

NEUROCARE INSTITUTE OF CENTRAL FLORIDA

PATIENT NAME _____
(LAST) (FIRST) (MI)

PREFERRED NAME _____

ADDRESS _____

MAILING _____

ADDRESS _____

PRIMARY TELEPHONE _____ SECONDARY _____

BIRTHDATE _____ AGE _____ MARITAL STAT. _____ SEX _____

SOCIAL SECURITY #: _____ RACE _____

PATIENT'S EMPLOYER /SCHOOL _____

EMPLOYER/SCHOOL _____
ADDRESS _____

WORK PHONE NUMBER _____ OCCUPATION _____

PRIMARY PHYSICIAN _____

PHYSICIAN ADDRESS _____

TELEPHONE _____

REFERRING PHYSICIAN _____

PHYSICIAN ADDRESS _____

TELEPHONE _____ SPECIALTY _____

INSURANCE INFORMATION

MEDICARE POLICY NUMBER _____

PRIMARY INSURANCE INFORMATION

NAME OF INS. CO. _____

ADDRESS OF INS CO. _____

NAME OF INSURED _____ RELATION TO PT. _____

POLICY NUMBER _____

GROUP NAME OR NUMBER _____

INS. CO. TELEPHONE # _____ INSURED'S BIRTHDATE _____

SECONDARY INSURANCE INFORMATION

NAME OF INS. CO. _____

ADDRESS OF INS. CO. _____

NAME OF INSURED _____ RELATIONSHIP TO PT _____

POLICY # _____

GROUP NAME OR NUMBER _____

INS. CO. TELEPHONE # _____ INSURED'S BIRTHDATE _____

HOW DO YOU INTEND TO PAY FOR THIS VISIT? _____

IS THIS A WORKER'S COMPENSATION OR AUTO ACCIDENT? _____

IF SO, IN WHAT STATE DID IT HAPPEN? _____

WAS THIS AN ACCIDENT OTHER THAN AUTO OR WORKER'S COMP? _____

IF SO, PLEASE EXPLAIN _____

DATE OF ACCIDENT _____ DO YOU HAVE AN ATTORNEY? _____

IF SO, ATTORNEY'S NAME _____

ATTORNEY ADDRESS _____

ATTORNEY TELEPHONE _____

PHARMACY INFORMATION

PHARMACY NAME _____ PHONE NUMBER _____

ADDRESS _____

EMERGENCY CONTACT

NAME _____
(LAST) (FIRST) (MI)

ADDRESS _____

PRIMARY TELEPHONE _____ RELATION TO PATIENT _____

Other than you, your insurance company and healthcare providers involved in your care, whom can we talk with about your health care information?

NAME	TELEPHONE #	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

Signature Date

Printed Name Relationship

DO YOU HAVE?

ADVANCED DIRECTIVE _____ HEALTHCARE SURROGATE _____

LIVING WILL _____ DO YOU WANT INFORMATION? _____

OFFICE FINANCIAL POLICY

The last several years have been a time of profound change regarding health care reform. It has become necessary to implement the following policies.

PLEASE READ THOROUGHLY AND SIGN THIS SHEET ON THE BACK

1. We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in, before you are seen by the doctor. A \$15.00 fee will be assessed for any co-payment not made at the time of service. It is the patient's responsibility to know the terms of their insurance plan.
2. You must bring your insurance card and photo I.D. with you and any authorization information you may have. Without these, we will be unable to see you.
3. We will file your insurance if we are providers for your plan. It is your responsibility to make sure we receive prompt payment from them. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should.
4. If your insurance denies payment on your account you will be asked to pay by check, cash or charge. If you do not pay in a timely fashion, you will be responsible for any and all charges not paid by your insurance company in accordance with the laws. Should your account become delinquent and over 90 days old, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.
5. In accordance with AMA CPT guidelines, we reserve the right to charge for telephone calls with our medical professionals that include evaluation and management of your medical condition. We will bill your insurance for such calls, but if it is not covered by your plan you may be responsible for the charges.
6. **HMO or PPO PATIENTS REQUIRING A REFERRAL:** You are responsible for making sure your visits with our office are authorized by your primary care physician (PCP). This authorization must be obtained before your scheduled visit. It is the patient's responsibility to make sure we have received authorization. If you do not have the proper authorization, your appointment will be rescheduled and you may be subjected to a \$50.00 charge for a missed office visit or a \$100.00 charge for a missed procedure.
7. **SELF-PAY PATIENTS:** This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate or patients who do not wish to use their insurance. Payment for medical services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash and money orders. We will provide you with a receipt.

8. Should you need to cancel or change your office visit appointment, you will be subject to a \$50.00 charge if you do not do so with 24 hours business day advanced notice. Should you need to cancel or change an appointment for a procedure, you will be subject to a \$100 charge if the change is not made with 2 business days advanced notice. By signing below, I agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

AS A FINAL NOTE:

Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

If you have any questions regarding this financial policy, please ask or call BEFORE you are seen by the doctor.

SIGNATURE

DATE

INSURANCE AUTHORIZATION & ASSIGNMENT OF BENEFITS

I, _____ AUTHORIZE MY INSURANCE COMPANY, ATTORNEY OR ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO NeuroCare Institute of Central Florida ALL CHARGES SUBMITTED FOR SERVICES RENDERED TO ME BY THE STAFF MEMBERS OF THIS CORPORATION.

I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY AND ALL CHARGES NOT PAID BY MY INSURANCE COMPANY. SHOULD MY ACCOUNT BECOME DELINQUENT AND OVER 120 DAYS OLD, THERE WILL BE A 25% COLLECTION CHARGE ADDED TO MY DELIQUENT BALANCE.

I AUTHORIZE NeuroCare Institute of Central Florida TO RELEASE ALL INFORMATION NECESSARY CONCERNING MY MEDICAL CONDITION TO MY INSURANCE CARRIER OR ATTORNEY FOR THE PURPOSE OF PROCESSING A CLAIM.

THIS AUTHORIZATION AND ASSIGNMENT OF BENEFITS WILL REMAIN VALID UNTIL I NOTIFY NeuroCare Institute of Central Florida IN WRITING OF ITS CANCELLATION. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE

DATE

NeuroCare Institute Of Central Florida

MEDICAL HISTORY

Date _____

Name _____ Age _____ Birthdate _____

Street _____ Phone: _____

City _____ Religion: Single Divorced
 Married Widow (er)

Occupation _____ All Previous Occupations _____ Occupation of Spouse _____

Birthplace _____ List all States or Countries in which you have lived _____

Education: Please circle the last grade you completed Grade 5 _____ High School 1 2 3 4 _____ Post Grade _____ yrs.
 6 7 8 _____ College 1 2 3 4 _____ Degrees _____

Please list reasons for referral to Neurologist

FAMILY HISTORY	Age	If Living Health	Age at Death	If Deceased Cause	Has any blood relative ever had:	Please Circle Answer no or yes Who
Father					Cancer	no or yes
Mother					Tuberculosis	no or yes
Brother or Sister	1.				Diabetes	no or yes
	2.				Heart Trouble	no or yes
	3.				High blood pressure	no or yes
	4.				Stroke	no or yes
	5.				Epilepsy	no or yes
Husband or Wife					Mental Illness	no or yes
Son or Daughter	1.				Suicide	no or yes
	2.				Congenital Deformities	no or yes
	3.					
	4.					
	5.					

PERSONAL HISTORY (Please circle all answers)

ILLNESSES: Have you ever had

Measles or German Measles..... no	yes	Tuberculosis.....no	yes	Any foods..... no	yes
Chickenpox or Mumps..... no	yes	Diabetes or Cancer..... no	yes	Adhesive tape..... no	yes
Whooping Cough..... no	yes	High or low blood pressure..... no	yes	Nail polish or other cosmetics.... no	yes
Scarlet fever or Scarletina..... no	yes	Depression or Anxiety..... no	yes	Tetanus antitoxins or serums..... no	yes
Pneumonia or Influenza..... no	yes	Food, chemical or drug poisoning no	yes	INJURIES: have you had any	
HIV or Hepatitis..... no	yes	Hay fever or asthma..... no	yes	Broken bones..... no	yes
Rheumatic fever or heart disease. no	yes	Hives or Eczema..... no	yes	Sprains or dislocations..... no	yes
Arthritis or Rheumatism..... no	yes	Frequent colds or sore throats..... no	yes	Lacerations (Extensive).....no	yes
Any bone or joint disease..... no	yes	Frequent infections..... no	yes	Concussion or head injury..... no	yes
Neuritis or neuralgia..... no	yes	Thyroid Disease..... no	yes	Ever been knocked out.....no	yes
Scatica or back pain..... no	yes	Any other disease..... no	yes	TRANSFUSIONS: have you ever had	
Polio or Meningitis..... no	yes	ALLERGIES: are you allergic to		Blood or Plasma transfusion	
Bladder or kidney infection..... no	yes	Penicillin or Sulfa..... no	yes	WEIGHT: Now _____, one yr. ago _____	
Gonorrhea or Syphills..... no	yes	Aspirin, Codeine or Morphine..... no	yes	Maximum _____ (year _____)	
Anemia or Jaundice..... no	yes	Mycins or other antibiotics..... no	yes		
Epilepsy or Seizures..... no	yes	Merthiolate or Mercurochrome..... no	yes		
Multiple Sclerosis..... no	yes	Any other drugs..... no	yes		
Migraine headaches..... no	yes				

Please review section you have just completed. Wherever you answered 'yes' fill in year (guess if necessary); also where there is more than one illness to a line circle the ones you have had. Example: Chickenpox or Mumps.....no yes

HOSPITALIZATIONS

SURGICAL PROCEDURES

	Date
1. Tonsillectomy.....no yes	_____
2. Appendectomy.....no yes	_____
3. _____	_____
4. _____	_____
5. _____	_____

MEDICAL ILLNESSES

	Disease	Date
1. _____		_____
2. _____		_____
3. _____		_____
4. _____		_____
5. _____		_____

ITEMS: Please check those you have done

Eye disease eye injury impaired sight ear disease ear injury impaired hearing
 Trouble with: nose sinuses mouth throat Have you checked any in this group?.....no yes

Fainting spells loss of consciousness convulsions paralysis dizziness frequent or severe headaches
 depression or anxiety hallucinations Have you checked any in this group?.....no yes

Enlarged glands goiter or enlarged thyroid skin disease Have you checked any in this group?.....no yes

Chronic or frequent cough chest pain or angina pectoris spitting up of blood night sweats
 shortness of breath palpitation or fluttering heart varicose veins swelling of hands, feet or ankles
 extreme tiredness or weakness Have you checked any in this group?.....no yes

Kidney disease or stones bladder disease albumin, sugar, pus, etc., in urine
 difficulty in urinating Have you checked any in this group?.....no yes

Stomach trouble or ulcers indigestion liver or gallbladder disease appendicitis
 colitis or other bowel disease hemorrhoids or rectal bleeding constipation or diarrhea
 recent change in bowel action or stools recent change in appetite or eating habits
 Have you checked any in this group?.....no yes

HABITS: Do you Sleep well?.....no yes Use alcoholic bev.....no yes Every day?.....no yes Smoke?.....no yes How much? _____ Exercise enough?.....no yes	List any drugs or medications you take regularly or often: _____ _____ _____ _____ _____	WOMEN ONLY: Menstrual history: Age at onset _____ Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Cycle: _____ days (from start to start)	Pains or cramps <input type="checkbox"/> yes <input type="checkbox"/> no Date of last period _____ Pregnancies: how many _____ Children born alive? _____ Stillbirths? _____ Prematures? _____ Caesarean sections? _____ Miscarriages? _____ Complications? <input type="checkbox"/> yes <input type="checkbox"/> no
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Current Medication List

Patient Name: _____ DOB: _____

List Allergies: _____

Height: _____ Weight: _____

Are you currently taking any nicotine product? Yes No

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: prescription and over the counter medications, herbals, vitamin/mineral/dietary supplement

Name of Current Medication/Dose (example: Aspirin tablet 325 mg)	Frequency/Route of Administration (example: 3 times daily orally)	Start Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		