NEUROCARE INSTITUTE OF CENTRAL FLORIDA

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

PREFERRED NAME _____

ADDRESS _____

_____

MAILING _____

ADDRESS _____

_____

PRIMARY TELEPHONE_____ SECONDARY_____

BIRTHDATE _____ MARITAL STAT. _____RACE_____ SEX _____

SOCIAL SECURITY #:_____EMAIL_____

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 DELIQUENT 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 ❑ Married ❑ Divorced ❑ 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 6 7 8 High School 1 2 3 4 College 1 2 3 4 Post Grade._____yrs. Degrees

Please list reasons for referral to Neurologist

FAMILY HISTORY	Age	If Living Health	Age at Death	If Deceased Cause
Father				
Mother				
Brother or Sister 1.				
2.				
3.				
4.				
5.				
Husband or Wife				
Son or Daughter 1.				
2.				
3.				
4.				
5.				

Has any blood relative ever had:	Please Circle Answer no or yes	Who
Cancer	no or yes	
Tuberculosis	no or yes	
Diabetes	no or yes	
Heart Trouble	no or yes	
High blood pressure	no or yes	
Stroke	no or yes	
Epilepsy	no or yes	
Mental Illness	no or yes	
Suicide	no or yes	
Congenital Deformities	no or yes	

PERSONAL HISTORY (Please circle all answers)

ILLNESSES: Have you ever had

Measles or German Measles..... no yes
Chickenpox or Mumps..... no yes
Whooping Cough..... no yes
Scarlet fever or Scarletina..... no yes
Pneumonia or Influenza..... no yes
HIV or Hepatitis..... no yes
Rheumatic fever or heart disease. no yes
Arthritis or Rheumatism..... no yes
Any bone or joint disease..... no yes
Neuritis or neuralgia..... no yes
Sciatica or back pain..... no yes
Polio or Meningitis..... no yes
Bladder or kidney infection..... no yes
Gonorrhea or Syphilis..... no yes
Anemia or Jaundice..... no yes
Epilepsy or Seizures..... no yes
Multiple Sclerosis..... no yes
Migraine headaches.....no yes

Tuberculosis.....no yes
Diabetes or Cancer..... no yes
High or low blood pressure..... no yes
Depression or Anxiety..... no yes
Food, chemical or drug poisoning no yes
Hay fever or asthma..... no yes
Hives or Eczema..... no yes
Frequent colds or sore throats..... no yes
Frequent infections..... no yes
Thyroid Disease..... no yes
Any other disease..... no yes

ALLERGIES: are you allergic to

Penicillin or Sulfa..... no yes
Aspirin, Codeine or Morphine..... no yes
Mycins or other antibiotics..... no yes
Merthiolate or Mercurochrome.....no yes
Any other drugs.....no yes

Any foods..... no yes
Adhesive tape..... no yes
Nail polish or other cosmetics.... no yes
Tetanus antitoxins or serums..... no yes

INJURIES: have you had any

Broken bones..... no yes
Sprains or dislocations..... no yes
Lacerations (Extensive).....no yes
Concussion or head injury.....no yes
Ever been knocked out.....no yes

TRANSFUSIONS: have you ever had

Blood or Plasma transfusion

WEIGHT: Now_____, one yr. ago_____

Maximum_____(year_____)

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

PLEASE TURN PAGE

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 ❑
difficutly 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	List any drugs or medications you take regularly or often:	WOMEN ONLY: Menstrual history:	Pains or cramps ❑ yes ❑ no
Sleep well?.....no yes	_____	Age at onset	Date of last period_____
Use alcoholic bev.....no yes	_____	Regular ❑ Irregular ❑	Pregnancies: how many_____
Every day?.....no yes	_____	Cycle: _____ days	Children born alive?_____
Smoke?.....no yes	_____	(from start to start)	Stillbirths?_____
How much?_____	_____		Prematures?_____
Exercise enough?.....no yes	_____		Caesarean sections?_____
			Miscarriages?_____
			Complications? ❑ yes ❑ no

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.		