Gardens Neurology – Patient information

First name:_____Last Name:_____ Gender: M F Other Race*_____

Date of Birth:____/____/_____SS#_____ Language*_____Ethnicity*_____
*These prompts are required by federal government rules and regulations

Home Address:_____ City:_____ State:_____ Zip:_____

Email Address*:_____Occupation:_____

Home Phone:( )_____ Cell: ( )_____ Alternate #: ( )_____ Preferred: Home Cell

Employer:_____Work Address:_____

Primary Care Physician:_____Referring Physician:_____

Spouse/Guardian/Other:_____Phone #:_____

Emergency Contact Person Name:_____Phone #:_____

☐ Please check here if person financially responsible (a.k.a Guarantor) is different than patient

Is this a worker's comp case? Yes No Auto Accident Injury? Yes No Work Related Injury? Yes No

Have you seen a Neurologist before? If so, who and when?_____

Insurance and Billing Information

Primary Insurance Company:_____ID#_____Group # _____

Policy Holder Name:_____ D.O.B._____ Relationship:_____

Policy Holder Place of Employer and address:_____

Secondary Insurance Company:_____

I authorize the release of any medical information to any insurance for the purpose of filing my medical claim.
By signing below, I certify that the insurance information given by me for payment by my insurance plan(s) is correct.

Medical Information

Local Pharmacy Name:_____ Phone #:_____

Mail-In Pharmacy Name:_____ Phone #:_____

I hereby consent to medical treatment for myself. I authorize payment to be made directly to Dr. Silvers. I understand that I am financially responsible for any services deemed not covered by my insurance. Deductibles, co-pays, and co-insurance payments are due at the time of service, while membership fees are annual. If I fail to make payments for services rendered, I am financially responsible for any and all costs and fees relating to the collection of my debt. Many insurance companies require a referral when a patient sees a specialist. I acknowledge that it is my responsibility to obtain a referral from my primary care physician (if needed by my insurance company) before all visits at Gardens Neurology. If proper referral is not obtained, I will be responsible for the all payments. Also, many insurance companies are part of a larger network and provide a greater benefit when the patient sees an in-network physician. I acknowledge that it is my responsibility to find out if Gardens Neurology is part of my insurance network and how my claim will be paid whether or not it is the case. For an out-of-network claim, I will be responsible for the balance after my insurance company's payment.

Signature:_____Date:_____

Gardens Neurology - Patient Questionnaire Form Part I

Patient Name:_____ Date:_____

Chief Complaint:_____

Past Medical History: (please check all that apply)

□ Diabetes mellitus □ Glucose intolerance □ Hypertension □ Hyperlipidemia
□ Atrial fibrillation □ Coronary artery disease □ Coronary angioplasty □ Stenting
□ Coronary bypass surgery □ Cardiac valve disease □ Pacemaker
□ CHF □ Other cardiac _____
□ HIV/AIDS □ COPD □ Asthma □ Kidney stones
□ Hyperthyroidism □ Hypothyroidism □ Multiple sclerosis □ Epilepsy
□ Stroke(s) □ Pulmonary emboli □ DVT
□ Other clotting condition_____
□ Obstructive sleep apnea: using CPAP Y N □ Migraine without aura □ Migraine with aura
□ Parkinson disease □ Other movement disorder(s) _____
□ Brain tumor □ Peripheral neuropathy □ Other neuromuscular condition_____
□ Mild cognitive impairment □ Alzheimer disease □ Other cognitive disorder_____
□ RLS □ Depression □ Anxiety □ Other neurological/psychiatric condition_____
□ Cancer (Type[s])_____ □ Treatments: (circle) radiation / chemotherapy
□ Other major medical conditions_____

Past Surgeries_____

Attach Medication List or Write Below – Include Medical Marijuana, Supplements, Dosage and Instructions:

_____

_____

_____

Attach Allergy list or Write Below:

_____

_____

Social History: (please circle)

Marital Status:	Single	Married	Separated	Divorced	Widowed
Alcohol Use:	Never	Rarely	Moderate	Daily	
Tobacco Use:	Never	Previously, but quit		Current packs/day _____	
Recreational Drug Use:	Never	Type/Frequency:_____			

Patient Family History: (please check all that apply)

	Father	Mother	Siblings	Children
Stroke ……	☐	☐	☐	☐
Migraine……	☐	☐	☐	☐
Epilepsy……	☐	☐	☐	☐
Dementia……	☐	☐	☐	☐
Parkinson's/Movement disorders……	☐	☐	☐	☐
Neuromuscular condition……	☐	☐	☐	☐

If deceased, cause of death _____ _____ _____ _____

Gardens Neurology - Review of Systems

DOB:_____Date: _____

Patient Name:_____

Weight:_____Height:_____

Hypertension	Y N
Smoking	Y N
Any falls in the last 12 months?	Y N
↳ If yes to falls, how many falls?	_____
were the falls with injury?	Y N

Cardiovascular

Lightheaded or dizziness	Yes
Chest pain or angina	Yes
Palpitations	Yes
Anemia	Yes
Bleeding tendencies	Yes
Shortness of breath	Yes

Constitutional Symptoms

Recent weight change	Yes
Fever	Yes
Fatigue	Yes
Rash or itching	Yes
Thyroid disease	Yes
Change in libido	Yes

Gastrointestinal/Urinary

Rectal bleeding/blood in stool	Yes
Abdominal pain/heartburn	Yes
Painful urination	Yes
Frequent urination	Yes
Incontinence	Yes

Psychiatric

Depression Y N

↳ **If yes, answer questions below**

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself, being a failure, let yourself/your family down	☐	☐	☐	☐
7. Trouble concentrating on things such as reading or watching TV	☐	☐	☐	☐
8. Moving/speaking slowly or being fidgety/restless moving more than usual	☐	☐	☐	☐
9. Thoughts of being better off dead or hurting yourself in some way	☐	☐	☐	☐

Musculoskeletal

Joint pain or swelling	Yes
Muscle weakness	Yes
Muscle pain or cramps	Yes
Low back pain	Yes
Neck pain	Yes

Neurological

Frequent headaches	Yes
Convulsions/seizures	Yes
Numbness or tingling	Yes
Tremors	Yes
Weakness and paralysis	Yes
Stroke	Yes
Traumatic brain injury	Yes
Difficulty walking	Yes
Memory loss	Yes
Daytime sleepiness	Yes
Anxious	Yes

Eyes/ENT

Visual loss	Yes
Double vision	Yes
Hearing loss/ringing in the ears	Yes

Other

_____

_____

_____

Gardens Neurology – Consent for Treatment and Release Information

I authorize Gardens Neurology, PLLC, use and disclosure of all individual identifiable personal health financial and demographic information (known as Protected Health Information or PHI) for the purpose of:
Providing medical treatment, obtaining payment and reimbursement, obtaining authorization from my insurance for tests (where required), requesting healthcare services from other providers, cooperating with other providers in my medical care, fulfilling request for information when specifically authorized by me, as well as doing all other things directly related to providing healthcare to me.

This purpose and all other uses are known as collectively Treatment, Payment, and Other healthcare options (TPO). I authorize any physician or healthcare facility to provide upon request any PHI to Gardens Neurology for the TPO.
I consent to Gardens Neurology discussing any or all of my medical care including evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, AIDS, HIV related infection or pregnancy with:

1. _____ Relationship:_____
2. _____ Relationship:_____
3. _____ Relationship:_____

I have been given the opportunity to review Gardens Neurology's Privacy Notice in the waiting room

By signing below, I consent to Gardens Neurology leaving messages on my answering machine (unless otherwise requested)

I understand my rights to restrict the use and discloser of PHI and to revoke this consent at any time in writing

I understand that should I choose not to consent to the terms & conditions of Gardens Neurology's Privacy Notice, the practice has the right to and will withhold treatment except where required by law.

<u>A note to new patients regarding potential membership enrollment and information:</u>

Since all new patients fill out these forms, it is impossible for us to predict whether your medical needs and neurological issues will be resolved in the next appointment or within the next few weeks, month or year. Our dedication is such that we will provide you with the best medical services regardless of whether you are a "one timer" or become a life-long patient. Once you are an established patient, and your plan of care has been determined and presented to you by Dr. Silvers, you will be given the opportunity to remain a patient in our practice, therefore continue to receive care from Dr. Silvers, for an annual membership fee, or choose to go elsewhere for your follow-up neurological care. This membership provides patients access to our office, staff, providers along with many enhanced benefits. If you choose to remain in our practice, an annual membership fee will apply and an agreement, along with all enhanced benefits, will be presented to you for your review. If you choose to go and seek treatment from another neurologist, your new patient chart will be sent to the doctor of your choice upon receiving an official request from you. This transfer of records will be at no additional cost to you.

Patient's name: (please print):_____ Signature:_____ Date:_____

Insured or guardian's signature:_____ Date: _____

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and discloser or protective health information for treatments, payments and other healthcare operations without a signed consent, and prohibits the use and discloser of protective health information for non-healthcare related activities without specific and explicit authorization.

Gardens Neurology - Statement of Patient Financial Responsibility and Payment Policy

Patient Name:_____**DOB:** _____

Thank you for allowing us to treat you for your neurological needs. As payment for these services are required, you are obligated to ensure payment of our fees in full (ie, copays, coinsurance, deductibles, membership, etc). As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf but please remember that **you are responsible for your insurance policy**. You are ultimately the one who is responsible for verifying benefits and for payment of your final/entire bill. **Due to many changes in insurance policies, we cannot be responsible for interpreting each individual policy. It is your responsibility to know your individual coverage and its limitations, as well as who is a provider for your plan. We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred.** Please remember that your insurance policy is a contract between you and your insurance company. It is your responsibility to know or find out, whether or not we are providers for your specific network. Membership fees are NOT covered by insurance.

Referrals

If you need a referral from your primary care doctor or from your insurance company to be seen in this office, the referral must be present prior to your visit and it is your responsibility to obtain one. Consequently, you will need to reschedule your visit should a referral not be available and a cancellation fee will apply. If you find out after your visit that a referral was necessary, you will be responsible for full payment if your insurance fails to pay us due to lack of such referral authorization. We welcome you to call and have your primary care physician fax their referral to us at 561-429-3184.

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pays. It is expected and appreciated at the time the service is rendered for the patients to pay each visit's copay. Because we are specialists, some diagnostic procedures are not considered part of your office visit co-payment and may be applied to your deductible and/or co-insurance. Please call your insurance company and learn about your coverage. It will save unnecessary out of pocket expenses.

Cancellation / No Show Policy

We understand you may miss an appointment due to various circumstances. However, you must call more than 24-hours prior to your appointment time if you need to cancel or reschedule. Failure to do so will result in a $75 no-show fee. We **always** attempt to confirm in-person, therefore if the appointment was not confirmed with you, we might give the time slot away to a waitlisted patient. We make multiple attempts, by phone text and email, to confirm so please contact us back to confirm and honor your scheduled appointment. Remember, the appointment was your choice of date and time.

Self-Pay

I do not have health insurance and will be responsible for services rendered by the staff at Gardens Neurology. You agree to pay Gardens Neurology, the full and entire amount for the consultation and treatment given at each visit. If Gardens Neurology is not a provider for your insurance company, or you choose to pay out of pocket, you will be considered a self-pay patient and we will collect our fee in full at the time of service.

I have read the above policy regarding my financial responsibility to Gardens Neurology, for providing services to me or the above-named patient. I authorize my insurer to pay any benefits directly to Gardens Neurology, the full and entire amount of bill incurred by me or the above named patient; or, if applicable I promise to pay in full any amount due (remaining balance) after payment has been made, or denied, by my insurance carrier. This financial responsibility form supersedes any prior writings which are now null and void and are no longer in effect.

Patient/Guarantor Signature_____Date_____

Gardens Neurology

NOTICE OF POLICY - CONTACTING DOCTOR OUTSIDE OF REGULAR OFFICE HOURS

Dr. Silvers is a solo out-patient practitioner. He and his staff are here to assist you during business hours. During the regular work week, the office is staffed from 8:00 a.m. to 5:30 p.m. Monday through Thursday and Friday 8:00 am to 5:00 pm (except federal holidays and doctor's vacations). Patients are encouraged to contact the office staff at any time, by phone or by portal, with any questions or concerns they may have.

OFFICE PHONE NUMBER IS 561-799-2831

Outside of regular business hours, or on weekend and holidays, patients may call the office number and leave a message for Dr. Silvers on the answering machine, or contact the doctor through the portal during non-business hours. The doctor will review all messages and will return calls within 24 hours during the week, or within 48 hours over the weekend.

FOR EMERGENCIES, CALL 9-1-1 FIRST AND FAST

If you have an urgent medical concern that arises outside of regular office hours, please immediately either 1) contact your primary doctor or 2) go to a nearby urgent care center or 3) go to the nearest hospital emergency room. Do not hesitate to seek immediate medical care. Then you may follow up with Dr. Silvers and our staff on the next business day. We want you to have the best possible response to your health concerns, so please follow this policy.

The undersigned has read and understands this Notice and verifies that he/she will respond as explained above.

Signature_____ Print Name_____ Date: _____

Patient/Guarantor Signature_____ Name: _____

YOU'RE INVITED!!

We invite you to join our patient portal. It is a new way of communicating with our office 24 hours a day, seven days a week. The portal is our way of making it more convenient for you to get in touch with us online.

Please complete the section below and return it to one of the medical assistants. You will then receive an email inviting you to join the portal.

If you need help with this new portal, please ask our staff to direct you and assist you with the necessary steps to sign on.

Name:_____ DOB:_____

Email: (please print clearly)_____

Signature:_____ Date:_____