NEUROLOGY CLINIC, PA

1333 Pine Street, Melbourne, FL 32901

321-984-9400 phone --- 321-984-0150 fax

***We are two blocks west of Holmes Regional Hospital, Corner of Pine St & Michigan Ave

Appointment with ____ Caitlin Featherston, APRN ____ David J Packey, MD

ON: _____ at _____ AM PM

*Please arrive 20 minutes prior to your appointment time with the exception of 1pm appointment- we close for lunch from 12-1.

For GPS systems please use complete address INCLUDING zip code

Please note: we single book our patients and therefore we have a **STRICT SCHEDULING POLICY. YOU MUST ARRIVE FOR YOUR APPOINTMENT WITH COMPLETED PAPERWORK.**

1. ARRIVING 10 MINUTES OR MORE AFTER SCHEDULED APPOINTMENT TIME or arriving at the appointment time without completed paperwork WILL RESULT IN RESCHEDULING.
2. Missed (no show) appointments are subject to a $75 no show fee. Patients that miss, cancel, or reschedule 3 consecutive appointments will not be allowed to schedule any further appointments with our office.
3. Test results are discussed in scheduled follow-up visits only. Results are NOT given over the phone. Test results, continued treatment and management are discussed and therefore the follow-up is considered a full appointment and billed as such.
4. Prescription refills are to be first requested by patient via their pharmacy. Due to federally regulated prescribing laws, we do NOT provide refills if patient has not been seen in office as dictated by our provider or within 12 months of previous visit. Special circumstances may be considered by provider. Refill requests are addressed within 24 hours (excluding weekends and holidays). Patients are responsible for compliance.
5. All copay, co-insurance, deductible , or fee balances are due at the time of service. *Botox patients: account balance must be paid in full AT or BEFORE your next injection appointment.
6. Forms processing fee of $25 is assessed for our completion of documents for DMV, Life Insurance, FMLA, and other forms at the discretion of management. Fee is due at the time of submission and must be paid by cash, credit, or debit only. NO CHECKS.
7. Any authorization required by insurance is patient's responsibility to confirm requirements by insurance and that, if needed, is in effect at the time of service.

Signing below acknowledges receipt of these policies. Failure to comply may result in discharge from practice.

Patient/Guardian signature _____

Date _____ Office Staff: _____

*If guardian signs, print patient name _____ DOB_____

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PATIENT INFORMATION

Legal Name: (first) _____ (last) _____

Date of Birth: _____ Gender: _____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Spouse Name: _____ Date of Birth: _____

Emergency Contact Name: _____

Phone: _____ Relationship: _____

If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. If our account is turned over to our collection agency, an additional fee of 25% of your total bill will be added to your balance.

Primary Insurance _____ ID _____
Policyholder Name _____ Date of Birth _____

Secondary Insurance _____ ID _____
Policyholder Name _____ Date of Birth _____

I hereby assign all medical benefits (money paid on my behalf for my medical care) to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private medical insurance, and any other health plans to Neurology Clinic, PA. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize release to my insurance carrier, employer and/or referring health care provider any information needed, including diagnosis and records of any treatment or examination rendered to me to process the claim.

I authorize Neurology Clinic to obtain records from hospitals, health care providers, and pharmacies that will assist the health care providers at Neurology Clinic with my care.

Lifetime signature authorization: This authorization and assignment are to be continuing, remaining in force until revoked in writing by myself or legal representative.

Patient/Legal Representative _____
Office Staff _____ Date _____

If Patient is a minor, provide parents name or legal representative and relationship.
Name _____ (circle) Parent Grandparent Guardian Other

Name _____ Date _____

MEDICATION with dosages (including vitamins and supplements) [if none, please print NONE]:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

ALLERGIES to medications, including types of reaction you have [if none, please print NONE]:

1. _____
2. _____
3. _____

SURGERIES/HOSPITALIZATIONS (list all) [if none, please print NONE]:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

FAMILY MEDICAL HISTORY (list any illness or disease past or present):

Father: _____
Mother: _____
Siblings: _____
[for women] Ages of your children: _____

OTHER INFORMATION:

Age: _____ Last grade of school completed: _____ Are you RIGHT _____ or LEFT _____ handed

Marital Status: _____ Employed_____ Retired _____ Disability _____ Unemployed _____

Do you drink alcoholic beverages? Yes ___ No ___ How many drinks daily? Beer ____ Wine ____ Alcohol ____

Do you drink caffeinated beverages? Yes ____ No ____ How many drinks daily? _____

Do you currently use any type of tobacco? Yes ____ No ____

If yes, what type of tobacco? _____ how much? _____ how often? _____

Have you used tobacco in the past? _____ Yes ____ No ____ If yes, when did you quit? _____

Do you have a Living Will? Yes ____ No ____ Legal health care proxy/surrogate? Yes ____ No ____

If yes, does your primary care doctor have a copy of these documents? Yes ____ No ____

----------OFFICE USE ONLY BELOW THIS LINE----------

BP _____ WT _____ HT _____ PULSE _____ HR _____ Reviewed by _____

IN ORDER TO COMPLY WITH INSURANCE DOCUMENTATION GUIDELINES THIS INFORMATION MUST BE OBTAINED AT EACH PATIENT VISIT

Patient Name _____ Date _____

Date of Birth _____ Primary Care Dr _____

Do you need any medications refilled today? YES/NO Any medical devices implanted? YES/NO

What pharmacy do you currently use (Name/Address)? _____

_____

Reason for today's visit: _____

ARE YOU CURRENTLY HAVING OR EXPERIENCED WITHIN THE LAST 30 DAYS?

General:			**Respiratory:**			**Genitourinary:**		
Covid	Yes	No	shortness of breath	Yes	No	frequent urination	Yes	No
Fevers	Yes	No	cough	Yes	No	unable to control bladder	Yes	No
Chills	Yes	No	sleep apnea/CPAP	Yes	No	kidney stones	Yes	No
Rash	Yes	No	**Gastrointestinal:**			difficulty voiding	Yes	No
Fatigue	Yes	No	constipation	Yes	No	**Neurological:**		
Sleep problems	Yes	No	diarrhea	Yes	No	headache	Yes	No
Weight gain/loss	Yes	No	vomiting	Yes	No	dizziness/fainting	Yes	No
Eyes:			nausea	Yes	No	lightheadedness	Yes	No
Eye pain	Yes	No	abdominal pain/cramp	Yes	No	weakness	Yes	No
Vision loss	Yes	No	swallowing problems	Yes	No	numbness/tingling	Yes	No
Blurring	Yes	No	change in appetite	Yes	No	balance problems	Yes	No
Double vision	Yes	No	incontinence	Yes	No	falls	Yes	No
Ear, Nose, Throat:			reflux	Yes	No	memory changes	Yes	No
Decreased hearing	Yes	No	**Musculoskeletal:**			confusion	Yes	No
Ringing/buzzing in ears	Yes	No	back pain	Yes	No	speech changes	Yes	No
Nose bleeds	Yes	No	neck pain	Yes	No	tremors	Yes	No
Sore mouth or nose	Yes	No	leg pain	Yes	No	**Psychiatric:**		
Hoarseness	Yes	No	joint pain/swelling	Yes	No	depression	Yes	No
Cardiovascular:			muscle cramps	Yes	No	anxiety	Yes	No
Chest pain	Yes	No	muscle weakness	Yes	No	hallucinations	Yes	No
Palpitation	Yes	No	stiffness	Yes	No	paranoia	Yes	No
Irregular heart beat	Yes	No						

FEMALES ONLY: Are you (circle)- pregnant / trying to become pregnant / using birth control / menopausal

HEALTH SCREENING: In the last year have you had (circle all that apply)

Colonoscopy Mammogram Pap Smear Flu Shot Pneumonia Shot
Covid Vaccine Shingles Vaccine

SMOKING STATUS: (circle) – Non-smoker / Smoker (packs/day ____) / Smokless Tobacco / E-Cig user

_____OFFICE USE ONLY BELOW THIS LINE_____

HT _____ WT _____ Pulse _____ O2 Sat _____ BP _____ Reviewed by ____

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Name _____ Date _____

CONSENT FOR COMMUNICATION AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that Neurology Clinic has a health information privacy policy. I can request the Neurology Clinic pamphlet "Notice of Privacy Practices" should I want a copy.

I understand that I have the right to determine my preferred method of communication, and the right to restrict certain types of communication. I further understand that Neurology Clinic must honor this request as to the method of communication if reasonable. Neurology Clinic may not ask me why I want certain methods of communication.

Please be assured that Neurology Clinic will not sell or share patient email addresses, and that the email addresses will only be used by Neurology Clinic staff members to facilitate communication with patients.

I give Neurology Clinic permission to contact me as follows: (check all that apply)

For APPOINTMENT information	Home phone____	Cell phone ____	At work ____
For BILLING information	Home phone ____	Cell phone ____	At work ____
For MEDICAL information	Home phone ____	Cell phone ____	At work ____

Can messages be left on your machine or voicemail for the above numbers: Yes ___ No ___

Please fill in as appropriate for what you checked above:

Home Phone _____
Cell Phone _____
Work Phone _____

I give Neurology Clinic permission to speak to the person(s) named below:

Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____
Name _____	Phone _____	Relationship _____

I understand that I have the right to object to the use and/or disclosure of my individually identifiable personal health information to other physicians or family members.
I object to the use and/or disclosure of my health information as follows: _____

_____

I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that Neurology Clinic has already taken action in reliance on my earlier effective consent.

_____ _____ _____

Signature of Patient or Legal Representative | Office Staff | Date

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PATIENT PORTAL

Using a computer or tablet, patients can contact Neurology Clinic to obtain an appointment, send notes to the office staff, and have access to their medical records and test results.

This is all done via a patient portal, which is available for use by a patient only AFTER that patient provides their email address. Once a patient gives their email address to the office staff at Neurology Clinic, they will be given information on how to sign-up for the patient portal.

Name _____ Date _____

Email Address _____

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