



Dear Prospective Patient ,

You have been referred to our office for evaluation of your neurological problem. In order to be thorough in our evaluation and be fully prepared for your visit, we require that you completely fill out and return all the following paperwork. **Your initial consultation will not be scheduled until we receive all the completed paperwork.**

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](http://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](http://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](http://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](http://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](http://www.netxneuro.com).

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date



**NORTHEAST  
TEXAS  
NEUROLOGY  
ASSOCIATES**

**GINA JETTER, MD, FAES**

**TALESH FREEMAN, APRN, FNP-C**

(903) 526-7055



www.netxneuro.com

(903) 593-4303



505 S. Fleishel Ave, Tyler, Texas 75702

**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**

## 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 many 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



## Headache Questionnaire

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

At what age did you have your first headache? \_\_\_\_\_

When did your current headaches begin? \_\_\_\_\_

When was your last headache? \_\_\_\_\_

How many severe headaches do you have in a month? \_\_\_\_\_ How long do they last? \_\_\_\_\_

How many days a month do you have no headache? \_\_\_\_\_

Do you have a warning before your headache? If so, describe.

\_\_\_\_\_  
\_\_\_\_\_

When you have a headache, what medications do you take and how many doses do you take?

\_\_\_\_\_  
\_\_\_\_\_

Do you take any of the following every day or week? If so, how many do you take?

Excedrin / Excedrin Migraine \_\_\_\_\_ pills a day / \_\_\_\_\_ pills a week

Ibuprofen / Advil / Motrin \_\_\_\_\_ pills a day / \_\_\_\_\_ pills a week

Acetaminophen / Tylenol \_\_\_\_\_ pills a day / \_\_\_\_\_ pills a week

Naproxen / Aleve / Anaprox \_\_\_\_\_ pills a day / \_\_\_\_\_ pills a week

Aspirin / BC Powder / Bufferin / Anacin \_\_\_\_\_ pills a day / \_\_\_\_\_ pills a week



How would you describe the pain of your most bothersome headaches?

Throbbing  
Aching  
Stabbing

Pulsating  
Pressure-like  
Electric – like

Dull  
Sharp  
Vise-like

Are your headaches brought on by:

Periods/hormonal changes  
Exercise  
Too much sleep  
Smoke

Alcohol  
Stress  
Odors  
Noise

Lack of sleep  
Bright lights / glare  
Hunger  
Certain foods

Which of the following symptoms do you have with your headaches?

Neck pain  
Light sensitivity  
Numbness  
Difficulty speaking  
Worsening of pain with movement

Nausea  
Dizziness  
Weakness  
Tearing

Vomiting  
Noise sensitivity  
Confusion  
Nasal congestion

Other (please describe):

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Check one answer for each question:

	Never (6)	Rarely (8)	Sometimes (10)	Very Often (11)	Always (13)
When you have a headache, how often is the pain severe?					
How often do headaches limit your ability to do usual daily activities including household work, school or social activities?					
When you have a headache, how often do you which you could lie down?					
In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?					
In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?					
In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?					

Total Score:

Have you tried any of the following treatments for your headaches (please circle)?

Biofeedback  
Acupuncture

Chiropractic  
Physical Therapy

Supplements: Feverfew, B2  
Magnesium, MigreLief,  
Co-Q 10, Petadolex

Have you ever been hospitalized for treatment of your headaches? If so, when? \_\_\_\_\_

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Have you every tried any of the following medications for your headaches (please circle)?

Excedrin / Excedrin  
Migraine  
Ibuprofen / Advil / Motrin  
Acetaminophen / Tylenol  
Naproxen / Aleve /  
Anaprox  
Aspirin / BC Powder /  
Bufferin  
Anacin

Midrin

Indocin / Indomethacin  
Cambia / Diclofenac

Sumatriptan / Imitrex /  
Treximet  
Almotriptan / Axert  
Eletriptan / Relpax  
Frovatriptan / Frova  
Naratriptan / Amerge  
Rizatriptan / Maxalt  
Zolmitriptan / Zomig

Axotal  
Esgic  
Fioricet / Butalbital  
Fiorinal / Butalbital

Reyvow / Lasmiditan  
Ubrelvy / Ubrogapant  
Nurtec / Rimegepant  
Amitriptyline / Elavil  
Nortriptyline / Pamelor  
Effexor / Venlafaxine  
Lithium

Atacand / Candesartan  
Benicar / Olmesartan  
Inderal / Propranolol  
Verapamil / Verelan /  
Calan

Botox  
Aimovig / Erenumab  
Ajoovy / Fremanezumb  
Emgality / Galcanezumab  
Vyepiti (Eptinezumab)

DHE - 45 / Migranal  
Ergostat

Flexeril  
Robaxin  
Valium  
Zanaflex / Tizanidine

Cymbalta / Duloxetine  
Gabapentin / Neurontin  
Lyrica / Pregabalin  
Lamictal / Lamotrigine  
Depakote / Valproic Acid  
Topamax / Topiramate /  
Trokendi  
Zonegan / Zonisamide

Codeine  
Darvon / Darvocet  
Demerol  
Hydrocodone  
Percocet / Oxycodone  
Percodan  
Stadol  
Talwin  
Ultram

Dexamethasone /  
Decadron  
Other steroids