Neurohealth Sciences Center – Patient Registration

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sir

Patient's Name (Last) _____ (First) _____ (MI) ____ Previous Name _____

Address Line 1 _____

City, State _____ ZIP_____ Pharmacy_____Pharmacy Phone_____

Home Phone _____ Cell No. _____ Work Phone _____Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ 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

Address Line 1 _____

City, State _____ ZIP_____

Home Phone _____ Work Phone _____ Ext. _____

Referring Provider Name _____

RESPONSIBLE PARTY INFORMATION (information used for patient balance statements)

Responsible Party ☐ Another Patient ☐ Guarantor ☐ Self **Check here if information is same as patient** ☐

Responsible Party 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_____ Employer Phone Number_____

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

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____ Date of Birth MM _____/DD _____/YYYY _____

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

Insurance Company/Phone Number_____ (_____)_____

Name of Insured_____ Patient Relationship to Insured_____

Subscriber ID (Policy Number)_____ Group ID_____ Copay Amount_____

Effective Date_____ Termination Date_____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): _____

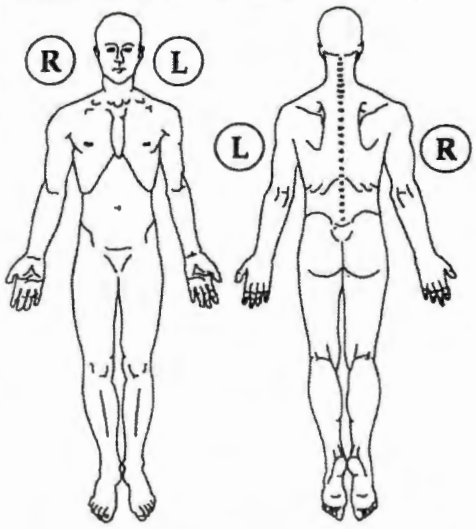
What aggravates the symptoms: _____

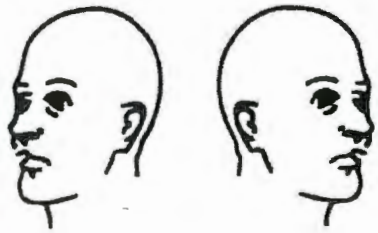
What reduces the symptoms: _____

Place check if you have other symptoms:

Symptom	Occurrence		Location
☐ Numbness	☐ Constant	☐ Intermittent	
☐ Pins/Needles/Tingling	☐ Constant	☐ Intermittent	
☐ Sharp Pain	☐ Constant	☐ Intermittent	
☐ Dull/Achy Pain	☐ Constant	☐ 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	☐ Better	☐ Worse	☐ No Change	
☐ Nerve Blocks	☐ Better	☐ Worse	☐ No Change	
☐ Medication Use	☐ Better	☐ Worse	☐ No Change	
☐ Chiropractor	☐ Better	☐ Worse	☐ No Change	
☐ Other	☐ Better	☐ Worse	☐ 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

Alocohol 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.

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

Date: _____

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

The NeuroHealth Sciences Center

Rafael Allende,MD
305 N. Mangoustine
Suite 100
Sanford, FL 32771
Ph: (407) 833-7505 Fax: (407)833-7509

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:**
☐ All PHI in Medical Record ☐ Admission Form ☐ Dictation Reports ☐ Physician Orders ☐ Intake/Output ☐ Clinical Test ☐ Medication Sheets	*(ex:2009 to 2011)*	☐ Operative Information ☐ Cath Lab ☐ Special Test/Therapy ☐ Rhythm Strips ☐ Nursing Information ☐ Transfer Forms ☐ ER Information		☐ Labor/Delivery Summary ☐ OB Nursing Assess ☐ Postpartum Flow Sheet ☐ Itemized Bill: ☐ UB-92 Claim: ☐ Other: ☐ Other:	

I understand that:

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: X_____	**Date:**
Printed Name of Patient/Guardian/ or Personal Representative: X_____	**Relationship of Personal Representative to Patient:**

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_____ **Date**_____
Please print full legal name

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: _____