QUALITY NEUROLOGY

Patient Registration Form

Please Print

Patient's Legal Name: (Last)_____(First)_____(MI)_____
Preferred Full Name: _____
Address: _____
City, State, Zip:_____
Home Phone Number: _____Cell:_____Work:_____
E-Mail Address:_____ Date of Birth: _____
☐ Female ☐ Male ☐ Choose not to disclose
Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American
☐ White ☐ Hispanic ☐ Choose not to disclose ☐ Other not listed
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose
Preferred Language: _____
Patient's Social Security Number:_____
Preferred Pharmacy:_____ Location:_____

Responsible Party Information **(Information used for patient balance statements)**

Responsible Party: ☐ Guarantor ☐ Self ☐ Check here if address and telephone is same as patient
Responsible Party Name:_____
Date of Birth: MM_____/DD_____/YYYY _____ Sex: ☐ Female ☐ Male ☐ Other
Responsible Party Social Security Number:_____ Phone Number:_____
Address:_____
City, State:_____Zip:_____

Insurance Information: Provide your insurance card(s) and Driver's License to the front desk at check-in.

Emergency Contact Information

Emergency contact name: (Last)_____(First)_____
Phone Number:_____ Do you have an Advance Directive: ☐ Yes ☐ NO
Health Care Surrogate Information:_____
_____

Emergency contact relationship to patient:_____
Address:_____
City, State:_____ Zip:_____
Home Phone:_____Mobile_____Work_____

Consent for care and Treatment

Signature of patient or personal representative: _____Date:_____
Printed name of patient or personal representative :_____
Relationship to Patient:_____

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Who referred you to us? (Please list physician's name, address, and phone number):

_____

_____

Please list any other physicians that you would like to receive correspondence regarding your care:

Name:
_____

Address:
_____
_____
_____

Phone:
_____

Name:
_____

Address:
_____
_____
_____

Phone:
_____

What problem were you referred for?

_____

May we leave a message on your Voicemail? ☐ Yes ☐ No

Would you like to receive text messages for reminders/updates? ☐ Yes ☐ No

Preferred Language? _____

Preferred method of contact? ☐ Home Phone Number ☐ Mobile Number ☐ Work Number
☐ Text ☐ Email

Please list any additional numbers that we can reach you at (such as spouse): _____

By signing below, you acknowledge the information above is correct and authorized by you.

_____ _____ _____

Please Print Patient Name | Patient Signature | Date

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PATIENT HISTORY FORM

Name: _____ **DOB:** _____ **Date:** _____

Medical History

Have you had any of the following?
If yes, please check the box.

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer: Type _____
- ☐ Kidney Disease
- ☐ Depression
- ☐ Diabetes: Type _____
- ☐ Hiatal hernia
- ☐ High Blood Pressure
- ☐ Liver Disease: Type _____
- ☐ Mental Illness: Type _____
- ☐ Heart Attack: When _____
- ☐ Heart Failure
- ☐ Lung Disease: Type _____
- ☐ Obesity
- ☐ Seizure
- ☐ Stroke: When _____
- ☐ Thyroid Issues: Explain _____
- ☐ Sexual Transmitted Disease/Infection: Type _____
- ☐ Other _____

Social History

Alcohol use? ☐ Yes ☐ No
# of drinks per day _____
# of times per week _____
Tobacco use? (now or ever)
☐ Yes ☐ No
Type _____
Amount per day _____
# of years used _____
Cups of caffeine per day: _____
Any illegal drug use: ☐ Yes ☐ No
Substance Abuse: ☐ Yes ☐ No

Surgeries/Operations:

have you had surgery on any of the following areas?

	Date of surgery
☐ Adenoids	_____
☐ Appendix	_____
☐ Back	_____
☐ Breast	_____
☐ Cataract	_____
☐ C-section	_____
☐ Gallbladder	_____
☐ Colon	_____
☐ Gastric bypass	_____
☐ Hernia repair	_____
☐ Hysterectomy	_____
☐ ☐ Total ☐ Partial	
☐ Joint replacement	_____
☐ Tonsils	_____
☐ Other (please explain)	

_____
_____
_____

Family History:

has any blood relative had any of the following?

Adopted: ☐ Yes ☐ No
☐ Unknown

	Relationship Maternal or Paternal (Circle one)
☐ Alcoholism	_____ M / P
☐ Anemia	_____ M / P
☐ Aneurysm	_____ M / P
☐ Type: _____	
☐ Asthma	_____ M / P
☐ Bleeding Issues	_____ M / P
☐ Cancer	_____ M / P
☐ Dementia	_____ M / P
☐ Depression	_____ M / P
☐ Early Death	_____ M / P
☐ Heart Failure	_____ M / P
☐ Heart Attack	_____ M / P
☐ Heart Disease	_____ M / P
☐ COPD	_____ M / P
☐ Diabetes	_____ M / P
☐ Type: _____	
☐ High Cholesterol	_____ M / P
☐ High B.P.	_____ M / P
☐ Kidney Disorder	_____ M / P
☐ Leukemia	_____ M / P
☐ Liver Disorder	_____ M / P
☐ Lupus	_____ M / P
☐ Mental Illness	_____ M / P
☐ Migraines	_____ M / P
☐ Parkinson's	_____ M / P
☐ Rheumatoid Arthritis	_____ M / P

(Continued on Back)

Family History (Continued)

- ☐ Seizure _____ M / P
- ☐ Stroke _____ M / P
- ☐ Substance Abuse _____ M / P
- ☐ Suicide _____ M / P
- ☐ Thyroid Disorder _____ M / P
- ☐ Other:

_____

_____

Current Medications

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

Allergy:	**Reaction:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Office Use Only:

Have you fallen in the past year?

☐ Yes ☐ No

If yes, how many? _____

Who do you live with? Spouse, children, other _____

What is/was your occupation?

_____

Retired: ☐ Yes ☐ No

Circle Handedness:

Right-handed

Left-handed

Both

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* 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 at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

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PATIENT NAME: _____ Date of Birth: _____

REVIEW OF SYSTEMS: PLEASE CIRCLE ALL THAT APPLY

General

Fever
Night sweats
Weight gain (How much) _____
Weight loss (How much) _____
Exercise intolerance
Sedation
Lack of energy
Chills
Malaise

Eye

Double Vision
Irritation
Vision changes
Eye disease/injury
Wears contacts/glasses

Ear, nose, and throat

Difficulty hearing
Ringing in the ears
Loss of Smell
Sinus problems
Sore throat
Gum disease
Mouth ulcer
Cavities
Sinus infection

Cardiovascular

Shortness of breath when walking
Shortness of breath when lying down
Palpitations
Known heart murmur
Light-headed upon standing
Ankle Swelling

Respiratory

Cough
Wheezing
Shortness of Breath
Sleep apnea

Gastrointestinal

Abnormal Pain
Nausea
Vomiting
Constipation
Change in appetite
Reflux/GERD

Genitourinary

Urinary loss of control
Difficulty urinating
Increased urinary frequency
Hematuria
Incomplete emptying
Erectile Dysfunction

Musculoskeletal System

Muscle aches
Muscle weakness
Joint pain
Back pain
Swelling in extremities
Neck pain
Difficulty walking
Cramps
Osteoporosis
Fractures

Endocrine

Fatigue
Diabetes

Neurologic

Weakness
Numbness
Seizures
Dizziness
Frequent or severe headaches
Migraines
Restless legs
Tremor
Number of falls in the past year _____
Short term memory loss
Misplacing items
Forgetting names
Poor long-term memory

Psychiatric

Depression
Sleep disturbances
Feeling unsafe in a relationship
Restless sleep
Anxiety
Irritability

Skin

Rash
Itching
Dry skin
Non-healing areas
Changes in hair/nails
Bruising

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24 Hour Cancellation Policy

Due to an increase in short term cancellations and missed appointments, we are now charging a fee for all missed appointments. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Quality Neurology reserves the right to charge a **$50.00 fee** for all missed appointments ("no shows") and appointments that are cancelled without a compelling reason, within a 24 hour advanced notice. All EEG and EMG appointments will be charged a **$100.00 fee** if not cancelled within a 24 hour advanced notice.

Missed appointments ("No Shows") and Cancelled appointments with less than a 24 hour notice, will be billed to the patient. This fee is not covered by insurance and must be paid prior to your next scheduled appointment. Multiple missed and/or cancelled appointments in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation, as we strive to best serve the needs of all patients.

We accept cash and all major credit cards as payment

By signing this policy, you acknowledge that you have received and understand this policy.

_____	_____	_____
Print Patient Name	Patient Signature	Date

QUALITY NEUROLOGY

Medical Disclosure Form

(Please Print)

Patient Name: _____

Date of Birth: _____

Phone Number : _____

I hereby authorize the disclosure of my Quality Neurology medical information to the following individuals:

Name/Relationship _____ Date of Birth _____

Name/Relationship _____ Date of Birth _____

Name/Relationship _____ Date of Birth _____

Name/Relationship _____ Date of Birth _____

By signing below, you acknowledge the information above is correct and authorized by you.

_____ _____ _____

Print Patient Name | Patient Signature | Date

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6800 NW 9th Blvd Ste 2 Gainesville, Fl. 32605

2970 W US Hwy 90 Ste 110 Lake City, Fl. 32055

Phone: 352-478-4700 Fax: 352-225-3399

Authorization to Release Medical Information

I hereby Request and Authorize:

Lucas Beerepoot, MD, Lindsay Falk, APRN, Dominique Greene, APRN of Quality Neurology

To Obtain From: _____

_____

The Following Information: ☐ All PHI In Medical Records

☐ Other: _____

_____

_____

From the Medical Records of:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

For the Purpose of: Continuation of Care

All INFORMATION HEREBY AUTHORIZED, MAY BE OBTAINED FROM THIS AGENCY AND WILL BE HELD STRICTLY CONFIDENTIAL AND CANNOT BE RELEASED BY RECIPIENT WITHOUT MY WRITTEN CONSENT. I UNDERSTAND THAT THIS AUTHORIZATION MAY INCLUDE SENSITIVE INFORMATION, SUCH AS COMMUNICABLE DISEASES/INFECTIONS, ALCOHOL OR DRUG USAGE/ABUSE, AND PSYCHOLOGICAL ISSUES.

_____ _____ _____

Print Patient Name | Patient Signature | Date

QUALITY NEUROLOGY

HIPAA NOTICE OF PRIVACY PRACTICES

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

The terms of this Notice of Privacy Practices ("Notice") apply to Quality Neurology LLC, its affiliates and its employees. Quality Neurology LLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Quality Neurology LLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA").

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc. Quality Neurology participates in a two-way record sharing portal with other providers that will enable records to be sent and viewed if you are a current patient with them, unless otherwise stated by patient not to portal share records.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment. Quality Neurology may also share information with collection agencies, if we are unable to receive payment owed to us.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
- Court or administrative ordered subpoena or discovery request;

• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law;
• To coroners and/or funeral directors consistent with law;
• If necessary to arrange an organ or tissue donation from you or a transplant for you;
• If you are a member of the military, we may also release your protected health information for national security or intelligence activities.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable format, if readily producible. Records will not be emailed to personal email addresses but will be available for pick up in the office or mailed to recipient. Requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Quality Neurology LLC Privacy Officer by phone at (352) 478-4700 or at the following address: 6800 NW 9th Blvd Suite 2 Gainesville, Fl. 32605. This Notice of Privacy Practices is also available on our Quality Neurology LLC web page at www.qualityneurology.com

_____	_____	_____
Please Print Patient Name	Patient Signature	Date

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Acknowledgement and Authorization

- I have read and understand the HIPAA/Privacy Policy for Quality Neurology LLC.
- I hereby assign my insurance benefits to be paid directly to the Healthcare Provider.
- I authorize Quality Neurology LLC to release medical information required to process my claim.
- I have read and understand the Financial Policy for Quality Neurology LLC.
- I authorize Quality Neurology LLC to obtain access to my medication history.

By signing below, you acknowledge that you have read, understand, and received copies (upon request) of our policies listed above.

_____	_____	_____
Print Patient Name	Patient Signature	Date