NORTH HOUSTON SPECIALTY PHYSICIANS
800 Peakwood Dr., Suite 2E
Houston, TX 77090
Tel: (281) 377-1000 Fax: (281) 866-0344

## Patient Information:

Last Name: First Name: Middle Name: Maiden Name

Social Security Number: Birth date: Sex: Male / Female

Street Address: City State Zip Code

Home Phone: Cell Number: Alternative Phone Number:

Email address:

Marital Status:
___Married ___Single ____Widowed ___Divorced___Separated

Are you a student?
___Full Time ____Part Time

Are You a Veteran? Yes / No

Primary Care Physician name & Number

Emergency Contact/Relationship/Phone #

## Responsible Party Information: ( if different than above)

Last Name: First Name: Middle Name:

Social Security Number Date of Birth: Sex: Male / Female

Relationship to Patient:

## Primary Insurance Information:

Name of Company: Policy Number: Group Number:

Name of Insured: Relationship: D.O.B.:

## Secondary Insurance Information: ( if Applicable)

Name of Company: Policy Number: Group Number:

Name of Insured: Relationship to Patient: D.O.B:

## Pharmacy Information:

Preferred Pharmacy: Pharmacy Phone Number:

## Signature of Patient / Guardian: Date:

X

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800 Peakwood Dr., Suite 2E
Houston, TX 77090
Tel: (281) 377-1000 Fax: (281) 866-0344

# Authorization for release of medical records

Patient Information (please print)

Name:_____ Date of Birth:_____
Social Security Number:_____
Address:_____
City:_____ State:_____ Zip Code:_____

X_____
Patient Signature

Release of Medical Records

Name:_____
Telephone Number:_____
Fax Number:_____

**Send To**
**North Houston Specialty Physicians**
**800 Peakwood Dr. Suite 2E**
**Houston, TX 77090**
**Tel: (281) 377-1000 Fax: (281) 866-0344**

Please send a copy of the following Medical Records only:

**___Lab reports** **___Consultations**
**___Diagnostic reports** **___Immunization records**
**___Last Clinic Notes**
**Other:**_____

**BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS**

**NORTH HOUSTON SPECIALTY PHYSICIANS**
**800 Peakwood Dr, Suite 2E**
**Houston, TX 77090**
**Tel: 281-377-1000 Fax: 281-866-0344**

## COMMUNICATION CONSENT

In compliance with federal law, it is North Houston Specialty Physicians not to release confidential, personal, and/or unauthorized information by home telephone, answering machine, voice mail, cellular telephone, pager, and fax. We will not leave a message on any answering machine where the recorded message does not identify the name or number called. Information will not be left with any unauthorized person who may answer your telephone.

I _____ authorize North Houston Specialty Physicians to leave any medical information pertaining to my care by the following methods. I will assume responsibility to notify North Houston Specialty Physicians whenever this information changes.

**Please list authorized numbers for you.**

Home: _____ May leave message on answering machine Yes or No.
Work: _____ May leave a voice mail message Yes or No.
Cell Phone: _____ E-Mail address: _____

I _____ authorize North Houston Specialty Physicians to leave any medical information pertaining to my medical care with the following person or persons.
I will assume responsibility to notify North Houston Specialty Physicians when this information changes.

**Spouse/Significant other:** _____ **Phone:** _____
**Parent:** _____ **Phone:** _____
**Brother/Sister:** _____ **Phone:** _____
**Son/Daughter:** _____ **Phone:** _____
**Other:** _____ **Phone:** _____

### PRIVACY PRACTICE ACKNOWLEDGEMENT

**I have received a copy of North Houston Specialty Physicians Notice of Privacy Practice.**

X _____ Date: _____
Patient signature

X _____ Date: _____
Parent or Guardian ( If patient is under age 18 )

X _____ Date: _____
Witness Signature

# NORTH HOUSTON SPECIALTY PHYSICIANS

800 Peakwood Dr. Suite 2E
Houston, TX, 77090
Tel: (281) 377-1000 Fax: (281) 866-0344

## Financial Policy

We hope to make your visits in our office as thorough and pleasant as possible. We also want you to have a full understanding of our financial policies and expectations for payment for services. Please carefully review and sign our financial policy, and let us know of any questions you may have.

The primary and final relationship is between the physician(s) of North Houston Specialty Physicians and our contract is with you. We will not compromise your medical care to satisfy **ANY** insurance company. Insurance is meant to help defray the cost of medical care and is **NOT** intended to dictate your treatment.

Payment is due expected in full at the time services are rendered unless other arrangements are made **PRIOR** to your appointment. This includes deductibles, co-payments, co-insurances and non-covered services.

As a courtesy we are happy to assist you in the filing of the most insurance claims, completing insurance forms, and insurance precertification. You will be responsible for any and all balances not covered by your insurance. It is your responsibility to know and understand your own insurance policy and the benefits covered. If you are not sure of your insurance benefits, **PLEASE ASK THEM**. It is not possible for us to familiarize ourselves with every insurance and plan.

You will receive a monthly statement requesting payment of any unpaid balance. If your account comes past due, please contact our offices to discuss payment arrangements and avoid further collection efforts.

There is a fee (currently $35) for any checks returned by the bank. Patients balances that go unpaid for 90 days or more will incur additional interest charges of 1% per month or 12% APR.

Appointments not cancelled with 24 hour notice may result in charges for time reserved.

We are here to serve your health needs and will work hard on your behalf, to contain fees and other charges while delivering you with quality health care.

**I have read and understand the above policies. I understand that I may receive copy of this form upon request.**

| | |
|---|---|
| _____ | _____ |
| Print Patient Name | Signature of Pt. or responsible party |
| _____ | _____ |
| Witness | Date |

# NORTH HOUSTON SPECIALTY PHYSICIANS

**Patient Name:** _____

**How did you hear about our doctor?** **Date:** _____

**Please check one**

| | |
|---|---|
| **Hospital Name:** | **Walk-In:** |
| **Zoc Doc Online:** | **Doctors Office:** |
| **Yellow Pages/Phone book** | **Other:** |
| **Friend:** | |
| **Family Member:** | |
| **Friend:** | |
| **Co-Worker:** | |
| **Living Magazine:** | |

**Whom do we thank for the referral?**

| |
|---|
| **PCP:** |
| **Referring Specialty Physician:** |
| **Hospitalist Referral:** |
| |

North Houston Specialty Physicians
Cuie Qiu, M.D., PhD
Board certified in Neurology
800 Peakwood Dr., Suite 2E
Houston, TX 77090

Phone: (281) 377-1000

Fax: (281) 866-0344

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Chief Complaint: _____

Medication Allergies: Please list all allergies

_____

Current Medications (please list all medications along with the strength and how often you take it)

_____

_____

_____

Medical Problems:

Please list any and all medical problems or conditions you have currently or in the past:

_____

_____

_____

Surgical History: (Please list any previous surgeries and hospitalizations with dates)

_____

_____

_____

Family History:

Mother's age: _____Deceased: Yes ____ or No_____ Age of death: _____ Cause of Death_____

Health Issues: _____

Father's age: ____Deceased: Yes____ or No _____ Age of death: _____ Cause of Death_____

Health Issues: _____

Number of Sister: ____ Health Issues _____

Number of Brothers: ____ Health Issues _____

Do you have any family history of: (please circle all that apply?)

| | | | |
|---|---|---|---|
| High blood pressure | Alzheimer's disease | Stroke | Heart Disease |
| Multiple Sclerosis | Diabetes | Parkinson's disease | Epilepsy |
| High Cholesterol | Cancer | Dementia | |

Patient Name: _____ Date of Birth: _____

Social History:

Marital status (circle one) Single Married Divorced Widowed Separated

Where did you grow up: _____ Highest Grade completed: _____

Occupation: _____ Name of Employer: _____ Phone: _____

Dominate hand: Right Left Military Branch: _____ Active Retired Reserve

Tobacco use (circle one): Current smoker Previous smoker Never smoked

Alcohol use: None____ Up to 2 drinks a day____ More than 2 drinks a day____ Wine, Beer, Whiskey. Last drink_____

Drug use recreational (circle one): Current Past Never

Review of systems- Currently experiencing (circle all that apply)

| | | | |
|---|---|---|---|
| **Constitutional** | | | |
| Recent weight gain | Feeling poorly | Fever | |
| Recent weight loss | Tired (fatigue) | Chills | |
| **Eyes** | | | |
| Eye pain | Drooping Eyelid | Blurry Vision | |
| Red eyes | Dry eye | Eyesight problems | |
| Loss of vision | Itchy eyes | Discharge form eyes | |
| **ENT** | | | |
| Nosebleeds | Earache | Sore throat | |
| Nasal Discharge | Loss of Hearing | Hoarseness | |
| **Cardiovascular** | | | |
| Chest pain | Fast heart rate | Leg Pain - Right or Left | |
| Palpitations | Slow heart rate | Swelling in lower leg – Right or Left | |
| **Respiratory** | | | |
| Shortness of breath | Cough | Wheezing | |
| Shortness of breath on exertion | Shortness of breath when lying down | | |
| **Sleep** | | | |
| Snoring | Insomnia | Sleep Apnea | Obstructive sleep apnea |
| **Gastrointestinal** | | | |
| Abdominal pain | Constipation | Heartburn | Nausea |
| Vomiting | Diarrhea | Black or Tarry stools | Bowel incontinence |
| Trouble swallowing | | | |
| **Genitourinary Female** | | | |
| Painful Urination | Pelvic pain | Vaginal discharge | Urinary incontinence |
| Painful menstruation | Abnormal vaginal bleeding | Frequent urination | Urgency |
| Lack of sex drive | | | |
| **Genitourinary Male** | | | |
| Painful urination | Night time urination | Frequent urination | Urgency |
| Hesitancy | Testicular pain | Genital lesions | Lack of sex drive |
| Impotence | | | |
| **Musculoskeletal** | | | |
| Joint pain | Joint swelling | Muscle cramps | Muscle weakness |
| Neck pain | Neck stiffness | Back pain | Sciatica |
| Limb pain right or left - arm or leg | Joint stiffness | | |

Patient Name: _____ Date of Birth: _____

**Integumentary:**

| | | | |
|---|---|---|---|
| Skin lesions | Itchy skin | Dry skin | Skin wounds |
| Changes in moles | Any unusual growth | | |

| Neurological Cognitive | Motor | Sensory |
|---|---|---|
| Confused or disoriented | Facial weakness- right or left | No sensation |
| Memory lapse/loss | Arm weakness- right or left | Numbness |
| Decreased concentrating | Hand weakness- right or left | Tingling |
| Difficulties in speech | Leg weakness- right or left | Burning sensation |
| Changes in thought pattern | Poor coordination | Hyperesthesia |
| Repeating questions | Difficulty writing | Tremors |

| General | | Gait |
|---|---|---|
| Seizures | Cluster headaches | Difficulty walking |
| Dizziness | Migraine headaches | Inability to walk |
| Fainting | Tension headaches | Ataxia (loss of muscle control) |
| Light headedness | Vertigo | Frequent falls or limping |

| Psychiatric | | |
|---|---|---|
| Suicidal | Anxiety | Change in personality |
| Sleep Disturbance | Depression | Emotional problems |

| Endocrine | | |
|---|---|---|
| Protruding eyes | Hot flashes | Deepening of the voice |
| Feeling of weakness | | |

| Heme/Lymph | |
|---|---|
| Easy bruising | Swollen glands |
| Easy bleeding | Swollen glands in the neck |

_____ _____

Patient Signature Date

_____ _____

Cuie Qiu, M.D. Date

North Houston Specialty Physicians- Cuie Qiu, M.D.,PhD., 800 Peakwood Dr. 2E,Houston,TX 77090 (281) 377-1000

PLEASE KEEP THIS FOR YOUR RECORDS.

# Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR PRIVACY OFFICER STEPHEN EPPSTEIN, M.D. AT (817) 514-5200.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, payment for your health care, or health care (clinic) operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related to health care services.

We are required to maintain the privacy of protected health information and to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices via our website, www.MCNT.com, or by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. An updated copy will also be posted in your physician's office.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a radiologist or pathologist) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare (Clinic) Operations: We may use or disclose, as-needed, your protected health information in order to support the professional and business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical and nursing students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical and nursing school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services, telephone answering services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, we may send you information about products or services that we believe may be beneficial to you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object** You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. We may use and disclose your protected health information in the following instances:

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object** We may use or disclose your protected health information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse,