Neurology Associates of Ormond Beach, P.A.

8 Mirror Lake Drive, Suite A
Ormond Beach, FL 32174
386-673-2500

870 Dunlawton Ave, Suite 109
Port Orange, FL 32127
386-427-3700

Welcome to Neurology Associates of Ormond Beach, P.A. Your physician has referred you to our office for your continued care. Your appointment is scheduled for:

_____

with

Dr. Dalia Fulop Dr. David McDonald Dr. James Scott Dr. Mandeep Garewal

Dr. Srivadee Oravivattanakul Erika Jacumin, PA-C Thor Fiol, PA-C

Alyssa Alvarez, APRN Maggie Skowronska, APRN

in our

Ormond Beach Office Port Orange Office

Enclosed you will find your new patient packet. Please complete this packet, using black ink and sign each page before your appointment. **This new patient package MUST be returned to our Ormond Beach office only PRIOR to your appointment. If we do not receive it prior, your appointment may be rescheduled.** This packet should contain 8 pages (not including this letter or the map). If you have any questions regarding the packet you may call the office or ask when you come to your appointment. You will receive a reminder call that will tell you to arrive 30 minutes prior to your appointment.

Please bring with you your photo ID, insurance card(s) and medication bottles to your first appointment. Your ID and insurance card(s) will be scanned into your electronic chart. ALL COPAYS/COINSURANCE are due at the time of service. BALANCES on your accounts will need to be paid before your next scheduled appointment. If you have an accepted HMO plan, please make sure that your primary doctor has sent us the authorization. **WE DO NOT ACCEPT MEDICAID OR ANY MEDICAID HMO PLANS, AUTO ACCIDENTS, WORKMAN'S COMPENSATION, AND/OR LIABILITY CASES.** If you have any questions regarding if we accept your insurance, please call our billing office prior to your visit. If you wish to have access to your medical records, please make sure you give us a legible email address.

Your initial visit may be with the physician, physician's assistant or nurse practitioner. Subsequent follow up visits may be scheduled with your doctor or his/her nurse practitioner or physician assistant.

During this time of COVID-19, we do require that everyone wears a MASK upon entry to our building.

We look forward to meeting you,

Neurology Associates Staff

Neurology Associates of Ormond Beach, P.A.
8 Mirror Lake Drive
Ormond Beach, FL 32174
Phone: 386-673-2500 Fax: 386-673-3204

Patient Registration Form

Patients Name: _____ **(as appears on insurance card)**

Address: _____ **City:** _____ **Zip:** _____ **ST:** ____

Social Security #: _____ **Date of Birth:** _____ **Sex:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

Race:	Marital Status:	Ethnicity:	Language:
__White __Hispanic	__Single __Married	__Non-Hispanic	__English
__African American/Black	__Divorced __Widowed	__Hispanic	__Spanish
__American Indian	__Separated	__Other	__Other

Primary Insurance: _____ **Policy #:** _____

Insured's Name: _____ **Social Security #:** _____ **DOB:** _____

Secondary Insurance: _____ **Policy #:** _____

Insured's Name: _____ **Social Security #:** _____ **DOB:** _____

Emergency Contact: _____ **Relation to patient:** _____

Address: _____ **Phone #:**_____

I hereby authorize Neurology Associates of Ormond Beach, PA, any medical providers, or insurance carriers to release any information necessary for insurance purposes to process any claim related to my care provided by Neurology Associates of Ormond Beach, PA.
I hereby authorize medical care to be rendered to myself or my dependent as deemed necessary by Neurology Associates of Ormond Beach, PA.

I hereby authorize direct payment of medical benefits to Neurology Associates of Ormond Beach, PA for services rendered. I understand that I am financially responsible for any balance not covered by my insurance, plus any additional charges/fees. If after 45 days my insurance has not responded I will be responsible for the total bill or remaining portion. I am aware that Neurology Associates of Ormond Beach, PA bills my insurance as a courtesy.

Medicare Release: I certify that the information given to me in applying for payment to Medicare is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf to Neurology Associates of Ormond Beach, PA. A photocopy of this form serves as a valid original document.

I acknowledge that I was provided a copy of notice of privacy practices for Neurology Associates of Ormond Beach, PA and that I have read and understand the notice of privacy practice.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

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CLINICAL HISTORY FORM

Name: _____ **DOB:** _____ **Age:** _____ **Gender:** _____

Referring Doctor: _____ **Primary Care Doctor:** _____

Reason for your visit: _____

Where is the location of your problem: _____

When did the symptoms first occur: _____

What makes it worse? _____ **Better?** _____

How long have you had these symptoms? _____ **Related to an injury?** _____

Was it work/motor vehicle/worker's comp/liability related_____ **Date of Injury:** _____

Are you currently working? _____ **Date last worked:** _____ **Work Capacity:** **Full or Part Time**

Review of Symptoms (check all that apply):

Constitutional
__Fever
__Night Sweats
__Weight Loss

Cardiovascular
__Shortness of Breath
__Chest pain
__Irregular Heart Beat

Respiratory
__Chronic cough/ coughing blood
__Emphysema
__Bronchitis
__Asthma

Gastrointestinal
__Blood in stool/ dark stool
__Nausea/Vomiting
__Abdominal pain

Endocrine
__Nipple Discharge
__Dry Skin
__Loss or gain of hair
__Weight gain or loss
__Excessive Thirst

Genitourinary
__Burning with urination
__Difficulty starting/ending urine stream
__Poor bladder control or incontinence
__Sexual Dysfunction
__Loss of sensation of genitals
__Inability to obtain, maintain erection

Sleep
__Insomnia
__Snoring
__Excessive leg movement
__Nightmare/Terrors
__Excessive daytime sleepiness

Hematology
__Easy Bruising
__Nose Bleeds
__Excessive bleeding with previous surgeries

Neurological
__Change of Vision (blurry/double)
__Loss of Hearing/Ringing in Ear
__Facial Numbness
__Decrease sense of smell/taste
__Smell or Taste
__Difficulty swallowing
__Slurred Speech
__Headache
__Dizziness
__Seizures
__Stroke
__Pain in arm(s)
__Pain in leg(s)
__Numbness/Tingling in arm(s)
__Numbness/Tingling in leg(s)
__Weakness in arm(s)
__Weakness in leg(s)
__Epilepsy

Psychological
__Depression
__Anxiety

Musculoskeletal
__Neck Pain
__Back Pain
__Trouble Walking

Neurology Associates of Ormond Beach, P.A.

Medical History:

__Heart Attack/Disease
__High Cholesterol
__High Blood Pressure
__Seizure
__Stroke
__Diabetes
__Kidney Problems
__Liver Disease
__Cancer
__HIV/AIDS
__Asthma/Lung Disease
__Neuropathy
__Other Neurological
__ **Pacemaker, VNS, Defibrillator, Stents, Stimulator**

History of Surgery & Hospitalizations:

Date	Surgery/Hospitalization	Reason

Family History

Father: Age_____ Alive/Deceased
Medical Condition(s) _____
Mother: Age_____ Alive/Deceased
Medical Condition(s) _____
Sibling: Age_____ Alive/Deceased
Medical Condition(s) _____
Sibling: Age_____ Alive/Deceased
Medical Condition(s) _____

Highest Level of Education:

__Grade School __Middle School __High School __GED __Technical __College

Social:

Do you exercise? __Y __N How often? _____
Do you smoke? __Y __N How many years? _____ How many per day? _____
Do you drink? __Y __N Number of drinks per week? _____
Do you use illicit drugs? __Y __N Which drug(s)? _____
Are you on a special diet? __Y __N What type? _____

Allergies to Medication (Drug & Reaction):

1. _____
2. _____
3. _____

List of current medications (attach list if necessary):

Name of Medication	Dosage	Frequency

Pharmacy:

Name: _____ Address: _____

Phone #: _____ Fax #: _____

My signature signifies that I have read, answered and understand the information included in this form as part of my medical evaluation.

Patient Signature: _____ **Date:** _____
Authorized Representative: _____ **Relation to patient:** _____

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Neurology, EMG, Neuromuscular, Epilepsy & Stroke Patient Responsibility

- ALL PAYMENTS such as co-pays, co-insurance, deductible, and outstanding balance are due at time of service
- You will have an added charge to your account if you do not show up for your appointment or call 24 hours in advance to reschedule. The charges are as follows:
  - $50.00 for a follow up visit
  - $100.00 for a testing visit
  - $250.00 for a sleep study
- There will be a $35.00 charge for a return check
- It is the responsibility of the patient to inform us of the location of the lab that will be used and call us when labs are completed.
- It is the patients' responsibility to update our office with any insurance changes to avoid non-payment from your insurance. If your insurance is not updated and payment is not satisfied by your insurance, you will be solely responsible for the services provided.
- It is the patients' responsibility to inform us of any address or phone number changes.
- It is the patients' responsibility to make sure we accept your insurance and if we are in network. Please see list of insurances we do not accept on following page.
- Please do not call prior to your appointment for test results unless instructed by your doctor.
- We ask that you call two weeks in advance for processing of your refills. It is the patients' responsibility to know when they need a refill. We DO NOT accept walk-ins for refills.
- Please see our list of insurances we do/do not accept.

I _____ acknowledge and understand the policy above.
(print name)

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

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This information may be disclosed to and used by the above individual or organization

Authorization to obtain, release or review protected health information

Patient Name: _____ Social Security #: _____

Address: _____ City: _____ St: _____

Zip Code: _____ Date of Birth: _____ Phone Number: _____

The following individual or organization is authorized to make the following disclosure
(LEAVE THIS SPACE BLANK FOR OFFICE USE)

Name: _____ Phone #:_____ Fax #: _____

Address: _____ City: _____ St: _____ Zip Code: _____

___History & Physical (office notes) ___ Labs ___ Radiology Reports ___X-Ray Films or CD's

Specific Dates Requested: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization stands as is.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this form. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain the information to be used or disclosed, as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality laws.
I understand that the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by federal and state regulations. I also understand that my health record may include information relating to AIDS/HIV and/or sexually transmitted disease.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

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I _____, hereby authorize Neurology Associates of
Patient/Guardian
Ormond Beach, P.A. or their representative, to take a photograph and/or record a video of
_____.
Name of Patient

I understand that such photograph(s) and/or video recordings may be used for clinical/educational purposes or in the event of legal action. Neurology Associates and it's duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s) and/or video recordings. **No photographs and/or video monitoring equipment are located in exam rooms or procedure areas.** Closed circuit video of patient waiting areas, check out and billing are for security purposes.

The undersigned also hereby transfers and assigns to Neurology Associates the right to copy the materials in whole or in part. No use of the material for educational purposes will identify me by name.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

Witness: _____ **Date:** _____

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Patient Authorization for Use and Disclosure of Protected Health Information

Neurology Associates of Ormond Beach, P.A. maintains a confidentiality policy with all patients' medical information. Please list the names of those that you give this office permission to speak with concerning your medical condition.

I _____ hereby give permission for this office to give information regarding my medical condition.

The information used or disclosed pursuant to this authorization (please check all that pertain)

___May ___May Not Include information related to HIV/AIDS
___May ___May Not Include information related to mental health
___May ___May Not Include information related to substance abuse or alcoholism

The name(s) listed below have my permission to discuss and/or receive information on my medical condition.

Name: _____ Relation to patient: _____
Name: _____ Relation to patient: _____
Name: _____ Relation to patient: _____
Name: _____ Relation to patient: _____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient to the members of the practice & research department and may no longer protected by the federal HIPPA Privacy Act. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted, signed and witnessed to the above address on this document.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____

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I _____ am aware that Neurology Associates does not participate with any Medicaid plans. I understand that I am responsible for any balance due on my account and **if in the future I sign up with a Medicaid plan,** I understand that I am responsible for any balance due on my account. I am aware that Neurology Associates bills my insurance as a courtesy to me.

I _____ am aware that my insurance may not pay for certain services, procedures and treatments. If my insurance does not pay for my visit in full I am aware that I am responsible for my balance due on my account.

*Please note that if your insurance requires an authorization for services rendered at our facility or by one of our doctors it is the referring physician and patient's responsibility to obtain a prior authorization before services are rendered.

Patient Signature: _____ **Date:** _____

Authorized Representative: _____ **Relation to patient:** _____