences & records to all insurance companies and/or PIP or Workers Comp Plans.

HEALTH CARE OPERATIONS – We are permitted to use or disclose your medical information for the purposes of healthcare operations, which are activities that support Gill Eye & Neuroscience's, and ensure that quality care is delivered.

DISCLOSURES WITHOUT PATIENT AUTHORIZATION – There are situations in which we are permitted by law to disclose or use your medical information without written authorization or opportunity to object. These include, but are not limited to, the following: Public Health Activities, Abuse/Neglect, health Oversight, Legal Proceedings, Law Enforcement, Workers' Compensation, Military or otherwise required by law.

RESTRICTION – You may request that a restriction or limit be placed on how your protected health information is used or disclosed for treatment, payment or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency situations.

INSPECTION/AMENDMENT OF MEDICAL INFORMATION – You may inspect and/or copy health information that is within the designated record set. You may request an amendment of your medical information in the designated record set also. Any such request must be submitted in writing to the Gill Eye & Neuroscience's Privacy Officer or Manager.

Gill Eye & Neurosciences is required by law and regulation to protect the privacy of patients' medical information, to provide notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect. This notice is subject to change at any time. If changes are made a new notice will be posted in the office where it can be seen.

IF YOU CHOSE TO DECLINE TO SIGN THIS NOTICE PLEASE INTIAL & DATE HERE: _____ _____
STAFF'S INTIALS: _____ **DATE:** _____ **Patient Signature** **Date**

Gill Eye and Neurosciences Financial Policy

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

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept Cash, Check, Visa, MasterCard, Discover, and American Express.

Your health plan will only pay for services that it determines to be "reasonable and necessary". If your health plan determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under program standards, your plan will deny payment for this service. In the event that your plan determines a service "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice, and I agree to be bound by its term. I also understand and agree that the practice may amend such terms from time to time.

_____

Printed Name of Patient

_____ _____

Signature of Patient or Responsible Party if a Minor Date

Gill Neuroscience
21212 Northwest Freeway Suite 515
Cypress, Texas 77429
Ph: 832.912.7777
Fax: 832.912.7777

COMPENSATION

(ALL PATIENTS MUST SIGN THIS FORM)

This letter is to inform you that if you are seeing our physician for treatment today, and you are currently involved with a Worker's Compensation case or PIP, we **DO NOT ACCEPT** Worker's Compensation Coverage/PIP at our office.

We are happy to administer care to you and truly appreciate your business.
Appointments may be made with our physician but **at the time of check out** the patient will be responsible for **PAYMENT IN FULL** for all services received.

Upon checking out please feel free to obtain a copy of all medical records, progress notes, a detailed description of services that were performed & a receipt so that you may submit your out of pocket fees to your Worker's Compensation Coverage/Case Manager/PIP.

Please sign below stating you are aware of our Worker's Compensation/PIP Policy.

Name of Patient or Personal Representative	**Signature of Patient or Personal Representative**	**Date Signed**
GUARDIAN'S PRINTED NAME (If the patient is under 18 years of age)	**GUARDIAN'S SIGNATURE**	**DATE SIGNED**

** PLEASE FEEL FREE TO ASK FOR A COPY OF THIS FORM

Gill Eye & Neuroscience *Paul Gill, M.D.* *Bobby Gill, M.D.* *Phone: 832/912-7777*
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RELEASE OF MEDICAL INFORMATION

I authorize Gill Eye & Neuroscience to release Medical records to other requesting Physcians (including AIDS/HIV records).

- ◯ **YES**
- ◯ **NO**

I authorize Gill Eye & Neuroscience to leave detailed messages regarding medical issues, records, diagnostic testing and lab results (including AIDS/HIV test).

- ◯ **YES**
- ◯ **NO**
  - ➢ **Phone #:** _____

I authorize Gill Eye & Neuroscience to discuss medical issues, records, diagnostic testing and lab results (including AIDS/HIV test) to the name(s) listed below:

- ◯ **YES**
- ◯ **NO**

Please list the full name(s) and relationship to the patient:

Name:_____**Phone#**_____**Relationship:**_____

Name:_____**Phone#**_____**Relationship:**_____

E-PRESCRIBING/MEDICATION HISTORY CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Gill Eye & Neuroscience can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. Understanding all of the above, I hereby provide informed consent to Gill Eye & Neuroscience to enroll me in the e-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name DOB

Patient/Responsible Party Signature Date

GILL EYE AND NEUROSCIENCE
21212 NORTHWEST FREEWAY SUITE, 515
CYPRESS, TEXAS 77429
PHONE: (832) 912-7777
FAX: (832) 912-7776

AUTHORIZATION FOR RELEASE OF PROTECED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I authorize *Gill Eye and Neuroscience* to (circle) **RELEASE TO / RECEIVE FROM :**
Name of person or Organization: _____

Address: _____ City _____ State _____ Zip _____

Phone #: _____ Fax #: _____

HEALTH INFORMATION TO BE RELEASED (check all that apply):

___ ALL RECORDS

___ Emergency Room	___ Radiology reports	___ Lab work	___ Radiology films
___ History & Physical	___ Drug/Alcohol info.	___ Pathology report	___ Billing records
___ Consultations	___ Psychiatric info.	___ HIV testing results	___ Cath Lab film
___ Discharge Summary	___ Operative Report	___ AIDS info.	

___ Other: _____

This information is being released for the following purpose:

___ Continued Care ___ Attorney/Litigation ___ Insurance ___ Disability Service

___ Other: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (180) days from the date of my signature, unless specified in writting here:

_____

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.
FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

_____

Signature of Patient or Legally Authorized Representative **Date**

_____

Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, personal reprentative, etc.)**