Florida Neurology, P.A.

Sampathkumar Shanmugham, M.D. - Nitesh Shekhadia, M.D. – Ramit Panara, M.D.

Lake Mary	Orange City	Tavares
755 Stirling Center Place Lake Mary, FL 32746 (407) 333-1718	2445 S. Volusia Ave. Suite C-3 Orange City, FL 32763 (386) 218-6867	2710 Dora Ave. Tavares, FL 32778 (352) 508-5076

TODAY'S DATE: _____ MALE / FEMALE (PLEASE CIRCLE)

PATIENT'S FIRST NAME: _____ LAST: _____

DOB: ____/____/____ SOCIAL SECURITY #: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

MARITAL STATUS: ____ SINGLE ____ MARRIED____ DIVORCED ____ SEPERATED ____ WIDOWED

NUMBER OF CHILDREN _____

EMPLOYED: YES / NO EMPLOYER NAME: _____

EDUCATION HIGHEST LEVEL COMPLETED _____

HOME PHONE: _____ WORK: _____

CELL PHONE: _____

RACE: _____ ETHNICITY: _____

LANGUAGE(S) SPOKEN: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY ADDRESS: _____

NAME OF REFERRING DOCTOR: _____

REFERRING DOCTOR'S PHONE NUMBER: _____

IS THIS VISIT RELATED TO AN AUTO ACCIDENT? YES / NO (PLEASE CIRCLE ONE)

IS THIS VISIT RELATED TO A WORKER'S COMPENSATION CLAIM? YES / NO (PLEASE CIRCLE ONE)

IN CASE OF AN EMERGENCY PLEASE CONTACT:

NAME: _____

CONTACT NUMBER: _____ RELATIONSHIP TO PATIENT: _____

CONFIDENTIAL COMMUNICATION

PLEASE ADVISE HOW YOU WISH TO BE CONTACTED BY OUR OFFICE.

___Home ___Work ___Cell ___Mail ____E-mail

___O.K. to leave a message with detailed information.

___Leave a message with a call-back number only.

IF YOU WISH TO RELEASE YOUR CONFIDENTIAL INFORMATION TO SOMEONE ELSE, PLEASE INDICATE THEM BELOW. ONLY YOU AND THIS PERSON WILL BE PERMITED TO HAVE ACCESS TO WRITTEN OR VERBAL INFORMATION.

NAME: _____

RELATIONSHIP TO PATIENT: _____

PATIENT SIGNATURE: _____ DATE: _____

PAYMENT AUTHORIZATION

I AT THIS MOMENT AUTHORIZE FLORIDA NEUROLOGY, P.A. TO RELEASE MEDICAL INFORMATION TO MY INSURANCE CARRIER FOR PAYMENT OF SERVICES PROVIDED. I AUTHORIZE PAYMENTS FOR SUCH SERVICES TO BE MADE DIRECTLY TO FLORIDA NEUROLOGY, P.A. I ALSO UNDERSTAND THAT IF MY INSURANCE CARRIER DOES NOT PAY FOR THE MEDICAL SERVICES PROVIDED, I AM FULLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE: _____ DATE: _____

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BOARD CERTIFIED PHYSICIANS

NEW PATIENT INFORMATION

Do you have or have you EVER had any of the following? (Check and specify all that apply)

O Diabetes Mellitus	O Pacemaker/Defibrillator	O Weight Loss
O High Blood Pressure	O Congestive Heart Disease	O Prostate Problems
O High Cholesterol	O Blood Clot/Emboli _____	O Bowl or Bladder Problems
O Cancer _____	O Sleep Disorder	O Anemia
O Heart Disease	O Parkinson's Disease	O Hernia
O Stroke / TIA	O Hyper / Hypothyroid	O Arthritis
O Heart Attack	O Lung Disease_____	O Vertigo

O Coronary Artery Disease / Angina O Emotional / Psych Problems_____

O Other medical illnesses Not Listed:

_____ _____

_____ _____

Tobacco Use: O Current O Past O Never
Age started_____ Age Quit_____ Amount per Day: _____

Alcohol Use: O Current O Past O Never
Frequency_____ Beer, Wine, Liquor use: _____

Substance Abuse: O Current O Past O Never

Please list all PREVIOUS Surgeries Including year:

_____
_____
_____

Please list ALL Physicians associated with your care:

_____
_____
_____

Florida Neurology, P.A.

NAME: _____ DATE: _____

PLEASE LIST ALL MEDICATIONS PRESENTLY TAKING:

PLEASE INDICATE DOSE AND FREQUENCY TAKEN

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____

PLEASE LIST ALL MEDICATION ALLERGIES:

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

PLEASE LIST ALL FAMILY MEDICAL HISTORY:

FAMILY MEMBER: (Mother, Father, Brother, etc.)

Condition (age deceased if applicable):

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

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BOARD CERTIFIED PHYSICIANS

FINANCIAL AGREEMENT

PLEASE INITIAL ALL BULLET POINTS

- _____ I AUTHORIZE FLORIDA NEUROLOGY, P.A. TO RELEASE MEDICAL INFORMATION TO MY INSURANCE CARRIER FOR PAYMENT OF SERVICES PROVIDED. I AUTHORIZE PAYMENTS FOR SUCH SERVICES TO BE MADE DIRECTLY TO FLORIDA NEUROLOGY, P.A.

- _____I AGREE IF MY INSURANCE CARRIER DOES NOT PAY FOR MEDICAL SERVICES PROVIDED THAT I AM FULLY RESPONSIBLE FOR PAYMENT.

- _____I AGREE TO PAY IF I MISS AN APPOINTMENT AND DO NOT GIVE A 24-HOUR ADVANCE NOTICE, I AGREE TO PAY **$75.00** FOR AN OFFICE APPOINTMENT AND **$100.00** FOR ANY OTHER PROCEDURES.

- _____I AGREE THAT ANY SERVICE PROVIDED BY FLORIDA NEUROLOGY, P.A. CAN BE TURNED OVER TO A COLLECTION AGENCY FOR NON-PAYMENT; I AM ALSO RESPONSIBLE FOR THE FULL AMOUNT PLUS ANY ADDITIONAL FEES TO FLORIDA NEUROLOGY, P.A.

- _____I AGREE TO PAY CO-PAY/DEDUCTABLE/SHARE OF COST AT THE TIME OF APPOINTMENT BEFORE SERVICES ARE RENDERED.

By signing your name below, you acknowledge that you have read and fully understand the information contained herein and therefore agree to the terms of the Financial Agreement.

_____ _____

PATIENT / GUARANTOR SIGNATURE DATE

_____

PRINT PATIENT / GUARANTOR NAME

IF YOU HAVE ANY QUESTIONS, PLEASE GET IN TOUCH WITH OUR BILLING DEPARTMENT AT 407.333.1718.

THANK YOU.

Florida Neurology, P.A.

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BOARD CERTIFIED PHYSICIANS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Last Name: _____ Date of Birth: _____

Patient's First Name: _____ Soc. Sec. #: _____

I request and authorize: _____ to release healthcare information of the patient named above to:

FLORIDA NEUROLOGY, P.A.
2445 S. Volusia Avenue-Ste. C-3
City: Orange City State: FL Zip Code: 32763
Office Phone: 386-218-6867
Fax: 386-218-6870

This request and authorization apply to the following:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Complete Medical Record: _____

_____

Patient Signature: _____ Date Signed: _____

Authorized Representative: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES 1 YEAR AFTER SIGNED.

FLORIDA NEUROLOGY, P.A.

Depression Screening

Please answer the questions below:

1. Are you basically satisfied with your life?	Yes	No
2. Are you in good spirits most of the time?	Yes	No
3. Do you prefer to stay home, rather than going out doing new things?	Yes	No
4. Do you feel your situation is hopeless?	Yes	No
5. Have you dropped many of your activities and interests?	Yes	No
6. Are you afraid that something bad will happen to you?	Yes	No
7. Do you feel you have more problems with memory than most?	Yes	No
8. Do you think most people are better off than you?	Yes	No
9. Do you feel that your life is empty?	Yes	No
10. Do you feel happy most of the time?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel full of energy?	Yes	No
13. Do you often get bored?	Yes	No
14. Do you often feel helpless?	Yes	No
15. Do you feel worthless the way you are now?	Yes	No

Screening Score:

FLORIDA NEUROLOGY, P.A.

2445 S. Volusia Avenue
Orange City, FL 32763
Phone : 386-218-6867

Name: _____

Height: _____ Weight: _____
Age: _____ Male/Female: _____

STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes (+1)	No
Do you often feel TIRED, fatigued, or sleepy during the daytime?	Yes (+1)	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes (+1)	No
Do you have or are you being treated for high blood PRESSURE?	Yes (+1)	No

BANG		
BMI more than 35kg/m2?	Yes (+1)	No
AGE over 50 years old?	Yes (+1)	No
NECK circumference > 16 inches (40cm)?	Yes (+1)	No
GENDER: Male?	Yes (+1)	No

TOTAL SCORE	

High risk of OSA: Yes 5 – 8

Intermediate risk of OSA: Yes 3 – 4

Low risk of OSA: Yes 0 – 2

Florida Neurology, P.A

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Notice of Privacy Policies for Florida Neurology, P.A.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction:

At **FLORIDA NEUROLOGY, P.A.**, we are committed to responsibly treating and using protected health information about you. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective and applies to all protected health information as defined by the federal regulations.

Understanding Your Health Record/Information:

Each time you visit FLORIDA NEUROLOGY, P.A., a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and plans for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among health professionals who contribute to your care,
- Legal document describing the care you receive,
- Means by which you or a third-party payer can verify that services billed were provided,
- A tool for educating health professionals,
- A source of data for medical research,
- A source of information for public health officials,
- A source of data for planning and marketing,
- A tool we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make informed decisions when authorizing disclosure to others.

Florida Neurology, P.A

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Your Health Information Rights:

Although your health record is the physical property of FLORIDA NEUROLOGY, P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or alternative locations,
- Request a restriction on certain uses and disclosures of your information provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

FLORIDA NEUROLOGY P.A. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices regarding the information we collect and maintain about you,
- Provide you with this notice as to our legal duties and privacy practices regarding the information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations,

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you. We will not use or disclose your health information without your authorization.

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PATIENT ACKNOWLEDGMENT RECEIPT OF PRIVACY NOTICE

I, _____ (Patient's name) hereby affirm that I have received a copy of the **Notice of Privacy Practices** from **FLORIDA NEUROLOGY, P.A.** Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this Notice from my healthcare provider. I understand that my signature on this Acknowledgement only signifies that I have received a copy of the Notice and does not legally bind or obligate me in any way. I understand that I am entitled to receive a copy of the Notice of Privacy Practices from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

Signature of Patient or Personal Representative _____

Name of Patient or Personal Representative _____

Date _____

Description of Personal Representative's Authority (if applicable) _____

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New Patient Consent Form

CONSENT FOR RELEASE OF INFORMATION:

As a patient in our practice, from time to time we may need to communicate with you or with physicians involved in your care when you are not in the office. To preserve your privacy, we would like you to indicate your preferred method for us to communicate information to you and ask your permission to communicate with your physicians. If no one is available to answer your phone, we need your permission to leave medical information about your care. We will **not** leave a detailed message regarding medical information if your name or phone number is not on your recorded message to identify your residence. Without specific permission, we will not release any of your medical information to another person. In some cases, you may wish for another person to have access to your medical information. Please indicate the full name and relationship of the persons you authorize us to discuss your care with. (i.e. spouse, parent, sibling, etc.) By acknowledging your signature, I am authorizing Florida Neurology P.A. to make available necessary medical information to all physicians involved in my care, family members/friends listed above. I assume responsibility to inform the practice of changes in my phone numbers(s) or my preference.

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the release of the information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Florida Neurology P.A. I authorize Florida Neurology P.A. to release any medical information requested by my health insurance carrier or any other third-party payer needed for any claim consideration; as well as to obtain any information concerning coverage and payments under my insurance policy. If I am without health insurance, payment for the office visit is required at the time of service. Additional services will be billed to me. After **120** days, your account will be referred to our collection agency if a personal balance remains without a payment agreement. Non-Emergency Services Provided without Referral Authorization: I understand that I must obtain a referral for non-emergency services from my primary care physician before any appointments at Florida Neurology. I am responsible for all deductibles, co-insurance, and non-covered services. I understand that if this office does not participate in my insurance plan, I am responsible for payment of any balance not covered by the nonparticipating insurance carrier.

NOTICE OF PRIVACY PRACTICES:

Any healthcare professional authorized to enter information into your medical record, all employees, staff, and other personnel at Florida Neurology P.A. who may need access to your information must abide by the Notice of Privacy Practices. All subsidiaries, business associates (e.g. billing service), sites, and locations of this practice may share medical information for treatment, payment purposes, or health care operations described in the Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared. Your healthcare provider must give you a notice that tells you how they may use and share your health information and how you can exercise your health privacy rights. The provider cannot use or disclose information in a way that is not consistent with their notice. The law requires your doctor to state in writing that you received the Notice of Privacy Practices.

MISSED APPOINTMENT POLICY:

All patients are required to give at least **24 hours** advanced notice when canceling an office consultation appointment and **72 hours** advanced notice when canceling an EMG, EEG, or Botox procedure. A missed appointment is defined as any appointment for which a patient does not arrive as scheduled (**"no show"**) or is canceled within the minimum notice listed above (**same-day cancellation**). The standard charge for all missed office appointments is $ 75 and $ 100 for all other procedures. Patients with insurance, other than Medicare and Medicaid, who are in danger of dismissal, have the option to pay a **$100** deposit that will be refunded if they show up for the appointment timely; otherwise, the deposit will be non-refundable.

ASSIGNMENT OF BENEFITS:

I and/or my insurance carrier(s) agree to pay, promptly, for health care services provided. I authorize payment directly to Florida Neurology, P.A., and all benefits payable.

RELEASE OF INFORMATION:

Florida Neurology P.A. or physicians who provide professional services to the patient are authorized to furnish medical information from my emergency medical record to the referring physician, if any, and to any insurance company or third-party payer to obtain payment of the account. Florida Neurology, P.A. is authorized to release information from my medical record to any other healthcare facility or provider to which my care may be transferred.

FINANCIAL RESPONSIBILITY:

In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insurer or third-party payer, including any deductible or co-payment, or any charges not covered under my plan and/or as a result of my failure to provide notification or obtain preauthorization for treatment as required by any insurer or third-party payer to Florida Neurology, P.A. Should my account be referred for collection, I agree to pay Florida Neurology, P.A. reasonable attorney fees and collection expenses.

Patient Name: _____

Signature of Patient: _____

Name of Patient's Personal Representative: _____

Signature of Personal Representative: _____

Date: _____