NORTHEAST TEXAS NEUROLOGY ASSOCIATES

GINA JETTER, MD, FAES
TALESH FREEMAN, APRN, FNP-C

(903) 526-7055
(903) 593-4303
www.netxneuro.com
505 S. Fleishel Ave, Tyler, Texas 75702

Dear Prospective Patient,

You have been referred to our office for evaluation of memory loss. Our evaluation will be unlike your other doctor's visits. We will spend a significant amount of time getting to know you and learning about your everyday life. We will also talk with your loved ones and caregivers about you. **Please bring a family member or caregiver to the appointment with you**. Often when your memory starts to be impaired, your loved ones will notice problems before you will.

We are very thorough in our evaluation. You and your caregiver will be asked to fill out several forms to help us get to know you and further explore what problems you are having. **We must receive all the following paperwork before an appointment is scheduled.**

Bring the following to your first appointment:

- All health insurance cards
- Driver's License or current government issued ID
- All of your medications

Talesh Freeman, a Nurse Practitioner, is a vital part of our team at NETNA. After our initial consultation, she will be seeing you at some of your visits following my treatment plan. In addition, Dr. Jetter serves as an Assistant Clinical Professor at the UT School of Medicine. Medical Students and Residents may accompany Dr. Jetter during your visit.

Our office is located at 505 S. Fleishel Ave, Tyler, TX 75702. Before your consultation, we invite you to visit our website at www.netxneuro.com to get to know us better.

We provide comprehensive care to our patients, and every person is important to us. We look forward to meeting you in person and helping you with your healthcare needs.

Sincerely,

Gina Jetter, MD

505 S. Fleishel Ave
Tyler, TX 75702
903-526-7055 p
903-593-4303 f
www.netxneuro.com

Updated 6/1/2025

PATIENT INFORMATION

Name (Last, First, MI): _____

Preferred Name: _____

DOB: _____ Age: _____ Gender: _____ Last 4 Digits of SSN: _____

Address: _____ City, State, Zip Code: _____

Race: *African American Asian Hispanic White Other* Marital Status: *Married Divorced Separated Widowed Single*

Employer: _____ Health Insurance Company: _____

Name of Insurance Policy holder: _____

If different than patient, what is the name and DOB of policy holder? _____

CONTACTS

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Care Doctor*:* _____

Preferred Pharmacy*:* _____ Location: _____

COMMUNICATION PREFERENCES

Preferred Number: _____	Pick One: Cell / Home / Work
Secondary Number: _____	Pick One: Cell / Home / Work
May we leave messages/text regarding your **appointment time/date** at the	Preferred number? ☐ Yes ☐ No
	Secondary number? ☐ Yes ☐ No
May we leave messages regarding your **medical testing results** at the	Preferred number? ☐ Yes ☐ No
	Secondary number? ☐ Yes ☐ No
May we leave messages regarding your **medical bill** at the	Preferred number? ☐ Yes ☐ No
	Secondary number? ☐ Yes ☐ No

Email Address:

_____

May we send emails regarding your **appointment time/date** to this email account? ☐ Yes ☐ No

May we send emails regarding your **medical testing results** to this email account? ☐ Yes ☐ No

May we send emails regarding your **medical bill** to this email account? ☐ Yes ☐ No

RELEASE OF INFORMATION:. Healthcare personnel needing information for continuity of care or for insurance purposes will be released my health information. I authorize release of my health information to the following (family, friend, caretaker) below:

Name of Person / Relationship	Name of Person / Relationship
_____	_____
_____	_____

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICE: I have reviewed Northeast Texas Neurology Associates (NETNA) office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. A copy is also on NETNA's website, www.netxneuro.com.

ACKNOWLEDGMENT OF REVIEW OF FINANCIAL POLICY: I have reviewed NETNA's Financial Policy, which outlines my financial responsibility to the practice. I understand that I am entitled to receive a copy of this document. A copy is on NETNA's website, www.netxneuro.com

AUTHORIZATION FOR TREATMENT: I voluntarily consent to receive health care services deemed necessary provided by NETNA. I understand that this consent to treatment will be valid and remain in effect unless revoked by me in writing.

ADVANCED PRACTICE PROVIDERS: NETNA has an advanced practice nurse to assist in the delivery of neurological care. As a patient at NETNA, you will initially be seen by a neurologist, who will always be directing your care. Continued care will be in a rotation with the physician and the nurse practitioner. I understand as a patient of NETNA, I will be seeing a nurse practitioner at some of my visits.

NO SHOW AND CANCELLATION POLICY: Notify the office **at least (48) business hours in advance** when unable to keep your scheduled appointment. A no-show appointment is defined as cancelling an appointment with less than 48 business hours notice, arriving 15 minutes after your scheduled appointment time, or not showing up for an appointment. If a patient has a no-show appointment, they must pay a $50 rescheduling fee ($200 for initial consults or procedures) before an appointment will be rescheduled. Any other future appointments already scheduled will be cancelled until the rescheduling fee is paid. A patient may be dismissed from the practice if there are 2 no-show appointments.

ACKNOWLEDGMENT OF TELEMEDICINE VISIT TERMS AND CONDITIONS: Telemedicine visits, or visits with audio and video capability are provided at NETNA where the patient and provider are not in the same location. If you choose a telemedicine visit, risks include service interruptions, interception and technical difficulties. The full Telemedicine visit Terms and Conditions can be found on our website, www.netxneuro.com

ACKNOWLEDGMENT OF USE OF ARTIFICIAL INTELLIGENCE: Our practice may use AI-powered scribe technology that records audio during your visit to assist with clinical documentation; your physician reviews and edits all AI-generated notes before they are finalized, and all recordings are handled in accordance with HIPAA privacy regulations. You have the right to decline the use of this technology at any time without affecting the quality of your care.

_____	_____	_____	_____
Signature of Patient or Legal Guardian	Signer's Printed Name	Patient Name if Different than signer	Date

Revised 1/1/2026

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CONSENT TO OBTAIN PATIENT MEDICAL RECORDS

Patient's Name:_____
Last First Middle

Date of Birth: _____

I consent to the medical records of the above named patient to be released to:

Northeast Texas Neurology Associates, PA
505 S. Fleishel Ave
Tyler TX 75702
(903) 526-7055 Fax (903) 593-4303

These records may be faxed or mailed. This authorization applies to all health care information for the purpose of continued health care.

I understand that my express consent is required to release any health care information if I have been tested, diagnosed, and/or treated for HIV (AIDS), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health information relating to such diagnosis, testing or treatment.

_____ _____
Signature of patient or authorized representative Date signed

Relationship to patient, if not patient: _____

Patient Address:_____

City:_____ State:_____ Zip: _____

Telephone: _____

AUTHORIZATION EXPIRES 1 YEAR AFTER DATE SIGNED

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Credit Card on File Policy

Northeast Texas Neurology Associates (NETNA) requires a credit card on file to make the billing process simple and easy for the clinic and our patients.

Your credit card information is stored within our secure electronic health record, which meets the strict HIPAA security standards. **We swipe your card into the system, and only the last 4 digits of the card are visible to any staff at NETNA. We do not write down nor keep any written information about your card including the number, expiration date or security code on the back of the card. Do not put any of that information on this form.**

For any balances owed after a visit or procedure, we will send you a statement in the mail. Within 28 days, if we have not received payment, we will send you an email notifying you that your card on file will be charged. If you wish to settle your balance by another payment method, please contact our office within those 28 days. We will send you a receipt after your card has been charged.

If your card is declined, we will contact you via phone. Your account becomes delinquent if not paid within 30 days after the date of the original statement. Further delinquency will be subject to collection. NETNA reserves the right to terminate a patient from the practice if payment is not received according to the agreed upon payment arrangements.

We understand that healthcare is often a large expense, and we are always willing to provide payment arrangements. These arrangements will require a credit card on file for monthly payments. Please contact our billing department if you need assistance with paying your outstanding balance.

By signing below, you acknowledge and agree to the NETNA's Credit Card on File policy. **AGREEMENT AND SIGNATURE BELOW IS REQUIRED OF ALL PATIENTS SEEN AT OUR CLINIC, EVEN IF YOU DO NOT HAVE A CREDIT CARD.** If the patient is not able to sign, the signer below is the legal guardian or responsible for the patient's account.

_____ _____

Name on Credit Card | Relation to Patient (Self, Guardian, etc)

_____ _____

Signature | Date

Revised 1/1/2026

NAME: DATE OF BIRTH TODAY'S DATE:

PREFERRED NAME:

Primary Care Doctor: _____

Why were you referred here / what problems are you having?

_____

_____

Please check the following tests you have had.

MRI Scan of the head EEG (Brain wave recording) EMG and Nerve Conduction Lumbar puncture (spinal tap)

Have you seen a neurologist before? YES / NO If so, what is her/his name and location?

_____

Please list any other **medical problems** you have. *Attach another page if needed.*

_____

_____

_____

Please list all **surgeries, injuries and pregnancies** and approximate date. *Attach another page if needed.*

_____

_____

Please list all your **current medications**, including vitamins and over the counter medications:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NAME: DATE OF BIRTH TODAY'S DATE:

List any **allergies** to medications: _____

List any illnesses in your **family**, especially those that are similar to your current problem.

_____

Do you currently **smoke**? Yes / NO If yes, how many packs per day? _____ For how long? _____
If you previously smoked, when did you quit? _____

Do you drink **alcohol**? Yes / NO If yes, how may drinks in a week? _____

Have you ever used any **illicit drugs**? Yes / NO If yes, what kind? _____ Last use? _____

PHQ-9: Depression Screen:

Over the last 2 weeks, how often have you been bothered by the following (please circle/check number)?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling/staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading or TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3

How difficult have these problems made it for you to do your work, take care of things at home or get along with other people? Not difficult / Somewhat difficult / Very difficult / Extremely difficult

Patient Name: _____DOB: _____ Date: _____

Person Completing Form and Relationship to Patient: _____

Do you live with the patient? YES / NO

Quick Dementia Rating System (QDRS)

The following descriptions characterize changes in the patient's cognitive and functional abilities. You are asked to compare the patient now to how they used to be – the key feature is ***change***. Choose ***one answer*** for each category that best fits the patient – ***NOTE***, not all descriptions need to be present to choose an answer.

1. MEMORY AND RECALL

0	No obvious memory loss or inconsistent forgetfulness that does not interfere with function in everyday activities
0.5	Consistent mild forgetfulness or partial recollection of events that may interfere with performing everyday activities; Repeats questions/statements, misplaces items, forgets appointments
1	Mild to moderate severe memory loss; more noticeable for recent events; interferes with performing everyday activities
2	Mild to moderate severe memory loss; only highly learned information remembered; new information rapidly forgotten
3	Severe memory loss, almost impossible to recall new information; long-term memory may be affected

2. ORIENTATION

0	Fully oriented to person, place and time nearly all of the time
0.5	Slight difficulty keeping track of time; may forget day or date more frequently than in the past
1	Mild to moderate difficulty keeping track of time and sequence of events; forgets month or year; oriented to familiar places but gets confused outside of familiar areas; gets lost or wanders
2	Moderate to severe difficulty, usually disoriented to time and place (familiar and unfamiliar); frequently dwells in the past
3	Only oriented to their name, although may recognize family members

3. DECSION MAKING AND PROBLEM SOLVING

0	Solves everyday problems without difficulty; handles personal business and financial matters well; decision-making abilities consistent with past performance
0.5	Slight impairment or takes longer to solve problems; trouble with abstract concepts; decisions still sound
1	Moderate difficulty with handling problems and making decisions; defers many decisions to others; social judgement and behavior may be slightly impaired; loss of insight
2	Severely impaired in handling problems, making only simple personal decisions; social judgement and behavior often impaired; lacks insight
3	Unable to make decisions or solve problems; others make nearly all decisions for patient

4. ACTIVITIES OUTSIDE THE HOME

0	Independent in function at usual level of performance in profession, shopping, community and religious activities, volunteering or social groups
0.5	Slight impairment in these activities compared to previous performance; slight change in driving skills; still able to handle emergency situations
1	Unable to function independently but still may attend and be engaged; appears “normal” to others; notable changes in driving skills; concern about ability to handle emergency situations
2	No pretense of independent function outside the home; appears well enough to be taken to activities outside the family home but generally needs to be accompanied
3	No independent function or activities; appear too ill to be taken to activities outside the home

5. FUNCTION AT HOME AND HOBBY ACTIVITIES

0	Chores at home, hobbies and personal interests are well maintained compared to past performance
0.5	Slight impairment or less interest in these activities; trouble operating appliances (particularly new purchase)
1	Mild but definite impairment in home and hobby function; more difficult chores or tasks abandoned; more complicated hobbies and interests given up
2	Only simple chores preserved, very restricted interest in hobbies which are poorly maintained
3	No meaningful function in household chores or prior hobbies

6. TOILETING AND PERSONAL HYGEINE

0	Fully capable of self-care (dressing, grooming, washing, bathing, toileting)
0.5	Slight changes in abilities and attention to these activities
1	Needs prompting to complete these activities but may still complete independently
2	Requires some assistance in dressing, hygiene, keeping of personal items, occasionally incontinent
3	Requires significant help with personal care and hygiene; frequent incontinence

7. BEHAVIOR AND PERSONALITY CHANGES

0	Socially appropriate behavior in public and private; no changes in personality
0.5	Questionable or very mild changes in behavior, personality, emotional control, appropriateness of choices
1	Mild changes in behavior or personality
2	Moderate behavior or personality changes, affects interactions with others; may be avoided by friends, neighbors or distant relatives
3	Severe behavior or personality changes; making interactions with other often unpleasant or avoided

8. LANGUAGE AND COMMUNICATION ABILITIES

0	No language difficulty or occasional word searching; reads and writes as well as in past
0.5	Consistent mild word finding difficulties, using descriptive terms or takes longer to get point across, mild problems with comprehension, decreased conversation; may affect reading and writing
1	Moderate word finding difficulty in speech, cannot name objects, marked reduction in word productions; reduce comprehension, conversation, writing and/or reading
2	Moderate to severe impairments in speech production or comprehension; has difficulty communicating thoughts to others; limited ability to read or write
3	Severe deficits in language and communication; little to no understandable speech is produced

9. MOOD

0	No changes in mood, interest or motivation level
0.5	Occasional sadness, depression, anxiety, nervousness or loss of interest/motivation
1	Daily mid issues with sadness, depression, anxiety, nervousness or loss of interest/motivation
2	Moderate issues with sadness, depression, anxiety, nervousness or loss of interest/motivation
3	Severe issues with sadness, depression, anxiety, nervousness or loss of interest/motivation

10. ATTENTION AND CONCENTRATION

0	Normal attention, concentration, and interaction with her/her environment and surroundings
0.5	Mild problems with attention, concentration, and interaction with environment and surroundings, may appear drowsy during the day
1	Moderate problems with attention, concentration, and interaction with her/her environment and surroundings, increased daytime sleepiness
2	Significant portion or the day is spent sleeping, not paying attention to environment, when having a conversation may say things that are illogical or not consistent with topic
3	Limited to no ability to pay attention to external environment or surroundings

	COGNITIVE SUBTOTAL (QUESTIONS 1, 2, 3, 8)
	BEHAVIORAL SUBTOTAL (QUESTIONS 4, 5, 6, 7, 9, 10)
	TOTAL QDRS SCORE

NORMAL	0-1
MILD COGNITIVE IMPAIRMENT	2-5
MILD DEMENTIA	6-12
MODERATE DEMENTIA	13-20
SEVERE DEMENTIA	20-30

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Behavior and Mood Questions: Does your loved one…

1. Get angry or hostile? Resist care from others? **YES / NO**

2. See and/or hear things that no one else can see/hear? **YES / NO**

3. Act impatient and cranky? Mood frequently changes for no reason? **YES / NO**

4. Act suspicious without good reason (example: believes that others are stealing from him/her or planning to harm him/her in some way? **YES / NO**

5. Seem less interested in his or her usual activities and plans of others? **YES / NO**

6. Have trouble sleeping at night? **YES / NO**

Functional Activities Questionnaire

	Normal (0)	Has Difficulty but does by Self (1)	Requires Assistance (2)	Dependent / Unable to do (3)
1. Writing checks, paying bills, balancing a check book.				
2. Assembling tax records, business affairs or papers.				
3. Shopping alone for clothes, household necessities or groceries.				
4. Playing a game of skill or working on a hobby.				
5. Heating water, making a cup of coffee, turning off the stove.				
6. Preparing a balanced meal.				
7. Keeping track of current events.				
8. Paying attention to, understanding, and discussing a tv show, book or a magazine				
9. Remembering appointments, family occasions, holidays, and medications.				
10. Travelling out of the neighborhood, driving, arranging to take buses.				

Never did but could do now – 0 points
Never did, but would have difficulty now – 1 point

Total: _____

Cut point of 9 (dependent in 3 or more activities) is recommended to indicate impaired function and possible cognitive impairment.

Caregiver Profile

1. Do you understand what Alzheimer's and / or other dementias are? **YES / NO**

2. Do you know where you can obtain additional information about the disease? **YES / NO**

3. Are you able and willing to provide care of assistance? **YES / NO**

4. Do you know where you can receive support as a caregiver? **YES / NO**

Safety Questions

1. Is the patient driving? **YES / NO**

2. Is the patient able to independently manage their own medications? **YES / NO**

3. . Is the patient able to independently manage their own finances? **YES / NO**

4. Are there concerns about safety in the home? **YES / NO**

5. Has the patient gotten lost in familiar places or wandered? **YES / NO**

6. Are unsecured firearms present in the home? **YES / NO**

7. Has the patient experienced unsteadiness or sustained falls? **YES / NO**

8. Does the patient live alone? **YES / NO**

If no, with whom does the patient live? If this patient lives in an Assisted Living or Nursing Facility, which one?

_____

Power of Attorney

Does the patient have a <u>medical</u> power of attorney? _____

Does the patient have a <u>financial</u> power of attorney? _____

Is there anything you wish to share with us privately? _____

_____

_____

_____

_____

_____

_____

_____