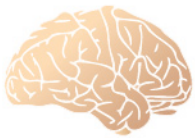

THE NEUROLOGY GROUP

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BRAD HERSKOWITZ, M.D.
SERGIO JARAMILLO, M.D.
BERNARD GRAN, M.D.
PAUL DAMSKI, M.D.
ALBERTO PINZON, M.D.

Your Name: _____ Today's Date: _____

Doctor: _____Your Email Address:_____

Date of Birth: _____ Age:_____ Social Security #:_____

Address: _____

City: _____ State: _____ Zip Code:_____

Home #:_____ Cell#:_____ Work#:_____

Sex: F or M Marital Status: S M Wid Sep Div Spouse's Name:_____

Emergency Contact:_____ Telephone #_____

*****What is the best method of contact and/or confirming appointment? _____*****

Medical Providers:
Primary Doctor's Name: _____ Telephone #_____

Fax: _____

Referring Physician's Name: _____

Telephone #: _____ Fax: _____

Employer Information:
Employer Name: _____ Telephone #:_____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Occupation: _____

Insurance 1: If Today's Visit Is Due To An Automobile Accident. Please Advise The Staff!

Type: HMO PPO POS MEDICARE W/C AUTO

Insurance Name: _____ Telephone#_____

ID#:_____ Group#: _____

Insurance 2:

Type: HMO PPO POS MEDICARE W/C AUTO

Insurance Name: _____

ID#:_____ Group#: _____

IF W/C AND AUTO ACCIDENTS:

Claim #:_____ Adjuster's Name: _____

Telephone#:_____ Date of Accident: _____

Office Policies you should know:

A. **Please alert our office of any insurance or address changes**
B. We are not Medicaid providers; if your secondary insurance is Medicaid you will be responsible for your annual Medicare deductible.
C. Tests done outside our office (Blood, X-ray, CT-Scan, MRI, etc) may take up to 2 weeks or longer for results. If you have not received a call back in two weeks please call our office.
D. Co-payments, co-insurances and deductibles are due at the time of service; otherwise your appointment will be rescheduled.
E. Please be aware that we are not your insurance company; therefore, we have limited Insurance benefit information. If you have any questions about your insurance benefits please contact the 1-800 numbers listed on your ID card. Thank you.
F. **If you are an HMO patient you will need an authorization or referral from your primary care physician or referring physician for every visit. It is your responsibility to make sure the referral is faxed, mailed, and/or brought to our office by the date of your appointment.** Without the referral you will be responsible for all services. New patient visits are $325 follow-up visits are $140.
G. **If you are here due to a car accident we will need the claim number from your car insurance, claim address, and the phone number to the claim representative.** Your health insurance does not cover these charges until your car insurance has processed the charges.
H. We welcome your suggestions or complaints about our office. You may submit any suggestions or complaints by mail at 9090 SW 87 CT. suite 200 Miami, FL 33176 Att: Practice Manager or by e-mail at Iclark@neuroscienceconsultants.com
I. For any medication refill please have the pharmacy fax us the request to 305-596-0657 at least 72 hours in advance.
J. If you would like a copy of these policies please ask the clerks.
K. Thank you for choosing our physicians.

Patient Signature: _____ Date: _____

THANK YOU

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Financial Agreement/ Assignment of Benefits:

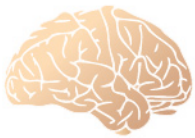
I hereby authorize payment to be made directly to Neuroscience Consultants LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered be the insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments, co-insurances and non-covered services. After receipt of a statement, if payment is not received by the next billing cycle, it is subject to a monthly finance charge. If an account is referred to an outside agency for collection, the patient agrees to pay all costs related to such action. An account will be referred to a collection service if no payment has been received within 90 days of service.

Patient or Guardian:_____Date:_____

HMO and Workman compensation patient notice:

You are responsible for obtaining a referral /authorization for your visits and or testing in our offices from your primary care physician or claims adjuster.

Patient or Guardian:_____Date:_____



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I, _____ give full authorization to discuss my medical treatment, medications, diagnosis, and/or financial information with the following Physicians and or family members only. I understand that my medical care will not be discussed with anyone that is not on this list.

_____ _____
Relation

_____ _____
Relation

_____ _____
Relation

_____ _____
Relation

_____ _____
Patient Signature Date

NSC MRI, LLC
4601 Ponce De León Blvd, Suite 100
Coral Gables, FL 33146

CONFIDENTIAL RECORDS RELEASE FOR MRI

In order to offer you the best quality of patient care we need to **obtain a CD** and Radiology report of **all prior MRI scans** that have been performed at other centers. By doing this our Radiologist will be able to do a comparison reading. This will also enable all images to be stored in one location with your other medical records. In addition, once your prior images are imported into our system your Neurologist will have immediate access to the images in his or her office.

Name of facility where prior MRIs were performed;

_____ Phone/Fax number_____

I hereby authorize and request the release of **all MRI images on CD** and the **Radiology report** of those studies to;

PLEASE FAX TO 305-596-0657

Patient Name_____ DOB_____

Account Number: _____ SSN_____

Patient Signature_____

Witness_____

Date_____

Please mail CD to:
NSC MRI, LLC
4601 Ponce De León Blvd, Suite 100
Coral Gables, FL 33146

Phone: 786-219-3145
Fax: 786-219-3155

THE NEUROLOGY GROUP

1. **What is your neurological complaint today?** _____

2. **CURRENT MEDICATIONS (include dose and frequency): For follow up patients, please update list.**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

3. **PHARMACY:** **Name:** _____
Address/ZIP: _____
Phone Number: _____

4. List any other neurologist seen in the past _____

5. **YOUR PAST MEDICAL HISTORY** (Circle if appropriate. **ADD OTHERS** not listed.)

Cancer or blood disease: (List type)

Heart and Blood Vessels: Atrial fibrillation, Congestive heart failure, Coronary artery disease, Heart attack, Hypertension, Peripheral Vascular Disease, High cholesterol

Lungs: Asthma, Emphysema, Bronchitis

Kidneys: Kidney stones, Prostate enlargement, Renal failure

Psychiatric/emotional: Depression, Anxiety, Alcohol or drug addiction/treatment

Gastrointestinal: Ulcer, Liver disease, Reflux disease

Endocrine/Hormonal: Diabetes (Type 1 or 2), Thyroid disease (hypo or hyper)

Neurologic: Dementia, Parkinson's, Epilepsy, Migraine, Head trauma, Stroke, Neuropathy

List date and reason for hospitalization or surgery: _____
_____

ARE YOU CURRENTLY PREGNANT or planning to become so shortly? _____

6. **ALLERGIES:**

a. Name of medication Type of Reaction

_____ _____

_____ _____

b. **Non-medication allergies:** (circle if present) Iodine Latex Seafood Other (specify)

Name:_____ **Date:**_____ **ECW #:** _____

7. **FAMILY MEDICAL HISTORY:** (Please indicate any neurologic/cardiologic or other pertinent diseases in your family.)

Father _____

Mother _____

Siblings/Others _____

8. **SOCIAL HISTORY:** Single Married Widow Divorced Separated

Number of Children: _____

Your Occupation: _____ _____ Check if retired.

Tobacco use : YES OR NO **(please circle)**

If Yes, how many cigarettes a day _____

Alcohol use (number of drinks most days):_____

9. **REVIEW OF SYMPTOMS**

General:	___ Fever	**Eyes:**	___ Blurred vision
	___ Weight loss		___ Eye pain
ENT:	___ Decreased hearing	**Cardiovascular:**	___ Chest pain
	___ Ringing in ears		___ Palpitations/Heart racing
Respiratory:	___ Shortness of breath	**Gastrointestinal:**	___ Abdominal pain
	___ Cough		___ Change in bowel habits
	___ Wheezing		___ Nausea
Genitourinary:	___Frequent urination	**Muscular/Skeletal:**	___ Muscle pain
	___ Urinary incontinence		___ Swollen joints
Skin:	___ Change in hair or nails	**Psychiatric:**	___ Anxiety
	___ Rash		___ Depression
			___ Suicidal thoughts
Endocrine:	___ Temperature intolerance	**Hematologic:**	___ Easy bruising
	___ Excessive thirst		___ Swollen glands

How tall are you? _____ **How much do you weigh?** _____

10. **SLEEP COMPLAINTS**

Do you snore? _____

Are you overly sleepy during the day? _____

What time do you fall asleep? _____

What time do you wake up in the morning? _____

How many times do you wake up at night and for what reason? _____

Does the need to move your arms or legs prevent sleep? _____

Name: _____ **Date:** _____ **ECW #:** _____

THE NEUROLOGY GROUP

Name of Patient: _____

Patient Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of APRIL-2010 from Neuroscience Consultants.

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Documentation of Good Faith Efforts

To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

- ☐ Patient refused to sign.
- ☐ Patient was unable to sign or initial because:

  _____

- ☐ The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):

  _____

Signature of Employee Completing Form: _____

Date Signed: _____