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. The office also had a no show fee for $25 per visit.
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: ______________

Medical Records Release

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

___________________________ Patient Signature _____________ Date
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: _________________________________________
   ____________________________________________________________________________________

6. ALLERGIES:
   a. Name of medication  Type of Reaction
   ____________________________________________________________________________________
   ____________________________________________________________________________________

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

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 #: __________