Florida Neurological Center

2237 SW 19th Avenue Road, Suite 101
Ocala, FL 34471
Ph (352) 867-9877 Fax (352) 867-1040
www.floridaneurologycenter.com

New Patient Information

Patient Name: ____ **Age:** ______

SS#: _____/_____/_____ DOB: _____/_____/_____ _____Male _____ Female

Mailing Address: ____
Street

____
City State Zip Code

Hm Ph: _____-_____-_____ Wk Ph: _____-_____-_____ Cell Ph: _____-_____-_____

Marital Status: _____Married _____ Single _____ Widowed _____Divorced _____ Other

Employment Status: _____Employed _____ Unemployed _____ Retired _____Disabled _____ Other

Who is your primary Doctor? ____

Insurance: Primary: ______________________________ Secondary: ______________________

Guarantor: (Name on insurance card) Primary; ____
Relationship to patient

Secondary: ____
Relationship to patient

Guarantor's Information: SS#: _____-_____-_____ DOB: _____/_____/_____

Place of Employment: ____

Emergency contact: ____
Name Relationship

____
Phone Number

What is the main reason for seeing the Neurologist today?

____

Medical History –Please check a_ disease or condition you have had in t past or have now:

☐ High blood pressure	☐ Diabetes	☐ Heart disease	☐Arthritis	☐ Anemia	☐ Thyroid disease
☐ Heart attack	☐ Asthma	☐ Glaucoma	☐ Stroke	☐ Migraines	☐ Acid reflux/ulcers
☐ Lung disease	☐ Depression	☐ Liver disease	☐ Seizures	☐ Epilepsy	☐ Kidney failure
☐ High cholesterol	☐ Muscle disease	☐ Kidney stones	☐ Anxiety	☐Neuropathy	☐ Psychiatric disease

☐ Cancer (where? ______________________ when? _________________________ therapy ___________________)

Please list any other health problems not described above or describe above condition further:

____

____

Please describe the main problem you are here to see a neurologist about today:

Surgical History – Please list any surgeries you have had and the approximate dates:

____

____

Current Medications: Please provide a list of your medications or write them here

Name	Strength (mg)	# of Tablets	# of Times per day

What over the counter medications or remedies do you take?

____

What recent brain or spine imaging have you had (CT or MRIs)?

____

____

List/describe any "alternative" or "complementary" therapies you are receiving:

____

Medication allergies: ____

Family History

Relative:	Father	Mother	Sister(s)	Brother(s)	Children
Age (if living)					
Cause/Age at time of death					
Cancer					
Seizures					
Stroke					
Heart attack					
Migraines					
Dementia					
Neuropathy					
Muscle problems					
Diabetes					
Movement disorders					
Psychiatric illness					
Glaucoma					
High blood pressure					

Social History

Do you smoke?

☐No Did you ever smoke? _____ If so, how much? ___________ How long? _______
When did you quit? _________

☐ Yes how much per day? ________ for how many years? _______

How much caffeine do you drink/day? ______________________________________
How much alcohol do you drink? ____

Family – ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant other
Children – How many? _______ What are their ages? _________________________

Occupation: ____
Education level (how far did you go in school?): ______________________________

Review of Systems: Please check symptoms you have had <u>in the past 3months</u>.

Constitutional

☐Weight loss ☐ Recurrent Fevers ☐Weight gain

Ophthalmology

☐Diminished vision ☐ Blurred vision ☐ Double vision ☐ flashing lights in the eyes

ENT/Respiratory

☐ Loss of hearing ☐ ringing in the ears ☐ Difficulty swallowing ☐ Snoring/daytime sleepiness

Cardiorespiratory

☐ Chest pain ☐ Shortness of breath ☐ Palpitations ☐ Leg swelling

GI

☐ Abdominal pain ☐ chronic diarrhea ☐ chronic constipation ☐ Loss of bowel control ☐ Nausea/vomiting

☐ Blood in stool

GU

☐Loss of bladder control ☐ Sexual difficulties ☐ Blood in urine

Musculoskeletal

☐ Neck pain ☐ Back pain ☐ Muscle cramping/stiffness ☐ Joint pain ☐ Joint stiffness ☐ Joint swelling

Endocrine

☐Fatigue ☐ Intolerant of cold ☐Intolerance of heat ☐ Hair loss

Hematologic

☐ Easy bruising ☐ Excessive bleeding ☐ frequent infections

Neurologic

☐ Numbness of arms/legs ☐Weakness of arms/legs ☐Memory loss ☐ Vertigo/spinning feeling

☐ Tremors/Shaking ☐ Difficulty walking ☐ Poor balance ☐ passing out ☐ severe headaches

Dermatologic

☐ Rash ☐Dry or sensitive skin

Psychiatric

☐Depressed mood ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Anxiety

☐ Frequent worried thoughts ☐ Hallucinations ☐Loss of interest in work or home activities

I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES

______________________________ ____________________
NAME DATE

I HAVE RECEIVED A COPY OF THE NOTICE OF RED FLAG POLICY AND PROCEDURES

______________________________ ____________________
NAME DATE

FLORIDA
NEUROLOGICAL
CENTER

No-Show Policy

A missed appointment leaves an empty slot that could have been used by a patient in need of medical care. Not cancelling an appointment in a timely fashion is unfair to other patients. We therefore request that patients who are unable to keep their scheduled appointments notify us, **352-867-9877**, at least 24 hours in advance, so the time might be made available to someone else.

A missed appointment, or "no-show," occurs when a patient fails to give notice that the appointment cannot be kept.

For established patients, a missed appointment will be rescheduled upon request after a no-show fee (which is not covered by insurance) of $100.00 has been paid.

Three missed appointments within 12 months may result in dismissal from our practice.

____
Patient Signature

____
Date

FLORIDA
NEUROLOGICAL
CENTER

NOTIFICATION OF ALTERNATE SUPPLIERS OF DIAGNOSTIC IMAGING SERVICES

Dear Valued Patient:

Florida Neurological Center has recommended that you seek diagnostic imaging services (MRI scan) as part of your course of treatment.

Pursuant to Section 6003 of the Patient Protection and Affordable Care Act, Florida Neurological Center is hereby providing notice to you that you may obtain diagnostic imaging services from another provider other than Florida Neurological Center if you so choose.

The following is a list of suppliers that provide such diagnostic imaging services within a twenty-five-mile (25-mile) radius of this location:

- Ocala Regional Medical Center, 1431 SW 1ST Avenue, Ocala, FL 34471
  352-401-1000
- Munroe Regional Medical Center, 1500 SW 1ST Avenue, Ocala, FL 34471
  352-351-7200
- Ocala Family Medical Center, 2230 SW 19th Avenue Road, Ocala, FL 34471
  (352) 237-4133
- Advanced Imaging, 8150 SW Hwy 200, Ocala, FL 34481
  352-854-2020
- West Marion Community Hospital, 4600 SW 46th Court, Ocala, FL 34474
  352-291-3000
- TimberRidge Imaging Center, 9521 SW Hwy 200, Ocala, FL 34481
  352-671-4300

If you elect not to use one of the aforementioned alternate suppliers, Florida Neurological Center will be pleased to provide your diagnostic imaging services.

Please acknowledge your receipt of this notification by signing below.

____
Patient's Signature

____
Patient's Printed Name

____
Date

FLORIDA
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Email Consultation Form

I, the undersigned, am a current patient of Dr. Kim and am interested in participating in his email service which will allow me to obtain medical advice from Dr. Kim through email.

I understand that this service is designed for non-emergency only.

Email is the quickest way to reach our office and is the preferred method of communication.

We urge you to use this email service instead of calling the office and leaving a message.

I understand and, by my signature below, agree that Florida Neurological Center cannot be held responsible for the confidentiality of any material once it has been sent to the listed email address.

______________________________ Patient's Name

______________________________ Patient's Signature

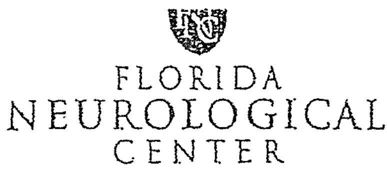
______________________________ Email Address

Please notify the office of any changes as only authorized email accounts will be allowed access.

Cut here

FLORIDA NEUROLOGICAL CENTER EMAIL ADDRESS

info@fncsolstice.com



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Patient Information Release Form

RELEASE OF INFORMATION – I, The below named patient do hereby authorize the FLORIDA NEUROLOGICAL CENTER to provide whatever diagnosis and treatment that is deemed necessary to the patient. I understand that my physician or subsequent health care provider may receive various reports to assist with my treatment.

I hereby authorize lifetime release of any medical records and other information, as required or may be required, for the payment of benefits payable by insurance or other third party sources of payment, in connection with treatment of the below named patient. I further authorize payment directly to the FLORIDA NEUROLOGICAL CENTER of any and all benefits payable arising from any insurance or other source, and which are otherwise payable to me.

I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. **I understand that billing to my secondary insurance plan is a courtesy of this office.** Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **I understand that it is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. If I do not make a payment on my account I understand that the FLORIDA NEUROLOGICAL CENTER reserves the right to reschedule my appointment until payment is received.** I also understand that a return check fee of $30.00 will be charged for each returned check.

I understand that if this account is assigned to an attorney or collection agency for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection.

I have read and fully understand the content of this patient information and medical release form. I have been presented with this provider's NOTICE OF PRIVACY POLICIES, detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of this notice.

Signature: ______________________________ Date: ____________________

Medical information and/or test results can be given to (check one):

________ NO ONE except myself

________ The following person (s)

1. *Name (s):* ______________________ *Relationship to patient:* ______________________
   Home #: ______________ *work #:* ______________ *Cell #:* ______________

2. *Name (s):* ______________________ *Relationship to patient:* ______________________
   Home #: ______________ *work #:* ______________ *Cell #:* ______________

***Leave telephone message on recorder concerning the following (check all that apply)**

____ *Prescriptions* ____ *test results* ____ *Referrals* ____ *Appointments*

Patient Signature: ______________________________ Date: ____________________

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Medication Agreement & Refill Policy

As part of your treatment, our medical staff may prescribe medications for you. As you know, medications can have serious side effects if they are not managed properly. Your health and safety are very important to us, and we need your help to make sure your treatment follows the prescribed guidelines. No prescriptions will be written for you unless you accept the following agreement.

1) I agree to follow the dosing schedule prescribed to me by my doctor.
2) I will ***never*** share, sell or exchange my medications with anyone for any reason.
3) I understand that I am ***solely*** responsible for the safekeeping of my medications. I will treat my medications as I would any valuable possession. I know that Florida Neurological Center does not replace **LOST OR STOLEN** prescriptions or controlled medications.
4) I understand that I should not drive or operate heavy machinery while I am taking medications that may cause drowsiness or impaired cognitive function.
5) I agree to notify Florida Neurological center if I experience any adverse effects or dosage problems with my prescribed medications. I may be asked to bring any unused medication to Florida Neurological Center for disposal.
6) I agree that if I receive a controlled substance prescription from Florida Neurological Center, I am not allowed to accept controlled substance prescriptions from any other physician without my doctor's consent.
7) I agree to use only one pharmacy for my pain-related medications. In the event, that circumstances require the use of another pharmacy, I will notify Florida Neurological Center of this immediately and provide them with all pertinent contact information
8) I understand that medication refill prescriptions involving narcotic pain medicine require a **scheduled appointment** with my primary doctor in the office. Narcotic pain medication refills will not be called into a pharmacy. Narcotic dosages will not be increased by phone.
9) I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no-show appointments. I understand that if I am more than 15minutes late to my scheduled appointment time, I will have to reschedule for another time.
10) The Florida Neurological Center phone triage hours are 8:00 am to 4:00 pm, Monday through Friday for Non- Emergency medication questions and refill requests. I know that I cannot call this line more than two times in any day. **It may take up to 48 hours before I receive a response to my request for a prescription refill.**
11) I know that I can be asked to bring any or all of my prescribed medications to my office appointment or at a random time for a prescription compliance check (Pill Count).
12) I understand that Florida Neurological center will write and dispense narcotic medication prescriptions on a 30 day basis. In order to receive another narcotic medication prescription I must schedule another office visit within 30 days of the date on my current prescription so my doctor can properly evaluate my progress.
13) I understand that abusive behavior or harassment toward any Florida Neurological Center Staff cannot be tolerated. The Doctor's will determine what actions can be considered harassment on a case-by-case basis and, if warranted, I can be dismissed from the practice.
14) I understand that dealing with a forged, falsified or altered prescription will result in my immediate dismissal from the Florida Neurological Center.
15) I understand the Florida Neurological Center reserves the right to PERFORM A URINE DRUG SCREEN AT ANY TIME WHILE I AM BEING TREATED WITH PRESCRIBED CONTROLLED SUBSTANCES. If the results of the urine drug screen do not reflect medicine prescribed by my doctor or test positive for illegal drugs, I understand that I can be dismissed immediately from the practice.

Pharmacy Name ____________________ Pharmacy Phone number ____________________

Patient Name (Print) ____________________ Patient Name (Sign) ____________________ Date ____________