HTNI

HOUSTON NEUROLOGICAL
TEXAS INSTITUTE

☐ Dr . ☐Miss ☐ Mrs. ☐ Ms. ☐Sir

Patient'sName(Last)_____(First)_____(MI)_____PreviousName_____
_____

Address Line 1_____

City, State_____ZIP_____

Home Phone_____Cell No._____Work Phone._____EXT_____

Primary Care Provider (PCP)_____Referring Provider_____

Rendering Provider Name (this practice)_____E-Mail Address:_____

Date of Birth: MM _____/DD_____YYYY_____ Sex ☐F – Female ☐M -Male ☐Transgender

Race: ☐Asian Native ☐Hawaiian/Pacific Islander ☐Black/African ☐American ☐White Hispanic ☐Other
☐Indian/Alaska Native ☐Declined

Language: ☐Russian ☐English ☐Spanish ☐Japanese ☐Chinese ☐Korean ☐French ☐German

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined

Marital Status: ☐Married ☐Legally Separated ☐Partner ☐Single ☐Divorced ☐Widowed

Social Security Number_____-_____-_____Employer Name_____

Employment Status: ☐FulTime ☐Part-time ☐Not Employed ☐Self-Employed ☐Retired ☐Active Military

Student Status: ☐F - Full-Time Student ☐p -Part-Time Student ☐N - Not a Student

Emergency Contact: Last Name _____First Name_____

Phone Number_____ Do you have a living will? ☐Yes ☐No

Emergency Contact Relationship to Patient _____Guardian

Address Line 1_____

City, State_____ ZIP _____

Home Phone_____ Work Phone _____Ext._____

Referring Provider Name_____

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RESPONSIBLE PARTY INFORMATION) (information used for patient balance statements)

Check here if the information is the same as the patient ☐

Responsible Party: ☐Another Patient ☐Guarantor ☐Self

Responsible Party Name (Last)_____First Name_____(M)_____

Guarantor Account Number_____ Date of Birth MM___DD___YYYY_____

Social Security Number_____Telephone_____

E-Mail Address_____ Sex ☐F – Female ☐M - Male

Address Line 1_____

City, State _____ZIP_____

Employer. _____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number. _____( )_____

Name of Insured. _____Patient Relationship to Insured_____

Subscriber ID (Policy Number) _____ Group ID_____Copay Amount_____

Effective Date. _____ Termination Date_____ Date of Birth MM___/DD___YYYY_____

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number_____(.)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number) _____Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM____ IDD____/YYYY

I agree that the information supplied on this form is accurate and up to date to the best of my knowledge.

Patient (or Responsible Party) Signature _____Date_____

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Name: _____ Date of Birth _____Height: _____Weight: _____

Reason for a visit today: _____

Do you smoke? ☐Yes ☐No If yes, how many packs per day? _____

Have you ever smoked? ☐Yes ☐No If yes, when did you quit? _____

Do you use alcohol? ☐Yes ☐No If yes, how many drinks per week? _____

Do you or have you used the following in the last 3 months? ☐Marijuana ☐Cocaine ☐Heroine ☐Methamphetamine

Current Medications	Dosage

Previous Surgeries	Date

Are you allergic to any medications? ☐Yes ☐No If yes, please list: _____

Have you ever had any of the following? (Circle all that apply):

- AIDS/HIV
- High Blood Pressure
- lung disease
- Skin Disease
- Thyroid Disease
- Epilepsy/Seizures
- Heart Disease
- Asthma
- Positive Bladder Problems
- Heroin Methamphetamine Date

Blood Clots
Liver Disease
Prostate
Stroke
Tuberculosis
Anxiety/Depression
Cancer
Hepatitis A/B/C
HIV/AIDS Positive
Joint Disease

Do any of these conditions run in your family? (Circle all that apply):

Addiction	Blood Clots	Alcoholism	Heart Disease
Psychiatric Disorder	Stroke	Joint Disease	Diabetes

Primary Care Physician Information:
Name: _____Phone: _____

Address: _____

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Pharmacy Information:
Name: _____ Phone: _____

Address: _____
How did you hear about us? (Circle any that apply): Website. Family/Friend Physician Internet

Please provide the name of where you heard about us so we can thank them: _____
Patient Name: _____

Date of Birth: _____

Patient Consent for Financial Communications

Financial Agreement:

I acknowledge that as a courtesy Houston Texas Neurosurgical Institute will bill the insurance company for services rendered to the patient.
I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance, and/or deductibles, or charges not covered by my insurance companies.
Assignment of Benefits:
I hereby assign to Houston Texas Neurosurgical Institute any insurance or third-party benefits available for health care services provided to me. I understand Houston Texas Neurosurgical Institute has the right to refuse or accept the assignment of such benefits. If these benefits are not assigned to Houston Texas Neurosurgical Institute, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.
Medicare Patient Certification and Assignment of Benefits:
I certify that any information I provide, if any, in applying for payment under Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Houston Texas Neurosurgical Institute by the Medicare or Medicaid program.
Houston Texas Neurosurgical Institute has no financial interest involving Diagnostic testing facilities and patients may have their diagnostic testing at their facility of choice.
A photocopy of this consent shall be considered as valid as the original.
Patient/patient representative signature:
Date:
If you are not the patient, please identify your relationship with the patient. Circle or mark relationship(s) from the list below:
• Spouse • Legal Guardian • Guarantor • Healthcare Power of Attorney • Other

Houston Texas Neurosurgical Institute files the patient's insurance claims, with the information provided by the patients and insurance companies for their coverage. The patients are financially responsible for their medical care which has been provided by Dr. Moradi. We will bill our patients per the insurance company's explanation of benefits provided to us.
The practice may drop or remove an insurance company from our listing, due to the rapid changes in the insurance market. Insurance changes occur at various times, sometimes without our knowledge.
A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative _____

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Signature_____

Date_____

PHYSICIAN DISCLOSURE OF FINANCIAL INTEREST

For patients referred to

Texas Imaging Network

www.texasimagingnetwork.com

- GALLERIA MRI & DIAGNOSTICS (WEST-U/MED CENTR

3391 Westpark Drive • Houston, Texas 77005
Phone: 281-888-2727 • Fax: 281-664-3792

- SUGARLAND IMAGING CENTER IF (STANDUP MRI) • SPRING IMAGING (WOODLANDS)

2655 Cordes Drive Suite130 • Sugarland, Texas 77479
26406 Interstate 45 • Spring, Texas 77386
Phone: 281-302-5410 • Fax: 281-664-5051
Phone: 832-299-6944 • Fax: 832-299-6945

- 1-10 MRI & DIAGNOSTICS (MEMORIAL CITY)

10929 Katy Freeway • Houston, Texas 77079
Phone: 281-501-0787 • Fax: 281-501-0775

- ELITE MRI & DIAGNOSTICS (TOMBALL)

444 Holderrieth Boulevard Suite 1 • Tomball Texas 77375
Phone: 281-255-6850 • Fax: 281-255-6843

- CLEAR LAKE IMAGING

202 North Texas Avenue Suite 400 • Webster, Texas 77598
Phone: 281-643-0444 • Fax: 281-338-2111

- SKY MRI AND DIAGNOSTICS (PEARLAND)

11711 Shadow Creek Pkwy Suite 146 C • Pearland, TX 77584
Phone: 832-895-1000 • Fax: 832-895-1250

Texas law requires that we disclose to you any financial interest that we may have in another healthcare entity to which you may be referred for diagnostic testing, so that

you may address any concerns you may have directly with your physician. Your referring physician is a member, owner, or investor in Texas Imaging Network. You have the option of going to a facility of your choosing every time for your diagnostic testing that is ordered.
By signing the below, you acknowledge your receipt of this Physician Disclosure of Financial Interest and understand that your referring doctor is an owner of this facility.

Print Patient Name: _____

Patient Signature: _____

Witness: _____

Date: _____