Patient Name_____ ◯ Male ◯ Female

Date of birth_____ Age_____ Social Security #_____ Cell Phone_____

Email (required for electronic med records access)_____

Home Address_____ City_____ State_____ Zip_____

Pharmacy_____ Address_____ City_____

Phone_____ Fax_____

Have you ever been seen by any of our doctors before? ☐ No ☐ Within the past 3 years ☐ More than 3 years ago
☐ Dr. Malka ☐ Dr. Subramanian ☐ Dr. Gu ☐ Dr. Umamaheswaran ☐ Linda Bark, APRN ☐ Jennifer Quinn, APRN
☐ Brooksville office ☐ Hudson office ☐ Trinity office ☐ Palm Harbor office ☐ Hospital: _____

Chief complaint_____

Temp_____ Height_____ Weight_____ Blood pressure_____ Pulse_____

Drug Allergy: _____ ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

Reaction (please describe): _____

Drug Allergy: _____ ☐ Very mild ☐ Mild ☐ Moderate ☐ Severe ☐ Unknown

Reaction (please describe): _____

Additional drug allergies: _____

Do you smoke? ☐ non-smoker ☐ ex-smoker ☐ 1-9 cigs/day ☐ 10-19 cigs/day ☐ 20-39 cigs/day ☐ 40+ cigs/day
☐ other:_____

Do you drink? ☐ non-alcohol user ☐ past alcohol excess ☐ 1-3 drinks/day ☐ 4-6 drinks/day ☐ 6+ drinks/day

Do you currently use or intend to use any of the following (*select all that apply**): ☐ No ☐ *Intend to use** ☐ *Currently use**
☐ Medical Marijuana ☐ Methadone ☐ Suboxone ☐ Recreational Drugs

PLEASE BRING ALL PILL BOTTLES OR PROVIDE A PRECISE LIST OF ALL PRESCRIPTIONS, MILLIGRAMS PER PILL, AND NUMBER OF PILLS TAKEN PER DAY OR WEEK OR MONTH

Brain, spine, nerve, heart, cancer surgery?_____ When? _____

Can you become pregnant? ☐ Yes ☐ No: *Why not?* _____

Emergency contact_____ Phone_____

Referring physician or source_____ Phone_____

Fax_____ NPI#_____ Medicaid #_____

Signature_____ Date _____

David W. Malka, M.D.
Board Certified Neurologist,

Qin Gu, M.D.
Board Certified Neurologist

DAVID W. MALKA, M.D., P.A.
D.B.A...
The MIND
MALKA INSTITUTE OF NEUROSCIENCE AND DISEASE

Linda S. Bark, M.S., APRN
Advanced Practice Registered Nurse

Jennifer D. Quinn, APRN
Advanced Practice Registered Nurse

www.malkainstitute.net

Medical Records Release, Privacy Rights, Policies, and Authorizations

I hereby certify that the information given by me is correct and can be used to apply for payment through Medicare under Title XVIII of the Social Security Act or through any other insurance carrier. I also herby authorize David W. Malka, M.D., P.A., dba The Malka Institute of Neuroscience and Disease (referred to hereon as The M.I.N.D.) to submit claims on my behalf to Medicare, Medicaid, and/or other insurance carriers for payment for medical services rendered by any of its affiliated physicians and authorized medical professionals. Any medical or other information about me needed to support such claim(s) may be released to Medicare, Medicaid, and/or any other insurance carrier without my further specific approval. I also assign all benefits payable, including Medigap benefits, to The M.I.N.D. and request that payments be made directly to the order of David W. Malka, M.D., P.A. I also hereby authorize the physicians and authorized medical professionals affiliated with The M.I.N.D. to provide any medical treatment which is proper and necessary within their judgement. I further recognize that the physicians practicing with The M.I.N.D. are independent contractors and agree not to hold The M.I.N.D. liable for actions or treatments provided or not provided by said physicians. Additionally, I recognize that The M.I.N.D., nor the practitioners practicing with The M.I.N.D. do not manufacture nor inspect products nor profit from any products offered by employees or suppliers and agree to hold David W. Malka, M.D., The M.I.N.D., and said practitioners harmless for any claims, representations or warranties, whether express or implied, as to the safety, reliability, durability, and performance of any such products.

The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in several areas and sets forth federal laws enforced by the US Department of Health and Human Services prohibiting the discrimination against persons with disabilities. All staff, managers, and partners of the M.I.N.D. are required to comply with and undergo training related to anti-discrimination policies. Additional information regarding ADA may be found posted in the office as well as on our website. If you believe you have been discriminated against on one of the protected bases, you may file a complaint with the HHS Office of Civil Rights (OCR).

I also acknowledge and agree to comply with the financial policy of The M.I.N.D., which includes the following: a) Payment of all charges is the patient's/patient's guardian's primary responsibility, and the filing of Medicare, Medicaid, or other insurance claims is made only as a courtesy to the patient. If for any reason, payment for such claim(s) is denied, in whole or in part, except as contracted between David W. Malka M.D., P.A., the providers, and Medicare, Medicaid, and/or other insurance carrier, then all balances will be due and payable by the patient of the responsible guardian, b) All payments of fees, copayments, or deductibles in the case of insured patients, are due and payable in cash or by credit/debit card at the time of service, c) All unpaid balances due and billed to the patient must be paid upon receipt of statement of account, d) If a check is returned by the bank unpaid for any reason, patient will be required to make immediate restitution in cash plus additional applicable service charges, e) Medicare assignments are accepted and Medicare claims are file on behalf of the patient who should not therefore file their own claim. Patient is responsible for 20% of the approved amount and any deductible that has not been met at the time of service, f) Patient assumes primary responsibility for obtaining insurance authorizations and primary physician referrals where needed prior to services being rendered, and if claims are denied because of lack of such authorization or referral, then patient will be liable for full payment for services rendered. The relationship is with the patient and The M.I.N.D.; the physicians and staff will not therefore become involved in legal disputes with attorneys and/or insurance companies, g) There are separate charges, to be paid in advance, for records, narrative reports, and completion of additional forms, h) Minors must be accompanied by an adult legal guardian i) If for any reason an appointment cannot be kept, it is the patient's and adjuster's (if applicable) responsibility to call and inform the office no later than 24 hours before the scheduled appointment and failure to do so will result in a service charge of $50 to be paid before the patient can be rescheduled j) excessive (3+) no shows will place the patient at risk of being discharged from the practice due to noncompliance k) any change of physician or request to see M.D. when scheduled to see APRN/PA are subject to a prepaid $50 change of provider service fee.

I authorize The M.I.N.D. to obtain from other providers as well as to use and disclose a copy of my entire health and medical record including mental health, drug alcohol abuse, HIV, AIDS, STD, and genetic testing records for the purpose(s) of, but not limited to, continued medical care, personal information, legal follow up, disability, and insurance. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, my information may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. I also understand that the entity I am authorizing to use/disclose the information may not receive compensation for doing so though a prepaid processing or copy fee will apply. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used/disclosed under this authorization. Finally, I understand that I may revoke this authorization in writing at any time, provided I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless formally revoked by me or my legal guardian in writing, this authorization shall not expire. Notices of additional patient privacy rights and privacy practices for Protected Health Information (HIPAA) can be found in the office and a copy will be given at my request. I authorize further to allow for the sending of automated electronic reminders and other electronic communications and understand I may revoke my permission at any time by calling the office.

The undersigned affirms they read, understand, and are bound by the above policies and authorizations set forth by David W. Malka, M.D., P.A., dba The Malka Institute of Neuroscience and Disease and understand they may change at any time.

Patient/Guardian Signature: _____ Date: _____

Guardian's Name (if applicable): _____

Patient's Name: _____ rev. 62323