NORTHEAST TEXAS NEUROLOGY ASSOCIATES

GINA JETTER, MD, FAES
TALESH FREEMAN, APRN, FNP-C

(903) 526-7055
(903) 593-4303
www.netxneuro.com
505 S. Fleishel Ave, Tyler, Texas 75702

Dear Prospective Patient ,

You have been referred to our office for evaluation of memory loss. Our evaluation will be unlike your other doctor's visits. We will spend a significant amount of time getting to know you and learning about your everyday life. We will also talk with your loved ones and caregivers about you. **Please bring a family member or caregiver to the appointment with you**. Often when your memory starts to be impaired, your loved ones will notice problems before you will.

We are very thorough in our evaluation. You and your caregiver will be asked to fill out several forms to help us get to know you and further explore what problems you are having. **We must receive all the following paperwork before an appointment is scheduled.**

Bring the following to your first appointment:

- All health insurance cards
- Driver's License or current government issued ID
- All of your medications

Talesh Freeman, a Nurse Practitioner, is a vital part of our team at NETNA. After our initial consultation, she will be seeing you at some of your visits following my treatment plan.

Our office is located at 505 S. Fleishel Ave, Tyler, TX 75702. Before your consultation, we invite you to visit our website at www.netxneuro.com to get to know us better.

We provide comprehensive care to our patients, and every person is important to us. We look forward to meeting you in person and helping you with your healthcare needs.

Sincerely,

Gina Jetter, MD

505 S. Fleishel Ave
Tyler, TX 75702
903-526-7055 p
903-593-4303 f
www.netxneuro.com

PATIENT INFORMATION

Name (Last, First, MI): _____

Preferred Name: _____

DOB: _____ Age: _____ Gender: _____ Last 4 Digits of SSN: _____

Address: _____ City, State, Zip Code: _____

Race: *African American Asian Hispanic White Other* Marital Status: *Married Divorced Separated Widowed Single*

Employer: _____ Health Insurance Company: _____

Name of Insurance Policy holder: _____

If different than patient, what is the name and DOB of policy holder? _____

CONTACTS

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Care Doctor*:* _____

Preferred Pharmacy*:* _____ Location: _____

COMMUNICATION PREFERENCES

Preferred Number: _____	Pick One: Cell / Home / Work
Secondary Number: _____	Pick One: Cell / Home / Work
May we leave messages/text regarding your **appointment time/date** at the	Preferred number? ☐ Yes ☐ No
	Secondary number? ☐ Yes ☐ No
May we leave messages regarding your **medical testing results** at the	Preferred number? ☐ Yes ☐ No
	Secondary number? ☐ Yes ☐ No
May we leave messages regarding your **medical bill** at the	Preferred number? ☐ Yes ☐ No

Email Address:

_____

May we send emails regarding your **appointment time/date** to this email account? ☐ Yes ☐ No

May we send emails regarding your **medical testing results** to this email account? ☐ Yes ☐ No

May we send emails regarding your **medical bill** to this email account? ☐ Yes ☐ No

RELEASE OF INFORMATION:

Healthcare personnel needing information for continuity of care or for insurance purposes will be released my health information. I authorize release of my health information to the following (family, friend, caretaker) below:

Name of Person / Relationship

_____

_____

Name of Person / Relationship

_____

_____

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES:

I have reviewed Northeast Texas Neurology Associates (NETNA) office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. A copy is also on NETNA's website, www.netxneuro.com.

ACKNOWLEDGMENT OF REVIEW OF FINANCIAL POLICY:

I have reviewed NETNA's Financial Policy, which outlines my financial responsibility to the practice. I understand that I am entitled to receive a copy of this document. A copy is on NETNA's website, www.netxneuro.com

AUTHORIZATION FOR TREATMENT:

I voluntarily consent to receive health care services deemed necessary provided by NETNA. I understand that this consent to treatment will be valid and remain in effect unless revoked by me in writing.

ADVANCED PRACTICE PROVIDERS:

NETNA has an advanced practice nurse to assist in the delivery of neurological care. As a patient at NETNA, you will initially be seen by a neurologist, who will always be directing your care. Continued care will be in a rotation with the physician and the nurse practitioner. I understand as a patient of NETNA, I will be seeing a nurse practitioner at some of my visits.

NO SHOW AND CANCELLATION POLICY:

Notify the office **at least (24) business hours in advance** when unable to keep your scheduled appointment. A no-show appointment is defined as cancelling an appointment with less than 24 business hours notice, arriving 15 minutes after your scheduled appointment time, or not showing up for an appointment. If a patient has a no-show appointment, they must pay a $50 rescheduling fee ($200 for initial consults or procedures) before an appointment will be rescheduled. Any other future appointments already scheduled will be cancelled until the rescheduling fee is paid. A patient may be dismissed from the practice if there are 2 no-show appointments. This includes appointments for procedures performed in our office as well as Epilepsy Monitoring Unit admissions.

ACKNOWLEDGMENT OF TELEMEDICINE VISIT TERMS AND CONDITIONS:

Telemedicine visits, or visits with audio and video capability are provided at NETNA where the patient and provider are not in the same location. If you choose a telemedicine visit, risks include service interruptions, interception and technical difficulties. The full Telemedicine visit Terms and Conditions can be found on our website, www.netxneuro.com.

_____ _____ _____

Signature of Patient or Legal Guardian **Printed Name** **Date**

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CONSENT TO OBTAIN PATIENT MEDICAL RECORDS

Patient's Name:_____
Last First Middle

Date of Birth: _____

I consent to the medical records of the above named patient to be released to:

Northeast Texas Neurology Associates, PA
505 S. Fleishel Ave
Tyler TX 75702
(903) 526-7055 Fax (903) 593-4303

These records may be faxed or mailed. This authorization applies to all health care information for the purpose of continued health care.

I understand that my express consent is required to release any health care information if I have been tested, diagnosed, and/or treated for HIV (AIDS), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health information relating to such diagnosis, testing or treatment.

_____ _____
Signature of patient or authorized representative Date signed

Relationship to patient, if not patient: _____

Patient Address:_____

City:_____ State:_____ Zip: _____

Telephone: _____

AUTHORIZATION EXPIRES 1 YEAR AFTER DATE SIGNED

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Credit Card on File Policy

Northeast Texas Neurology Associates (NETNA) requires a credit card on file in order to make the billing process simple and easy for the clinic and our patients.

Your credit card information is stored within our secure electronic health record, which meets the strict HIPAA security standards. **We swipe your card into the system, and only the last 4 digits of the card are visible to any staff at NETNA. We will not write down nor keep any written information about your card including the number, expiration date or security code on the back of the card.**

For any balances owed after a visit or procedure, we will send you a statement in the mail. Within 21 days, if we have not received payment, we will send you an email notifying you that your card on file will be charged. If you wish to settle your balance by another payment method, please contact our office within those 21 days. We will send you a receipt after your card has been charged.

If your card is declined, we will contact you via phone. Your account becomes delinquent if not paid within 30 days after the date of the original statement. Further delinquency will be subject to collection. NETNA reserves the right to terminate a patient from the practice if payment is not received according to the agreed upon payment arrangements.

We understand that healthcare is often a large expense, and we are always willing to provide payment arrangements. These arrangements will require a credit card on file for monthly payments. Please contact our billing department if you need assistance with paying your outstanding balance.

By signing below, you acknowledge and agree to the NETNA's Credit Card on File policy. If the patient is not able to sign, the signer below is the legal guardian or responsible for the patient's account.

_____ _____

Name on Credit Card | Relation to Patient (Self, Guardian, etc)

_____ _____

Signature | Date

NAME: DATE OF BIRTH TODAY'S DATE:

PREFERRED NAME: _____

Primary Care Doctor: _____

Why were you referred here / what problems are you having?

_____

_____

Please check the following tests you have had.

MRI Scan of the head EEG (Brain wave recording) EMG and Nerve Conduction Lumbar puncture (spinal tap)

Have you seen a neurologist before? YES / NO If so, what is her/his name and location?

_____

Please list any other **medical problems** you have. *Attach another page if needed.*

_____

_____

_____

Please list all **surgeries, injuries and pregnancies** and approximate date. *Attach another page if needed.*

_____

_____

Please list all your **current medications**, including vitamins and over the counter medications:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME: _____ DATE OF BIRTH _____ TODAY'S DATE: _____

List any **allergies** to medications: _____

List any illnesses in your **family**, especially those that are similar to your current problem.

_____

Do you currently **smoke**? Yes / NO If yes, how many packs per day? _____ For how long? _____
If you previously smoked, when did you quit? _____

Do you drink **alcohol**? Yes / NO If yes, how may drinks in a week? _____

Have you ever used any **illicit drugs**? Yes / NO If yes, what kind? _____ Last use? _____

PHQ-9: Depression Screen:

Over the last 2 weeks, how often have you been bothered by the following (please circle/check number)?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling/staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading or TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home or get along with other people? Not difficult / Somewhat difficult / Very difficult / Extremely difficult

Patient Name: _____DOB: _____ Date: _____

Person Completing Form and Relationship to Patient: _____

Do you live with the patient? YES / NO

How much contact do you have with the patient (Circle One)?

- Less than 1 day a week
- 1 day a week
- 2 days a week
- 3-4 days a week
- 5 or more days a week

In each section, please circle the one number that most closely applies to your loved one. Please circle the answer that seems to apply most of the time.

Memory

0 Normal memory
1 Occasionally forgets things that they were told recently. Does not cause many problems
2 Mild consistent forgetfulness. Remembers recent events but often forgets parts.
3 Moderate memory loss. Worse for recent events. May not remember something you just told them. Causes problems with everyday activities.
4 Substantial memory loss. Quickly forgets recent or newly-learned things. Can only remember things that they have known for a long time.
5 Does not remember basic facts like the day of the week, when last meal was eaten or what the next meal will be.
6 Does not remember even the most basic things

Speech and Language

0 Normal ability to talk and to understand others.
1 Sometimes cannot find a word, but able to carry on conversations.
2 Often forgets words. May use the wrong word in its place. Some trouble expressing thoughts and giving answers.
3 Usually answers questions using sentences but rarely starts a conversation.
4 Answers questions, but responses are often hard to understand or don't make sense. Usually able to follow simple instructions.
5 Speech often does not make sense. Can not answer questions or follow instructions.
6 Does not respond most of the time.

Recognition of Family Members

0 Normal – Recognizes people and generally knows who they are
1 Usually recognizes grandchildren, cousins, or relatives who are not seen frequently but may not recall they are related
2 Usually does not recognize family members who are not seen frequently. Is often confused about how family members such as grandchildren, nieces, or nephews are related to them.

3 Sometimes does not recognize close family members or others who they see frequently. May not recognize their children, brothers or sisters who are not seen on a regular basis.
4 Frequently does not recognize spouse or caregiver.
5 No recognition or awareness of the presence of others.

Orientation to Time

0 Normal awareness of time of day and day of week
1 Some confusion about what time it is or what day of the week, but not severe enough to interfere with everyday activities
2 Frequently confused about time of day
3 Almost always confused about time of day.
4 Seems completely unaware of time.

Orientation to Place

0 Normal awareness of where they are even in new places
1 Sometimes disoriented in new places
2 Frequently disoriented in new places
3 Usually disoriented, even in familiar places. May forget that they are already at home.
4 Almost always confused about place

Ability to Make Decisions

0 Normal – as able to make decisions as before
1 Only some difficulty making decisions that arise in day-to-day life
2 Moderate difficulty. Gets confused when things get complicated or plans change.
3 Rarely makes any important decisions. Gets confused easily.
4 Not able to understand what is happening most of the time.

Social and Community Activity

0 Normal – acts the same with people as before
1 Only mild problems that are not really important, but clearly acts differently from previously years.
2 Can still take part in community activities without help. May appear normal to people who don't know them.
3 Often has trouble dealing with people outside the home without help from caregiver. Usually can participate in quiet home activities with friends. The problem is clear to anyone who sees them.
4 No longer takes part in any real way in activities at home involving other people. Can only deal with the primary caregiver.
5 Little or no response even to primary caregiver.

Home Activities and Responsibilities

0 Normal. No decline in ability to do things around the house.
1 Some problems with home activities. May have more trouble with money management (paying bills) and fixing things. Can still go to a store, cook or clean. Still watches TV or reads a newspaper with interest and understanding.

2 Makes mistakes with easy tasks like going to a store, cooking or cleaning. Losing interest in the newspaper, TV or radio. Often can't follow long conversations on a single topic.
3 Not able to shop, cook, or clean without a lot of help. Does not understand the newspaper or the TV. Cannot follow a conversation.
4 No longer does any home based activities.

Personal Care / Cleanliness

0 Normal. Takes care of self as well as they used to.
1 Sometimes forgets to wash, shave, comb hair, or may dress in wrong type of clothes. Not as neat as they used to be.
2 Requires help with dressing, washing and personal grooming.
3 Totally dependent on help for personal care.

Eating

0 Normal, does not need help eating food that is served to them.
1 May need help cutting food or have trouble with some foods, but basically able to eat by themselves.
2 Generally able to feed themselves but may require some help. May lose interest during the meal.
3 Needs to be fed. May have trouble swallowing.

Control of Urination and Bowels

0 Normal – does not have problems controlling urination or bowels except for physical problems.
1 Rarely fails to control urination (generally less than one accident per month)
2 Occasionally failure to control urination (about once a week)
3 Frequently fails to control urination (more than once a week)
4 Generally fails to control urination and frequently can not control bowels.

Ability to Get from Place to Place

0 Normal, able to get around on their own. (May have physical problems that require cane or walker.)
1 Sometimes gets confused when driving or taking public transportation, especially in new places. Able to walk places alone.
2 Cannot drive or take public transportation alone, even in familiar places. Can walk along outside for short distances. Might get lost if walking too far from home.
3 Cannot be left outside alone. Can get around the house without getting lost or confused.
4 Gets confused and needs help finding their way around the house.
5 Almost always in a bed or chair. May be able to walk a few steps with help, but lacks sense of direction.
6 Always in bed. Unable to sit or stand.

Total Score: _____ (0-18 Mild; 19-36 Moderate; 37+ Severe)

Activities of Daily Living Questions

ACTIVITIES	INDEPENDENCE (1 POINT) No supervision or personal assistance needed	DEPENDENCE (0 POINTS) WITH supervision, direction, personal assistance or total care
BATHING POINTS: _____	Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity **(1 point)**	Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing **(0 points)**
DRESSING POINTS: _____	Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes **(1 point)**	Needs help with dressing self or needs to be completely dressed **(0 points)**
TOLIETING POINTS: _____	Goes to toilet, gets on and off, arranges clothes, cleans genital area without help **(1 point)**	Needs help transferring to the toilet, cleaning self or uses bedpan or commode **(0 points)**
TRANSFERRING POINTS: _____	Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable **(1 point)**	Needs help in moving from bed to chair or requires a complete transfer **(0 points)**
CONTINENCE POINTS: _____	Exercises complete self control over urination and defecation **(1 point)**	Is partially or totally incontinent of bowel or bladder **(0 points)**
FEEDING POINTS: _____	Gets food from plate into mouth without help. Preparation of food may be done by another person **(1 point)**	Needs partial or total help with feeding or requires parenteral (tube) feeding **(0 points)**

Katz Index of Independence in Activities of Daily Living

Total Points: _____

Behavior and Mood Questions: Does your loved one…

1. Get angry or hostile? Resist care from others? **YES / NO**

2. See and/or hear things that no one else can see/hear? **YES / NO**

3. Act impatient and cranky? Mood frequently changes for no reason? **YES / NO**

4. Act suspicious without good reason (example: believes that others are stealing from him/her or planning to harm him/her in some way? **YES / NO**

5. Seem less interested in his or her usual activities and plans of others? **YES / NO**

6. Have trouble sleeping at night? **YES / NO**

Safety Assessment Checklist

1. Is the patient still driving? **YES / NO**
2. Is the patient able to manage their own medications? **YES / NO**
3. Are there concerns about safety in the home? **YES / NO**
4. Has the patient gotten lost in familiar places or wandered? **YES / NO**
5. Are firearms present in the home? **YES / NO**
6. Has the patient experienced unsteadiness or sustained falls? **YES / NO**
7. Does the patient live alone? **YES / NO**
8. If no, with whom does the patient live? If this patient lives in an Assisted Living or Nursing Facility, which one?

_____

Caregiver Profile

1. Do you understand what Alzheimer's and / or other dementias are? **YES / NO**
2. Do you know where you can obtain additional information about the disease? **YES / NO**
3. Are you able and willing to provide care of assistance? **YES / NO**
4. Do you know where you can receive support as a caregiver? **YES / NO**

Power of Attorney

Does the patient have a <u>medical</u> power of attorney? _____

Does the patient have a <u>financial</u> power of attorney? _____

Is there anything you wish to share with us privately? _____

_____

_____

_____

_____