NEW PATIENT REGISTRATION INFORMATION

Last Name: _____First Name: _____MI_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____Cell Phone: (_____) _____

Email: _____

Social Security : _____Driver's License : _____State: _____

Date of Birth: _____Age: _____Gender (circle one): Female Male Other

Race: _____Preferred Language: _____Ethnicity: _____

Marital Status (circle one): Single Married Divorced Widowed

Employment Status (circle one): Full-Time Part-Time Retired Unemployed Student

Occupation: _____

Employer's Name: _____

Employer's Address:_____

City: _____ State: _____Zip: _____

Pharmacy Name and Address: _____

Phone: _____

Emergency Contact Name: _____Phone: _____

Relationship: _____

RESPONSIBLE PARTY AND BILLING INFORMATION

Patient Relationship to Responsible Party (circle one): Self Spouse Child Other: _____

Last Name: _____First Name: _____MI: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: (___) _____Cell Phone: (___) _____Email: _____

Social Security: _____Date of Birth: _____Gender: _____

OTHER PATIENT INFORMATION

Spouse's Name: _____Employer: _____

Occupation: _____Work Phone: (___) _____Cell Phone: (___) _____

PRIMARY INSURANCE

Please provide a copy of the insurance card.

InsuranceCompany:_____Address:_____

Policy Holder Name: _____Sex: _____ Date of Birth: ___/___/_____

Social Security: _____Patient Relationship to Insured Party: _____

Insurance ID: _____Group Name/Number: _____

SECONDARY INSURANCE

Insurance Company: _____Address: _____

Policy Holder Name: _____Sex: _____ Date of Birth: ___/___/___

Social Security : _____Patient Relationship to Insured Party: _____

Insurance ID: _____Group Name/Number: _____

REFERRAL INFORMATION

Who referred you to NeuroEdge Clinic (circle one): Friend/Relative/ Internet

Referring Physician: _____Phone: _____

Primary Care Physician: _____Phone: _____

NeuroEdge Clinic PLLC

REASON FOR VISIT:

_____

_____

PATIENT MEDICAL HISTORY: Please circle all that apply

Atrial Fibrillation	Cancer	High Blood Pressure	Liver Problems	Myasthenia	Passing out
Anemia	Depression	High Cholesterol	Lung Problems	Neck/Back pain	Restless legs
Arthritis	Diabetes	Hydrocephalus	Memory Problems	Neuropathy	Sleep problems
Asthma	Fibromyalgia	Kidney Problems	Multiple Sclerosis	Others:	Stroke
Blood Clot	Headaches	Leukemia/Lymphoma	Muscle Disease	Parkinson's disease	Tremor

SURGICAL/ HOSPITALIZATION HISTORY: Please provide at least one below

Pacemaker DBS VNS Baclofen pump Spinal cord stimulator Stent

Others:

_____

DRUG ALLERGIES:

_____
_____
_____

MEDICATION LIST: Please list the name, strength, and frequency

_____
_____
_____
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_____
_____
_____

PREVIOUS TESTS:

MRI, CT, EEG? Where & When?_____

SOCIAL HISTORY:

Occupation:_____Homemaker Retired

Education Level: Grade School High School College Post- Graduate

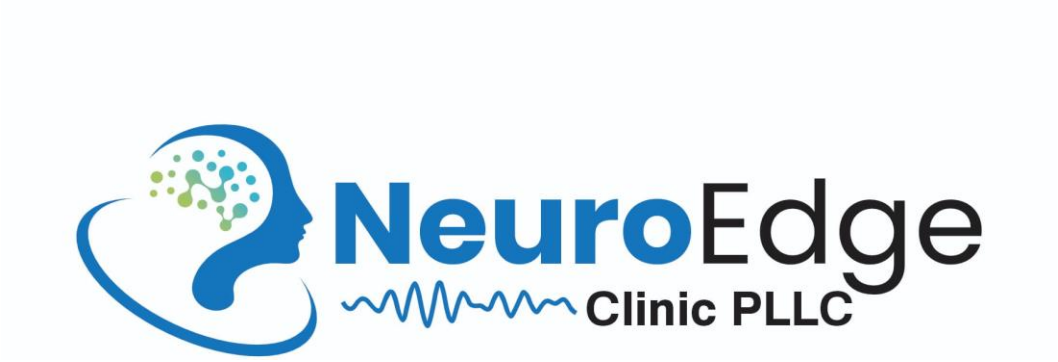
Do you smoke? Yes No If so, how many cigarettes/packs per day? _____

Did you smoke in the past? Yes No If so, for how long? _____

Do you drink alcohol? Yes No If so, for how long? _____

Have you used recreational drugs? Yes No If so, please list: _____

Within the past 12 months, have you fallen? Yes No



Family History

Alcoholism:	If so, Who?	Neuropathy:	If so, Who?
Dementia:	If so, Who?	Parkinsons Disease:	If so, Who?
Diabetes:	If so, Who?	Sleep disorders:	If so, Who?
Epilepsy/Seizure:	If so, Who?	Stroke:	If so, Who?
Migraine:	If so, Who?	Tremor:	If so, Who?
Multiple Sclerosis:	If so, Who?	Other:	If so, Who?

Health Insurance Portability and Accountability (HIPPA)

NeuroEdge Clinic PLLC understands that the medical information about you and your health is personal, and we are committed to protecting this information. We create a record of the care and services you receive at our facilities to provide quality care and to comply with legal requirements. We comply with HIPPA policy which describes the disclosure and access to your health information. A copy of our Privacy Notice will be provided to you upon request.

I authorize NeuroEdge Clinic to release any of my medical or insurance information necessary to process my medical claims and coordinate/manage my healthcare.

With whom may we discuss information about your care, treatment or diagnosis?

Name: _____Relationship: _____

Name: _____Relationship: _____

Medical Records Request Form

_____ _____ _____

PATIENT NAME DATE OF BIRTH SOCIAL SECURITY NUMBER

I authorize the use and disclosure of Health Information about me as described below:

Hospital/ Facility authorized to release my health information:

_____

Address, Phone and Fax number:

_____

Health information that may be used/ disclosed is limited to the following:

( ) Entire Record ( ) Other_____

Dates of Treatment: _____

Patient Information is needed for: ( ) Continuation of medical care. ( ) Other: _____

METHOD OF DELIVERY:

Fax to 817-964-3080 or Mail to 1315 Waters Edge Dr, Suite 107, Granbury, TX: 76048

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

_____

PATIENT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE_____

NAME OF PATIENT'S OR AUTHORIZED REPRESENTATIVE: _____

DATE: _____RELATIONSHIP TO PATIENT: _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION / NOTICE OF PRIVACY PRACTICES / APPOINTMENT OF AUTHORIZED REPRESENTATIVE

At NeuroEdge Clinic PLLC we are committed to securing the privacy of your health information. Accordingly, we have posted our "Notice of Privacy Practices". We would like your acknowledgment that you have been advised that NeuroEdge Clinic PLLC has such a Notice.

I hereby assign, transfer, and set over to NeuroEdge Clinic PLLC all my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits, including medical, surgical, psychiatric, and/or substance abuse (drug or alcohol) information. This authorization shall remain valid until written notice is given by me revoking said authorization.

I understand that this order does not relieve me of my obligation to pay such bills if not paid/covered/found medically necessary by my commercial/third party/government plan or insurance company. I am also financially responsible for any balances due after payments by my insurance company.

I appoint NeuroEdge Clinic PLLC to act as my authorized representative in requesting an appeal from my insurance plan regarding its denial of services or denial of payment.

All charges are due at the time of service. If any procedure is indicated, I am responsible for furnishing insurance claim forms to the office prior to the procedure.

_____	_____	_____	_____
PATIENT SIGNATURE	DATE	WITNESS SIGNATURE	DATE

NeuroEdge Clinic PLLC: Address: 1315 Waters Edge Dr, Ste 107 Granbury, Tx 76048
Phone: (817) 964-3013 Fax: (817) 964-3080

CREDIT CARD ON FILE POLICY

At NeuroEdge Clinic PLLC we require keeping your credit or debit card on file as convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid. Your credit card information is kept confidential and secure and payments to your card are processed **only** after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I_____, authorize NeuroEdge Clinic PLLC to charge the portion of my bill to my financial responsibility to the following creditor debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐Discover

Credit card Number: _____

Expiration Date:_____/_____

CVV Code_____

Cardholder name: _____

Signature: _____

Billing Address:_____

City:_____State:_____Zip:_____

I (we), the undersigned, authorize and request NeuroEdge Clinic PLLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This Authorization relates to all payments not covered by my insurance company for services provided to me by NeuroEdge Clinic PLLC.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to NeuroEdge Clinic PLLC in writing and the account must be in good standing

Patient Name (Print) _____

Patient Signature: _____ Date:_____

NeuroEdge Clinic: Address: 1315 Waters Edge Dr Ste 107 Granbury, Tx 76048
Phone: (817) 964-3013 Fax: (817) 964-3080

FINANCIAL POLICY

Effective Date: June 05, 2025

1. Insurance and Billing

- We work with many major insurance carriers and will file claims on your behalf. - It is your responsibility to: • Present a valid insurance card at every visit. • Know your insurance benefits, including co-pays, deductibles, and covered services. • Inform us promptly of any changes in your insurance coverage. Please note: You are financially responsible for any services not covered by your insurance.

2. Co-Pays and Deductibles

All co-pays, co-insurance, and deductibles are due at the time of service. We do not allow co-pays to be billed unless special arrangements have been made in advance.

3. Self-Pay and Out-of-Network Patients

If you do not have insurance or we do not participate in your insurance network, full payment is due at the time of service. Financial assistance may be available on a case-by-case basis. Please speak to our billing department before your appointment if you need help.

4. Non-Covered or Elective Services

Certain procedures (e.g., diagnostic testing, long-term EEG monitoring, Botox for migraines) may not be covered by your insurance. We will inform you in advance if this applies and require your written consent to proceed with the service and accept financial responsibility.

5. Accepted Payment Methods

We accept the following forms of payment: - Cash - All major credit and debit cards (Visa, MasterCard, Discover, American Express)

6. Account Balances and Billing

Statements are sent via email, text and paper for any balances after insurance payments. Balances are due within 30 days of the statement date unless a payment plan has been established. Accounts not paid within 90 days may be sent to a collection agency and may result in dismissal from the practice.

7. Refunds

Refunds for overpayments will be processed once all insurance claims have been finalized and any patient responsibilities are resolved.

Patient Acknowledgment

I have read and understand the Financial Policy of NeuroEdge Clinic PLLC. I agree to abide by these terms and understand that I am ultimately responsible for payment of all services rendered

_____	_____	_____
PATIENT NAME	PATIENT SIGNATURE	DATE

NeuroEdge Clinic: Address: 1315 Waters Edge Dr Ste 107 Granbury, Tx 76048
Phone: (817) 964-3013 Fax: (817) 964-3080