Negroski Neurology
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NEW PATIENT REGISTRATION FORM

Date: _____

Demographics

Patient Name: _____ DOB: _____ SSN: _____

Race: White | African-American | Hispanic | Asian | American Indian or Alaska Native | Native Hawaiian or Other Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: Married Single Divorced Widowed

Preferred Language: _____

Reason for Visit: _____

Prior tests for this Problem? CT MRI Lab Tests Other:

Ordering Doctor: _____

Name of Hospital You have Been Seen At, If any: _____

Referring Doctor: _____

Primary Care Physician: _____

Contact Information

Primary Address	Out of Town Address
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Reside at this Address
Mobile Phone _____ Work/Other _____	From: _____ To: _____
Email	Out of Town Phone #:

Emergency Contact _____ Relationship _____ Phone _____

Address _____ State _____ Zip _____

Insurance Information

Please be aware: You are responsible for the payment of all charges regardless of the status of any insurance claims. Authorizations for services under HMO contracts must be obtained from your primary care physician before services are rendered.

Primary Insurance Company: _____ Policy #: _____

Group #: _____ Claim#: _____

Address: _____ State: _____ Zip: _____

Main Subscriber Name: _____ DOB: _____ SSN: _____

Guarantor: _____ *Does your insurance company require a referral?* Yes No

Secondary Insurance Company: _____ Policy #: _____

Group #: _____ Claim#: _____

Address: _____ State: _____ Zip: _____

Main Subscriber Name: _____ DOB: _____ SSN: _____

Guarantor: *Does your insurance company require a referral?* Yes No

PLEASE MAKE SURE ALL BLANKS ARE FILLED IN. IF IT DOESN'T APPLY WRITE "NO" OR "N/A".
PLEASE MAKE SURE ALL SIGNATURE BOXES ARE SIGNED

NEW PATIENT REGISTRATION FORM

Patient Financial Responsibility

* Payment is expected in full at the time of service for all patients without insurance.
* You understand that your medical services will be billed to your insurance company and that any copays, deductible, and/or coinsurance related to your insurance coverage is expected at the time of service. Exclusions to this policy include Medicare, except for Medicare replacement plans or managed care plans that have a copay, deductible and/or coinsurance.
* Your insurance coverage is between you and your insurance company. You will need to familiarize yourself with the way your insurance company works and how it will pay for tests or procedures. It is your responsibility to know if you need pre-authorization for a procedure or testing and which laboratory is required. It is your responsibility to contact your insurance company and ask if it requires a referral to our office or to any other facility that our doctor(s) may refer you to for medical care, testing or procedures. If that is the case, you will need to contact your Primary Care Physician and have him/her fax your referral directly to our office prior to the date of your appointment.
* Negroski Neurology is not responsible for any out-of-pocket expenses that you may incur in relation to any medications, diagnostic testing and/or procedure(s).
* If your insurance company is not participating, you understand that payment is expected at the time of service and that your visit will be filed with your insurance company.
* If you have a balance after your insurance company has paid us, you will be sent a statement itemizing the services rendered and the balance due. That balance is due upon receipt.
* Our business office will bill your primary and secondary insurances, however, proper billing requires that we have accurate information. A copy of your insurance card(s) and photo ID will be made at the time of your initial visit. If your insurance information changes, you will need to let the receptionist know as soon as possible. If we do not have accurate insurance information, a referral from your PCP if required, or a pre-authorization for testing if required, then the entire balance for your visit may be your responsibility.
* Patients scheduled for an appointment for a Motor Vehicle Accident (MVA) understand that you **must** inform the practice of your MVA coverage when making your appointment and you **must** inform the practice if you have already seen any other providers/physicians. You understand that all charges for medical services rendered for you at Negroski Neurology are due and **must** be paid prior to service.
* Any forms that need to be filled out by our office pertaining to, but not limited to, disability or insurance adaptive equipment, will be completed during a dedicated office visit. If you are logistically or physically unable to attend an office visit, then applicable fees would apply at a minimum of $50.00 per form, to be paid by you, prior to the completion of the forms/documents. You will be presented with a statement of the amount due, depending on the size of the form(s) to be filled out and this amount **must** be paid in advance.
* I understand that failure to comply with the above stated requirements could result in collection activities regarding my account. Costs of attorneys and/or court fees would be my responsibility.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE, FULLY ACCEPTS ALL SPECIFIED TERMS ABOVE.

Patient Name/ Legally Responsible Party	Patient/ Legally Responsible Party Signature	Date

Assignment of Insurance Benefits

Medicare & Supplemental Insurance

I request that payment of authorized Medicare Benefits be made on my behalf to Negroski Neurology for any services rendered or furnished to me by the physician(s). I authorize any holder of medical information about me to release to the Federal Centers for Medicare and Medicaid (CMS) and its State Agency and any fiscal intermediaries needed to determine these benefits or the benefits payable for related services.

I also request that the payment of Medigap(my medicare supplement) benefits be made on my behalf to Negroski Neurology for any services furnished to me by the physician(s). I authorize any holder of medical information needed to determine these benefits for related services.

I understand that I am responsible for payment of any non-covered service(s), deductible(s), and/or co-payment(s) due.

Do You have A Medicare Replacement?	Yes → Name of Company: _____ ID: _____
	No → Medicare #: _____

Commercial Insurance

I request that payment of authorized benefits be made on my behalf to Negroski Neurology for any services provided by the physician(s) of this group. I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract.

I understand that I am responsible for payment of any charges in full, including non-covered services, deductible and/or co-payments due. I further understand that it is my responsibility to notify this office of any prior authorization or pre-certification required by my insurance company or my HMO contract in order to obtain payment, and to advise this office of participating facilities where appropriate.

We require a copy of your insurance card(s) and driver license at the time of your first appointment. Be sure to inform us if your insurance information changes.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE ABOVE, FULLY ACCEPTS ALL SPECIFIED TERMS ABOVE.

Patient Name/ Legally Responsible Party	Patient/ Legally Responsible Party Signature	Date

NEW PATIENT REGISTRATION FORM

Missed Appointments

We value the doctor/patient relationship, which we believe is built on mutual trust and respect. It is important that you realize that your scheduled appointment time is reserved just for you. We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments and arriving on time. We understand that circumstances occur that do not allow you to keep your scheduled appointment and therefore request that you notify us a minimum of 24 hours in advance if you are unable to keep your scheduled appointment to avoid a missed appointment fee. When we receive advanced notice of cancellation, we are able to accommodate other patients who are in need of urgent care.

Any cancellation not made at least 24 hours before the scheduled appointment time or not showing up for your scheduled visit is considered a missed appointment and subject to a Missed Appointment Fee which is not covered by insurance.

MISSED APPOINTMENT FEES

Office Visits	**Tests and Procedures**			
New Patient: $50.00	MRI: $300.00	Botox: $100.00
Follow up Visit: $25.00	EMG: $100.00	EEG: $50.00

Contact Permissions

I wish to be contacted in the following manner (please check all that apply):

□ Home Telephone: ( )

□ Cell Telephone: ( )

□ Work Telephone: ( )

May we leave appointment, billing, and/or medical information on your answering machine/voice mail? Yes No

I give permission for Negroski Neurology share appointment, billing or medical information with the following persons named below:

Consent To Treat

I consent to treatment, diagnostic and/or therapeutic services as ordered and/or provided by Donald Negroski, M.D. / Valeriy Sabodash, M.D. / Daniel Sellers, PA-C

Pt Initials

Physician's Assistant

Our practice provides medical services by utilizing Certified Physician Assistants (PA-C) to assist in providing comprehensive Neurologic care to our patients. Our Physician Assistants are certified nationally, and they are qualified and trained to perform medical services in the State of Florida under the supervision of our physicians. Your physician may schedule or recommend an appointment or services with his Physician Assistant to assist in with timely continuance of your medical care.

BY SIGNING BELOW YOU UNDERSTAND OFFICE APPOINTMENTS, AT THE DISCRETION OF OUR PHYSICIANS, MAY BE SCHEDULED WITH A PHYSICIAN ASSISTANT AND THAT YOU AGREE TO RECEIVE APPOINTMENTS AND SERVICES PROVIDED BY TO YOU BY THE PHYSICIAN ASSISTANT.

Patient Name/ Legally Responsible Party | Patient/ Legally Responsible Party Signature | Date

NEW PATIENT REGISTRATION FORM

MEDICAL HISTORY

Please List All Medications You Are Currently Taking:							
Medication Name	Strength	Frequency	Date Started	Medication Name	Strength	Frequency	Date Started

Known Allergies? If Yes, write name of allergy and reaction(s): _____

Review of Systems: (check any that you have recently experienced)

Systemic	GI	Cardiovascular	Hematological	ENT
☐ Fatigue	☐ Loss of appetite	☐ Chest pain	☐ Easy bruising	☐ Earache
☐ Fever	☐ Trouble swallowing	☐ Fast heart rate	☐ Easy bleeding	☐Hearing Loss
☐ Chills	☐ Heartburn/abdominal pain	☐ Palpitations	**Skin**	☐ Ringing in ears
☐ Weight Change	☐ Nausea/Vomiting	**Pulmonary**	☐ Itching	☐ Nose bleeds
Musculoskeletal	**GU**	☐ Shortness of breath	☐ Rash	☐ Nasal discharge
☐ Joint Pain	☐ Urinary frequency	☐ Cough	**Endocrine**	☐ Throat Pain
☐ Back Pain	☐ Incontinence	☐ Wheezing	☐ Excess sweating	**Eye**
☐ Muscle aches	☐ Kidney Stones	**Psychological**	☐ Excess Thirst	☐ Flashing Lights
☐ Pain in hands and feet	☐ Hesitancy	☐ Anxiety	☐ Change in libido	☐Light sensitivity
Head	**Neck**	☐ Depression		☐ Eye Pain
☐ Headache	☐ Neck Pain	☐ Insomnia		☐ Double Vision
☐ Facial/Sinus Pain	☐ Neck Stiffness			☐ Blurry Vision

Your Medical History (check each box that applies)

☐ Migraine Headache	☐ Coronary artery disease	☐ Thyroid disease	☐ Polio
☐ Tension Headache	☐ Congestive heart failure	☐ Liver disease	☐ Rheumatic fever
☐ Epilepsy/Seizures	☐ Arrhythmias	☐ Hepatitis	☐ Allergy/Hay fever
☐ Stroke	☐ Heart murmur	☐ Renal/kidney disease	☐ Current smoker _____ per day
☐ Head injury	☐ Hypertension	☐ Digestive/bowel problems	☐ Quit smoking _____ago
☐ Neuromuscular problems	☐ Peripheral vascular disease	☐ Gastric ulcer	☐ Currently drink _____ per day
☐ Spinal cord injury	☐ Anemia	☐ Arthritis	☐ Quit drinking _____ago
☐ Cervical spine disease	☐ Bleeding disorder	☐ Cancer	☐ Depression/Anxiety
☐ Lumbar spine disease	☐ COPD	☐ TB	☐ Genitourinary disease
☐ Peripheral neuropathy	☐ Pneumonia	☐ HIV	☐ Venereal disease
☐ CNS malignancy	☐ Diabetes	☐ Mumps	☐ Menstrual problems
☐ Heart attack/MI	☐ Endocrine problems	☐ Measles	☐ Sexual dysfunction

Preferred Pharmacy			
Name		Phone	
Address		Fax	
		Zip	

Surgical History				
☐ No Prior Surgeries				
No	**Yes**	**Type**	**Date**	**Reason**
☐	☐	Head:		
☐	☐	Neck:		
☐	☐	Back:		
☐	☐	Other:		

Family Medical History		
	Father	**Mother**
Heart disease	Y | N	Y | N
Cancer	Y | N	Y | N
Epilepsy	Y | N	Y | N
Stroke	Y | N	Y | N
Parkinson's Disease	Y | N	Y | N
Migraines	Y | N	Y | N
Mental illness	Y | N	Y | N
Dementia	Y | N	Y | N
Alive (at age)		
Deceased (at age)		