Baylor Scott & White HEALTH

Lakeway Neurology Specialty Clinic
200 Medical Pkwy St 320
Lakeway, TX 78738
Phone: 512-654-1234 Fax: 512-654-0177

TO:	Jane	FROM:	Rebecca, LVN / Dr. Freeman
EMAIL:	Jane@apinet.com	PHONE:	512-654-0174
PHONE:		FAX:	512-654-0177
PAGES:	5	DATE:	6/30/2020
RE:	New Patient Paperwork	CC:	

****OUR OFFICE *DOES* REQUIRE A MASK AT ALL TIMES****

Good morning Jane, it was a pleasure speaking with you on the phone. Please fill out these forms the best that you can, write or attach your full updated medication list, and bring it them to your appointment. You may also fax it back to 512-654-0177. If you have any questions in the mean time, please do not hesitate to reach out to us.

I am also attaching a Authorization for Release of Medical Records, and a Verbal Consent form. Please provide information for any provider that you would like us to request records from, outside the Baylor Scott and White network. If you have multiple providers, you will need 1 form for each provider. The verbal consent form is giving all Baylor Scott and White employees permission to speak to whoever you may list, regarding your care.

Some of the paperwork might look familiar from a previous appointment you may have had at another Baylor Scott and White, however we are just updating your records.
Thank you!

Rebecca, LVN

SCOTT&WHITE Healthcare

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____

Address: _____

Telephone: _____ Fax Number: _____

To release the information indicated from the medical record of:

Patient Name	Date of Birth	Medical Record Number
Jane A. Copeland	4.10.1952	
Street Address	City, State Zip	Telephone Number
1040 Chaparral Ct.	Blanco, TX 78606	512.657.4691

Please release this information to:

Individual/Organization Name		Telephone Number
Scott & White Healthcare	LAKEWAY NEUROLOGY DR. BLAKE FREEMAN	512-654-1234
Street Address	City, State Zip	Fax Number
200 MEDICAL PARKWAY SUITE 320	AUSTIN, TX 78738	512-654-0177

Please release the following information for these treatment dates: _____

Please provide information in this format: ☒ Paper copies ☐ CD ☐ USB Drive

Include this information (if applicable): ☐ Alcohol/Drug ☐ Genetics ☐ HIV/AIDS ☐ Mental Health

Purpose: Continued Care

☒ Summary information (clinic notes, history & physical, operative reports, pathology reports, consultations, discharge summary)

☒ EKG/EEG/EMG reports

☐ Immunization records

☒ Laboratory reports

☒ Radiology reports

☒ Radiology images

☐ Other: _____

_____

_____

I understand the following:

- I am not required to sign this authorization to obtain treatment.
- If the recipient of this information is not a covered entity under federal or state privacy law, the information may be subject to redisclosure by the recipient.
- I may revoke this authorization in writing at any time except to the extent the healthcare provider has already relied on this authorization. To revoke my authorization, I will provide a written request to _____.

This authorization will expire in 180 days or at the date or event specified here: _____

Signature of Patient or Legal Representative	Printed Name of Patient or Legal Representative	Date
Jane A. Copeland	Representative's Authority to Act for Patient	06.30.2020

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MEDICAL CENTER
LAKEWAY

PAST MEDICAL HISTORY	Yes	No	Comments:
Stroke		X	
Dementia		X	
Seizures		X	
Head Trauma		X	
Brain Infection		X	
Blood Disorder		X	
Liver Problem		X	
Heart Problem		X	
Cancer / Tumor	X		Benign ovarian fibroids and sinus tumors. No cancer
Kidney Disease		X	
Diabetes		X	Was prediabetic before losing weight. Never took meds
Depression	X		
Anxiety	X		
Headaches		X	

N

PAST SURGICAL HISTORY: Peritonitis,Tonsilectomy,hysterectomy, uphrectomy, torn meniscus, gallbladder, sinus surgery,

Reason(s) you have been referred to clinic: Fall in June 2019 resulted in problems which will not resolve.

FAMILY HISTORY: Is there any history of neurological disorders in your family?
If so, whom and what condition? No

SOCIAL HISTORY:

If you work, what do you do? CEO of technology company
Do you drink alcohol/how much per week? 2 glasses wine
Do you smoke tobacco? No How many packs per day? N/A How many years? Never

CURRENT MEDICATIONS:

Medication:	Dose:	Frequency:	Comments
Alprazolam	5mg	2xdaily	Anxiety
Amlodipine	5mg	1xdaily	BP
Levothyroxine	.1	1xdaily	Myxedema
Omeprazole	40 mg	1xdaily	Acid reflux
Clonodine patch	.1 daily	1xweekly	BP
Vivelle Dot HRT Patch	.0375	2xweekly	HRT

Do you take any herbal medications or supplements? If so, what type? Branch chain amino acids, multi vitamin, D3, Primal Fuel organic protein and collagen

Drug allergies: Aleve, NSAIDS, Sulphur **PREFERRED PHARMACY:** Walgreens, Dripping Springs
Celebrex, Cocaine derivatives, opiates, Delaudid, Hydrocodone

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MEDICAL CENTER
LAKEWAY

REVIEW OF SYMPTOMS:	Yes	Comments:
Weight gain	☐	
Weight loss	☐	
Fatigue	☐	
Night sweats	☐	
Intolerance to cold or heat	☐	Frequently feel cold
Easy bleeding or bruising	☐	
Nervousness or agitation	☐	
Depression	☒	Get depressed when pain is extreme
Agitation	☒	Can't concentrate or settle when in pain
Disturbed sleep	☐	
Memory problems	☐	
Ringing of the ears	☐	
Double vision	☐	
Blurred vision	☐	
Headaches	☐	
Numbness	☒	Left foot, toes, hip. Right thigh back, transient pain and numbness
Dizziness	☐	
Shortness of breath	☐	
Tightness across chest	☐	
Chest pain	☐	
Palpitations	☐	
Problems with skin / rash	☒	Some Actinit Keratosis
Swollen Joints	☐	
Nausea	☐	
Vomiting	☐	
Constipation	☐	
Diarrhea	☐	
Urinary urgency / frequency	☐	

Baylor Scott & White HEALTH

MRN:

Patient Identification

Permission for Verbal Communication

Jane A Copeland | 04.10.1952 | 512.657.4691

Patient Name | Date of Birth | Phone Number (s)

1040 Chaparral Ct. Blanco, Texas, USA 78606

Full Address (City, State, and Zip Code)

I permit Baylor Scott & White Health physicians and staff to discuss my personal medical health information, in person and/or by telephone, with the following family members and/or friends involved in my medical care for the following purposes:

- **To orally schedule or confirm my appointments;**
- **To discuss results of diagnostic tests, diagnosis, prognosis, and treatment plans; or**
- **To discuss billing and payment for medical services**

I understand that this document applies to all departments, healthcare providers and/or employees with Baylor Scott & White Health. I understand that this authorization is voluntary and that once this information is disclosed to the person(s) designated that it may be re-disclosed by them and may no longer be protected by state or federal privacy laws.

	Name	Relationship	Phone Number
1.	Mark Watson	Significant other	512.413.6454
2.	Joe Raymond	Family member	512.694.1483
3.			

I further understand that I may revoke this authorization at any time by sending a written statement of revocation to Baylor Scott & White Health – HIM Department.

This document of Permission for Verbal Communication will expire upon revocation, or at the date or event specified here 12.31.2020**.**

This document does not permit the release of written information to these individuals. My refusal to sign this authorization will not negatively affect my health care at Baylor Scott & White Health.

Jane A. Copeland — 06.30.2020

Patient Signature — Date

Patient's Representative on behalf of patient — Relationship to patient — Date

Witness (if patient has Representative sign) — Date