Patient Personal History

Name: _____ Age: _____ Date of Birth _____

Sex: _____ Marital Status: _____ Social Security Number: _____

Address: _____
(Street & Number) (City) (State) (Zip)

Home Phone: _____ Cell Phone: _____

Office Phone: _____ Email: _____

Chief Complaint: _____

Date Symptoms Started _____ Previous Similar Symptoms? Yes ( ) When: _____ No ( )

Referred by: _____

Primary Care Physician: _____

IF TREATED BY ANOTHER PHYSICIAN FOR THIS PROBLEM (Other than referring physician)

Date: _____ Name: _____ Address: _____

Person Responsible for Bill

Name: _____ Relationship to Patient: _____

Address: _____
(Street & Number) (City) (State) (Zip)

ARE YOU EMPLOYED? Full Time( ) Part Time( ) Not Employed( ) Retired( ) Student FT( ) Student PT( )

Employer's Name: _____

Employer's Address: _____ Phone: _____

Primary Insurance

Insured's Name: _____ Relationship to patient: _____

SSN of Insured: _____ Date of birth of Insured: _____

Primary Insurance Company: _____

Policy #: _____ Group #: _____

Insurance Company Address: _____

Phone: _____ Insured's Employer: _____

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO **NEUROLOGICAL SERVICES OF ORLANDO, P.A.**

Signature of insured or authorized person: _____

Date: _____

Neurological Services of Orlando

Name: _____ Date: _____ Age: _____ Handedness: _____

Please describe the problem you are being seen for today: _____

When did your problem begin and what treatment have you had? _____

Have you had any tests for this problem? Yes / No What type of test? _____

Where/When? _____

Primary Care Physician: _____

Are you having difficulty with any of the following? **(Please circle if applicable)**

General: weight loss, weight gain, fever, fatigue

Eyes: eye pain, vision loss, double vision

ENT: ringing in the ears, hearing loss, nasal congestion

CV: chest pain, palpitations, loss of consciousness

Respiratory: cough, shortness of breath

GI: nausea, vomiting, diarrhea, constipation, abdominal pain

GU: bloody urine, bladder problems

M/S: joint pain, joint swelling, muscle cramps

Skin: rash, skin ulcers, wounds

Neuro: numbness, tingling, weakness, tremors

Psych: anxiety, depression, bipolar disorder, schizophrenia

Endo: cold intolerance, thyroid masses, frequent urination

Heme/Lymphatic: anemia, bleeding, bruising, swelling

Allergic/Immunologic: urticaria, immunodeficiency

Please list additional medical problems: _____

Please list previous surgeries: _____

SOCIAL HISTORY

Do you smoke or use tobacco? Yes / No How much? _____ Quit/Year? _____

Do you drink alcohol? Yes / No How much/often? _____

Marital status: Married / Single / Divorced / Widowed Children? _____

What type of work do you do? _____

FAMILY HISTORY

Diabetes: Yes / No Relative: _____ Cancer: Yes / No Relative: _____

High Blood Pressure: Yes / No Relative: _____ Heart Disease: Yes / No Relative: _____

Sleep Apnea: Yes / No Relative: _____ Migraines: Yes / No Relative: _____

Parkinson's: Yes / No Relative: _____ Dementia: Yes / No Relative: _____

Other: _____ Relative: _____

BP: _____ P: _____ HT: _____ WT: _____ BMI: _____

Neurological Services of Orlando, PA

Mark J. Klafter DO, Daniel H. Jacobs MD, Navin Verma MD

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

Allergies: None( ) _____

_____

Medication	Dose	Directions

Name of Pharmacy: _____

Pharmacy Phone Number or Intersection: _____

Authorization for Use or Disclosure – Neurological Services of Orlando, P.A. Request

ATTENTION! HEALTHCARE PROVIDER:

Please provide the medical records requested by Neurological Services of Orlando, P.A. as Authorized by the patient listed below.

Patient Name: _____

SS#: _____ DOB: ____/____/____

Street or PO Box: _____

City, State, Zip: _____

Phone Number (Day): _____ Phone Number (Evening): _____

I, _____, hereby authorize _____ to use and/or disclose my PHI as follows:

Disclose to: ☐ Via Fax ☐ Via Mail Neurological Services of Orlando, P.A.
3849 Oakwater Circle
Orlando, FL 32806
Phone: 407-240-1762 Fax: 407-812-5869

Disclosure Purpose: **For treatment, at the request of the patient.**

Disclosure Description: ☐ Billing ☐ Lab Reports ☐ X-Rays ☐ History
☐ Shot Records Only ☐ Radiology Reports ☐ Pathology Reports ☐ Entire Record
☐ Other **(Describe):** _____

_____ For records dated from: _____ to: _____

I understand that:

- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The statements included in this Authorization are binding on the Provider.
- The use or disclosure requested under this Authorization ____will ____ will not result in direct or indirect remuneration to the Provider from a third party.

I understand that I have the right to:

- Revoke this Authorization, in writing, at any time by sending such written notification to the Provider. I also understand that such a revocation will not have any affect on any information already used or disclosed by the Provider before the Provider received my written notice of revocation.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- My revocation of this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

This Authorization will expire in one hundred eighty (180) days: _____ (Date)

_____ _____
Name of Patient or Personal Representative* Signature of Patient or Personal Representative

_____ _____
Relationship of Patient or Personal Representative Date

**Personal Representative may be requested to provide verification of representative status.*

Notice of Privacy Practices Acknowledgement and Consent

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

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The *Notice of Privacy Practices* tells you how we may use and disclosed your protected health information (PHI). Please read it.

- We will use and disclose your PHI to treat you and bill for the service we provide.
- We will use and disclose your PHI to operate our practice.
- We will use and disclose your PHI as required by law.

All of the ways we may use and disclose your PHI are explained in greater detail in the Notice.

You have the following rights with respect to your PHI:

- To inspect and receive a copy of your PHI.
- To receive an accounting of disclosure to whom we have given a copy of your PHI.
- To request us to correct a mistake in your PHI.
- To request that we not use or disclose your PHI.
- To request us to change the way we contact you.

All of these rights are explained in greater detail in the Notice.

I acknowledge and agree that I have receive a copy of Neurological Services of Orlando, P.A.'s *Notice of Privacy Practices.*

_____ _____

Signature of Patient or Personal Representative* Date

CONSENT:

I acknowledge and agree that the practice may disclose my PHI and medical record information to the following individuals (Name & Relationship to Patient):

_____

_____

_____

Please note: Revocations to consent must be submitted to the practice in writing.

I consent to the use and disclosure of my PHI for treatment, payment and healthcare operations as described in the *Notice of Privacy Practices.* I know that if I do not consent, you cannot provide services to me.

_____ _____

Signature of Patient or Personal Representative* Date

**Personal Representative may be requested to provide verification of representative status.*

Neurological Services of Orlando, PA

Mark J. Klafter DO, Daniel H. Jacobs MD, Navin Verma MD

Notice of Practices Policies

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

_____ **MEDICAL RECORD COPIES**

Initial

A patient may request Medical Records be released by completing a HIPAA compliant release form.

Medical Records released to the patient, directly to another provider or facility for continuation of care or to a new physician will be sent without charge.

Medical Records released to an attorney or insurance company will be assessed a charge of $1.00 per page for this service. The requested records will be forwarded upon receipt of payment.

Please allow 7-10 business days for processing of all requests.

_____ **NOTICE OF MISSED OR CANCELLED APPOINTMENTS**

Initial

There is a $50.00 fee for all missed or cancelled office appointments with less than 24 hours notice. It is the patient's responsibility to notify the office if they need to cancel or reschedule their appointment within this time frame.

Emergencies will be taken into consideration.

_____ **FMLA/ DISABILITY FORMS**

Initial

Effective January 1, 2017, there will be $35.00 fee for the completion of Forms for FMLA.

The $35.00 FMLA form fee is due when the forms are given to the Practice for completion and must be paid prior to faxing an employer or picked up by the patient or a family member.

The fee for Disability forms ranges from $35 to $350 depending on specific requests. These forms will be billed if possible to the insurance company or attorneys office. If this is not covered the patient will be responsible for payment.

I, _____, acknowledge receipt and acceptance of these policies.

Patient Name

_____ _____

Signature of Patient or Personal Representative* Date

Neurological Services of Orlando, P.A.

- **Financial Policy** We require payment in full for any amounts designated to be the patient's responsibility at the time services are rendered. This may include co-pays, co-insurance, past due balances and/or deductible amounts. Once your claim is processed by your insurance carrier, any additional amounts owed will be billed to you.

- **Non-Contracted Insurance Carrier(s)** We strive to contract with as many insurance carriers as possible, but if we are not contracted with your insurance carrier, you will be required to pay in full at the time of service if you do not have out of network benefits.

- **Insurance Coverage** We have contracts with several insurance companies that may cover part or all of your services. Please inform the receptionist of any type of insurance coverage you may have, so your claims can be handled properly. You are responsible for knowing the specific rules of your insurance company with regard to network physician's participation, pre-certification, referrals, second opinions and follow-ups, and coverage and benefit exclusions. Often your primary care physician can assist you with this. While we are happy to help you receive the maximum benefits allowed by your insurance carrier, bear in mind that it is your responsibility to pay any copayment, deductible, coinsurance, or non-covered amounts not paid by your insurance company. Your carrier will make final benefit determination once a claim is received in their office. Failure to present your current insurance information prior to services being rendered may result in denial of your claim and subsequent billing for unpaid services. Even though we assist you in receiving reimbursement from your insurance company, please understand that you, the patient, ultimately have the final responsibility for your bill.

- **Non-Insurance Payment** Your insurance carrier must remit payment or deny your insurance claim within 90 days of initial notice of claim. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier, as we feel it is necessary to work together to resolve any insurance problem. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge.

- **Managed Care Referral Process** If you are covered by a managed care plan, it may be necessary for our staff to obtain a referral prior to scheduling your appointment. If your insurance company requires a referral, it is your responsibility to work with your primary care physician to obtain this referral prior to scheduling your appointment. Careful attention to the specifics of your insurance plan can help you avoid incurring out of pocket expenses for medical treatment. If you are seen without a valid referral, all charges will be the responsibility of the patient or legal guardian

- We accept cash, check, MasterCard, Visa, Discover and American Express. Our fee for a returned check is $45.00. **We are unable to honor post dated checks.**

- We utilize a third-party billing company, Central Tec Services, if you have any questions about a statement received or would like to pay a balance over the phone, please contact them at 407-261-8930.

_____ _____

Signature of Patient or Personal Representative* Date

_____ _____

Print Name Date of Birth

Neurological Services of Orlando, PA

Mark J. Klafter DO, Daniel H. Jacobs MD, Navin Verma MD

Please circle all the medical history that is present.

Present / Absent: Alcoholism

Present / Absent: Alzheimer's disease

Present / Absent: Anxiety

Present / Absent: Asthma

Present / Absent: Bell's Palsy

Present / Absent: Cerebral Palsy

Present / Absent: Chest Pain

Present / Absent: COPD

Present / Absent: Dementia

Present / Absent: Diabetes

Present / Absent: Glaucoma

Present / Absent: Guillain-Barre Syndrome

Present / Absent: Hearing Loss

Present / Absent: Heartburn

Present / Absent: High Cholesterol

Present / Absent: Hypertension

Present / Absent: Insomnia

Present / Absent: Migraine

Present / Absent: Myasthenia Gravis

Present / Absent: Parkinson 's disease

Present / Absent: Skin Disorder

Present / Absent: Smoking

Present / Absent: Visual Impairment

Present / Absent: Allergic Rhinitis

Present / Absent: Anemia

Present / Absent: Arthritis

Present / Absent: Atrial Fibrillation

Present / Absent: Bipolar Disorder

Present / Absent: Cervical Spine Cord Injury

Present / Absent: Congestive Heart Failure

Present / Absent: Coronary Atherosclerosis

Present / Absent: Depression

Present / Absent: Epilepsy Status Epilepticus

Present / Absent: Gout

Present / Absent: Headache

Present / Absent: Heart Attack

Present / Absent: Herniated Disk

Present / Absent: High Lipids

Present / Absent: Hypothyroid

Present / Absent: Kidney Disease (chronic)

Present / Absent: Multiple Sclerosis

Present / Absent: Osteoporosis

Present / Absent: Seizures

Present / Absent: Sleep Apnea

Present / Absent: Stroke

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Please List Previous Surgeries

	Type of Surgeries:	Month:	Year:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			