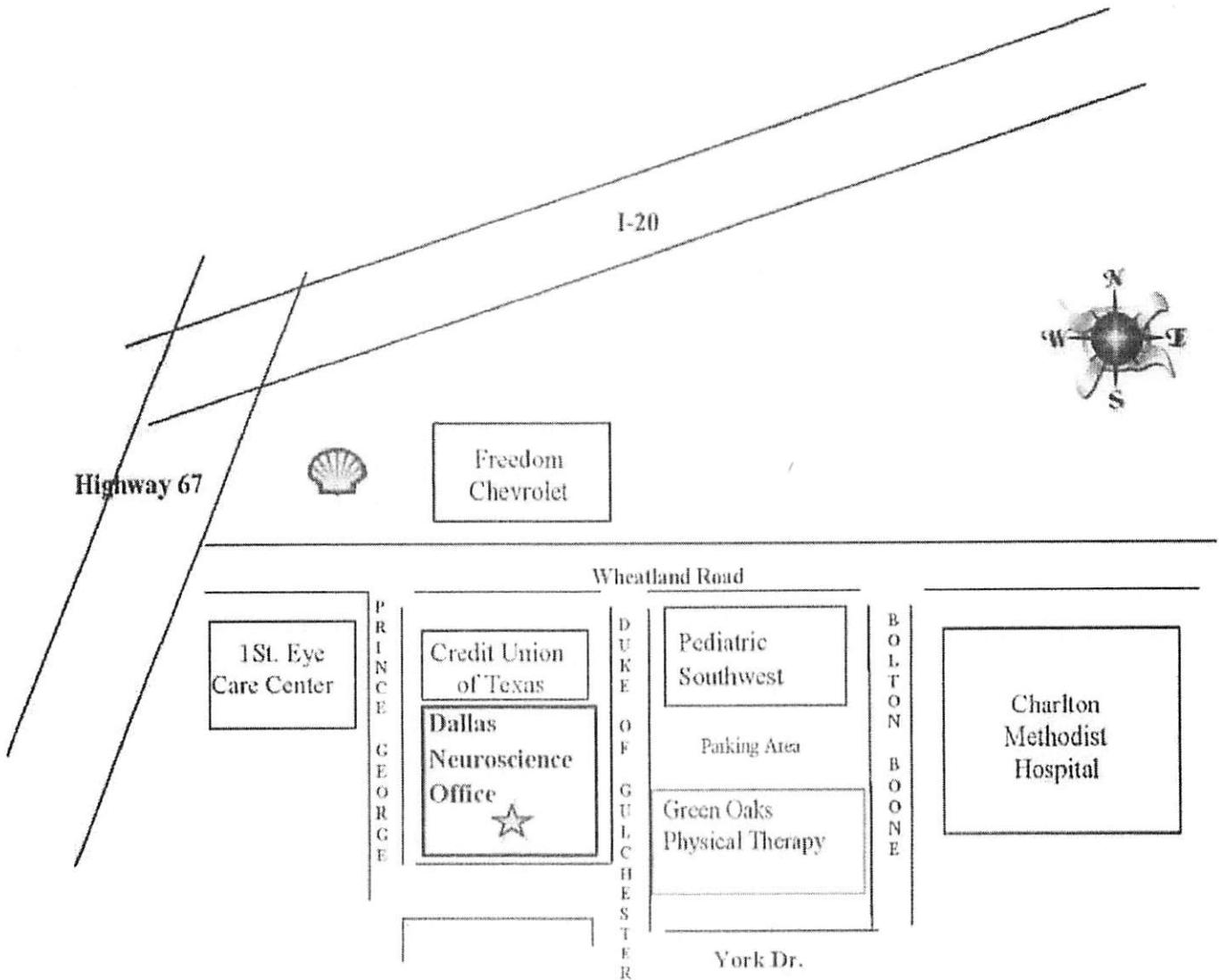


# DNS

OFFICE LOCATION MAPS: 1001 ROBBIE MINCE WAY, DESOTO, TX 75115

OUR BUILDING HAS A DARK GREEN SHINGLE ROOF, AND WILL SAY "DNS NEUROLOGY" WE ARE DIRECTLY BEHIND THE CREDIT UNION OF TEXAS BANK.



Richard Ahn, MD  
DALLAS NEUROSCIENCE, P.A.  
**PATIENT INFORMATION FORM**

Name (First) \_\_\_\_\_ (MI) \_\_\_\_\_ (Last) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_ Sex M / F

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

(Please only list phone numbers where you can be reached)

Contact Preference (circle): Home / Cell

For Cell Phones: Consent to TEXT Reminders: Y / N

Social Security # \_\_\_\_\_ Marital Status S M D W

E-mail \_\_\_\_\_ Race \_\_\_\_\_

Are you under the care of a **Nursing Home, Palliative Care, Hospice or Inpatient Rehab Facility**? Yes/ No  
If YES, STOP HERE and inform the front desk immediately.

Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Referring Physician Address \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Pharmacy Address / Location \_\_\_\_\_

\*Preferred Lab Facility \_\_\_\_\_

**PATIENT INSURANCE INFORMATION**

Primary Insurance Company \_\_\_\_\_ Ins. ID # \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder: SELF SPOUSE PARENT

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Ins. ID # \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder: SELF SPOUSE PARENT

Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and understood your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

This notification will remain in force unless I decide to update or change it. This form is updated annually.

PATIENT NAME (Please print): \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATIONSHIP TO PATIENT (POA COPY REQUIRED): \_\_\_\_\_

DATE: \_\_\_\_\_

I hereby authorize Dallas NeuroScience, P.A. to release my personal medical information to the persons listed below. Please write in "None" if you do not authorize any other persons to have access to your information. You may continue on the back if more space is needed.

**FULL NAME**

**RELATIONSHIP TO PATIENT**

**PHONE NUMBER**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Richard Ahn, M.D.**  
Dallas NeuroScience, PA  
1001 Robbie Mince Way, DeSoto, TX 75115  
Phone: (214) 622-6300, Fax: (214) 622-6310

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I, the undersigned patient, hereby affirm that the services received from Dr. Richard Ahn will be filed under my medical insurance policy. I further affirm that I will not now, nor in the future, file a workers' compensation claim, an automobile accident claim, or any other accident or injury-related insurance claim for these services. I understand that this office does not accept third-party billing arrangements.

If any medical equipment is loaned to me, the undersigned patient or guardian, by Dallas NeuroScience, PA, I agree to return it in the condition it was loaned to me in. Any damage or abuse to the equipment will result in me being held financially responsible for the full cost of the equipment. Additionally, I agree to return any and all equipment loaned to me at the time/date specified by the technician at the time of service

I, the undersigned patient or guardian, hereby affirm that the patient listed below is NOT under the care of any **Nursing Home Facility, Palliative Care, Hospice or Inpatient Rehab Facility** at the date of service. If the patient is or will be under the care of any of the above facilities, I will inform the office staff immediately.

I, the undersigned patient or guardian, hereby affirm that Dr. Richard Ahn respectfully declines court appearances, as his schedule requires him to provide continuous patient care on a daily basis. Due to these obligations, he is unable to take time off to attend hearings, depositions, custody cases, disability disputes, etc.

**All patients must read and sign this form before receiving services.**

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**Patient's Name (Please Print)**

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**Patient's Date of Birth**

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**Relationship to Patient (If other than patient)**

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**Date**

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**Signature**

**Richard Ahn, M.D.**  
**Dallas NeuroScience, PA**  
**FINANCIAL POLICY**

Thank you for choosing the office of Dr. Richard Ahn as your health care provider for neurological services. As part of our professional relationship, it is important you have an understanding of our financial policy.

**All patients must read and sign this form before receiving services.**

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As medical providers, our relationship is with you, the patient, and NOT your insurance company. Your insurance is a contract between you, your insurance company, and possibly your employer. **It is your responsibility to know and understand the level of services covered by your insurance company.**

It is your responsibility to provide us with your most current insurance information. If you fail to provide accurate insurance information, your insurance company may deny the claim. **If the claim is denied, you will be financially responsible for the services rendered. That includes office visits, procedures, telemedicine visits and phone calls that are personally returned by the physicians, Dr. Richard Ahn and Rosa Luna, NP.**

Your co-payment, co-insurance, and/or deductible are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, these estimates we receive from your insurance company are estimates alone. You are responsible for paying the full amount determined by your insurance company once they have filed the claim – regardless of the estimation we are given. **Please be aware that some or all of the services provided may not be covered in full by your insurance company. You are financially responsible for services not covered by your insurance company.**

You must provide us with your most current billing information, including address and telephone numbers. If your information changes, it is your responsibility to provide us with the updated information.

If you have a balance on your account, we will send a statement to you as notification of this balance. Payment is due in full upon receipt of this statement. If you are not able to pay the balance in full, you must contact our office to discuss a payment schedule. **If you fail to contact our billing office to arrange payment, or do not make payments as agreed upon in your payment schedule, your account may be referred to a professional collection agency. If this occurs, you will no longer be able to receive services from any of the physicians encompassing Dallas NeuroScience, PA until your account is paid in full.**

If you submit payment by check and the bank returns the check unpaid for any reason (e.g. insufficient funds), you will be responsible for a \$35.00 returned check charge. This charge must be paid in full plus the amount of the returned check, before any further services will be provided to you. You understand that we will not accept any checks in the future from you; any future payments must be made by cash or credit/debit card.

**It is your responsibility to keep your account up to date and not carry a balance. You understand and accept that balances left on your account may affect your ability to see our providers. Failure to keep your account balance current may require us to cancel or reschedule your appointment.**

I have read and understand this financial policy. This record of agreement is in effect for the duration of my treatment by these providers.

\_\_\_\_\_  
**Patient's Name (Please Print)**

\_\_\_\_\_  
**Patient's Date of Birth**

\_\_\_\_\_  
**Relationship to Patient (if other than patient)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

**Richard Ahn, M.D.**  
**Dallas NeuroScience, PA**  
**Non-Medical Services Form**

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**Charges for Non-Medical Services:**

Accept **Cash or Card** for these services.

- Medical Records \$25 (1-20 pages) / \$50 (21-50 pages)
- Billing Records \$25
- FMLA Paperwork \$40
- Ins Disability Forms (multiple pages) \$70
- 1 Page-Disability Form \$50
- Disability Parking Placard Form \$20
- General Forms \$50

***All disability forms require a recent office visit and examination within 2 months of the request.***  
**Reminder:** If your insurance requires a referral number, it is patient's responsibility to acquire one from their primary care physician. **Otherwise, appointment will be rescheduled.**

**Appointment Policy:** ***We require a 24 hour notice for appointment cancellation/reschedule required***  
**After 2 No-Shows, Same Day Cancellations or mix or match** patient will be dismissed from our practice.

**Must Provide Insurance Card/Identification for every visit! No Exceptions!**\*If you do not have your insurance cards with you, your appointment will be rescheduled. **Copies are not accepted!**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# **MEDICAL RECORDS RELEASE AUTHORIZATION**

I, \_\_\_\_\_, hereby authorize you to release my medical records, by fax or mail, including copies of clinical notes, and lab/diagnostics results to the following:

Dallas Neuroscience, P.A.

1001 Robbie Mince Way Desoto, TX 75115

Phone: (214) 622-6300 FAX: (214) 622-6310

I understand and agree with that:

- Records obtained will be for the continuation of care.
- This authorization will expire one year from the date I sign it. I may revoke this authorization at any time by notifying Dallas Neuroscience, P.A., in writing. However, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date