

Neurohealth Sciences Center – Patient Registration

PATIENT INFORMATION

(Please Print)

Form fields for Patient Information including title (Dr., Miss, Mr., Mrs., Ms., Sir), name (Last, First, MI, Previous Name), address (Line 1, City, State, ZIP, Pharmacy, Pharmacy Phone), contact info (Home Phone, Cell No., Work Phone, Ext.), providers (Primary Care Provider, Referring Provider, Rendering Provider Name, E-Mail Address), date of birth (MM/DD/YYYY), sex (F - Female, M - Male, Transgender), race (American Indian or Alaska Native, Asian, Native Hawaiian or Other Pacific Islander, Black or African American, White, Declined), ethnicity (Hispanic or Latino, Not Hispanic or Latino, Declined), language (English, Spanish, Indian, Japanese, Chinese, Korean, French, German, Russian, Other), marital status (Married, Single, Divorced, Widowed, Legally Separated, Partner), social security number, employer name, employment status (1 - Full-Time, 2 - Part-Time, 3 - Not Employed, 4 - Self-Employed, 5 - Retired, 6 - Active Military), student status (F - Full-Time Student, P - Part-Time Student, N - Not a Student), emergency contact (Last Name, First Name, Phone Number, Do you have a living will? Yes/No, Emergency Contact Relationship to Patient, Guardian), and address (Line 1, City, State, ZIP, Home Phone, Work Phone, Ext.).

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Form fields for Responsible Party Information including title (Another Patient, Guarantor, Self), name (Last, First, MI), guarantor account number, date of birth (MM/DD/YYYY), social security number, telephone, e-mail address, sex (F - Female, M - Male), address (Line 1, City, State, ZIP), employer, and employer phone number.

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Primary Insurance Information including insurance company/phone number, name of insured, patient relationship to insured, subscriber ID (policy number), group ID, copay amount, effective date, termination date, and date of birth (MM/DD/YYYY).

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Form fields for Secondary Insurance Information including insurance company/phone number, name of insured, patient relationship to insured, subscriber ID (policy number), group ID, copay amount, effective date, termination date, and date of birth (MM/DD/YYYY).

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ Date _____

NeuroHealth Sciences Center

New Patient Information Sheet

Rafael Allende, MD & Matthew Burry, MD

Patient Name: _____ Date: _____

Primary Care Physician: _____ Referring Physician: _____

Please describe the reason for your visit: _____

Symptoms:

When did symptoms begin: _____

When does the pain/problem occur (i.e.: morning/night): _____

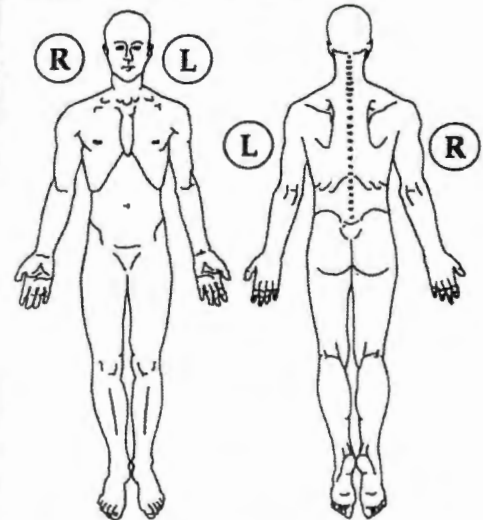
What aggravates the symptoms: _____

What reduces the symptoms: _____

Place check if you have other symptoms:

Symptom	Occurrence		Location
Numbness	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	
Pins/Needles/Tingling	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	
Sharp Pain	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	
Dull/Achy Pain	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	

Shade the areas you have pain



Rate Your Pain

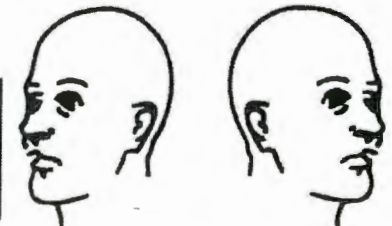
Pain Scale: 0 = No Pain 10 = Worse Pain

Today: _____ Past Week: _____

Please check current or previous therapy:

Types of Therapy	Effect on your Symptoms			Month/Year
Physical Therapy	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Nerve Blocks	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Medication Use	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Chiropractor	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	
Other	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No Change	

DISABILITY STATUS	Yes	No	Type
Are you currently on disability?			
Have you applied for disability?			
Last Day you worked:			



Is this injury a result of?

Motor Vehicle Accident? Yes No

Work Related Injury? Yes No

Date of Injury: _____

If yes, to either of the above, explain how injury occurred:

ALLERGIES: None

List all known allergies to medication, food, or latex

NAME OF MEDICATION/FOOD/LATEX	TYPE OF REACTION

CURRENT MEDICATION: No Medications

List all medications you are taking

(Include over the counter, vitamins, and herbs)

NAME OF MEDICATION	DOSE/MG	FREQUENCY

NAME OF MEDICATION	DOSE/MG	FREQUENCY

MEDICAL HISTORY:

List all medical problems for which you are currently being treated (high blood pressure, diabetes, Heart)

MEDICAL PROBLEM

MEDICAL PROBLEM

SURGICAL HISTORY: No Hospitalization

List all surgical procedures or major hospitalizations and year of occurrence.

Year	REASON FOR HOSPITALIZATION

Year	REASON FOR HOSPITALIZATION

FAMILY HISTORY:

List pertinent family history (diabetes, heart disease, cancer, etc)

PARENTS	AGE	LIVING	DECEASED	MAJOR ILLNESS/CAUSE OF DEATH
Father				
Mother				
SIBLINGS				

Date of last flu vaccine	
Date of last pneumococcal vaccine	
Date of last mammogram (if applicable)	
Date of last colonoscopy	
Have you had any falls within the last 12 months? If yes, please explain:	
Do you take one or more medications that may cause dizziness or loss of balance?	

SOCIAL HISTORY

Alcohol Use: None

Amount: _____ per Day Week Month Year

Tobacco Use: None

_____ Packs/Cigars per day for _____ # of years. Quit smoking _____ years ago.

Street Drug Use: None

Type: _____ Frequency: _____ days/weeks/months. Date of last use: _____

REVIEW OF SYSTEMS: Please place check if you have or have had problems related to the following systems.

General		Comments	Genitourinary		Comments
<input type="checkbox"/>	Unexplained Weight Loss		<input type="checkbox"/>	Incontinence/Retention	
Eyes/Ears			<input type="checkbox"/>	Prostate Enlargement	
<input type="checkbox"/>	Double/Blurred Vision		Musculoskeletal		
<input type="checkbox"/>	Hearing Loss		<input type="checkbox"/>	Arthritis/Location	
<input type="checkbox"/>	Cataracts		Endocrine		
Pulmonary			<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	Thyroid	
<input type="checkbox"/>	COPD/Emphysema		Hematological		
<input type="checkbox"/>	Sleep Apnea		<input type="checkbox"/>	Blood Clots	
<input type="checkbox"/>	Pneumonia in past year		<input type="checkbox"/>	Hemophilia	
<input type="checkbox"/>	Shortness of Breath with exertion		<input type="checkbox"/>	Von Williebrands Disease	
Cardiovascular			Neurological		
<input type="checkbox"/>	High Blood Pressure		<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Heart Attack		<input type="checkbox"/>	TIA/Stroke	
<input type="checkbox"/>	Pacemaker/AICD		Psychiatric		
<input type="checkbox"/>	Valve Disease		<input type="checkbox"/>	Depression/Anxiety	
<input type="checkbox"/>	Chest Pain		Other		
<input type="checkbox"/>	Congestive Heart Failure		<input type="checkbox"/>		
Gastrointestinal			Cardiac/Pulmonary Testing		
<input type="checkbox"/>	Heart Burn/Indigestion/Reflux		<input type="checkbox"/>	Stress Test	
<input type="checkbox"/>	Bowel Incontinence		<input type="checkbox"/>	Heart Angiogram	
<input type="checkbox"/>	Liver Disease/Hepatitis		<input type="checkbox"/>	Echocardiogram	
<input type="checkbox"/>	Ulcers		<input type="checkbox"/>	Pulmonary Function Test	

Date: _____

Person Completing Form (please print): _____ Signature: _____

The NeuroHealth Sciences Center

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations					
Patient's Name:		Date of Birth:		Social Security Number: XXX-XX- ____	
Requesting Records From: (Previous PCP, Specialist, Facility, etc.)		Recipient's Name: (TO) Neurohealth Sciences Center			
Provider's Address:		Address 1: 305 N Mangoustine Ave			
		Address 2: Suite 100			
		City: Sanford		State: FL	Zip: 32771
Description of Information to be Used or Disclosed					
Description:	Date of Service:	Description:	Date of Service:	Description:	Date of Service:
<input type="checkbox"/> All PHI in Medical Record <input type="checkbox"/> Admission Form <input type="checkbox"/> Dictation Reports <input type="checkbox"/> Physician Orders <input type="checkbox"/> Intake/Output <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets	(ex: 2009 to 2011)	<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath Lab <input type="checkbox"/> Special Test/Therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer Forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/Delivery Summary <input type="checkbox"/> OB Nursing Assess <input type="checkbox"/> Postpartum Flow Sheet <input type="checkbox"/> Itemized Bill: <input type="checkbox"/> UB-92 Claim: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I understand that: <ol style="list-style-type: none"> 1. I may refuse to sign this authorization and that it is strictly voluntary. However, refusal to sign will render this form invalid. 2. I understand that protected health information may include information and records protected under Federal and State Law such as; alcohol, drug abuse, mental health, AIDS or HIV testing or treatment. 3. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. 4. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 5. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 6. There may be a reasonable fee to obtain a copy the information being requested on this form. 7. I am allowed a copy of this form after I sign it. 					
Section C: Required Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Guardian/ or Personal Representative:				Date:	
X _____					
Printed Name of Patient/Guardian/ or Personal Representative:				Relationship of Personal Representative to Patient:	
X _____					

The Neurohealth Sciences Center

PATIENT NAME _____ DATE OF BIRTH _____

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. _____ (Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, The Neurohealth Sciences Center may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)

Third Party Collection. I acknowledge that The Neurohealth Sciences Center may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to The Neurohealth Sciences Center any insurance or other third-party benefits available for health care services provided to me. I understand The Neurohealth Sciences Center has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to The Neurohealth Sciences Center, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to The Neurohealth Sciences Center by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for The Neurohealth Sciences Center, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that The Neurohealth Sciences Center or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or The Neurohealth Sciences Center or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X _____ Date _____

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

- | | |
|----------------|------------------------------|
| Spouse | Guarantor |
| Parent | Healthcare Power of Attorney |
| Legal Guardian | Other (please specify) _____ |

First Point of Contact Screening

Patient Name _____
Please print full legal name

Date _____

We are committed to providing the safest environment for our patients and together we can prevent the spread of germs.

Please complete the questionnaire below. If you answer yes to any of the questions, please be considerate of others and act appropriately such as covering your cough, washing your hands, and covering any open wounds.

For the protection of our patients, we gladly supply and encourage the use of tissue, masks, hand sanitizer, and Band-Aids.

1. Do you have any of the following symptoms? YES NO

If yes, please circle the symptoms you have now, or have had, over the past seven days?

- **Fever**
- **Night sweats**
- **Sneezing or runny nose**
- **Cough**
- severe headache
- stiff neck
- muscle or joint pain (circle one or both)
- new rashes or open sores on your skin or in your mouth
- redness, swelling, or discharge of your eyes (pink eye)
- unexplained bleeding
- vomiting or diarrhea

2. In the past three weeks, have you traveled outside the U.S.? YES NO

If yes, please list where: _____

3. In the past three weeks have you had close contact with someone who has traveled outside the U.S.? YES NO

If yes, please list where: _____

Thank you for your help and support in caring for our patients and community.

TO BE FILLED OUT BY OFFICE STAFF

Reviewed by: _____

Action taken:

- No action taken
- Isolate
- Cough/ hand washing etiquette provided
- Mask provided
- PM/ Lead clinical notified

Thank you for trusting us with your healthcare!

Patient Name _____ DOB _____

CONTROLLED SUBSTANCE / PAIN MANAGEMENT AGREEMENT

• **The purpose of this Agreement is to prevent misunderstandings** about certain medicines you will be taking for pain management or controlled substance such as anti-anxiety medication (Examples-Valium, Xanax) or ADD/ADHD medications. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals. _____ Pt. Initials

• **I understand that this Agreement is essential to the trust and confidence** necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement. _____ Pt. Initials

• **Because these medicines have the potential for abuse or diversion, strict accountability is necessary.**

• **I understand that if I break this Agreement,** my doctor will stop prescribing these pain-control medications/controlled substances _____Pt. initials

• **I agree to notify my doctor of any and all pain medications or prescriptions that I receive from other providers** (effective from date of this agreement and ongoing). Such notification should occur by next business day following receipt of prescription. If I fail to alert my doctor I understand I may be discharged from the practice. _____Pt. initials

• **I understand that someday my doctor may wean me partially or totally from narcotics** if he/she determines that, in the long run, this is likely to be in my best interests. In such situations other meds or therapies will likely be suggested as part of my new treatment plan. I agree to respect my doctor's opinion in such circumstances and comply with the new treatment plan _____Pt. Initials

• **I understand that if I am suspected of diverting or distributing my pain medications/controlled substances, my doctor will immediately cease prescribing** these medications. In this case, my doctor will be required to comply with local state and/or federal reporting requirements and investigation. _____ Pt. initials

• **I would also be amenable** to seeking psychiatric treatment, psychotherapy and/or psychological treatment if my doctor deems necessary. _____Pt. initials

• **I agree to I communicate fully and honestly with my doctor** about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain. _____ Pt. initials

• **If the medication causes drowsiness, sedation, or dizziness, I understand that I must not drive a motor vehicle or operate machinery that could put my life or someone else's life in jeopardy.** I also understand that my state may have regulations concerning driving while under the influence of drugs and accept responsibility for adhering to those regulations. _____ Pt. Initials

• **I understand the use of opiates or pain medications in combination with anti-anxiety medications such as Valium or Xanax may cause me to stop breathing and abnormal heart rhythms resulting in injury or death.** _____ Pt. initials

• **I understand that strong medications, which may include opiates and other controlled substances, which I may be prescribed, have potential risks and side effects, including the risk of addiction.** An over-dosage with an opiate medication may cause injury or death. Other possible complications include, but are not limited to, constipation, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function. _____ Pt. Initials

• **I will not use any illegal controlled substances, including marijuana, cocaine, etc., nor will I misuse or self-prescribe/medicate with legal controlled substances.** Use of alcohol will be limited to a time when I am not driving, operating machinery and will be infrequent. _____ Pt. Initials

• **I will not share, sell or trade my medication with anyone.** _____ Pt. Initials

• **I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or anti-anxiety medicines from any other doctor.** _____ Pt. Initials

• **I will inform my doctor of ALL current medications** including herbs, vitamins, supplements, and over-the-counter medications. I will provide an updated medication list during every visit. _____ Pt. Initials

• **I will not alter my medicine in any way or use any other administrative method other than what has been prescribed me.**

Long-term agents (MS Contin, Oxycontin, etc.) must be taken whole and are not allowed to be broken, chewed, crushed, injected and/or snorted. Potential toxicity could occur due to rapid absorption if taken inappropriately, which may lead to death. _____ Pt. Initials

• **I understand that suddenly stopping some medications** (including opioids and sedatives) can cause substantial discomfort over and above any increase in my chronic pain causing psychological distress, extreme achiness and fatigue, nausea, trembling, etc. _____ Pt. Initials

• **I will avoid withdrawal symptoms** by budgeting my pills, not taking more medications than prescribed, and keeping my appointments for refills. I understand that 'running out' of itself is not grounds for insisting on an 'emergency or urgent appointment'. _____ Pt. initials

• **I will safeguard my pain medicine/controlled substances from loss or theft.** Lost or stolen medicines will not be replaced. _____ Pt. Initials

• I agree that refills of my prescriptions for pain medicine/controlled substance will be made only at the time of an office visit. No refills will be available during evenings or on weekends. _____Pt. Initials

• I agree that prescriptions for pain medicine/controlled substances will not be refilled earlier than the agreed upon renewal date. _____Pt. Initials

• (Males Only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my prescriber/provider may check my blood or request that my primary care provider do routine testing to see if my testosterone level is normal. Please be aware your insurance may not cover this test, therefore if deemed medically necessary you agree to be responsible for any costs not covered by your insurance. _____Pt. Initials

• (Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this medication, I will immediately call my obstetric doctor and prescribing prescriber/provider to inform them. I am aware that should I carry a baby to delivery while taking these medications; the baby will be physically dependent upon opioids. Infant drug withdrawal can be life threatening. If a female of childbearing age, I certify that I am not pregnant and will use appropriate contraceptive measures during the course of treatment with opioids/controlled substances. _____Pt. Initials

I agree to use _____(Name) Pharmacy, Located at _____(Address/City), Telephone number (_____) _____, for filling prescriptions for all of my pain medicine /controlled substance.

• If I chose to have my medications filled by a new pharmacy not listed above, I will be required to sign an amendment to this agreement with my updated pharmacy information. _____Pt. Initials

• I understand that changing date, quantity, or strength of medicines or altering a prescription in any way is against the law. Forged prescriptions and/or forged provider's signatures are also against the law and will result in an immediate termination from this practice. _____Pt. Initials

• I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine or other controlled substances. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. _____Pt. Initials

• I agree that I will submit to a blood or urine test if requested by my doctor to determine my compliance with my program of pain control medicine/controlled substance. Tests may include screens for illegal substances, and your cooperation is required. **Refusal of such testing may subject you to an abrupt / rapid wean schedule in order for the medication to be discontinued or prompt termination from care.** _____Pt. Initials

• I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time. _____Pt. Initials

• I will bring all unused pain medicine or controlled substance to every office visit related to the management of my pain treatment program _____Pt. Initials

• I understand that any serious misbehavior such as yelling, threatening, cursing, etc. will likely be cause for dismissal from the practice. _____Pt. Initials

• I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document has been given to me. _____Pt. Initials

This agreement is entered into on this _____ day of _____, _____.

(date) (month) (year)

Patient signature: _____

Prescriber/provider signature: _____

Witness/staff signature: _____