Neurology Institute of Melbourne
Patient Information

Name ______________________________ Birthdate ______________________

Permanent Address: ____

Primary Phone: __________________ Alternate Phone: ______________________

Seasonal Address : ____

SSN: ______________ Marital Status: __________ Insurance: __________________

Insured's Name: ______________________ Birthdate: ______________________

Emergency Contact: __________________________ Phone __________________

Nearest Relative (not living with you) ____________________ Phone ______________

How did you hear about us? ____________________ Primary Care Physician ______________

Is this visit related to Workers Comp or Auto accident? (please specify) Date of Injury ______________

Has this visit been scheduled through Vocational Rehabilitation? Counselor ______________

I hereby assign all medical benefits including major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plan to Neurology Institute of Melbourne, PA. This assignment remains in effect until revoked by me in writing.

Your portion of the office visit is due at the time of service. As a courtesy to you, we will file your initial insurance claim. It is your responsibility to obtain authorization for all services. If for any reason your insurance company or health plan refuses payment, you are responsible for the balance of payment for services rendered, including any and all service charges or missed appointment fees.

Signature ______________________________ Date ______________________

New Patient Review of Systems: Please check all that apply

GENERAL

____ Frequent headaches

DERMATOLOGICAL

____Painful scalp
____Skin problems
____Bruise easily
____Eczema
____Hives

OPTHAMOLOGIC

____Blurry vision
____Eyesight worsening
____Double vision
____Eye Pain
____Eyes water or burn
____Cataracts
____Other eye problems

ENT

____Hearing difficulties
____Frequent infections
____Ringing or buzzing in ears
____Earaches
____Loss of sense of smell
____Nose bleeds
____Trouble bleeding with mouth closed
____History of sinusitis
____Previous skull fracture
____ Painful or tender over sinuses

RESPITORY

____Shortness of breath
____Cough which produces sputum
____Cough which produces NO sputum
____History of pneumonia
____History of tuberculosis
____Pain with breathing
____Wheezing

CARDIOVASCULAR

____High blood pressure
____Chest pain
____Leg cramps produced by walking
____History of heart murmur
____Previous heart attack
____History of angina
____History of rheumatic fever
____Attacks of racing heart beat

DIGESTIVE

____Difficulty swallowing
____Heartburn
____Stomach pains
____Vomiting
____Vomit blood / coffee colored
____Bloated
____Diarrhea
____Black stools
____Constipation
____Liver disease

GENITOURINARY

____Unusually frequent urination
____Wake up at night to urinate
____Burning on urination
____Constant full bladder
____History of urinary infections
____Prostate problems
____Menstrual problems

MUSCULOSKELETAL

____Whiplash injury
____Neck pain
____Neck lumps / swelling
____Neck stiffness
____Low back injury
____Low back pain

NEUROLOGICAL

____Fainting spells
____Light headedness
____Dizzy spells
____Convulsions (seizures)
____History concussion or trauma
____Tremors or shakiness
____Uncontrolled jerking
____Changes in handwriting
____Sudden loss of vision
____Sudden fall to the floor
____Loss of memory
____Numbness of arms / legs
____Weakness in arms / legs
____Hx of encephalitis / meningitis
____History of stroke
____Difficulty with balance
____Difficulty with speech
____Period of coma or loss of consciousness

NEUROLOGY INSTITUTE OF MELBOURNE

New Patient Health History Form

Name____________________ DOB______________ Today's Date______________

Height___________ Weight_______ BP__________ Pulse __________

Please list ALL of your **medications and dosages** including **vitamins** and **over the counter products.**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Please list ALL **allergies to medications** and **reactions.**

MEDICATION____________________ REACTION________________________

MEDICATION____________________ REACTION________________________

MEDICATION____________________ REACTION________________________

FAMILY HISTORY: Please indicate the relation of any **family members** diagnosed with the following conditions. If no relative had the condition, please circle "none."

Alzheimer's Disease:	____________________	none
Brain tumors:	____________________	none
Lou Gehrig's Disease (ALS):	____________________	none
Migraines:	____________________	none
Multiple Sclerosis:	____________________	none
Neuropathy:	____________________	none
Parkinson's Disease:	____________________	none
Psychiatric Disorders:	____________________	none
Strokes:	____________________	none

MAJOR ILLNESSES: Please circle any of the following illnesses with which you have been diagnosed or prescribed treatment.

High Cholesterol	Acid Reflux	Cataracts	Stroke
Thyroid Problems	Heart Valve Disorder	Psych. Disorders	Ulcer
Diabetes	Anemia	Depression	Seizures
Heart Disease	Anxiety	Kidney Disease	Arthritis
High Blood Pressure	Diverticular Disease	Emphysema	Asthma
Atrial Fibrillation	Fibromyalgia	Meningitis	Glaucoma
Back Problems	Neuropathy	Prostate Problems	

Cancer (please explain)____

HABITS: Please circle the appropriate answer.

Smoking: *Type:*	current (#________ / day)	former (quit _______ years ago)	never
Drug Use: *Type:*	current: (#________ / day)	former (quit _______ years ago)	never
Alcohol:	regular: (#________/ day)	occasional (#_______ / month)	never

Please list ALL **surgeries** and **approximate dates.**

PROCEDURE_________________________ DATE_________________________________

PROCEDURE_________________________ DATE_________________________________

PROCEDURE_________________________ DATE_________________________________

PROCEDURE_________________________ DATE_________________________________

PROCEDURE_________________________ DATE_________________________________

PROCEDURE_________________________ DATE_________________________________

Neurology Institute of Melbourne
Office Policies
(Please initial in each provided space)

Appointments

As a courtesy, we allow 15 minutes for lateness. After 15 minutes, we reserve the right to reschedule. We have a "reminder call" program in place, also as a courtesy, whereby all scheduled patients are called the workday before the appointment to confirm. It is your responsibility to make note of your appointments and arrive as scheduled; this policy is in effect even if we are unable to reach you by phone to confirm your appointment. As we do not double book appointments, if you do not cancel a scheduled appointment 24 hours in advance, you create a vacancy in our schedule which cannot be filled. For this reason, it is our policy to charge the following "NO SHOW" FEES.

$50.00 FOR A MISSED FOLLOW UP APPOINTMENT

$100.00 FOR A MISSED TEST (NERVE CONDUCTION, EMG, EEG)

$500.00 FOR A MISSED 72 HOUR AMBULATORY EEG

Insurance

We accept most private insurances excluding Health First and HMO plans. ***It is the patient's responsibility to contact the insurance company to verify that Dr. Unger is a network provider for that plan. If for any reason your insurance company or health plan refuses payment, you are responsible for the balance of payment for services rendered, including any and all service charges or missed appointment fees.***

It is also the patient's responsibility to provide proof of current insurance at the time of the appointment. Scanned or photographic copies of the insurance card is not considered valid proof. If this information is not available, please make arrangements with the receptionist to utilize the private pay option. There is a discount for private pay patients who do not have current insurance. Additionally, payments are due at the time of service or subject to a $25.00 administration service charge. This includes coinsurance payments for Medicare. PLEASE NOTE: WE DO NOT ACCEPT MEDICAID AT ALL. If you have any questions regarding billing, please contact our billing service company, Seabreeze Medical Billing at 1-877-159-5650.

Medical Records

All requests for medical records must be in writing and may take up to 14 days to process. All patient accounts must be paid in full before medical records are released. Medical records to / from another physician may be requested by completing the form in our office. As a courtesy, we provide the first copy of your medical records at no charge. In accordance with Rule 64B8-10.003 Administrative code, our office charges for reproducing additional copies of medical records at $1.00 per page for the first 25 pages and $.25 per page thereafter. Payment for records must be made in advance.

Forms and Read Fees

The business office collects a $50.00 service charge prior to the completion of any forms generated outside of our office. Also, in order to provide you with the best possible care, Dr. Unger reads ALL films (MRI, CT), including those that may have been read by another physician / facility. A read fee is charged for each scan, and we will submit this bill to your insurance company as a convenience to you. Should your insurance provider deny payment for this service, your maximum responsibility will not exceed $50.00 per scan.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ______________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________ ______________________

Please *print* name of Patient   Please *sign* for Patient/Guardian of Patient

______________________ ______________________

Legal Representative/Guardian   Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgements or Consents: ______________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sir Name ☐ Other ______________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ______________ Relationship: ______________

Name: ______________ Relationship: ______________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because ☐
Other (please describe) ☐

____
Signature of Privacy Officer

HIPAA made EASY™
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Neurology Institute of Melbourne
Financial Policies

We are happy you have chosen Dr. Unger as your neurologist and we will strive to give you the best medical care. We understand that in addition to needing to feel comfortable with your physician, you may have concerns about the financial policies of our practice.

Our office collects co-payments / co-insurance at the time services are rendered. Any amount not collected at that time will be assessed a $25.00 service fee. We accept cash, all major credit cards, and personal checks. A returned check fee of $25.00 will be assessed and you will be unable to make subsequent payments by check should your check be returned by your bank.

For all serviced rendered to minor patients we will look to the accompanying adult for payment (including any past due balances). We will not get involved in arrangements made between divorced parents or custodial agreements.

We will file insurance for patients who participate in insurance plans. In order to do this as accurately and efficiently as possible, we MUST see your insurance card at each visit. If you do not have your actual insurance card available, the visit will be expected to be paid in full. Any applicable credit amounts will be refunded to you once contracted insurance information is received and your insurance company provides payment.

If your visit is auto or worker's compensation related, we must be informed immediately. The charges for auto related visits will be billed to your auto insurance company and, as a courtesy, to your major medical carrier. We must have the following information prior to billing your auto insurance : auto insurance company, claim number, adjuster's name and phone number and mailing address for billing. All balances are the responsibility of the patient. We do not accept letters of protection from attorneys.

Any services that we file with your insurance company that are not responded to after 90 days from the date of service may be transferred to the patient balance which will remain the responsibility of the patient until payment is received or written correspondence is received from the insurance company verifying that payment is forthcoming from them. Any balances not paid within 90 days will be forwarded to our collection agency unless prior arrangements have been made with our office. All fees associated with the collection of a debt will be the responsibility of the patient. PLEASE NOTE: WE CANNOT SCHEDULE OR SEE PATIENTS IN COLLECTIONS STATUS. COLLECTIONS STATUS MUST BE CLEARED PRIOR TO THE PATIENTS ARRIVAL FOR THEIR VISIT.

A monthly statement will be sent to you by our billing company, Seabreee Medical Billing, detailing unpaid charges. If you have any questions regarding items which have not been paid by your insurance, we ask that you contact your insurance company or employer as benefit packages vary by employer and policy.

NON-COMPLIANCE WITH THIS FINANCIAL POLICY MAY RESULT IN DISMISSAL FRO M THE PRACTICE.

I have read and understand the financial policies of the practice and agree to be bound by its terms. I also understand and agree that such terms may be amended at will by the practice.

Patient Name ____

Signature ______________________________ Date ________________