Welcome to the office of Kiran Shah, M.D. and Alpa Shah, M.D. Enclosed you will find History form, Registration form, Release of Medical record form, Receipt of Privacy Policy form, Consent form, Privacy notice, Appointment and Cancellation policy, Payment Policy form that you will have to complete prior to your arrival for the appointment. Completion of these forms is vital for an efficient and thorough evaluation of your condition and health needs. Please arrive for your appointment at least TWENTY MINUTES AHEAD OF TIME so that we may gather any additional information before your scheduled appointment. We make every effort to see our patients in a timely manner. IF YOU ARE LATE FOR YOUR APPOINTMENT, RESCHEDULING MAY BE NECESSARY.

Most HMO plans require a referral from your primary care physician for a visit to specialist like us. A referral must be in place prior to your visit or you will be personally financially responsible for any and all charges incurred from your visit. Please bring a referral from your primary care physician.

Our office hours vary according to individual physician schedules, but our staff is available from 8:30 a.m. to 5:00 p.m. Monday to Friday. After business hours, calls are handled by an automated answering service. Our office is not equipped to manage life threatening emergencies. You should call 911 or report to an emergency room for all medical emergencies. Our office may call to confirm your appointments, PLEASE LET US KNOW IF YOU DO NOT WANT US TO CONTACT YOU AT CERTAIN LOCATIONS.

Your co-payments or payments towards your insurance deductible will be collected at the time of your visit. We will file secondary insurance, however if you have Medicare, please ask them to file for you. If you no health insurance, full payment is expected at the time of your appointment, in the form of cash, check, Visa/Master card or money order.

Should your medical condition require hospitalization or certain types of testing, pre-approval from your insurance company may be necessary. We will attempt to make appropriate arrangements as quickly as possible, but your assistance and notification of your insurance carrier may be required. You should understand that in some instances, our requests for hospitalization and tests are denied by the insurance carrier. If you have a medical emergency, pre-approval is usually not necessary.

As a patient of Neurology & Sleep clinic, you will receive an excellent neurological care and have access to most modern neurodiagnostic testing facility. We will provide refills for medications that we have prescribed AS LONG AS CERTAIN GUIDELINES ARE FOLLOWED. PLEASE DO NOT WAIT UNTIL YOU HAVE EXHAUSTED YOUR SUPPLY OF MEDICATION BEFORE REQUESTING REFILLS. If your request is appropriate and is received prior to 3:00 p.m. on a regular business day, we will attempt to refill the same day. After hours, on weekends, and on holidays, the on-call physician CANNOT refill prescriptions or begin new medications over the phone.

Thank you for choosing Neurology & Sleep clinic and taking the time to read this information and completing the enclosed forms. We hope that the above information will be useful and we look forward to seeing you.

I have read and understand the above office policy- _______________________

(Patient Signature and Date)
Name: _________________________________

Height: __ Ft __ in.  Weight: _____ lbs.  Neck Girth: _____ in.  Handed: Right / Left

Occupation: ___________________________  Education: High school  GED  College  PhD/Masters

What is the reason for your visit? ____________________________________________________________

When did symptoms start? __________________________ Does it occur daily, weekly, monthly or randomly? ______

What is the location of the symptoms? __________________________ Does it involve any other body part? ______

What makes it worse? __________________________  What makes it better? __________________________

How do you rate your symptoms? (0- none, 10- worst ever) _____ Related to work injury or automobile accident? ______

How do the symptoms affect your daily activities at home and work? ____________________________

Have you tried any medications (over the counter or prescribed)? ________________________________

Please provide results and location of recent CT, MRI, Blood work, EMG, EEG, Sleep Study: ____________________________

Do you have any of the following symptoms at PRESENT TIME?

Headache  Visual change  Nausea/Vomiting  Dizziness/Vertigo  Difficulty swallowing

Difficulty speaking  Memory problems  Tremors  Hearing problems  Seizures

Falls  Passing out  Snoring  Daytime sleepiness  Fatigue

Restless legs  Muscle Stiffness  Hand/Arm pain  Neck pain  Foot/leg pain

Low back pain  Hand weakness  Tingling/Numbness  Difficulty walking  Incontinence

Other: __________________________________________________________________________________

Past Medical History:  Hypertension  Diabetes  High Cholesterol  Sinus disease

Heart disease/CHF  COPD/Emphysema  Stroke  Brain tumor/ Aneurysm  Bleeding disorder

Cancer  Stomach Ulcer  Depression/Anxiety  Liver disease  Kidney disease

Hypothyroidism  Vitamin Deficiency  Anemia  Other: __________________________________________________________________________________

Past Surgical History: (Please list all surgeries and dates):

Brain  Neck  Back  Heart  Carotid  Tonsils  Knee  DBS

VNS  Others: ___________________, __________________, ____________

Have you had any recent accidents or injuries? ____________________________________________________

Have you had any recent hospitalization? ____________________________________________________________________
### Family History:
(State the health information of the following family members)

Parents: ____________________________  Siblings: ____________________________  Children: ____________________________  
Grand-Parents: ____________________________  Extended Family: ____________________________  
Are you adopted: _____  Does any hereditary disorder run in your family? ____________________________  

### Social History:

Tobacco:  Never Smoked: _____  Former Smoker: _____  Quit Date: ________  Current every day Smoker: _____  
Alcohol:  Do not Drink: _____  Occasional/Social Drinker: _____  Heavy Drinker: _____  Used to drink: ________  
Illicit Drugs:  Do you take drugs? _____  Which ones? _____  How often: _____  Used to take in past: ________  
Caffeine:  Coffee ________  Tea ________  Soda _____  How many and how often? ____________________________  
Marital Status:  Single  Married  Divorced  Widower  
Do you exercise regularly? How often per week: ________  Spouse’s job: ____________________________  

### Allergies: (Medications & Food):

__________________________________________________________________________  

### Medications: (List all medications – prescribed and over the counter- with dosage)

__________________________________________________________________________  
__________________________________________________________________________  
__________________________________________________________________________  
__________________________________________________________________________  
__________________________________________________________________________  
Do you take Aspirin or other Anti-platelet medication? _____  Since how long? _____  

### Review of system: Please circle any problems that are present at present?

- Fever  Chills  Night sweats  Weight gain  Weight loss  Bleeding  Bruising  Hearing problems  Vomiting  
- Double vision  Blurry vision  Palpitation  Chest pain  Shortness of breath  Constipation  Diarrhea  Nausea  
- Urinary incontinence  Anxiety  Depression  Skin Rash  Sexual complaint  Joint Pains  

### Epworth Sleepiness Scale:
(How likely are you to doze off or fall asleep in the following situations? 0- would never doze, 
1- Slight chance of dozing, 2- Moderate chance of dozing, 3- High chance of dozing.)

- Sitting and Reading  0  1  2  3  
- Watching Television  0  1  2  3  
- Sitting inactive in a public place (theatre)  0  1  2  3  
- As a car passenger for an hour without break  0  1  2  3  
- Lying down to rest in the afternoon  0  1  2  3  
- Sitting and talking to someone  0  1  2  3  
- Sitting quietly after lunch without alcohol  0  1  2  3  
- In a car, while stopping for few minutes in traffic  0  1  2  3  

**Total**  _____________
### Sleep Environment:

<table>
<thead>
<tr>
<th>Question</th>
<th>Options 0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>What time do you sleep on weekdays?</td>
<td></td>
</tr>
<tr>
<td>What time do you sleep on weekends?</td>
<td></td>
</tr>
<tr>
<td>What time do you wake up on weekdays?</td>
<td></td>
</tr>
<tr>
<td>What time do you wake up on weekends?</td>
<td></td>
</tr>
<tr>
<td>Average number of awakenings during sleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Do you read in Bed?</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Do you carry work to bed?</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Do you watch TV in bed?</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Does your bed partner have sleep problems?</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Do you nap in daytime, If yes, how long?</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Trouble falling asleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Trouble staying asleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Snoring</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Your Breathing stops at night</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Wakes up to pass urine at night</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Heartburns at night</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Leg kicking at night</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Sweating at night</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Teeth grinding at night</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Inability to move while falling asleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Unusual vision at sleep onset</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Feel Groggy/tired on awakening</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Morning headaches on awakening</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Wake up with dry mouth</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Nightmares</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Seizures during sleep</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Daytime sleepiness</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Daytime fatigue</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Fights sleep while driving</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Loss of strength/falls when startled</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Have Memory problems</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>Had motor vehicle accident due to sleepiness</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>History of narrowed airway or enlargement of tonsils/adenoids:</td>
<td></td>
</tr>
<tr>
<td>History of Tonsillectomy/Adenoidectomy:</td>
<td>Yes No</td>
</tr>
<tr>
<td>Prolong sitting at work or home or Lack of regular exercise:</td>
<td>Yes No</td>
</tr>
<tr>
<td>Sleep Study in past:</td>
<td>Yes No</td>
</tr>
<tr>
<td>CPAP or BiPaP tried in past</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

---

I have reviewed and completed all 3 pages of History Form today.

_________________________  _________________________
Patient or Guardian Signature  Date
REGISTRATION FORM

Patient Information:
Patient (Last, First): ____________________________________________ D.O.B: __________________
Address: __________________________________________________________________________________
City: ___________________________ State: ___________ Zipcode: __________________ Gender: ________________
Ph # Home: ____________________ Cell: ___________________ Work: ______________________________
DL#: _____________________ Marital Status: ____________ Social Security #: ___________________________
Parent’s Name (if Patient is Minor): _____________________________________________________________
Employer Name: ___________________________ Occupation: _________________________________
Employer Address: _________________________________________________________________________
Name & Address of nearest relative (not living with you): _________________________________________
Phone: ____________________________
Pharmacy Name: ___________________________ Pharmacy Phone: _____________________________
Pharmacy Address: ___________________________ Pharmacy Fax: ______________________________
Referring Physician Full Name: ___________________________ Phone: _____________________________
Primary Care Physician Name: ___________________________ Phone: _____________________________

Primary Insurance Company Information
Insurance Company Name: ___________________________ Phone #: ______________________________
Group #: ___________________________ Policy #: ________________________________
Insured Name: ___________________________ D.O.B: __________________
Soc Sec #: ___________________________ Relationship to patient: _______________________________

Medicare # (if Applicable): ___________________________ Medicaid # (if applicable): _____________

Secondary Insurance Information
Is Patient covered by additional insurance? □ Yes □ No
Subscriber Name ________________________ Birthdate ___________ Relationship to Patient: __________
Insurance Company: ______________________ Policy #: __________________ Group #: __________________
Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Neurology and Sleep Clinic, LLP files claims for Medicare assignment and only the managed care plans, which we are contracted. Claims will not be filed with other insurance carriers. If you plan to pay by check and it is dishonoured, a processing fee of $25 will be assessed.

Assignment of Benefits: I assign to the treating physician of Neurology and Sleep Clinic, LLP all payments for medical services rendered to my dependents or myself for services filed to insurance on my behalf.

Phone Call Message Consent:
I authorize that messages may be left for the patient about appointment reminders and/or medical information regarding patient care:

At work _____ on home answering machine _____ with spouse or other family member _______
Initial Initial Initial
Name of spouse ______________________ Name of family member(s) ______________________
On a cell phone ______ Number of cell phone ____________________
Initial
I may revoke consent for any or all of the above initialled items at any time in writing. I certify that all information provided to Neurology and Sleep Clinic, LLP is correct.

For Medicare Patients Only
I authorize the treating physician of Neurology and Sleep Clinic to release medical information about me to the Social Security Administration and the Health Care Financing Administration (HCFA) or its intermediaries, or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Neurology and Sleep Clinic, LLP. Regulations pertaining to Medicare assignment of benefits apply.

I also authorize the same release of information to any Medicare supplemental insurance entities (i.e. Medigap) and further request payment of medical insurance benefits to the party who accepts assignment.
Patient Name: ___________________________ D.O.B: __________ SSN: ___________________________

Consent to Treatment:
I hereby give my consent for medical treatment by the physicians or under the direction of the physicians of Neurology and Sleep Clinic.

_________________________________________  ____________________
Patient’s or Guardian’s Signature             Date

Release of Medical Records:
I hereby authorize Kiran Shah, MD or Alpa Shah, MD (circle one) to send or obtain my medical information needed for my care.

I understand that the specific information to be released may include all physician records as well as treatment of drug or alcohol abuse, mental illness, or communicable disease; this does include Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). I also understand that this authorization may be revoked by the person giving authorization by written and dates notice, except to the extent that disclosure of information had been made prior.

You have the right to limit medical information we discuss to someone involved in your care, if you wish to do so, please write down any persons or facilities that you do not want to receive information and the information that you want limited. Please note that Neurology & Sleep Clinic does not have to agree to your request.

_________________________________________  ____________________
Patient’s or Guardian’s Signature             Date

Restriction List:
____________________________________________________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Authorization List:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
NEUROLOGY & SLEEP CLINIC
KIRAN SHAH, MD
ALPA SHAH, MD
4217 Marsh Ridge Rd, Ste 120
Carrollton, TX 75010
Phone: (972) 306 6300
Fax: (972) 306 6500
www.thebrainmd.com

Patient Name: ________________________________ D.O.B: __________________

Notice of Privacy Practices

I understand that as part of my healthcare, Neurology & Sleep Clinic originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

Neurology & Sleep Clinic’s Notice of Privacy Policies provides specific information and a complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that Neurology & Sleep Clinic reserves the right to change the Notice of Privacy Practices. If changes are made to the Notice of Privacy Practices, they will be posted in the office where they can be seen, and I will have the opportunity to review the changes. I understand that I have the right to restrict the use/or disclosure of my personal health information for treatment, payment or healthcare operations and that Neurology & Sleep Clinic is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent that Neurology & Sleep Clinic has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that 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.

I have been provided access and have reviewed Neurology & Sleep Clinic Notice of Privacy.

______________________________
Patient’s or Guardian’s Signature
______________________________
Date

Appointment and Cancellation Policy:

Please provide our office with 48 hours notice if you must cancel testing ordered or you may be subject to a $ 50.00 cancellation fee.

Please note: your insurance company does not cover this charge. Repeated “no show” appointments could result in referring you back to the insurance company for reassignment to another specialist. I understand that the office will make every attempt to place a reminder call for my appointments. However, whether or not a confirmation call is placed, I am still held responsible for remembering my appointment day and time.

______________________________
Patient’s or Guardian’s Signature
______________________________
Date

Financial Disclosure

This disclosure is being provided to you and your health care representative because we may be referring you to Baylor Medical Center at Carrollton for further treatment or evaluation. We or our immediate family member has an ownership or investment interest in Baylor Medical Center at Carrollton. We are informing you of this financial interest to assist you in making an informed decision about your treatment options. Please let us know if you have any questions about our relationship to Baylor Medical Center at Carrollton or your treatment evaluation options.

Patient Acknowledgement

I, ________________________________ (Print Patient’s Name), hereby acknowledge that I have had the opportunity to ask my physicians any questions about his or her financial interest in Baylor Medical Center of Carrollton. I further acknowledge that my physician informed of his or her financial interest at the time he/she referred me to Baylor Medical Center of Carrollton.

______________________________
Patient’s or Guardian’s Signature
______________________________
Date