Thank you for making an appointment. Dr. Blue graduated from Wake Forest University School of Medicine. She completed her internship and residency in neurology and her fellowship in cerebrovascular disease at the same institution. Although patient care is her primary concern, she is active in the political and business aspects of medicine. She has held leadership positions as President of Tarrant County Medical Society, President of Tarrant County Medical Society Board of Trustees, and President of Texas Neurological Society, which represents over six hundred neurologists. She has served on the Medical Advisory Board for the State of Texas.

Her many community activities include Board of Directors of James L. West Alzheimer's Special Care Center, Mayor's Council on the Homeless, Women's Policy Forum and downtown Rotary Club of Fort Worth. Dr. Blue has three daughters and three grandchildren. Her hobbies include travel, music and theater.

Please complete the attached forms and bring them to the appointment with you. You will also need all your insurance card(s), pharmacy card and photo ID.

DIRECTIONS TO THE FORT WORTH OFFICE

1001 Washington Avenue

FROM THE WEST:

Approaching from the west on I-30 eastbound
Exit Summit Avenue/Henderson Street
Follow the signs for Henderson Street
* Turn right onto Henderson and travel south on Henderson
* Cross Pennsylvania (large intersection with stoplight)
* Turn left onto Dashwood (third street to the left)
* Turn right onto Washington (second street to the right)
* 1001 Washington Avenue on the corner of Washington and Dashwood

FROM THE EAST:

Approaching from the east on I-30 westbound
Exit Summit Avenue and turn left onto Summit
Cross over I-30 bridge and turn left immediately
Follow the signs for Henderson Street
* Continue as directed by the (*) instructions listed above

FROM I-35 SOUTH:

Exit Rosedale, South of I-30 and turn left onto Rosedale.
Go past Chase bank (will be on the right)
Turn right onto College Avenue
Go to first street, and turn left onto Dashwood
Office is second building on the left, on the corner of Dashwood and Washington Avenue.

FROM I-35 NORTH:

***** Exit Rosedale which is Just south of I-30. *****
Turn right onto Rosedale. Go past Chase Bank (will be on the right).
SEE ABOVE

DIRECTIONS TO THE WEATHERFORD OFFICE

3115 Fort Worth Highway #200

FROM THE EAST: Take exit 414 off I-20, for Highway 180 Fort Worth Highway. After the first stoplight which is at the intersection of Lakeshore Drive and Highway 180, go approximately ¼ mile and turn right into the driveway for the building.

FROM THE WEST: Exit off I-20 onto Lakeshore Drive. Turn left onto Lakeshore Drive and then left at the traffic light onto Highway 180. Go approximately ¼ mile. The building is on the right.

The building at 3115 Fort Worth Highway faces Jerry's Chevrolet. It is located between the Toyota dealership and Parker County Storage.

NEUROLOGICAL SERVICES OF TEXAS, P.A.
PATIENT INFORMATION

Please bring a valid photo ID, all current insurance cards and pharmacy cards with you to your appointment.
APPT. DATE:___________

NAME:____SEX:___________
Last MI First

BIRTHDATE:____SOCIAL SECURITY #:______________________

PHONE:____(**PLEASE CIRCLE PREFERRED NUMBER**)
home work cell

ADDRESS:____CITY:_________________STATE:______ZIP:___________

MARITAL STATUS:_____SINGLE_____MARRIED_____WIDOWED_____DIVORCED

REF DR/PROVIDER:_______________________________PRIMARY CARE/SUPERVISING DR:_________________________
(if a nurse practitioner or physician's assistant, if known)

RETIRED:_____YES_____NO

If retired, last job title:_________________________Last employer_________________________year retired_______________

EMPLOYED:____________________________________JOB TITLE:____

EMPLOYER
ADDRESS:____CITY:_______________________STATE:_____ZIP:__________

AUTO INJURY:_____YES_____NO **WORKER'S COMP INJURY:**_____YES_____NO

EMERGENCY CONTACT

NAME:____ RELATION TO PATIENT:____________________________
Last MI First

PHONE NUMBER TO CONTACT FOR EMERGENCY:____

GUARANTOR BUSINESS INFORMATION IF OTHER THAN PATIENT
(Do not complete if patient is guarantor.)

NAME:____DOB:__________________________SEX:_____MALE_____FEMALE
Last MI First

Social Security #:_________________________________PHONE:____(**CIRCLE PREFERRED NUMBER**)
home work cell

ADDRESS (if different from patient):____

NAME OF EMPLOYER **OF GUARANTOR:**____

EMPLOYER ADDRESS:____
City State Zip

OFFICE POLICY & INSURANCE:
We appreciate the opportunity to work with you in regard to your health care. The purpose of our office policy is to inform patients of their responsibility before the time of service. If you do not understand some of the statements please ask for help.
INSURANCE AUTHORIZATION: **(Must be signed if you have insurance coverage, which we are to file. Otherwise we will ask you to sign an insurance waiver and pay at time of service.)**
I HEREBY ASSIGN PERMISSION TO NEUROLOGICAL SERVICES OF TEXAS, P.A. TO PROVIDE INFORMATION CONCERNING MY MEDICAL EVALUATION AND TREATMENTS TO MY INSURANCE CARRIERS. I ALSO CERTIFY BY MY SIGNATURE THAT I HAVE GIVEN CORRECT AND COMPLETE INFORMATION WITH REGARD TO MY COVERAGE. IF I HAVE NOT, THEN I UNDERSTAND THAT PAYMENT OF ANY BILLS INCURRED WILL BE MY RESPONSIBILITY.
DATE:____________________________SIGNATURE:____

ASSIGNMENT OF BENEFITS: I HEREBY ASSIGN NEUROLOGICAL SERVICES OF TEXAS, P.A. ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT WITHIN THE CONFINES OF MY POLICY NOT PAID BY MY INSURANCE COMPANY WITHIN A 120 DAY PERIOD, INCLUDING DIAGNOSTIC SERVICES, EVALUATION, LABORATORY TESTING, AND NON-COVERED EXPENSES.
DATE:___________________________SIGNATURE:____

PAYMENT POLICY: WE COLLECT COPAYS AND/OR PAYMENT IN FULL AT THE TIME OF SERVICE. IF FOR ANY REASON YOU CANNOT PAY AT THE TIME OF SERVICE, YOU MUST NOTIFY THE OFFICE BEFORE SERVICES ARE RENDERED**. IF YOUR INSURANCE COMPANY REQUIRES YOU TO HAVE A REFERRAL IT IS YOUR RESPONSIBILITY TO MAKE SURE THE OFFICE IS IN POSSESSION OF AN ACTIVE REFERRAL PRIOR TO THE TIME OF YOUR VISIT.**

CURRENT INFORMATION: IF YOU GIVE INACCURATE OR OUT-DATED INFORMATION WITH REGARD TO YOUR HEALTH INSURANCE COVERAGE, AND PAYMENT IS SUBSEQUENTLY DENIED OR WITHHELD, THEN YOU WILL BE RESPONSIBLE FOR PAYMENT OF OUTSTANDING BALANCES WITHIN THIRTY DAYS OF NOTIFICATION.

CANCELLATIONS: PLEASE NOTIFY THE OFFICE 48 HOURS IN ADVANCE OF YOUR APPOINTMENT IF YOU NEED TO CANCEL OR RESCHEDULE. FOR LATE CANCELLATION THERE IS A CHARGE OF $45.00 FOR AN OFFICE VISIT AND $80.00 FOR A TESTING APPOINTMENT. YOUR INSURANCE COMPANY WILL NOT REIMBURSE YOU FOR THIS CHARGE. IN APPLICABLE CASES, WE ARE GLAD TO COMPLETE MEDICAL FORMS WITH REGARD TO YOUR NEUROLOGICAL PROBLEMS, AFTER PAYMENT OF AN APPROPRIATE FEE. OUR FEE FOR RETURNED CHECKS IS $60.00. WE MAY ALSO CHARGE A FEE FOR ANCILLARY SERVICES SUCH AS PREAUTHORIZATION OF MEDICATIONS.

PLEASE SIGN THAT YOU UNDERSTAND AND AGREE TO THE TERMS OF OUR OFFICE POLICY.

DATE:__________________________SIGNATURE:____

GENERAL CONSENT TO TREAT:
I AUTHORIZE AND DIRECT NEUROLOGICAL SERVICES OF TEXAS, P.A. TO TREAT MY MEDICAL CONDITION OR THE CONDITION OF THE PATIENT I REPRESENT, IN THE WAY THEY MAY DETERMINE ADVISABLE.

I ACKNOWLEDGE THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE OUTCOME OF TREATMENT.

DATE:_________________________SIGNATURE:____

DATE:_________________________WITNESS:____

INSURANCE INFORMATION AND DOCUMENTS

PATIENT NAME:______________________________________
(printed)

DATE:__________________________

INSURANCE INFORMATION: Please note your primary and secondary coverage, and your tertiary coverage if applicable. At the time of your visit, we will copy your primary insurance card, secondary insurance card, tertiary insurance card if applicable **and your pharmacy card.** If your information changes at any time in the course of your treatment in our office, then it is your responsibility to notify us immediately of that change and to supply copies of your current insurance cards.

If a guardianship or power of attorney is effective at the time service is provided to you in our office, please provide a copy of that document.

We will also need a copy of your government-issued photo ID. Only currently valid identification documents should be provided. It is your responsibility to notify us if your identification information changes.

*** PLEASE BRING A PHOTO ID, ALL OF YOUR CURRENT INSURANCE CARDS, AND YOUR PRESCRIPTION CARD WITH YOU TO YOUR OFFICE VISIT.**

I affirm by my signature that I have provided complete and accurate information. I recognize that providing incomplete or incorrect information is considered fraudulent by the United States government. I will be responsible for any and all charges denied by my insurance company or other payors as a result of inaccurate information that I have provided.

I also agree to pay any charges incurred if payment is denied because of incomplete information with regard to providers I have seen and diagnostic studies and treatments that I have received. I understand that insurance companies will sometimes refuse to pay for services that are duplicated in a short period of time.

DATE:______________________________SIGNATURE:____

DATE:______________________________WITNESS:____

PATIENT RECORD OF DISCLOSURES

COMMUNICATION INFORMATION:

In general the HIPAA privacy rules give patients the right to permit or deny disclosures of their protected health information (PHI) except in exceptional circumstances, such as communication with another healthcare provider to assist in your medical care.

The information on this page will remain in effect until revoked in writing.

Normal or abnormal test results can be communicated to me as designated below, as well as appointment and other information: (CHECK ALL THAT APPLY)

	O.K. to leave message with detailed information	**Leave message with call back number only**
CELL TELEPHONE NUMBER ______________________________	_____YES_____NO	_____YES_____NO
HOME TELEPHONE NUMBER ______________________________	_____YES_____NO	_____YES_____NO
WORK TELEPHONE NUMBER ______________________________	_____YES_____NO	_____YES_____NO
MAY MAIL INFORMATION TO MY HOME ADDRESS	_____YES_____NO	

Special comments with regard to communication of my health information:____

____

PERSONS WHO MAY RECEIVE MY PROTECTED HEALTH INFORMATION:

I consent and authorize the release of my protected health information to the following (check all that apply):

_____Myself

_____My spouse____ name/phone number

_____My parent(s)________________________________ name(s)/phone number(s)

_____My child(ren)____ name(s)/phone numbers

_____Other parties________________________________ name(s)/phone number(s)

EXCEPTIONS OR COMMENTS:____

DATE:____SIGNATURE:____

Revised 09/08/2017