NeuroEndocrine
CONSULTING

Dear New Patient:

Welcome to NeuroEndocrine Consulting. Enclosed please find our New Patient packet. Please do your best to fill out the requested information completely and accurately. If you have any questions, please call our office and we will be happy to assist you. The thoroughness and completeness of this information improves our ability to help you. It enables us to review your documents before your visit, determine whether we are able to address you health needs and take better advantage of your appointment time.

Please note that our practice is currently full and we have a waiting list for new patients. **If you would like to be added to our waiting list, please complete this packet and return it to us as soon as possible.** We will contact you to let you know we have received and reviewed your information. As appointment openings become available, we will call you to schedule your initial appointment. This is based on the order in which we receive the paperwork. You can send your packet by mail, fax or drop it off at our office. Please bring originals of completed paperwork (if not mailed) to your appointment.

When your initial appointment is scheduled, please have copies of your recent lab tests and pertinent diagnostic studies faxed to our office. This should include tests/studies over the last 12 months. If applicable, request your most recent mammogram and pap test results.

Request these records from the ordering providers at least **2 weeks before your visit**. You can use the "Authorization to Release Medical Records" form in this package to make these requests. On this form, please indicate that records should be faxed to us no later than 1 week before your appointment. This will allow time for the records to be copied, sent and incorporated into your medical history.

It is important to be on time for your appointment. If you are late, you limit the time we can spend learning about you and beginning your care. We schedule one hour for the initial evaluation and in total, you can expect your appointment to last 1 ¼ to 1 ½ hours. This also includes reviewing the completeness of your medical history documents, taking vital signs and explaining test orders. A map to our office location is included on the "Contact" page of our website. Please allow adequate time for your travel in busy Westlake Hills.

As a courtesy, allow at least 2 business days advance notice if you need to reschedule or cancel your appointment. Payment can be made with cash, personal check or credit card (Visa, MasterCard and Discover are accepted) and is due at time of service. A complete list of our policies is available on our website www.NeuroEndocrineConsulting.com.

Please do not hesitate to contact us should you have any questions. We look forward to meeting you.

Respectfully,

Nancy Benzel, PA- C

Nancy Benzel, PA-C | **Office** (512) 540.4182 | **Fax** (512) 879.9046
3839 Bee Cave Road | Suite 202 | Austin, Texas 78746
NeuroEndocrineConsulting.com

NeuroEndocrine
CONSULTING

New Patient Package Table of Contents

Nancy Benzel, PA-C | **Office** (512) 540.4182 | **Fax** (512) 879.9046
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NeuroEndocrine Consulting LLC

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best Phone to Return Calls / Confirm Appts: _____ E-Mail: _____

Employer: _____ Occupation: _____

Business Address: _____

Birthdate: _____ Single / Married / Separated / Divorced Male / Female

Driver License #: _____ SSN: _____

Maiden Name: _____ Other Name: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Physician: _____ Referred by: _____

Reason for Office Visit/Chief Complaint: _____

RESPONSIBLE PARTY

Please initial if responsible party is same as above: _____

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best Phone to Return Calls / Confirm Appts: _____ E-Mail: _____

Birthdate: _____ SSN: _____ Male / Female

Driver License #: _____ Relationship to Patient: _____

Patient / Responsible Party Signature: _____

Print Name: _____ Date: _____

NeuroEndocrine
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Patient Office and Financial Policies

The following office policies were developed to ensure appropriate attention to the needs of patients and to facilitate an efficient flow of office operations. We thank you in advance for your consideration, cooperation and compliance.

Office Hours:

- Monday, Tuesday and Thursday - 9:00 am to 3:30 pm

  Wednesday - 9:00 am to Noon, Friday - Closed

- Cancellations: We require 2 business days notice to cancel or reschedule an appointment to avoid a charge at the full rate of the missed office visit. Monday appointments should be cancelled by Wednesday. Missed appointment fees must be paid prior to receiving future services. Please note that insurance companies will not reimburse missed appointment fees.
- Holiday Refills: We are closed on major holidays. Please check your medications and ask your pharmacy to fax a refill request to our office 2 business days prior to the holiday.
- After-Hours Calls: We do not offer after hours call service. We encourage all patients to have a designated primary care provider for non-emergency after-hours services. In case of a medical emergency, call 911 or proceed to the closest emergency room.

Appointments:

Call: 512-540-4182 Email: support@neuroendocrineconsulting.com

New Patients: appointments for new patients will be scheduled after receipt of your completed New Patient Package which can be found on our website on the "Patient Forms" page. We would also be happy to mail the package upon request.

Fee Schedule

Initial consultations with new patients: $475.

1 hour $350.00 | 45 minutes $262.50 | 30 minutes $175.00 | 15 minutes $87.50

All other visit fees or extra time will be prorated at $87.50 per 15-minute increment.

Patient requested medical record copies: $25.00 for the first 20 pages and $0.50 per page thereafter, plus postage. The cost of the test kits and supplements that you purchase from our office will be added to your bill at checkout. Patients are also responsible for making payment arrangements directly with laboratory and radiological service providers.

Payments

Payment is required at the time of your visit, and may be made with cash, personal check or credit card (Visa, MasterCard and Discover are accepted). Patients are expected to keep their account paid in full in order to maintain ongoing treatment. Checks cannot be post-dated or held and returned checks will be subject to bank charges.

NeuroEndocrine CONSULTING

Patient Office and Financial Policies

Insurance Billing

NeuroEndocrine Consulting LLC does not bill or accept 3rd party payments from insurance carriers, Medicare or Medicaid. We provide receipts that patients can submit to their insurance carriers for reimbursement. Typically, only office visits are eligible for coverage. Reimbursement will generally be available if your plan covers out-of-network provider services. HSA accounts can be used for qualifying items and services. Please check with your insurance carrier to confirm your covered benefits.

Nancy Benzel, PA-C has opted out of the Medicare program. No claims for reimbursement may be submitted to Medicare for her services although Medicare will continue to pay for orders for ancillary covered services (i.e. prescriptions, lab tests, diagnostic studies, etc). If you are a Medicare beneficiary (or eligible), Medicare rules require that you execute a "Medicare Private Contract" in order to receive treatment.

Lab Results

Interpretation of lab results is an important part of determining your health status and treatment plan. An office visit is generally necessary to discuss these results and answer your questions. We will contact you if your results require immediate attention. Otherwise, results will be discussed during your next visit or phone consultation.

You are responsible for completing lab orders and other diagnostic tests before your scheduled appointment. The processing time needed by the lab or diagnostic facility varies by the type of test ordered. Please allow at least 3 days for lab work and up to 4 weeks for specialty tests such as hormones, neurotransmitters, iodine levels and diagnostic imaging studies. These timeframes will be explained at the time the tests are ordered.

Prescription Refills

We review your medication and supplement lists during your visits. Please be prepared to tell us how many refills remain on each of your prescriptions so that we can determine refills and dosages while we are together reviewing your chart. If you need a refill prior to your next scheduled appointment, please have your pharmacy FAX the request to our office with 2 business days advance notice.

HIPAA Policy and Patient Confidentiality

NeuroEndocrine Consulting respects the privacy of protected health information and understands the importance of keeping this information confidential and secure. Please carefully review our "Notice of HIPAA Privacy Practices" that describes how your medical information may be used and disclosed and how you can get access to this information.

For your protection, we cannot release any information without your signed consent. This includes information for another provider, a spouse or family member. All patients 18 or older must sign a consent form if they wish for their health information to be discussed with a parent.

By signing below, I acknowledge that I have read and agree to NEC's Office and Financial Policies.

_____ Date: _____

Patient (or Legal Guardian) Signature

_____ _____

Patient Name Legal Guardian Name (if applicable)

NeuroEndocrine
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Patient Email Policy & Consent

NeuroEndocrine Consulting provides patients the ability to communicate via electronic mail (email) for non-urgent administrative matters if the arrangement is agreed to by both parties. This email option is available to established patients at least 18 years old or the parent or guardian of a minor. In order to utilize email communications, you must agree to the following requirements:

Privacy and Security of Email. Your email may be forwarded as appropriate to respond to your request. As such, staff other than your provider may have access to emails that you send. Such access will only be in order to provide service to you. Otherwise, your email will not be forwarded without your prior consent, except as authorized/required by law.

NeuroEndocrine Consulting cannot and does not guarantee the privacy or security of any messages being sent over the Internet. There is the potential that email sent over the Internet can be misdirected or intercepted and read by others.

It is also possible that information you consider sensitive in nature may be inadvertently seen by someone with access to your email application. You should be aware that your employer may view email you send via an employer provided account.

Authenticating Your Identity. We are required to take measures to establish that a patient requesting services by email is in fact the person the sender claims to be. You should include your full name and best daytime call-back phone number in every email message that you send. Please only use your authorized email address to send mail.

Appropriate Uses for Email. Email can be effective for routine requests and simple messages. We allow emails to:

- O Make, change, cancel and confirm appointments.
- O Submit custom cream refill orders using the standard form available on our website.
- O Send/receive release forms, lab orders and other paperwork.

Email is not an effective tool to communicate your health status and medical questions. ***NeuroEndocrine Consulting does not accept emails pertaining to medical/health matters.*** This information should be discussed via phone or in person at an office visit.

Permanent Record. A copy of relevant email communications will be documented in your medical record.

Response Time. We will process emails during business hours and you will you will generally receive a response within two business days. If you do not receive a response within this timeframe, please contact our office.

Patient Name _____ Authorized Email _____

I understand the risks and procedures involved with using email and that the confidentiality of my individually identifiable health information may be compromised when sent via email. I agree to the terms listed above and I hereby voluntarily request the use of email as one form of communication with NeuroEndocrine Consulting.

Signature _____ Signature Date _____

Parent/Guardian Name (if patient is a minor) _____

This Patient Email Policy & Consent along with our Notice of Privacy Practices constitutes a notice of privacy practices for email use as required by the Texas State Board of Medical Examiners.

NeuroEndocrine
CONSULTING

(2017-2019)

Medicare Private Contract

THIS CONTRACT is between Nancy Benzel, PA-C ("Practitioner"), whose principal place of business is located at 3839 Bee Cave Rd., Suite 202 Westlake Hills, TX 78746 and the below named patient ("Patient"), who is a Medicare beneficiary covered under Medicare pursuant to Section 4507 of the Balanced Budget Act of 1997.

Patient / Medicare Beneficiary

Name: _____

Date of Birth: _____ Medicare #: _____

Address: _____

Patient's legal representative: _____.

Where appropriate, the term "Patient's legal representative" is substituted for "Patient" below.

The Practitioner has informed the Patient that Practitioner has opted out of Medicare for the two year period beginning on July 1, 2017 (effective date) and ending on July 1, 2019 (expiration date). A separate contract between the parties is required for each opt-out period.

The Practitioner agrees to provide treatment ("Services") as mutually agreed upon by the parties. In exchange for the Services, Patient agrees to make payments to the Practitioner, according to the charge rates in effect at time of Service. This Contract does not obligate either party to a specific course or duration of treatment. It is limited to financial arrangements between the Practitioner and the Patient.

Practitioner may order, certify or refer Patient for Medicare-covered items and services, provided Practitioner is not paid, directly or indirectly, for such services. The Practitioner is not excluded from Medicare under sections 1128, 1156, 1892 or any other section of the Social Security Act.

Patient agrees, understands and acknowledges the following:

- Patient understands that Medicare payment will not be made for any items or services furnished by the Practitioner that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
- Patient accepts full responsibility for payment of Practitioner's charges for all services furnished by Practitioner.
- Patient agrees not to submit a claim to Medicare or to ask Practitioner to submit a claim to Medicare program.
- Patient understands that Medicare limits do not apply to what Practitioner may charge for items or services furnished by Practitioner.

- Patient understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
- Patient enters into this Contract with the knowledge that he/she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare. Patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient acknowledges that this Contract is not entered into during a time when Patient requires emergency or urgent care services
- Patient will be provided a copy of the Contract before Services are furnished under the terms of the Contract.
- Patient acknowledges that this document is written in sufficiently large print for Patient to read.
- Practitioner will retain the original Contract with original signatures of both parties for the duration of the opt-out period and will be available to CMS upon request. Practitioner agrees to expediently submit appropriate affidavits with Medicare carriers to maintain opt-out.

THIS CONTRACT is executed by the parties to be effective on_____, and end on July 1, 2019.

Patient Signature

(Or Patient's legal representative)

Nancy Benzel, PA-C Signature

NeuroEndocrine
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Patient Consent for Use and Disclosure of Protected Health Information

NeuroEndocrine Consulting, LLC and its Providers (NEC, Provider) create and maintain medical and related records that include personal healthcare information, including health records, symptoms, demographic information, diagnoses, examination and test results, treatment, and plans for future care or treatment. This is called "protected health information".

I understand and consent to the use and disclosure of my protected health information by NEC to carry out treatment, payment and health care operations (TPO), including:

- Treatment. This includes the provision, coordination, or supervision of my healthcare and related services, including the coordination or management of my care and consultation between healthcare professionals related to my treatment, or my referral to another healthcare professional.
- Payment for healthcare services provided to me. This includes actions undertaken by a health plan to decide coverage or the provision of benefits to me, by my Provider or a health plan to obtain or provide compensation for my care, or otherwise related to me.
- Healthcare Operations. This includes quality assessment and improvement activities; reviewing provider performance and training; activities relating to health insurance and benefits; conducting or arranging for medical review, legal services, and audits; business planning and development; and business management and general administrative activities.

I understand and agree that:

- I have the right to review NEC's Notice of Privacy Practices prior to signing this Consent. The notice provides a more detailed description of the uses and disclosures of my protected health information. NEC reserves the right to revise the Notice of Privacy Practices at any time and I have the right to obtain a revised notice: a) online at neuroendocrineconsulting.com, For Patients page, b) by calling the office and requesting a copy, or c) asking for a copy at the time of my next appointment.
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations. I understand and agree that NEC is not required to agree to any restrictions that I may request, but if NEC agrees, it will be bound by that restriction.
- I may revoke my consent in writing except to the extent that NEC has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NEC may decline to provide treatment to me.

With this consent, I agree that NEC may contact me by phone, voicemail, or mail at primary and alternate locations/addresses I have designated. Email may also be used if I execute NEC's Patient Email Policy and Consent document. I understand all of these channels will assist in communications pertaining to my questions, laboratory test results, patient statements, insurance requests, appointment reminders, and practice announcements, among others.

By signing this form, I am consenting to allow NeuroEndocrine Consulting to use and disclose my protected health information to carry out its TPO activities.

Patient (or Legal Guardian) Signature	Date
Patient Name	Legal Guardian Name (if applicable)

NeuroEndocrine CONSULTING

Nancy Benzel, PA-C

New Patient Medical History

Please fill-out the entire questionnaire completely. Attach additional page(s) if more space is necessary.

Patient Name: _____ Referred By: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

Please list the conditions for which you are seeking treatment and the approximate timeframe the symptoms began:

_____

_____

_____

_____

ALLERGIES

☐ No known drug allergies

Medication Allergies:

Yes		Your Reaction:	Yes		Your Reaction:
☐	Aspirin		☐	Penicillin	
☐	Codeine		☐	Sulfa	
☐	Latex		☐	X-ray dye	
☐	Morphine		☐	Other:	

Food and Environmental Allergies:

_____

_____

_____

_____

_____

BIRTH / CHILDHOOD

Yes	No	
☐	☐	Did your mother experience any difficulties or significant stressors (e.g. smoking, alcohol, DES) during your pregnancy and/or complications with your delivery? If so, please describe:
☐	☐	Were you breast fed as an infant? If so, for how long: _____
☐	☐	Were you a healthy child?
☐	☐	Did you have any significant childhood illnesses, infections, injuries? If so, please explain:
☐	☐	Did you experience any significant childhood developmental events (divorce, deaths, adoption, abuse, traumatic losses or events)? Please explain:

FEMALE OBSTETRIC / GYNECOLOGICAL

Age menses started: _____ Age menses stopped: _____ (if applicable)

How many days do you typically bleed (including mild spotting)? _____

Are your periods: ☐ Light? ☐ Medium? ☐ Heavy?

How many days between cycles? _____ (1st day of bleeding to 1st day of bleeding)

Have your periods been regular? If not, please describe irregularities:

_____

Yes	No	
☐	☐	Do you perform breast self exams?
☐	☐	Are you currently using some form of birth control? If so, please specify. _____
☐	☐	Have you ever taken birth control pills? If so, at what ages and for how many years? Did you experience any problems?

Patient Name: Birth Date:

Pregnancies - Please indicate (if any):

	#	Difficulties and Complications
Live Births		
Miscarriages		
Abortions		
Total Pregnancies		

MEDICAL REVIEW OF SYSTEMS: Please indicate current and past medical conditions and symptoms.

Current	Past	
GENERAL		
☐	☐	Changes in appetite
☐	☐	Changes in energy level
☐	☐	Changes in thirst
☐	☐	Changes in weight
SKIN/HAIR		
☐	☐	Acne
☐	☐	Bruising or bleeding
☐	☐	Dry Skin
☐	☐	Eczema
☐	☐	Hair loss, change in hair texture
☐	☐	Loss of pigment
☐	☐	Moles
☐	☐	Psoriasis
☐	☐	Rashes
☐	☐	Ulcers
☐	☐	Warts
☐	☐	Other:
HEAD/EYES/EARS/NOSE/THROAT		
☐	☐	Headaches
☐	☐	Loss of consciousness
☐	☐	Blurred vision
☐	☐	Cataracts
☐	☐	Contact lenses or glasses
☐	☐	Double vision
☐	☐	Glaucoma
☐	☐	Visual difficulty
☐	☐	Chronic ear infection
☐	☐	Ear tubes
☐	☐	Hearing aids
☐	☐	Hearing difficulty
☐	☐	Ringing in ears
☐	☐	Allergies
☐	☐	Nosebleeds
☐	☐	Sinusitis
☐	☐	Dental problems
☐	☐	Dentures
☐	☐	Dry mouth
☐	☐	TMJ
☐	☐	Neck pain/stiffness
☐	☐	Polyps

Current	Past	
HEAD/EYES/EARS/NOSE/THROAT		
☐	☐	Sore throat
☐	☐	Swollen glands
☐	☐	Other:
LUNGS/RESPIRATORY		
☐	☐	Asthma
☐	☐	Chronic bronchitis
☐	☐	Cough
☐	☐	Emphysema
☐	☐	Pleurisy
☐	☐	Pneumonia
☐	☐	Shortness of breath
☐	☐	Smoker (or second hand)
☐	☐	Tuberculosis
☐	☐	Other:
HEART/CIRCULATORY		
☐	☐	Abnormal EKG
☐	☐	Arrhythmia
☐	☐	Chest pain
☐	☐	Heart disease
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	High cholesterol
☐	☐	Low blood pressure
☐	☐	Palpitations
☐	☐	Other:
LIVER		
☐	☐	Cirrhosis
☐	☐	Elevated liver enzymes
☐	☐	Hepatitis
☐	☐	Jaundice
☐	☐	Other:
GASTROINTESTINAL, URINARY		
☐	☐	Black bowel movement
☐	☐	Chronic urinary tract infection
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Digestive Problems
☐	☐	Gallbladder Disease
☐	☐	Heartburn, trouble swallowing
☐	☐	Kidney Stones

Current	Past	
GASTROINTESTINAL, URINARY		
☐	☐	Nausea
☐	☐	Rectal bleeding, hemorrhoids
☐	☐	Stress incontinence
☐	☐	Urinary problems
☐	☐	Other:
FEMALE GENDER RELATED		
☐	☐	Abnormal periods
☐	☐	Bacterial vaginosis
☐	☐	Breast discharge
☐	☐	Breast lumps(fibrocystic disease)
☐	☐	Breast pain, tenderness
☐	☐	Complications of pregnancy
☐	☐	Endometriosis
☐	☐	Heavy menstrual bleeding
☐	☐	High sex drive
☐	☐	Hot flashes
☐	☐	Low sex drive
☐	☐	Night sweats
☐	☐	Ovarian cysts
☐	☐	PMS – breast tenderness
☐	☐	PMS – cramps
☐	☐	PMS – emotional/mood swings
☐	☐	PMS – water retention
☐	☐	Postpartum depression
☐	☐	Spotting between periods
☐	☐	Use of estrogen/progesterone
☐	☐	Vaginal discharge
☐	☐	Vaginal dryness
☐	☐	Vaginal infections
☐	☐	Sexually Transmitted Disease. Specify type:
☐	☐	Other:
MALE GENDER RELATED		
☐	☐	Difficulty urinating
☐	☐	Difficulty with erection
☐	☐	Epididymitis
☐	☐	High sex drive
☐	☐	Impotence
☐	☐	Low sex drive
☐	☐	Pain or lumps in testicles

Patient Name: Birth Date:

Current Past

MALE GENDER RELATED
- ☐ ☐ Penile discharge
- ☐ ☐ Prostate disease
- ☐ ☐ Swelling of groin
- ☐ ☐ Sexually Transmitted Disease. Please specify:
- ☐ ☐ Other:

MUSCLE/BONE
- ☐ ☐ Arthritis - osteoarthritis
- ☐ ☐ Arthritis - rheumatoid
- ☐ ☐ Back pain
- ☐ ☐ Bursitis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Gout
- ☐ ☐ Joint pain
- ☐ ☐ Lyme disease
- ☐ ☐ Muscle spasms/cramps
- ☐ ☐ Osteopenia
- ☐ ☐ Osteoporosis
- ☐ ☐ Swollen joints
- ☐ ☐ Tendonitis
- ☐ ☐ Other:

BLOOD
- ☐ ☐ AIDS/HIV +
- ☐ ☐ Anemia
- ☐ ☐ B12 deficiency
- ☐ ☐ Clotting problems
- ☐ ☐ Contact w/ blood products
- ☐ ☐ High blood sugars
- ☐ ☐ Iron deficiency
- ☐ ☐ Low blood sugars
- ☐ ☐ Transfusions
- ☐ ☐ Other:

NEUROLOGICAL
- ☐ ☐ Alzheimer's disease
- ☐ ☐ Brain tumor

Current Past

NEUROLOGICAL
- ☐ ☐ Carpal Tunnel
- ☐ ☐ Cerebral hemorrhage
- ☐ ☐ Dizziness, lightheadedness
- ☐ ☐ Fainting spells
- ☐ ☐ Loss of balance
- ☐ ☐ Memory difficulty
- ☐ ☐ Migraines
- ☐ ☐ Numbness
- ☐ ☐ Parkinson's disease
- ☐ ☐ Peripheral neuropathy
- ☐ ☐ Restless leg syndrome
- ☐ ☐ Seizures/convulsions
- ☐ ☐ Stroke
- ☐ ☐ Tension Headache
- ☐ ☐ Tingling
- ☐ ☐ Tremor
- ☐ ☐ Weakness, paralysis
- ☐ ☐ Other:

ENDOCRINE
- ☐ ☐ Addison's disease
- ☐ ☐ Cushing's disease
- ☐ ☐ Elevated prolactin
- ☐ ☐ Excessive sweating
- ☐ ☐ Graves disease
- ☐ ☐ Hashimoto's thyroiditis
- ☐ ☐ Heat or cold intolerance
- ☐ ☐ Hyperparathyroidism
- ☐ ☐ Hyperthyroidism
- ☐ ☐ Hypothyroidism
- ☐ ☐ Other:

SLEEP
- ☐ ☐ Daytime sleepiness
- ☐ ☐ Difficulty falling asleep
- ☐ ☐ Difficulty staying asleep
- ☐ ☐ Difficulty waking up

Current Past

SLEEP
- ☐ ☐ Excessive snoring
- ☐ ☐ Frequent nighttime urination
- ☐ ☐ Leg cramps
- ☐ ☐ Nightmares
- ☐ ☐ Recurrent dreams
- ☐ ☐ Restless leg syndrome
- ☐ ☐ Sleep apnea
- ☐ ☐ Waking up gasping/choking
- ☐ ☐ Waking up tired, not rested
- ☐ ☐ Waking up with anxiety
- ☐ ☐ Other:

MENTAL/EMOTIONAL
- ☐ ☐ ADD / ADHD
- ☐ ☐ Addiction - alcohol
- ☐ ☐ Addiction - drug
- ☐ ☐ Anger outbursts
- ☐ ☐ Anorexia / bulimia
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar disorder
- ☐ ☐ Cry easily
- ☐ ☐ Depression
- ☐ ☐ Difficulty focusing
- ☐ ☐ Irritability
- ☐ ☐ Mood swings
- ☐ ☐ Obsessive compulsive disorder
- ☐ ☐ Panic attack
- ☐ ☐ Postpartum depression
- ☐ ☐ Schizophrenia
- ☐ ☐ Thoughts of suicide
- ☐ ☐ Other:

CANCER

If you have had cancer, please specify the type(s):

☐ ☐ _____

☐ ☐

TRAUMA/SURGICAL / HOSPITALIZATION

☐ ☐ Have you suffered any major injuries, auto accidents, broken bones, dislocated joints, head trauma or loss of consciousness? If yes, please list including dates/ages:

☐ ☐ Have you had any surgical procedures or hospitalizations related or in addition to the above? If yes, please list including dates/ages:

Patient Name: Birth Date:

PREVENTIVE CARE

Please list your most recent exams and diagnostic tests:

Yes	Most Recent Date	Normal	Abnormal
☐ Annual physical exam		☐	☐
☐ Eye exam		☐	☐
☐ Bone density test		☐	☐
☐ Chest x-ray		☐	☐
☐ Colonoscopy		☐	☐
☐ Mammogram		☐	☐
☐ Pap Test		☐	☐
☐ Prostate exam		☐	☐

If you have ever had any abnormal/atypical results for any of these tests, please describe:

PRACTITIONER LIST

Primary Care and OB/Gyn:

Name | Clinic	Specialty	Seen Since	Reason	Frequency

Specialty Practitioners (including medical specialists, chiropractors, acupuncturists, physical therapists and other providers:

Name | Clinic	Specialty	Seen Since	Reason	Frequency

RELATIONSHIPS

Are you currently? ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Number and ages of your children:

	#	Ages
Daughters		
Sons		

How many children are currently living in your household?_____

List significant life events in your past and current stresses (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc)

EDUCATION / OCCUPATION

Last degree/grade completed:_____ Last school attended:_____

Current job/career:_____ If retired, what was your vocation?_____

Average work hours/week: _____ Rate your job satisfaction (1-10): _____

Patient Name: Birth Date:

LIFESTYLE / PERSONAL HABITS

Rate your level of stress (1-10):_____ Rate your level of happiness (1-10): _____

What do you do to have fun?

Do you exercise regularly? If so, please describe what you do?

Exercise	How Long	How Often	Exercise (con't)	How Long	How Often

Do you utilize relaxation techniques such as meditation, yoga, biofeedback or other stress reduction practices?

Please list any foods that you:

Avoid

Crave

Are you on a special diet (vegetarian, gluten-free, etc)? If so, please specify:_____

Would you consider your diet to be mostly: ☐ Healthy ☐ Unhealthy?

Do (did) you consume or use?	Current # per day	Current days/week	Past # per day	Past days/week	Quit Date
Caffeine, type:_____					
Diet drinks, artificial sweeteners					
Alcoholic beverages					
Tobacco If yes, for how many years? _____					
Drugs (marijuana, cocaine, stimulants, sedatives, narcotics, diet pills) If yes, for how many years? _____					

Number of bowel movements per day: _____

What do you consider your ideal/healthy weight? _____ When was the last time you weighed this? _____

SLEEP

Typical bedtime: _____ Typical waking hour: _____ Avg hours of sleep per night: _____

How many hours of sleep do you feel you need per night to function optimally? _____

Yes No

☐ ☐ Is your sleep disturbed during the night? If so, please describe:_____

☐ ☐ Have you had a sleep study? If so, when and what did you learn?_____

PSYCHOLOGICAL

Yes No

☐ ☐ Have you ever had neurological, cognitive or psychiatric testing? If so, please describe when and which tests were conducted:_____

☐ ☐ Have you ever been in an inpatient treatment program for an emotional disturbance (e.g. anxiety, depression, etc)?

Patient Name: Birth Date:

FAMILY HISTORY

Please indicate whether each close relative is living or deceased and their current age or their age at death.

Relative	Living Current Age (s)	Deceased Age at Death	Relative	Living Current Age	Deceased Age at Death
Mother (Moth)			Maternal Grandmother (M-Gm)		
Father (Fath)			Maternal Grandfather (M-Gf)		
Brothers (Bro)			Paternal Grandmother (P-Gm)		
Sisters (Sis)			Paternal Grandfather (P-Gf)		

Please list blood relatives who have had had any of the following conditions including you, parents, grandparents, siblings, children, aunts, uncles, cousins, etc. The abbreviations above can be used for your close relatives.

Condition	Relatives	Condition	Relatives
Addiction - alcohol		Heart disease	
Addiction - drug		Hypertension	
Alzheimer's disease		Kidney disease	
Anxiety		Liver disorder	
Arthritis		Migraine headaches	
Asthma		Osteoporosis	
ADD / ADHD		Parkinson's disease	
Blood clots		Peripheral neuropathy	
Depression/mood disorders		PMS	
Diabetes		Stroke	
Digestive system disorder		Thyroid disorders	
Early menopause		Ulcer disease	
Epilepsy		Urinary/prostate	

Cancer. Specify: Relatives

Autoimmune disorder (such as multiple sclerosis).

Specify:

Reproductive system condition or abnormality.

Specify:

Other conditions which are common in your family.

List:

Patient Name: Birth Date: Age:

MEDICATIONS AND SUPPLEMENTS LIST

Current Medication List:

Taken From|To	Name, Dosage, Times per Day	Medical Condition	Effectiveness, Side Effects, Issues

Current Supplement List:

Prior Medication Attempts to Address Current Medical Conditions:

NeuroEndocrine
CONSULTING

New Patient Authorization for Release of Medical Records

Please have copies of your recent lab tests and pertinent diagnostic studies faxed to our office. This should include tests/studies over the last 12 months. If applicable, request your most recent mammogram and pap test results.

Request these copies from the ordering providers 2 weeks before your visit. This allows time for the records to be sent and incorporated into your medical history. You can use the "Authorization to Release Medical Records" form on the following page to make this request. In the space provided on this form, please indicate that records should be faxed to us no later than the date 1 week before your appointment.

Nancy Benzel, PA-C | **Office** (512) 540.4182 | **Fax** (512) 879.9046
3839 Bee Cave Road | Suite 202 | Austin, Texas 78746
NeuroEndocrineConsulting.com

NeuroEndocrine
CONSULTING

Authorization for Release of Medical Records

PATIENT INFORMATION (PLEASE PRINT):

Name:_____

Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____

RELEASE MY MEDICAL RECORDS

FROM: Name: _____

Telephone:_____

Fax:_____

TO: NeuroEndocrine Consulting LLC and Nancy Benzel, PA-C

Please send medical records no later than:_____

Please release a copy of my medical records including:

_____History and Physical

_____Progress Notes

_____Lab Tests

_____Other Records:

_____Diagnostic Studies

_____Pap Smear (most recent)

_____Mammogram (most recent)

For Past Patients of NeuroEndocrine Consulting (2007-2011)

_____I request that my Neuroendocrine Consulting medical chart be returned to Neuroendocrine Consulting and Nancy Benzel, PA-C.

BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MEDICAL RECORDS.

_____ Date:_____

Patient (or Legal Guardian) Signature

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