

Robert Chudnow, MD, PA
Anthony Riela, MD, PA
Gerald So, MD, PA
Mary Baiyeri, MD

Dear Parents of: _____

Welcome to Texas Child Neurology!

Your child has been scheduled an office visit in our pediatric neurology office on:

_____. Check-in time for the **FIRST VISIT ONLY** will be
_____. (Which is 30 minutes prior to your scheduled appointment).

Follow-up appointments we ask that you plan to arrive at least 15 minutes prior to the scheduled appointment. This will help us should the physician be running ahead of time and can see you earlier than scheduled.

Please plan your travel to our office accordingly as tardiness affects those that may be scheduled after you and it will help us to be able to see your child at the time they were scheduled. Otherwise, we will need to reschedule for a new date and time.

We are enclosing a New Patient Packet for you to complete prior to your arrival.

Full payment is always collected prior to you seeing the physician along with re-verifying insurance cards at each visit. Please be prepared to show all active insurance cards at the time of your appointment. If you find that you are unable to make payment, we will be happy to assist in rescheduling for a new date and time. We are set up to receive credit card payments of MasterCard and Visa only, as well as payments made by cash or check. If you require a referral number from your insurance carrier, please understand that this is your responsibility as the insurer to obtain this from your PCP and not our office. We must have it in our office 48 hours prior to your appointment or we will have no choice but to reschedule for a later date and time should you arrive for the appointment and we have yet to receive it.

We look forward to assisting you with your medical needs.

Thank you.

The Physicians and Staff of Texas Child Neurology

Revised 6/2008

TEXAS CHILD NEUROLOGY, LLP
1708 COIT RD., SUITE 150
PLANO, TEXAS 75075
Office # 972-769-9000 Fax # 972-769-0035

Welcome to Our Practice

WE HOPE THAT THE FOLLOWING INFORMATION WILL BE HELPFUL TO YOU. WE RESPECT YOU AND YOUR TIME AND WE WOULD LIKE TO MAKE YOUR VISIT TO OUR OFFICE AS PLEASANT AND AS EFFICIENT AS POSSIBLE.

LOCATION: WE ARE APPROXIMATELY ¼ MILE NORTH ON COIT FROM MEDICAL CENTER PLANO. OUR OFFICE IS LOCATED AT THE SIGNAL LIGHT OF COIT RD AND AMERICAN DR, WHICH IS BETWEEN PARK BLVD AND 15TH ST.

OFFICE HOURS:

BY APPOINTMENT ONLY:

MONDAY -THURSDAY 8:00AM - 4:30PM, FRIDAY 8:00AM- 3:00PM

WE CLOSE FOR LUNCH AT 11:30AM TO 1:00PM.

OUR PHONES ARE NOT EQUIPPED TO TAKE MESSAGES DURING THIS TIME.

CANCELLATION / NO SHOWS:

WE REQUIRE 24 HOURS NOTICE IF YOU ARE UNABLE TO MAKE YOUR APPOINTMENT AND RESERVE THE RIGHT TO CHARGE YOU IF YOU FAIL TO CONTACT OUR OFFICE IN A TIMELY MANNER.

AFTER TWO (2) FAILED APPOINTMENTS, THE DR. HAS THE RIGHT TO RELEASE YOU FROM HIS CARE AND REFUSE TO APPROVE ANY FURTHER MEDICATION REFILLS.

IF YOU ARE LATE FOR YOUR APPOINTMENT, WE HAVE THE RIGHT TO RESCHEDULE YOUR APPOINTMENT AS THIS DELAY AFFECTS NOT ONLY THE PHYSICIANS' BUT ALSO OTHERS THAT MAY COME AFTER YOU.

PRESCRIPTIONS:

REFILLS ARE APPROVED DURING OFFICE HOURS ONLY

IF YOU NEED A REFILL ON A PRESCRIPTION, YOU NEED TO CALL YOUR PHARMACY AND REQUEST A REFILL. THEY WILL CONTACT OUR OFFICE FOR APPROVAL.

REQUIRE 48 HOURS NOTICE WHEN REQUESTING MEDICATION REFILLS OF ANY KIND.

THERE IS A \$10.00 FEE FOR ALL TRIPPLICATE PRESCRIPTIONS REQUESTED IF DONE OUTSIDE OF A REGULAR SCHEDULED OFFICE VISIT.

FINANCIAL / INSURANCE REFERRAL POLICY:

WE COLLECT PATIENT Co-PAYS AND/ OR DEDUCTIBLES PRIOR TO YOU SEEING THE PHYSICIAN. PLEASE BE PREPARED TO PAY. WE ACCEPT CASH, CHECK, MASTERCARD AND VISA.

ALL INSURANCE REFERRALS MUST BE IN OUR OFFICE 48 HOURS PRIOR TO YOUR APPOINTMENT.

IF WE DO HAVE THEM BEFORE YOUR APPOINTMENT WE WILL HAVE NO CHOICE BUT TO RESCHEDULE.

MEDICAL INSURANCE: INSURANCE CARDS ARE CHECKED AT EVERY VISIT.

YOUR INSURANCE MAY NOT COVER THE FULL COST OF YOUR CHARGES, REGARDLESS OF INSURANCE, PAYMENT REMAINS YOUR PERSONAL RESPONSIBILITY AND IS DUE BEFORE YOU SEE THE PHYSICIAN. **OUR OFFICE IS CURRENTLY NOT ACCEPTING ANY NEW MEDICAID PATIENTS.**

WE LOOK FORWARD TO SERVING YOUR MEDICAL NEEDS.

ROBERT CHUDNOW, MD

GERALD SO, MD

ANTHONY RIELA, MD

MARY BAIYERI, MD

Revised 6/2008

Texas Child Neurology, LLP
Coit America Medical Building * 1708 Coit Rd., Suite 150 * Plano, Texas 75075 * Ofc. 972-769-9000
1643 Lancaster Dr., Suite 304 * Grapevine, Texas 76051 * Ofc. 972-769-7592

DRIVING DIRECTIONS

PLANO Office

North: Denton / Carrollton / Coppell Area:

Take Hebron Pkwy (East) which will turn into Park Blvd (544), turn right on Coit Rd.
We are located at the corner of Coit Rd and American Dr, North of Medical Center of Plano.

South: Waco / Waxahachie Area:

Option #1:

Take 35E north to Dallas Toll way. (See ** below for office directions)

Option #2:

Take 35E north to 75 North (Sherman) Go North on 75 to 15th St. exit.
Turn left on 15th and turn right at Coit, (approximately the 7th red light).
We are located at the corner of Coit Rd and American Dr, North of Medical Center of Plano.

East: Marshall / Tyler / Mesquite Area:

Take 20 West to 635 North to 75 North. Note: 635 North will become 635 West
Go north on 75 to 15th St. exit.
Turn left on 15th and turn right at Coit, (approximately the 7th red light).
We are located at the corner of Coit Rd and American Dr, North of Medical Center of Plano.

West: Abilene / Fort Worth Area:

East on 20 to 820 (Ft Worth)
Take 820 north to 121 towards Grapevine.
Take 121 (from Grapevine) to 635 east to Dallas Toll way.
(See ** below for office directions)

Dallas Toll way:

Go North on Dallas Toll way to Plano Pkwy exit.
Go right on Plano Pkwy to Coit Rd.
Turn left on Coit Rd and go thru the 15th St red light.
We are located at the corner of Coit Rd and American Dr, North of Medical Center of Plano.

George Bush Turnpike / 190:

If coming from the West, you will need to go East on George Bush / 190 to Coit Rd exit. Turn left on Coit Rd. and go north to American Dr. and turn right and then right again, into parking lot of our medical building complex.

If coming from the East, you will need to go West on George Bush / 190 to Coit Rd exit. Turn right on Coit Rd. and go north to American Dr. and turn right and then right again, into parking lot of our medical building complex. COIT AMERICA MEDICAL BUILDING.

Texas Child Neurology Financial / Office Policies

Patient name: _____ **DOB:** _____

Payment:

Payment is due at the time of service. If you have insurance, your co-pay and/or deductible, along with any co-insurance amount due will be collected prior to your seeing the physician.
We accept MasterCard, Visa, cash and checks. Initials _____

Insurance:

As one of your insurance company preferred providers, **we require you to first meet your copay, deductible and/or any part that your insurance does not pay, at the time of service.** Most misunderstandings about insurance can be avoided if you understand what your policy provides. **If your insurance company chooses not to pay Texas Child Neurology for whatever reason or they choose to delay payment, YOU will be responsible for payment. If payment is not received within 60 days from your insurance company, you will become responsible for the outstanding balance. Payment is expected at the time of service.** Our office will assist you as our patient in filing your claims that we are contracted with and after obtaining all insurance information needed from you. However, the stated policies regarding payment must be implemented because insurance companies have become more cavalier in the prompt processing of claims by physicians' offices. We **ARE NOT** responsible for your insurance or **YOUR** bill. Initials _____

Delinquent Accounts:

Delinquent accounts will be reported to our collection service. Please let us know if your payment will be late in arriving at the office or if a payment arrangement may be needed. Our desire is to help you. Initials _____

Insurance Carriers Requiring Referral Numbers (HMO, POS, EPO):

If your insurance carrier requires you to have a referral number prior to your seeing a specialist, our office must be in receipt of the referral number before your arrival. If we do not have it upon sign-in, your appointment will be rescheduled to a later date and time. Initials _____

Late Arrivals:

In order for the physicians to see their patients in a timely manner, your help in arriving promptly for your appointment is required. We reserve the right to reschedule your appointment to a new date and time if you are more than 10 minutes late for your appointment as this not only affects you it affects others that have a scheduled appointment after you. Initials _____

Cancellations / No Shows / Reschedules:

There is a \$25.00 charge for patients who cancel, reschedule or NO SHOW an appointment without giving a 24-hour notice, as these appointment times could have been given to another patient(s) in need. Initials _____

Prescriptions:

There is a \$10.00 charge for all triplicate (controlled drug) prescriptions **given outside of a regular scheduled appointment.** We do not charge this fee if the script is given at the time of an office visit. A refill approval can be upheld if account is not in good standing. Prompt payment is appreciated. Our office requires a 48-hour notice when requesting any medication refill. **No Refills are approved after hours. You are required to call during office hours to script refill requests.** Initials _____

Returned Checks:

There is a \$30.00 charge for all returned checks. If a check is filed with the DA's office for collection, all fees incurred in the filing will be your responsibility as well. After a check has been returned twice for NSF, payments to our office will be on a cash basis only. Initials _____

Out Patient Procedures Ordered:

Patients are financially responsible for any outpatient procedure(s) ordered by their physician. Our office will assist in obtaining proper authorizations for the procedure prior to the date and time. You, the insured, are ultimately responsible for what your coverage requires and we suggest you contacting your insurance carrier to verify your benefits and preauthorization requirements prior to having the procedure done. Our office will not be responsible for your charges. Initials _____

Parent / Guardian's Signature

Date

EMERGENCY / NEXT OF KIN / CONTACT PERSON (someone other than the parent / guardian);

Name: _____ Phone #: _____

PRIMARY CARE PHYSICIAN (PCP): _____

Address: _____

Office Phone #: _____ Fax #: _____

**PRIMARY
INSURANCE INFORMATION**

INSURANCE CO: _____

CUSTOMER SERVICE # _____ PRECERT PH# _____

INSURANCE ADDRESS: _____

PLAN TYPE: HMO PPO POS EPO INDEMINTY

COPAY AMOUNT: _____ REFERRAL REQUIRED? NO _____ YES _____

INSURED'S NAME: _____ DOB: _____

E-mail Address: _____

SS#: _____ RELATIONSHIP TO PATIENT: _____

GROUP / PLAN #: _____

INSURED'S EMPLOYER: _____

I hereby assign, and set over to TEXAS CHILD NEUROLOGY all of my rights, title, and interest to my MEDICAL reimbursement benefit under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoking said authorization give written notice. **I understand that I am financially responsible for all charges whether or not they are covered by insurance.**

PATIENT / PARENT / GUARDIAN SIGNATURE

DATE

Patient Name: _____ DOB: _____

Health Insurance Portability and Accountability Act
NOTICE OF PRIVACY PRACTICES

Texas Child Neurology, LLP
1708 Coit Rd., Suite 150
Plano, Texas 75075

Telephone: (972) 769-9000

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's, PPO's, managed care organizations, IPA's, Medicare/Medicaid other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof. In order to ensure the patients' privacy is protected at all times, our office policy does not allow medical records to be faxed. All requests for medical records will be returned via mail.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect a copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. By signing below you acknowledge that you have received a copy of the "Notice of Privacy Practices" and should you have any questions regarding this notice you may discuss them with the designated Privacy Officer.

Parent Signature _____ Date _____

Child's Name _____ DOB _____

TEXAS CHILD NEUROLOGY, LLP
1708 COIT RD., SUITE 150
PLANO, TEXAS 75075
Of c. # 972-769-9000 Fax # 972-769-0035

Robert Chudnow, MD

Anthony Riel a, MD
MD

Gerald So, MD

Mary Baiyer i,

Date: _____

Patient's Name _____

Date of Birth _____ Age _____ School grade _____

Complete Home Address _____

Home phone _____ Work phone _____

Pediatrician or Family doctor _____ Office phone _____

Address _____ Fax _____

Referring physician _____

Other Neurologists that you have seen: _____

CHIEF PROBLEM: Please write a brief statement describing your child's neurological condition

LIST ALL CURRENT MEDICATIONS

Name of Medication	Dosage

LIST ALL ALLERGIES TO MEDICATIONS

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PATIENT HISTORY - GENERAL MEDICAL

Has your child had all the immunizations necessary for his or her age? YES NO

Has your child ever been hospitalizations for a medical (nonsurgical) problem? List hospital and child's age.

Any operations? (Give hospital and child's age and reason for surgery)

Has your child ever complained of or been seen by a physician for:

- | | | |
|---|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Frequent Vomiting | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Feeding Problems | <input type="checkbox"/> Abnormal weight loss/gain |
| <input type="checkbox"/> Blurred or abnormal vision | <input type="checkbox"/> Slow Development | <input type="checkbox"/> Difficulty tolerating heat or cold |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Learning Difficulties | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Seizures without fever | <input type="checkbox"/> Growth Failure | <input type="checkbox"/> Chronic fatigue |
| <input type="checkbox"/> Seizures with fever | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Genetic Diseases |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Mental retardation | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Birth defect | <input type="checkbox"/> Weakness of muscles | <input type="checkbox"/> Tingling or numbness in feet or hands |

DEVELOPMENTAL HISTORY

Pregnancy and newborn history:

Did you carry your child for the full 9 months? If no, how long? _____

Child's birth weight _____ Birth length _____ Inches _____

Medications during pregnancy _____

Problems during pregnancy:

Illnesses _____ Infections _____ Other _____

Labor: Length of labor _____ hours. Any difficulties? _____

Delivery: Vaginal C-section If C-section, why? _____

Any difficulties? _____

Did your child come home from the hospital with you? YES NO

Any special care needs in infancy? YES NO

Growth and developmental milestones:

At what age did your child?

Sit _____ Say first words _____ Stand _____

Walk _____ Speak in sentences _____ Toilet train _____

FAMILY HISTORY

Please recall family members to the best of your ability back to the patient’s grandparents.

Condition	Father	Mother	Father’s Parent	Mother’s Parent	Siblings	Children
Arthritis						
Asthma						
Bleeding Disorder						
Cancer						
Diabetes						
Heart Disease						
Hypertension (High Blood Pressure)						
Kidney Disorder						
Thyroid Disease						
Other						
Other						

FAMILY HISTORY – NEUROLOGICAL DIAGNOSIS

Brain Tumor						
Cerebral Palsy						
Dementia/Alzheimer’s						
Depression						
Epilepsy						
Learning Disability (Such as dyslexia)						
Manic-depression						
Mental Illness						
Mental Retardation						
Migraine Headache						
Multiple Sclerosis						
Muscle Disease						
Nervous Breakdown						
Neurofibromatosis						
Parkinson’s Disease						
Peripheral Neuropathy						
Seizures						
Stroke						
Tuberous Sclerosis						

Any other medical conditions that run in the family not mentioned above?

Have family members had substance abuse (alcoholism or drug abuse)? Are any family members in prison? Have there been any suicide attempts in any family members? _____

Did you have special concerns about development or behavior when he/she was a toddler or pre-school age?

How has your child performed in school? _____

Has the school system provided any special accommodations for your child? _____

What are your child's interests or hobbies? _____

Has your child had any of these tests?

TEST	DATE	WHERE DONE	RESULTS	
MRI	_____	_____	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal
CT	_____	_____	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal
EEG	_____	_____	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal
EMG	_____	_____	<input type="checkbox"/> normal	<input type="checkbox"/> abnormal

MOOD INVENTORY (if appropriate)

Does your child make self-deprecatory statements such as: "I'm dumb" or "I'm stupid" or "nobody likes me" or "they are all picking on me"? _____

Can your child have fun? _____ Does he/she have a problem with anger? _____

Is your child often silly, giddy, rude or crude and hyperactive? _____

Has there been any sexual acting out? _____

Does your child have trouble falling asleep or awaken at night and have trouble going back to sleep? _____

Will he/she visit you during the night or ask to sleep in your room? _____

Does your child sleepwalk, sleep talk, grind their teeth when sleeping, or have excessive nightmares? _____

Does your child become sleepy during the day or fall asleep at school, in the car or during boring activities? _____

Has there been recent lying? _____ Stealing? _____, Cruelty to animals? _____, Fire setting or match play? _____

Is your child distractible? _____ Impulsive? _____ Accident-prone? _____ Intrusive, (nosey)? _____

Is your child a daredevil? _____, Is he/she destructive? _____ Affectionate? _____

How is your child's modesty? _____ Pain tolerance? _____

Is your child too sensitive to criticism? _____, Any phobias or compulsions? _____

How do you hope that your physician at Texas Child Neurology will be able to help your child? Is there anything else you would like to tell the doctor not already covered in this questionnaire?

Medication Refill request Form

Parents: Below is a list of all the information we need to refill your medication. This may be used as a guideline while phoning or e-mailing a request to us or you may make copies and fill it out to be faxed directly to us at:

972-769-0035

Email: pharmacy@texaschildneurology.com

Physician: _____ Date: _____

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number _____

Medication: _____

* Please note if the medication contains the letters XR or ER for the extended release medications*

Dosage: _____

Directions: _____

30 day supply

90day supply for mail order

Mail

Pick Up in Plano

Pick Up in Grapevine

*** Please note that ADD/ADHD medications CAN NOT be called into the pharmacy per Texas Laws. They must be picked up or mailed. *****

Who is requesting the refill: _____

****Please note that refills can take up to 48 hours to process so please plan accordingly. There is also a \$10.00 charge for all ADD/ADHD medication refills filled outside of a doctor's visit. Please use your mail order when available. We can then issue a 90-day and 30 day supply giving you four (4) months of medication, therefore cutting down on the amount of refills and cost. ADD/ADHD prescriptions also have an expiration date of seven (7) days after the date on the script. Please call your pharmacy and have them fax us a refill request on all medication refills other than the ADD/ADHD medications. Please note that past due balances and missed appointments may delay your refills. For billing questions please call 972-769-9000 ext 222. Thank You.

MasterCard Visa

Credit Card Information: Card # _____ Exp Date: _____

Please indicate if you would like for TCN to keep the Credit Card information on file for future medication refill request only. YES NO

Signature _____

*I authorize Texas Child Neurology to bill my credit card \$10.00 for the triplicate, and if applicable, any past due balance. *

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