NEUROLOGY ONE

| | | |
|---|---|---|
| Date: | Marital Status: Single/Married/Widowed/Separated/Divorced | Gender: Male/Female |
| Last Name: | First Name: | Initial: |
| Address: | | Apt: |
| City: | State: | Zip Code: |
| Last 4 numbers Social Security: | Date of Birth: | |
| Tel #: | Mobile #: | E-mail: |
| Occupation: | Who referred you to us? | |
| Primary Insurance: | Member ID: | |
| Secondary Insurance | Member ID: | |
| Pharmacy Name: | Telephone Number: | |
| Referring Physician: | Fax Number: | |
| Is there anyone you authorize us to discuss your medical information? | | |
| Any doctor you want us to send copies of notes? | | |

Authorization for Release of Medical Information: I hereby authorize Neurology One to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims and authorization. I also hereby consent to disclosure of my health information to provide diagnosis and treatment clinicals to my primary care physician for coordination of care.

Payment policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, copayments, coinsurance, or other amounts unpaid by my insurance, if benefits assigned. Neurology One, files plan for Medicare assignment and only the managed care plans, which are contracted. Claims will not be filed with order insurance carriers. If your plan to pay by check and it's dishonored, a processing fee of $35 would be assessed.

Signature: _____ Date: _____

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Patient Name: _____ Date: _____ Date of Birth: _____

Name of doctor who referred you here/your primary care: _____

Main complaint that brings you here today: _____

**Past Medical History:**

- ☐ AIDS/HIV
- ☐ Abnormal Heart Rhythm
- ☐ Asthma
- ☐ Blood Clots
- ☐ Brain Surgery/implants/clips
- ☐ Cancer
- ☐ Cardiac Implants
- ☐ Depression
- ☐ Anxiety
- ☐ Diabetes
- ☐ Dialysis
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lyme disease
- ☐ Major Head Trauma
- ☐ Meningitis/Encephalitis
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Stroke

Have you had any surgery? If so, when?

_____

_____

Social History:

Marital Status (please circle): Single/Married/Widow/Separated/Divorced

Occupation (if retired, what you used to do): _____

How many children: _____

Smoking: ☐ Yes ☐ No If yes, how may packs per day: _____

Alcohol: ☐ Yes ☐ No If yes, how much and what you typically drink: _____

Recreational or current illicit drug use: Yes ☐ No ☐ If yes, specify: _____

**Family History:**

List any illnesses running in your family or genetic disorders:

_____

_____

**Medication history:**

List any medication you are currently taking and dosages (include supplements):

Medication Allergies: _____

## Review of Systems:

(check those that are yes, leave blank if no)

**Constitutional:**

- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fever

**Cardiovascular:**

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Unable to tolerate exertion
- ☐ Short of breath when flat

**Ophthalmological:**

- ☐ Double vision
- ☐ Blurred vision
- ☐ Loss of vision

**Musculoskeletal:**

- ☐ Fractures
- ☐ Joint Pains
- ☐ Muscle Cramps

**Genitourinary:**

- ☐ Incontinence
- ☐ Frequent urination
- ☐ Difficulty starting urine

**Dermatological:**

- ☐ Rash

**Endocrinological:**

- ☐ Cold Intolerance
- ☐ Heat Intolerance

**Respiratory:**

- ☐ Shortness of breath with exercise

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- ☐ Shortness of breath at rest
- ☐ Wheezing
- ☐ Cough
- ☐ Blood in sputum

**Gastrointestinal:**

- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Incontinence of bowel

**Psychiatric:**

- ☐ Depression
- ☐ Suicidal thoughts
- ☐ Suicidal Plans

- ☐ ENT
- ☐ Ringing in the ears
- ☐ Loss of hearing
- ☐ Ear pain

**Neurological:**

- ☐ Fainting
- ☐ Seizure
- ☐ Headache
- ☐ Dizziness
- ☐ Unsteadiness
- ☐ Numbness

Are you currently pregnant: Yes ☐ No ☐

Patient Signature: _____ Physician Signature: _____

NEUROLOGY ONE

**HIPAA NOTICE OF PRIVACY PRACTICES**
**As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information:** Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to, quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility. We may use or disclose your protected health information, as necessary, to contact you to check the status of your equipment.

**We may use or disclose your protected health information in the following situations without your authorization:** as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation. Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.**

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

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**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

**You may have the right to have our organization amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law** to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information, if you have any questions concerning or objections to this form, please ask to speak with our President in person or by phone at 407-572-7300.

**Associated companies with whom we may do business**, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

**We welcome your comments:** Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

More information about HIPAA law is available in our clinic and available to you at your request.

_____ _____

Signature of Patient Date

NEUROLOGY ONE

**New Patient Consent Form**

**Consent to Treatment:**

I _____ recognize that I need medical services. I consent to care at Neurology One by its physician and his/her assistant and staff. I understand that the practice of medicine is not an exact science and that any treatment and/ or prescribed medication may involve risk and side effects. I understand that I will be informed about the availability of alternate modes of treatment or procedures and their benefits and risks, including no treatment at all, except in emergencies.

**Use of Medical Information:**

I understand consistent with Florida and federal law, Neurology One will share all medical information as necessary for continuation of care and with any other institution or person as allowed by law. As an example, I understand that Neurology One does not have an in-house lab and uses an out-sourced medical laboratory and my lab work and personal information is shared to accomplish testing I may desire. Privacy and confidentiality of personal health information is important at Neurology One. There are policies in place to ensure that your personal health information is available only to authorized persons who need access to this information to provide medical care. No patient information leaves this office either electronically, by fax, or paper record without specific authorization by the patient.

**Financial Agreement:**

I acknowledge that I am responsible for all charges for services provided to me, my spouse, and my dependents payable in full on the day that services are rendered. I understand Neurology One will Bill my insurance for services rendered minus my patient portion. Insurance includes Medicare. If I utilize the patient membership program provided by a third party I will ensure that my monthly fees are paid in full each month and my service is active on the day of service.

I have read and fully understand to my satisfaction, this entire document consisting of consent to treat, use of medical information, and financial information. I have had an opportunity to ask questions and received answers. I also authorize release of any necessary medical record information by Neurology One and to any referrals on my behalf.

Signature: _____Date: _____

Printed Name of Person (If not Patient) and please indicate relationship (if signing for someone else):

_____ _____

Print Name Relationship to Patient

I understand that my healthcare provider will make decisions using the information I have provided regarding diagnosis and treatment. I hold Neurology One and its staff harmless if any adverse reactions occur as a result of information that was omitted. The providers at Neurology One collaborate with neurologists in the community in case you need admission to the hospital. We are also willing to discuss any medical issues with treating physicians while you are in the hospital to help your condition. Also, by signing below, I authorize Neurology One and its representatives to disclose my Personal health Information (PHI) to organizations, its affiliates, agents, representatives, and service providers to help enable treatment for myself, such as pre-authorizations, obtaining coverage for my medications, etc. I further authorize my disclosure of this information to third parties to enable services for such purposes, including to perform insurance coverage verification and insurance reimbursement services, and that such consent and direction applies to disclosures made through the duration of the medical therapy. I also authorize and by signing below Opt-In for Neurology One to send emails and text messages to remind me about my appointments. *We are going to be sending automated SMS text message/email reminders about your upcoming appointments. If this is a problem for you please notify us.*

Signature: _____ Date: _____

NEUROLOGY ONE
ADVANCED CENTER FOR NEUROSCIENCE & BRAIN WELLNESS

# Appointment No Show/24 Hour Notice Policy

When patients do not show for their appointments, those timeframes are typically lost and unused. We have patients in a waiting list in need for appointments, and if you inform us that you will not be able to come, we can provide those spaces to those patients on the waiting list. You might need one of those spaces in the future as well and will appreciate having them.

A patient will be considered a "no show" if they miss their scheduled appointment time or cancels within less than a 24-hour time block. If a 24 hours' notice isn't received, the following fees will be charged:

- $35 for an ESTABLISHED patient appointment
- $50 for a NEW patient appointment
- $50 for an IN-OFFICE PROCEDURE appointment

This fee is not covered by insurance and it is at the discretion of the patient. Please be aware that confirmation calls are a courtesy and not the office's responsibility.

I, (print name) _____ understand that and recognize that *Neurology One* has stated in their policy to charge me $35 or $50 fee if I fail to come for my scheduled appointment without a 24-hour notice. I agree to the following:

- To pay this fee when applicable
- That I understand I will be unable to schedule future appointments until the payment has been received
- That it is my responsibility to keep track of the appointments that I schedule with the office
- That it is not *Neurology One*'s job to contact me of my upcoming appointments.

Patient's Signature: _____ Date:_____

Tel. 407-916-0304 Fax. 888-960-6364 email: info@neurologyone.net
Clinic Address: 7151 University Blvd. Suite 100, Winter Park, FL, 32792

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ADVANCED CENTER FOR NEUROSCIENCE & BRAIN WELLNESS

**Authorization to Request Protected Health Information (PHI) from Other Providers**

Patient Name:_____ Date of Birth:_____

Last 4 SSN:_____ ID Presented:_____

By signing this form, I authorize and grant permission for the facility below to send PHI to Neurology One, (secured fax number 888-960-6364, address 7151 University Blvd, Suite 100, Winter Park, FL, 32792):

Person/Facility:_____

Fax:_____

Address:_____

What PHI may be shared? (check all that apply)

- ☐ Mental Health/Psychiatric Treatment
- ☐ History and Physical
- ☐ Rehabilitation Records
- ☐ Emergency Room Records & Alcohol or Substance Abuse Treatment
- ☐ Discharge Summary & Operative Report(s)
- ☐ Other:_____

This authorization permits the entity/provider named above to use and disclose (share) certain protected health information (PHI). By signing this authorization, I am giving permission for the entity/provider named above to release some of my PHI for treatment purpose as I have directed. The PHI may include information about mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmissible disease. This authorization may be used until it expires to share the same type of PHI indicated above, which may be created in the future. I understand that this authorization will remain in effect until I revoke it in writing (i.e., tell the entity/provider to cancel it). I understand that I have the right to revoke this authorization, but only to the extent that the entity/provider has not already taken action based on this authorization. I may revoke this authorization by providing a written statement to the entity/provider named above. If I refuse to sign this authorization, doing so will not affect my treatment, payment, enrollment, eligibility for benefits or the quality of care that I receive. I understand that PHI shared per this authorization may no longer be protected by state law or the federal health privacy law and could be re-disclosed by the person or entity that receives it.

Signature of Patient/Representative:_____ Date:_____

# Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medication in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

**I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.**

_____ _____

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

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# Consent to Use or Disclose Information via ELECTRONIC MEANS

The purpose of this informed consent form is to provide written information regarding the risks, benefits, and alternatives of the procedure named above.

I hereby consent to engage exchanging Protected Health Information via ELECTRONIC MEANS with Neurology One. I understand that "ELECTRONIC MEANS" includes email, texting and interactive audio, video, or data communications. I understand that "ELECTRONIC MEANS" also involves the transmission of my medical information, both orally and visually, to health care practitioners. The laws that protect the confidentiality of my medical information also apply to "ELECTRONIC MEANS". As such, I understand that the information disclosed by me during my treatment is confidential. I understand that there are risks and consequences from using "ELECTRONIC MEANS", including, but not limited to, the possibility, despite reasonable efforts on the part of my Provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transfer of my medical information could be interrupted by unauthorized persons; and/or unauthorized persons could access the electronic storage of my medical information. In addition, I understand that "ELECTRONIC MEANS" services are not intended to diagnose or treat. I also understand that if my Provider believes I would be better served by another form of medical services (e.g., face-to-face services), I will be referred to a medical services provider who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of medical treatment and that despite the efforts of my Provider, my condition may not be improved, and in some cases, may even get worse. I understand that "ELECTRONIC MEANS" communication does not and should not replace a traditional doctor's office visit, and therefore, I am proceeding with this "ELECTRONIC MEANS" communication at my own risk and understanding. I also understand that should my condition or my responsible parties be an emergency, I should contact local emergency response by dialing 911. I certify that the information provided in this medical form is true and accurate to the best of my ability. I also understand that omitting medical information or misinforming a Neurology One Provider may result in inaccurate diagnosis and treatment.

I have read the above information and agree that the electronic communications described above may include protected health information (PHI) about me / the patient, when necessary. I have read and understood the information provided above. I have discussed it with a Neurology One Provider/staff, and all of my questions have been answered to my satisfaction. I hereby release Neurology One and its employees from any and all liability that may arise from the release of information as I have directed.

Patient Name:

Patient Signature:

Date: