Neurology Associates of Ormond Beach, P.A.

8 Mirror Lake Drive, Suite A
Ormond Beach, FL 32174
386-673-2500

Welcome to Neurology Associates of Ormond Beach, P.A. Your physician has referred you to our office for your continued care. Your appointment is scheduled for:

_____

with

Dr. Dalia Fulop	Dr. David McDonald	Dr. James Scott	Dr. Tina Nigam
(386-676-6334)	(386-676-6336)	(386-676-6338)	(386-267-7255)
Katrina Akin, APRN	Alyssa Alvarez, APRN	Dianne David, APRN	Ella Cheban APRN

Enclosed you will find your new patient packet. Please complete this packet, using black ink and sign each page before your appointment. **This new patient package MUST be returned to our office PRIOR to your appointment. If we do not receive it prior, your appointment may be rescheduled.** This packet should contain 8 pages (not including this letter or the map). If you have any questions regarding the packet you may ca// the office or ask when you come to your appointment. You will receive a reminder call that will tell you to arrive 30 minutes prior to your appointment.

Please bring with you your photo ID, insurance card(s) and medication bottles to your first appointment. Your ID and insurance card(s) will be scanned into your electronic chart. ALL COPAYS/COINSURANCE are due at the time of service. BALANCES on your accounts will need to be paid before your next scheduled appointment. If you have an accepted HMO plan, please make sure that your primary doctor has sent us the referral. **WE DO NOT ACCEPT MEDICAID OR ANY MEDICAID HMO PLANS, AUTO ACCIDENTS, WORKMAN'S COMPENSATION, AND/OR LIABILITY CASES.** If you have any questions regarding if we accept your insurance, please call our office prior to your visit. If you wish to have access to your medical records, please make sure you give us a legible email address.

Your initial visit may be with the physician, physician's assistant or nurse practitioner. Subsequent follow up visits may be scheduled with your doctor or his/her nurse practitioner or physician assistant.

We look forward to meeting you,

Thank You
Neurology Associates Staff

Neurology Associates of Ormond Beach, P.A.
8 Mirror Lake Drive
Ormond Beach, FL 32174
Phone: 386-673-2500 Fax: 386-673-3204

Patient Registration Form

Patients Name: _____(as appears on insurance card)

Address: _____City: _____Zip: ___ ST:

Social Security#: _____Date of Birth: _____Sex: _____

Home#: _____ Cell#: _____Email: _____

Race:	Marital Status:	Ethnicity:	Language:
_ White _Hispanic _African American/Black _American Indian	_Single _ Married _ Divorced _ Widowed _Separated	_Non-Hispanic _Hispanic _ Other	_English _Spanish _ Other

Primary Insurance: _____ Policy#: _____

Insured's Name: _____ Social Security#: _____DOB: _____

Secondary Insurance: _____ Policy#: _____

Insured's Name: _____ Social Security#: _____DOB: _____

Emergency Contact: _____Relation to patient: _____

Address: _____Phone#:_____

Ihereby authorize Neurology Associates of Ormond Beach, PA, any medical providers, or insurance carriers to release any information necessary for insurance purposes to process any claim related to my care provided by Neurology Associates of Ormond Beach, PA.

I hereby authorize medical care to be rendered to myself or my dependent as deemed necessary by Neurology Associates of Ormond Beach, PA.

I hereby authorize direct payment of medical benefits to Neurology Associates of Ormond Beach, PA for services rendered. I understand that I am financially responsible for any balance not covered by my insurance, plus any additional charges/fees. If after 45 days my insurance has not responded I will be responsible for the total bill or remaining portion. I am aware that Neurology Associates of Ormond Beach, PA bills my insurance as a courtesy.

Medicare Release: I certify that the information given to me in applying for payment to Medicare is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Neurology Associates of Ormond Beach, PA. A photocopy of this form serves as a valid original document.

I acknowledge that I was provided a copy of notice of privacy practices for Neurology Associates of Ormond Beach, PA and that I have read and understand the notice of privacy practice.

Patient Signature:---------- Date: _____

Authorized Representative: _____ Relation to patient: _____

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CLINICAL HISTORY FORM

Name: _____ **DOB:** _____ **Age:** ___ **Gender:** ___ _

Referring Doctor: _____ **Primary Care Doctor:** _____

Reason for your visit: _____

Where is the location of your problem: _____

When did the symptoms first occur: _____

What makes it worse? _____ **Better?** _____

How long have you had these symptoms? _____ **Related to an injury?** _____

Was it work/motor vehicle/worker's comp/liability related_ Date of Injury: _____

Are you currently working? ___ **Date last worked:** _____ **Work Capacity:** **Full or Part Time**

Review of Symptoms (check all that apply):

Constitutional
_Fever
_Night Sweats
_ Weight Loss

Cardiovascular
_Shortness of Breath
_Chest pain
_Irregular Heart Beat

Respiratory
_Chronic cough/
coughing blood
_Emphysema
_Bronchitis
_Asthma

Gastrointestinal
_Blood in stool/
dark stool
_Nausea/Vomiting
_Abdominal pain

Endocrine
_Nipple Discharge
_Dry Skin
_Loss or gain of hair
_Weight gain or loss
_Excessive Thirst

Genitourinary
_Burning with urination
_Difficulty starting/ending
urine stream
_Poor bladder control
or incontinence
_Sexual Dysfunction
_Loss of sensation of
genitals
_Inability to obtain,
maintain erection

Sleep
Insomnia
_Snoring
_Excessive leg movement
_Nightmare/Terrors
_Excessive daytime
sleepiness

Hematology
_Easy Bruising
Nose Bleeds
_Excessive bleeding with
previous surgeries

Neurological
_Change of Vision (blurry/double)
_Loss of Hearing/Ringing in Ear
_Facial Numbness
_Decrease sense of smell/taste
_Smell or Taste
_Difficulty swallowing
_Slurred Speech
Headache
_Dizziness
_Seizures
_Stroke
_Pain in arm(s)
_Pain in leg(s)
_Numbness/Tingling in arm(s)
_Numbness/Tingling in leg(s)
_Weakness in arm(s)
_ Weakness in leg(s)
_Epilepsy

Psychological
_Depression
_Anxiety

Musculoskeletal
Neck Pain
_Back Pain
_ Trouble Walking

Neurology Associates of Ormond Beach, P.A.

Medical History:

_Heart Attack/Disease
_High Cholesterol
_High Blood Pressure
_Seizure
_Stroke
_Diabetes
_Kidney Problems
Liver Disease
Cancer
_ **Pacemaker, VNS, Defibrillator, Stents, Stimulator**
_HIV/AIDS
_Asthma/Lung Disease
_Neuropathy
_Other Neurological

History of Surgery & Hospitalizations·

Date	Surgery/Hospitalization	Reason

Family History

Father: Age_____ Alive/Deceased
Medical Condition(s) _____
Mother: Age_____ Alive/Deceased
Medical Condition(s) _____
Sibling: Age__ Alive/Deceased
Medical Condition(s) _____
Sibling: Age__ Alive/Deceased
Medical Condition(s) _____

Highest Level of Education:

_Grade School _Middle School _High School _GED _Technical _College

Social:

Do you exercise? _ Y **_N**
Do you smoke? _Y **_N**
Do you drink?_Y **_N**
Do you use illicit drugs? _Y **_N**
Are you on a special diet?_Y **_N**
How often? _____
How many years? ___ How many per day? ___ _
Number of drinks per week? _____
Which drug(s)? _____
What type? _____

Allergies to Medication (Drug & Reaction):

1.
2.
3.

List of current medications (attach list if necessary):

Name of Medication	Dosage	Frequency

Pharmacy:

Name: _____ Address: _____
Phone#: _____ Fax#: _____

My signature signifies that I have read, answered and understand the information included in this form as part of my medical evaluation.

Patient Signature: _____ **Date:** _____

Authorized Representative: Neurology Associates of Ormond Beach, P.A
Relation to patient: _____ 8 Mirror Lake Drive
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Neurology, EMG, Neuromuscular, Epilepsy & Stroke Patient Responsibility

- ALL PAYMENTS such as co-pays, co-insurance, deductible, and outstanding balance are due at time of service
- **You will have an added charge to your account if you do not show up for your appointment or call 24 hours in advance to reschedule.** The charges are as follows:
- **No-show "New Patient appointments" will have a charge of $50.00 added when re-scheduling.**
-
    - $50.00 for a follow up visit
    - $100.00 for a testing visit

- There is a $25.00 charge for completing disability paperwork, social security forms, FMLA and OMV forms.
- There will be a $35.00 charge for a return check
- It is the responsibility of the patient to inform us of the location of the lab that will be used and call us when labs are completed.
- It is the patients' responsibility to update our office with any insurance changes to avoid non-payment from your insurance. If your insurance is not updated and payment is not satisfied by your insurance, you will be solely responsible for the services provided.
- It is the patients' responsibility to inform us of any address or phone number changes.
- Please do not call prior to your appointment for test results unless instructed by your doctor.
- We ask that you give us at least 48 hours in advance for processing of your refills. Please do not expect that refills can be done on a Friday afternoon. It is the patients' responsibility to know when they need a refill. We DO NOT accept walk-ins for refills.

_____ acknowledge and understand the policy above.
(print name)

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

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This information may be disclosed to and µsed by the above individual or organization

Authorization to obtain, release or review protected health information

Patient Name:_____ Social Security#: _____

Address: _____City: _____St: __ _

Zip Code: _____Date of Birth: _____ Phone Number: _____

The following individual or organization is authorized to make the following disclosure
{LEAVE THIS SPACE BLANK FOR OFFICE USE)

Name: _____ Phone#:_____ Fax#: _____

Address: _____City: _____St: ___ Zip Code: __ _

_ History & Physical (office notes)_ Labs _ Radiology Reports _X-Ray Films or CD's

Specific Dates Requested: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization stands as is.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this form. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain the information to be used or disclosed, as provided in CFR164.524._1 understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality laws.
I understand that the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by federal and state regulations. I also understand that my health record may include information relating to AIDS/HIV and/or sexually transmitted disease.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

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_____ hereby authorize Neurology Associates of
Patient/Guardian
Ormond Beach, P.A. or their representative, to take a photograph and/or record a video of

_____
Name of Patient

I understand that such photograph(s) and/or video recordings may be used for clinical/educational purposes or in the event of legal action. Neurology Associates and it's duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s) and/or video recordings. **No photographs and/or video monitoring equipment are located in exam rooms or procedure areas.** Closed circuit video of patient waiting areas, check out and billing are for security purposes.

The undersigned also hereby transfers and assigns to Neurology Associates the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

Witness: _____ **Date:** _____

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Patient Authorization for Use and Disclosure of Protected Health Information

Neurology Associates of Ormond Beach, P.A. maintains a confidentiality policy with all patients' medical information. Please list the names of those that you give this office permission to speak with concerning your medical condition.

_____hereby give permission for this office to give information regarding my medical condition.

The information used or disclosed pursuant to this authorization (please check all that pertain)

_May _May Not Include information related to HIV/AIDS
_May _May Not Include information related to mental health
_May _May Not Include information related to substance abuse or alcoholism

The name(s) listed below have my permission to discuss and/or receive information on my medical condition.

Name: _____Relation to patient: _____
Name:_____ Relation to patient: _____
Name:_____Relation to patient: _____
Name: _____Relation to patient: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient to the members of the practice & research department and may no longer protected by the federal HIPPA Privacy Act. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted, signed and witnessed to the above address on this document.

Patient Signature: _____Date: _____

Authorized Representative: _____Relation to patient: _____

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_____ am aware that Neurology Associates does not participate with any Medicaid plans. I understand that I am responsible for any balance due on my account and **if in the future I sign up with a Medicaid plan.** I understand that I am responsible for any balance due on my account. I am aware that Neurology Associates bills my insurance as a courtesy to me.

_____ am aware that my insurance may not pay for certain services, procedures and treatments. If my insurance does not pay for my visit in full I am aware that I am responsible for my balance due on my account.

*Please note that if your insurance requires an authorization for services rendered at our facility or by one of our doctors it is the referring physician and patient's responsibility to obtain a prior authorization before services are rendered.

Patient Signature: _____ Date: _____

Authorized Representative: _____ Relation to patient: _____

Advanced Directive

Do you have an Advanced Directive? YES___ NO___

If Yes, please select which advanced directive you have below and make a copy for the office ASAP

1. Living Will _____
2. Health Care Surrogate_____
3. Organ Donor
4. DNR
5. Power of Attorney___

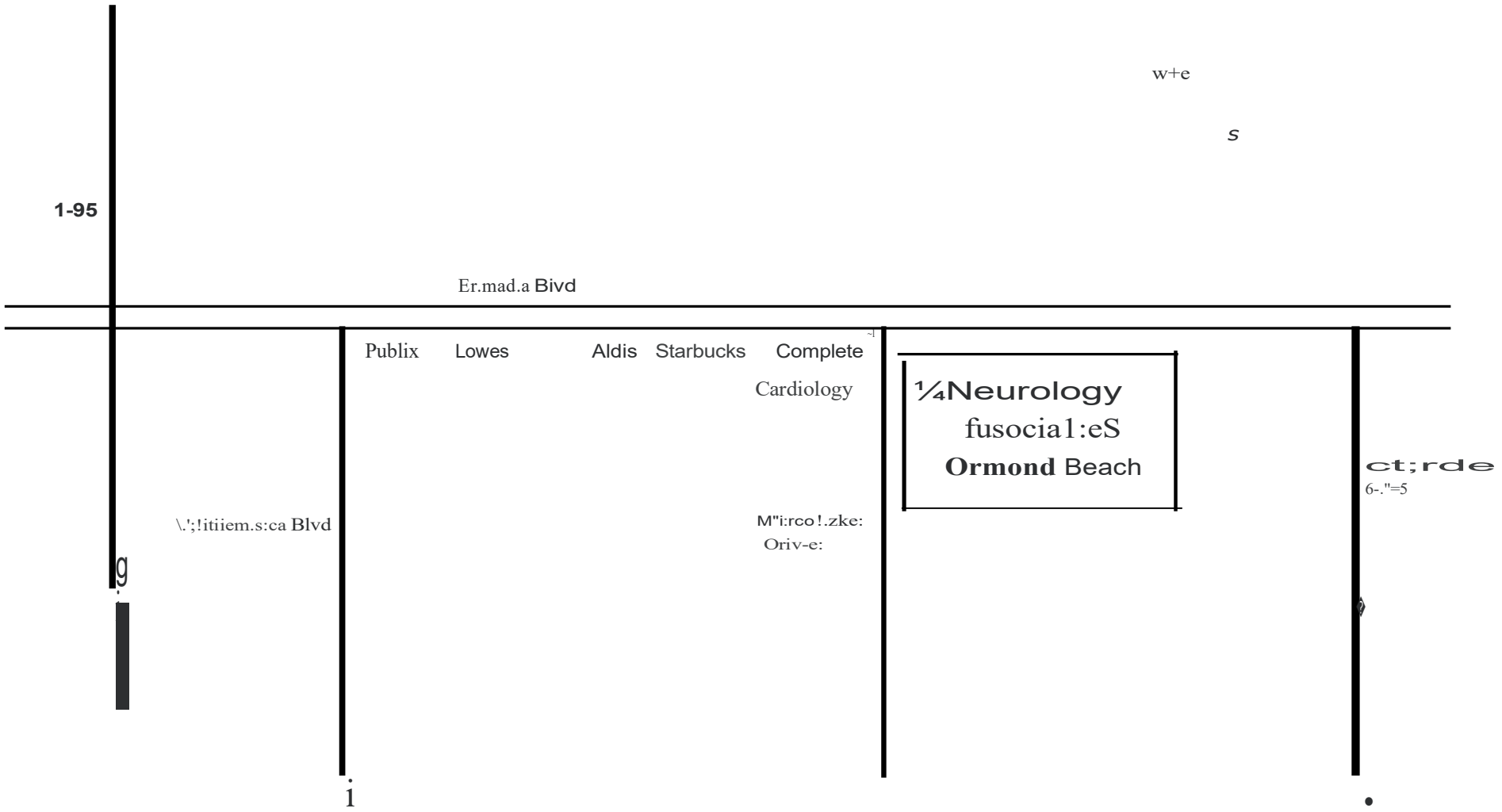
Print name: _____

DOB: _____

Signature: _____

Date: _____

For office use only AD received Date_____



Neurology Associates **of Orm nd** Beach
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(p) .3-8&--673---2500