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, P.A.

Mark J. Klafter, D.O., Daniel H. Jacobs, M.D., Ahmed Sadek, M.D., Navin Verma, M.D., Justin K. Lindquist, M.D.

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

Allergies: None( ) _____

_____

Medication	Dose	Directions

Name of Pharmacy: _____

Pharmacy Phone Number or Intersection: _____

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 <u>in writing</u>.

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, P.A.

Mark J. Klafter, D.O., Daniel H. Jacobs, M.D., Ahmed Sadek, M.D., Navin Verma, M.D., Justin K. Lindquist, M.D.

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.

Mark J. Klafter, D.O., Daniel H. Jacobs, M.D., Ahmed Sadek, M.D., Navin Verma, M.D., Justin K. Lindquist, M.D.

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