THE NEUROLOGY GROUP Your Name: _____ Email Address: _____

Date of Birth: _____ Age: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Home #:_____ Cell#:_____ Work#:_____

Sex: F or M Marital Status: S M Wid Sep Div Spouse's Name: _____

Emergency Contact: _____ Telephone #_____

PHARMACY: Name: _____
Address/ZIP: _____
Phone Number: _____

Primary Doctor's Name: _____Referring Physician's Name: _____

Insurance Name: _____

ID#:_____ Group#: _____

Office Policies you should know:

A. **Please alert our office of any insurance or address changes**
B. We are not Medicaid providers; if your secondary insurance is Medicaid you will be responsible for your annual Medicare deductible.
C. Tests done outside our office (Blood, X-ray, CT-Scan, MRI, etc) may take up to 2 weeks or longer for results. If you have not received a call back in two weeks please call our office.
D. Co-payments, co-insurances and deductibles are due at the time of service; otherwise your appointment will be rescheduled.
E. Please be aware that we are not your insurance company; therefore, we have limited Insurance benefit information. If you have any questions about your insurance benefits please contact the 1-800 numbers listed on your ID card. Thank you.
F. **If you are an HMO patient you will need an authorization or referral from your primary care physician or referring physician for every visit. It is your responsibility to make sure the referral is faxed, mailed, and/or brought to our office by the date of your appointment.** Without the referral you will be responsible for all services. New patient visits are $440 follow-up visits are $200.
G. **If you are here due to a car accident we will need the claim number from your car insurance, claim address, and the phone number to the claim representative.** Your health insurance does not cover these charges until your car insurance has processed the charges.
H. We welcome your suggestions or complaints about our office. You may submit any suggestions or complaints by mail at 9090 SW 87 CT. suite 200 Miami, FL 33176 Att: Practice Manager or by e-mail at lcarballo@fcneurology.net
I. For any medication refill please have the pharmacy fax us the request to 305-596-0657 at least 72 hours in advance.
J. If you would like a copy of these policies, please ask the clerks.

Patient Signature: _____ Date: _____

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Financial Agreement/ Assignment of Benefits:

I hereby authorize payment to be made directly to Neuroscience Consultants LLP and The Neurology Group its subsidiary of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered by the insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments, co-insurances and non-covered services. After receipt of a statement, if payment is not received by the next billing cycle, it may be subject to a monthly finance charge. If an account is referred to an outside agency for collection, the patient agrees to pay all costs related to such action. An account will be referred to a collection service if no payment or payment plans has been received within 90 days of service.

Patient or Guardian: _____ Date:_____

HMO and Workman compensation patient notice:

You are responsible for obtaining a referral /authorization for your visits and or testing in our offices from your primary care physician or claims adjuster.

Patient or Guardian: _____ Date:_____

Carequality/Commonwealth Patient Opt-Out Info (optional)

Carequality/Commonwealth is a nationwide health information exchange (HIE). The HIE allows doctors, nurses, pharmacists, other health care providers to securely share a patient's vital medical information electronically. The purpose is to improve patient care by making sure doctors, hospitals and other health care providers have a complete and recent picture of your health when and where it is needed for your treatment or care. You have the right to ask that your medical information not be disclosed or shared by the Carequality/Commonwealth Framework. Your choice to opt-out of the health information exchange will not affect your ability to access medical care. If you wish to opt-out, please sign below.

<u>If you do not choose to opt-out you will be defaulted to opt-in</u>

☐ I choose to Opt-Out

Medical Records Release

I, _____ give full authorization to discuss my medical treatment, medications, diagnosis, and/or financial information with the following Physicians and or family members only. I understand that my medical care will not be discussed with anyone that is not on this list.

_____ _____ Relation _____ _____ Relation

_____ _____ Relation _____ Patient Signature _____ Date

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1. **What is your neurological complaint today? _____**

2. **CURRENT MEDICATIONS (include dose and frequency): For follow up patients, please update list.**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

4. List any other neurologist seen in the past _____

5. **YOUR PAST MEDICAL HISTORY** (Circle if appropriate. **ADD OTHERS** not listed.)

Cancer or blood disease: (List type)

Heart and Blood Vessels: Atrial fibrillation, Congestive heart failure, Coronary artery disease, Heart attack, Hypertension, Peripheral Vascular Disease, High cholesterol

Lungs: Asthma, Emphysema, Bronchitis

Kidneys: Kidney stones, Prostate enlargement, Renal failure

Psychiatric/emotional: Depression, Anxiety, Alcohol or drug addiction/treatment

Gastrointestinal: Ulcer, Liver disease, Reflux disease

Endocrine/Hormonal: Diabetes (Type 1 or 2), Thyroid disease (hypo or hyper)

Neurologic: Dementia, Parkinson's, Epilepsy, Migraine, Head trauma, Stroke, Neuropathy

List date and reason for hospitalization or surgery: _____
_____

ARE YOU CURRENTLY PREGNANT or planning to become so shortly (circle one)? YES/NO

6. **ALLERGIES:**

a. Name of medication | Type of Reaction

_____	_____
_____	_____

b. **Non-medication allergies:** (circle if present) Iodine, Latex, Seafood, Other (specify)

Name:_____ Date:_____ ECW #: _____

7. **FAMILY MEDICAL HISTORY:** (Please indicate any neurologic/cardiologic or other pertinent diseases in your family.)

Father _____

Mother _____

Siblings/Others _____

8. **SOCIAL HISTORY:** Single Married Widow Divorced Separated

Number of Children: _____Your Occupation: _____ Retired: YES/NO

Tobacco use (please circle): YES OR NO If Yes, how many cigarettes a day: _____

Alcohol use (please circle): None/ Rarely/ Occasional/ Daily/ Socially/ Weekly/ Moderately

9. **REVIEW OF SYMPTOMS**

General:	___ Fever	**Eyes:**	___ Blurred vision
	___ Weight loss		___ Eye pain
ENT:	___ Decreased hearing	**Cardiovascular:**	___ Chest pain
	___ Ringing in ears		___ Palpitations/Heart racing
Respiratory:	___ Shortness of breathe	**Gastrointestinal:**	___ Abdominal pain
	___ Cough		___ Change in bowel habits
	___ Wheezing		___ Nausea
Genitourinary:	___Frequent urination	**Muscular/Skeletal:**	___ Muscle pain
	___ Urinary incontinence		___ Swollen joints
Skin:	___ Change in hair or nails	**Psychiatric:**	___ Anxiety
	___ Rash		___ Depression
			___ Suicidal thoughts
Endocrine:	___ Temperature intolerance	**Hematologic:**	___ Easy bruising
	___ Excessive thirst		___ Swollen glands
Rheumatology:	____ Joint Pain	**Gynecology:**	____Breast Cancer
***AH**	____ Skin Rash	***AH**	____Uterine Ovarian Cancer
	____ Arthritis		_____Abnormal Menstrual Cycle
	_____ Myalgia's		

How tall are you? _____ **How much do you weigh? _____**

10. **SLEEP COMPLAINTS**

Do you snore? _____

Are you overly sleepy during the day? _____

What time do you fall asleep? _____

What time do you wake up in the morning? _____

How many times do you wake up at night and for what reason? _____

Does the need to move your arms or legs prevent sleep? _____

Name: _____ Date: _____ ECW #: _____