NeuroSensory Centers
of America™
Austin
Kendal Stewart, MD/Susan Haynes, APRN,FNP/Stephen Young, PA-C

We are excited that you have made an appointment with our office.

Here is what to expect on your first visit.

Upon arriving you will be checked in by our front desk team member who will check you in and take you back to a room.

Once in a room you will then speak to one of our medical assistant team members for a history intake, vitals, and current medication list.

Then the provider will come in and go over your medical history and current medical issues with you and give you a treatment plan.

The medical assistant will go over all instructions with you and make sure you understand your treatment plan.

Finally, you will go to the checkout desk and make your next appointment and payment.

You should plan to be with us a minimum of 2 hours from the time you get here to the time you leave our office.

Should you ever have any questions or concerns please feel free to contact me at any time.

Thank you.
Deanna Solis
Office Manager
512-338-9840 ext. 5

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PATIENT REGISTRATION FORM

Patient name (First) _____ **MI** ____ **(Last)** _____

Date of birth_____ **Age** _____ **Sex M / F** **Marital Status S M W D**

Street Address _____

City _____ **State** _____**Zip code** _____

Home# _____ **Cell#** _____ **Work#** _____

Employer name_____ **Occupation**_____

Email address_____

Who referred you to our office _____

If patient is a minor parent or legal guardian name_____

- I authorize, Kendal Stewart, MD/Susan Haynes. APRN, FNP/Stephen Young, PA-C and any employee working
  under the direction of the providers, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health or the patient listed above and may include (but not limited to) preventative, diagnostic, therapeutic, maintenance, assessment or review of physical/mental status. function of the body and the sale or dispensing of drugs. supplements, devices, equipment or other items required and in accordance with a prescription. This consent includes contact and discussion with other health care professionals for care and treatment.
- I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and f may obtain these revised notices by wanting the practice by phone or in writing. I understand I have the right to request how my protected health in formation (PHI) has been disclosed. I also, have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions.
- I understand that I am financially responsible for all services rendered to me and that no insurance is accepted.
- I understand that if I cancel an appointment with less than 48 business hour notice or failure to show up for an appointment I will be charged a fee of $150.

Printed name_____**Signature** _____ **Date**_____

NeuroSensory Centers of America™
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Disclosure: Dietary Supplements and Genetic testing

This document serves to inform you that Dr. Stewart serves as the Chief Science Officer and lead formulator for Neurobiologix, as well as GX Sciences, Inc. a nutrigenomic genetic lab and does have a financial ownership with the companies. As patients, you are under no obligation to purchase or use any dietary supplements or genetic testing discussed or recommended by Kendal Stewart, M.D. or his staff.

To ensure quality, all dietary supplements distributed by Neurobiologix are manufactured in a facility that is certified by the National Science Foundation (NSF) and abides by Good Manufacturing Practices (cGMP) enforced by the U.S. Food & Drug Administration.

Nutritional items discussed or recommended are available for purchase at pharmacies, online or other retail locations.

*These products are not approved by the Food and Drug Administration and are not intended to diagnose, treat, cure or prevent a disease.

Patient Signature: _____ Date_____

Printed Name: _____

11719 Bee Cave Rd. #204, Austin, Tx. 78738 • (T) 512.338.9840 (F) 512.338.0863
www.neurosensorycenters.com

HEALTH HISTORY

Confidential

Patient Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

GENITO-URINARY
- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL
- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting

CARDIOVASCULAR
- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT
- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes

SKIN
- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

MEN only
- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other

WOMEN only
- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other

Date of last menstrual period _____
Date of last Pap Smear _____
Have you had a mammogram? _____
Are you pregnant? _____
Number of children _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts
- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes
- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio
- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infection
- Venereal Disease

MEDICATIONS List medications you are currently taking.

ALLERGIES To medications or substances

Pharmacy Name **Phone**

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if your blood relative had any of the following:

	ADD/ADHD		High Blood Pressure
	Allergies (airborne)		Infertility
	Allergies (food)		Irritable Bowel Syndrome
	Alzheimer's		Kidney disease
	Arthritis, Gout		M.S.
	Asthma		Meniere's
	Bipolar		Migraines
	Cancer		Parkinson's
	Diabetes		Seizures
	Dizziness / Vertigo		Shingles
	Hearing Loss		Speech disorder
	Heart disease, Stroke		Thyroid disease

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Alcohol	
	Street Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

Have you ever had a blood transfusion? ____ Yes ____No

If yes, please give approximate dates. _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature or Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

NeuroSensory Centers of America™
Austin

Telemedicine/Zoom Informed Consent

Telemedicine/Zoom services involve the use of secure interactive videoconferencing equipment or telephone and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. I may revoke my right at any time by contacting NeuroSensory Center of Austin's office manager at 512-338-9840.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that NeuroSensory Center of Austin does not accept insurance and I am financially responsible for all services provided by them.

Telemedicine visits are only used for acute issues in between regularly scheduled appointments. If you are changing an office visit to a phone consult you will be billed as a zoom. See pricing under Zoom visits.

The charges for phone consult visits are as follows:

5-10 minutes $80 / 11-20 minutes $160 / 21-30 minutes $250

Zoom visits are used in place of regularly scheduled appointments when a patient is unable to make it into the office. The charges for zoom visits are as follows:

14 minutes $250 / 15-24 minutes $307 / 25-39 minutes $367 / 40 minutes + $407

Over 55 minutes will incur additional fees or cause another appointment to be made.

7. I understand that this document will become a part of my medical record. By signing this form, I attest that I (a) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (b) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine/zoom visits shared with me in a language that I understand.

_____
Patient/Parent/Guardian printed name

_____ _____
Signature Date

NeuroSensory Centers of America™

Austin
NOTICE OF PRIVACY PRACTICES

PLEASE REVIEW CAREFULLY & KEEP FOR YOUR RECORDS

NeuroSensory Center of Austin is required by law to provide you with this Notice so that you will understand how we may use or share your information from your healthcare records. Healthcare records includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information." We are required to adhere to the terms outlined in this Notice. If you have any questions about this Notice, please contact our Office Manager.

UNDERSTANDING YOUR HEALTH RECORD AND INFORMATION

Each time you are treated at our office, a record of your visit is made containing health and financial information. Typically, this record contains information about your condition, the treatment we provide and payment for the treatment. We may use and/or disclose this information to:

- plan your care and treatment, communicate with other health professionals involved in your care, document the care you receive, educate health professionals, provide information for medical research, provide information to public health officials, evaluate and improve the care we provide

Understanding what is in your record and how your health information is used helps you to:

- ensure it is accurate, better understand who may access your health information, make more informed decisions when authorizing disclosure to others

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe the ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall into one of the categories.

- **For Treatment**. We may use or disclose health information about you to provide you with medical treatment. We may disclose health information about you to doctors, nurses, therapists or other clinic personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. We may also disclose health information about you to people outside the clinic who may be involved in your medical care. This may include family members, or visiting nurses to provide care in your home.
- **For Payment**. We may use and disclose health information about you so that the treatment and services you receive at NeuroSensory Center of Austin may be paid to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations**. We may use and disclose health information about you for our day-to-day health care operations. This is necessary to ensure that all patients receive quality care. We may also use and disclose information for professional review, performance evaluation, and for training programs. Your health information may be used and disclosed for the business management and general activities of the clinic including resolution of internal grievances, and customer service. In limited circumstances, we may disclose your health information to another entity subject to HIPAA for its own health care operations. We may remove information that identifies you so that the health information may be used to study health care and health care delivery without learning the identities of patients. If you are receiving therapy services, we may disclose general information about your progress.

OTHER ALLOWABLE USES OF YOUR HEALTH INFORMATION

- **Business Associates**. There are some services provided in our clinic through contracts with business associates. When these services are contracted, we may disclose your health information so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.
- **Providers**. Many services provided to you, as part of your care at our clinic, are offered by participants in one of our organized healthcare arrangements. These participants include a variety of providers such as doctors, nurse practitioners, physician assistant, licensed vocational nurse, or medical assistants.
- **Treatment Alternatives**. We may use and disclose health information to tell you about possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services and Reminders**. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a friend or family member who is involved in your care. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- **As Required By Law**. We will disclose health information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety**. We may use and disclose health information about you to prevent a serious threat to your health and safety or the health and safety of the public or another person. We would do this only to help prevent the threat.

- **Organ and Tissue Donation**. If you are an organ donor, we may disclose health information to organizations that handle organ procurement to facilitate donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.
- **Research**. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with patient needs for privacy of their health information. Before we use or disclose health information for research, the project will have been approved through this research approval process. We may, however, disclose health information about you to people preparing to conduct a research project so long as the health information they review does not leave their facility.
- **Workers' Compensation**. We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Reporting** Federal and state laws may require or permit the clinic to disclose certain health information related to the following:
    - *Public Health Risks*. We may disclose health information about you for public health purposes, including:
        - Prevention or control of disease, injury or disability; Reporting births and deaths; Reporting child abuse or neglect; Reporting reactions to medications or problems with products; Notifying people of recalls of products; Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease; Notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
    - *Health Oversight Activities*. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
    - *Judicial and Administrative Proceedings:* If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
    - *Reporting Abuse, Neglect or Domestic Violence:* Notifying the appropriate government agency if we believe a patient has been the victim of abuse, neglect or domestic violence.
- **Law Enforcement**. We may disclose health information when requested by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process; To identify or locate a suspect, fugitive, material witness, or missing person; About you, the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement; About a death we believe may be the result of criminal conduct; About criminal conduct at the Facility; and In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors**. We may disclose medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Correctional Institution:** Should you be an inmate of a correctional institution, we may disclose to the institution or its agents health information necessary for your health and the health and safety of others.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Although your health record is the property of NeuroSensory Center of Austin, the information belongs to you. You have the following rights regarding your health information:

- **Right to Inspect and Copy**. With some exceptions, you have the right to review and copy your health information.

  You must submit your request in writing to our office Medical Records Clerk. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend**. If you feel that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have this right for as long as the information is kept by or for the Facility.

  You must submit your request in writing to our Office Manager. In addition, you must provide a reason for your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us; i8/20/20198/20/2019s not part of the health information kept by or for our clinic; or Is accurate and complete.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures". This is a list of certain disclosures we made of your health information, other than those made for purposes such as treatment, payment, or health care operations.

  You must submit your request in writing to our office Medical Records Clerk. Your request must state a time period which may not be longer than six years from the date the request is submitted and may not include dates before 7 years prior to today's date. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you may request that we limit the health information we disclose to someone who is involved in your care or the payment for your care. You could ask that we not use or disclose information about a surgery you had to a family member or friend.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  You must submit your request in writing to our office Medical Records clerk. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Alternate Communications**. You have the right to request that we communicate with you about medical matters in a confidential manner or at a specific location. For example, you may ask that we only contact you via mail to a post office box.

  You must submit your request in writing to our Office Manager. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- **Right to a Paper Copy of This Notice**. You have the right to a paper copy of this Notice of Privacy Practices even if you have agreed to receive the Notice electronically. You may ask us to give you a copy of this Notice at any time. To obtain a paper copy of this Notice, contact our Office Manager

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our office and on the website. The Notice will specify the effective date on the first page, in the top right-hand corner. In addition, if material changes are made to this Notice, the Notice will contain an effective date for the revisions and copies can be obtained by contacting the Office Manager.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Facility or with the Secretary of the Department of Health and Human Services. To file a complaint with NeuroSensory Center of Austin, contact our Office Manager. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I have been given a copy of NeuroSensory Center of Austin's *Notice of Privacy Practices*, which describes how my health information is used and shared. I understand that NeuroSensory Center of Austin has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Office Manager.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

_____ _____
Signature of patient or Guardian Date

_____
Print Name

_____
Relationship to patient (Parent, Guardian, Executor of Estate, Health Care Power of Attorney)

Release of information

I give my permission for my medical records to be discussed with the following person(s):

Print name_____

Print name_____

Print name_____