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_____

NEUROLOGY CLINIC, PA

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

NEUROLOGY CLINIC, PA

1333 Pine Street, Melbourne, FL 32901

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

NEUROLOGY CLINIC, PA

1333 Pine Street, Melbourne, FL 32901

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 _____

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.