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 your neurological problem. In order to be thorough in our evaluation and be fully prepared for your visit, we require that you completely fill out and return all the following paperwork. **Your initial consultation will not be scheduled until we receive all the completed paperwork.**

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

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

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Spell / Seizure / Black Out Questionnaire

Name: _____ DOB: _____ Date: _____

At what age did you start having spells / seizures? _____

When was the last time you had a spell / seizure? _____

How often do you have a spell / seizure? _____

What is the longest time you have gone without having a spell / seizure? _____

What triggers your spells / seizures? _____

Please describe what happens before, during and after each type of your spells or seizures:

_____

_____

_____

_____

Have you ever been injured from a spell or seizure? If yes, describe injury. _____

Have you ever had a continuous seizure that you had to be hospitalized for? _____

Do you have a Vagal Nerve Stimulator? If yes, when was it put in? _____

Have you ever had surgery for seizures? If so, when and where was the surgery performed?

_____

Please mark each seizure medication you have taken in the past and why the medication was stopped. If stopped due to side effects, please describe effects.

Name of Medication	**When taken and reason for stopping**
Briviact (Brivaracetam)	
Carbamazepine (Tegretol)	
Cannabidiolol Oral Soluntion (Epidiolex)	
Cenobamate (Xcopri)	
Clobazam (Onfi)	
Clonazepam (Klonopin)	
Diazepam (Valium, Diastat)	
Eslicarbazepine (Aptiom)	
Ethosuximide (Zarontin)	
Ezogabine (Potiga)	
Felbamate (Felbatol)	
Gabapentin (Neurontin)	
Lacosamide (Vimpat)	
Lamotrigine (Lamictal)	
Levetiracetam (Keppra)	
Lorazepam (Ativan)	
Oxcarbazapine (Trileptal, Oxtellar)	
Perampanel (Fycompa)	
Phenobarbital	
Phenytoin (Dilantin)	
Pregabalin (Lyrica)	
Rufinamide (Banzel)	
Tiagabine (Gabitril)	
Topiramate (Topamax, Trokendi)	
Valproic Acid (Depakote, Divalproex)	
Vigabatrin (Sabril)	
Zonisamide (Zonegran)	