HIT **Headache Institute of Texas**
400 N. Loop 1604 E., Ste. 345
San Antonio, TX. 78232
Phone (210) 402-2920 Fax (210) 403-9827

DATE:___________________

Dear Mr./Mrs./Ms.______________________,

Thank you for choosing to see **Nasha Holt, MD, and Jeff Turner,PT, DPT,** with the **Headache Institute of Texas.** Please complete the enclosed information regarding your pain, health history, and contact information on the patient intake forms provided for you. You must bring the completed forms to the office on:

________, ___________ at _______ a.m./p.m. at our _________________ location.
(arrival time) (see map attached)

ATTACHED WITH YOUR COMPLETED FORMS, PLEASE HAND CARRY ANY MRIs, X-RAY OR CT FILMS AND REPORTS. IF THE FORMS ARE NOT COMPLETELY FILLED OUT WHEN YOU ARRIVE IN OUR OFFICE, YOUR APPOINTMENT MAY BE RESCHEDULED.

Please be aware that you are liable for any applicable co-pays at office and facility visits. You should follow up with your insurance company to be prepared for the cost that may possibly be incurred. Please bring your insurance card to your appointment. If you do not understand the questions and require assistance, arrive 30-45 minutes prior to your office appointment and please call our office.

We appreciate your cooperation and if you have any questions or require further assistance, please feel free to contact our office.

Thank you,

Headache Institute of Texas

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ASSIGNMENT OF BENEFITS

Private insurance authorization for assignment of benefits and information release:

I, the undersigned, authorize payment of medical benefits to the **Headache Institute of Texas** for any services furnished to me by the physician or physical therapist. I understand I am financially responsible for any amount not covered by my insurance policy. I also authorize the **Headache Institute of Texas** to release to my insurance company, referring physician, or any other consultants on my case information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Date_______________ Signed_____________________________

MEDICARE LIFETIME SIGNATURE ON FILE

I request that payment of authorized Medicare benefits be made on my behalf to **Headache Institute of Texas** for any services furnished to me by the physician or physical therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

Date_______________ Signed_____________________________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of the **Headache Institute of Texas**.

_____________________________ _________________________

Print Patient Name Date

____

Patient Signature

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LITIGATION / ACCIDENT / INJURY STATEMENT

The **Headache Institute of Texas** is pleased to offer you treatment for your injury or suffering. However, you are advised that according to most commercial insurance policies and generally accepted practice, treatment for work related chronic injuries must first be filed under Texas Workman's Compensation. We will be happy to assist you in this process. Also, if your case is being handled by a lawyer, this is a litigation case and our office needs to be informed before services are rendered. We must also inform you that the **Headache Institute of Texas** will not accept third party payment/letters of protection.

My case **is / is not** being handled by a lawyer *(circle one)*.

I ______________________ hereby certify that I **am / am not** *(circle one)* seeking treatment for an illness or injury that resulted from an incident/accident at my place of **work** or from a **motor vehicle accident** *(circle one)*.
MVA/Date of Incident ____________________________
If applicable, Lawyer's Name _______________________ Phone # ________________

____________________________ ________________________
Print Patient Name Date

____
Patient Signature

PHOTOGRAPH AUTHORIZATION

I hereby authorize the **Headache Institute of Texas** to take my photograph for inclusion in my consult letter and medical chart retained by the clinic. I understand this photograph will be used for the purpose of identification and familiarization by the office staff, clinic physician(s), physical therapist(s), and consulting physicians. It will also be used on consult letters that we send to your other physicians.

____
Patient Signature

HIT Headache Institute of Texas

AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION

(Please complete ONLY your contact information at the top of the page before your 1st appointment).

NAME OF PATIENT (PLEASE PRINT) ______________________ DATE OF BIRTH ______________

CURRENT STREET ADDRESS ______________________ SOCIAL SECURITY NUMBER ______________

CITY STATE ZIP ______________________ CURRENT PHONE NUMBER ______________

E-MAIL ADDRESS ______________________ ALTERNATE/CELL PHONE ______________

PLEASE DO NOT FILL OUT ANYTHING BELOW THIS LINE UNTIL WE TELL YOU WHICH OF YOUR DOCTORS WE NEED TO REQUEST MEDICAL INFORMATION FROM.

RELEASE FROM: (PLEASE PRINT)
NAME: ______________________
ADDRESS: ______________________
PHONE: ______________________

THE FOLLOWING INFORMATION FROM MY RECORDS:

- ☐ COMPLETE HEALTH RECORD(S) (1)
- ☐ HISTORY & PHYSICAL (5)
- ☐ RADIOLOGY REPORTS/FILMS (8)
- ☐ OPERATIVE REPORTS (2)
- ☐ LABORATORY REPORTS (6)
- ☐ ALL NUCLEAR MEDICINE REPORTS (9)
- ☐ PROGRESS NOTES (3)
- ☐ DISCHARGE SUMMARY (7)
- ☐ PATHOLOGY REPORTS (10)
- ☐ OTHER (PLEASE SPECIFY (4) ______________________
- ☐ FINANCIAL RECORDS (11)

☐ DO ☐ DO NOT (CK APPLICABLE BOX) AUTHORIZE THIS INFORMATION TO BE FAXED. IF YES, FAX ____________

FOR THE TREATMENT DATES FROM *(Approximate Month, Year)*: ______________ TO *(Approximate Month, Year)*: ____________

I UNDERSTAND THAT AUTHORIZATION WILL INCLUDE ***ALL*** INFORMATION ***EXCEPT*** THAT RELATING TO (Initial those items you do not want to be released):

________ ACQUIRED IMMUNE DEFICIENCY SYDROME (AIDS) OR HUMAN IMMUNE DEFICIENCY SYNDROME (HIV) INFECTION
________ PSYCHIATRIC CARE
________ TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE
________ GENETIC TESTING

THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF MEDICAL CARE.

THE DATE, EXTENT OR CONDITION UPON WHICH THIS AUTHORIZATION EXPIRES IS ______________ NOT TO EXCEED 24 MONTHS (EXCEPT FOR RESEARCH PURPOSES, STATE "NONE" FOR EXPIRATION DATE). I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION. UNLESS OTHERWISE STATED OR REVOKED, THIS AUTHORIZATION WILL EXPIRE IN NINETY (90) DAYS FROM THE DATE BELOW.

I UNDERSTAND AND AGREE TO PAY A REASONABLE COPYING FEE TO COVER THE COST OF TRANSFER. I FURTHER UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT OR PAYMENT OR MY ELIGIBILITY FOR BENEFITS. I MAY INSPECT OR COPY ANY INFORMATION TO BE USED OR DISCLOSED UNDER THIS AUTHORIZAITON. I UNDERSTAND THAT PROVIDER'S RECORDS MAY CONTAIN INFORMATION CREATED BY AN ENTITY OTHER THAN THE **HEADACHE INSTITUTE OF TEXAS** AND THEREFORE IS NOT RESPONSIBLE FOR THE INFORMATION CONTAINED IN SUCH INCORPORATED INFORMATION (INCLUDING THE ACCURACY, COMPLETENSESS, RELEVANCE, LEGIBILITY OR LACK THEREOF OF SUCH INCORPORATED RECORDS). I EXPRESSLY REQUEST RELEASE OF ALL RECORDS MAINTAINED BY THE **HEADACHE INSTITUTE OF TEXAS** CONCERNING ME, INCLUDING INCORPORATED RECORDS. I ACKNOWLEDGE THAT THE **HEADACHE INSTITUTE OF TEXAS** HAS NO AND ASSUMES NO DUTY TO ME REGARDING THE CONTENT OF OR OMISSIONS FROM SUCH INCORPORATED RECORDS.

HIT Headache Institute of Texas

I HEREBY RELEASE THE **HEADACHE INSTITUTE OF TEXAS** AND ITS PERSONNEL FROM ALL LEGAL RESPONSIBILITY OF LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE. THE **HEADACHE INSTITUTE OF TEXAS** IS NOT RESPONSIBLE FOR COMPLETENESS LEGALITY OR OMISSIONS CAUSED BY THE COPYING OF ANY MEDICAL RECORDS FROM ANOTHER INSTITUTION.

____ ______________________________

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTAIVE DATE

PRINTED NAME OF PATIENT'S REPRESENTATIVE________________________ RELATIONSHIP TO PATIENT ________________.

☐ PATIENT DECLINES AUTHORIZATION FOR THE USE OR RELEASE OF PROTECTED HEALTH INFORMATION (DATE/INITIALS__________)