NEUROLOGY ASSOCIATES OF NORTH FLORIDA, Inc.

1550 Roberts Drive *Jacksonville Beach, FL 32250* *(904) 249-4456*

Please present insurance cards & photo ID at window.
Co-pay is due at the time of service.

Date _____

Last Name _____ First Name _____ Middle Initial ___

Street Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Date of Birth _____ Male or Female

Occupation/Employer _____

Spouse's Name _____

If under 18, Parent/Guardian _____

Emergency Contact (other than spouse) _____

Phone # _____ Relationship _____

Do we have permission to (please circle yes or no):

Leave a message on your answering machine at home?	Yes	or	No
Leave a message at your place of employment?	Yes	or	No
Discuss your medical condition with any member of your household?	Yes	or	No

If yes, whom _____ Relationship _____

(Please circle below, if applicable)

Race: _____ Unknown I decline to provide

Ethnicity: _____ Unknown I decline to provide

Primary Language: _____ I decline to provide

Patient Signature: _____

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Patient Name _____ **DOB** _____ **Date** _____

Weight _____lbs **Height** _____ft_____in **Pregnant** Yes No

MEDICAL HISTORY: Please circle if you have or have had any of the following conditions.

DIABETES	LIVER DISEASE	PACEMAKER
STROKE OR TIA	KIDNEY DISEASE	OSTEOARTHRITIS
HEART DISEASE	SEIZURES	BIPOLAR
CANCER	MIGRAINES	DEPRESSION
ASTHMA	DIFIBRILLATOR	HYPOTHYROIDISM

ALLERGIES to medications: _____

MEDICATIONS (including over the counter): Provide a list (if available)

_____ _____

_____ _____

_____ _____

SURGICAL HISTORY: List major operations and when performed:

_____ _____

_____ _____

REVIEW OF SYSTEMS: Please circle any symptoms you have been experiencing:

HEADACHES	ACUTE CONFUSION	TINNITUS
DOUBLE/BLURRY VISION	TREMOR	SLURRED SPEECH
INCONTINENCE	TROUBLE WALKING	DIZZINESS/VERTIGO
IMBALANCE	MEMORY LOSS	FAINTING

NECK PAIN W/ LEFT RIGHT ARM HAND NUMBNESS TINGLING PAIN WEAKNESS

BACK PAIN W/ LEFT RIGHT LEG FOOT NUMBNESS TINGLING PAIN WEAKNESS

SOCIAL HISTORY

Marital Status _____ Number of children _____

What do you do for a living? _____

Do you smoke? _____ Did you ever smoke? _____ How much? _____ How long _____

Do you drink? _____ How much? _____Have you ever drank heavily in the past? _____

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Richard J. Boehme, M.D., Ph.D.

Insurance Assignment and Instruction for Direct Payment to Provider

I, _____, hereby instruct and direct my insurance company pursuant to Florida Statute F.S. 627.422 to pay by check or draft made out to and mailed directly to the above named provider for professional or medical services. And any reimbursements otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by them. The payment to not exceed my indebtedness to the above named provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability, or any other Health or Medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above named provider.

This assignment includes but is not limited to all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above named provider. This assignment also includes that right to recover any attorney fees and costs for such an action brought by the provider as my assignee.

I also agree that the above mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for the payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company. All self-pay patients are expected to pay for services in full at the time services are rendered. Ultimately, payment responsibility rests with you, the patient.

I also authorize the release of any information pertinent to my case or claim to the above named provider or any attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorized the above named provider to file any formal or informal complaints that are necessary to the Insurance Commissioner's Office or any other agency or court they deem appropriate on my behalf.

Signature of Patient (Claimant)

_____ Date _____

Signature of Policy Holder (Insured) if other than Patient

_____ Date _____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your protected Health Information

Your protected health information will be used by **Neurology Associates of North Florida, Inc.** or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction in writing on the use or disclosure of your protected health information.

Neurology Associates of North Florida, Inc. may or may not agree to restrict the use or disclosure of your protected health information.

If Neurology Associates of North Florida, Inc. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Neurology Associates of North Florida, Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to **Neurology Associates of North Florida, Inc.** to use and disclose my health information in accordance with it.

_____	_____
Name of Patient (Print)	Signature of Patient Representative
_____	_____
Signature of Patient	Patient Representative Name and Relationship

_____

Date

Neurology Associates of North Florida

1550 Roberts Drive Jacksonville Beach, FL 32250 Phone (904) 249-4456 Fax (904) 249-7703

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient:_____ **Last 4 SSN:** _____ **DOB:** _____

Information to Be Used or Disclosed
The information covered by this authorization includes:

_____

Persons Authorized to Use or Disclose Information
Information listed above will be used or disclosed by:

_____
Name of Person/Organization

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:

_____
Name of Person/Organization

Expiration Date of Authorization: This authorization is effective through _____ unless Revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to **NEUROLOGY ASSOCIATES OF NORTH FLORIDA, INC.**

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulation.

_____ _____
Name of Patient (Print) Signature of Patient Representative

_____ _____
Signature of Patient Patient Representative Name and Relationship

_____ _____
Date Witness