Countryside Neurology, Inc
2595 Tampa Road Suite V&W
Palm Harbor, FL -34684
Phone: 727-712-1567; Fax: 727-796-2719

New Patient Information Form
Mr. Mrs. Ms. Miss (circle one)

Today's Date: _____
Referred by: _____
Primary or Specialist _____

Last Name	First Name	Middle	
Social Security	D.O.B	Height	Weight
Address	Apt #	City, St, Zip	
Home Phone	Work Phone	Cell Phone	
Spouses Name	Phone		
Nearest Relative Not Living With you	Relation	Phone	

Insurance Information

Primary Company Name	Policy	Group
Address	City, St, Zip	Phone #
Secondary Company Name	Policy #	Group#
Address	City, St, Zip	Phone #
Auto Insurance (if applicable)	Adj.	Claim#

As a courtesy, we will file your primary insurance only. You are required to make payment to us at time of visit if you are not insured. Please let us know if you have any questions regarding our policies.

Signature of Patient/ Guardian/Responsible Party: Date of Visit:

Name printed: _____

□ Reviewed by Dr. Khademi

Countryside Neurology, Inc

The following information is very important to your health. Please take your time to fill out the form fully and accurately. Please CIRCLE any of the following symptoms/illness you have or are experiencing, explain additional information if needed in the explain column.

Neurology	**Gastrointestinal**	**Urology**	**Explain**
Seizure	Ulcers	Difficult urination	
Pass out	Blood in stool	Erectile Dysfunction	
Headache	Constipation	Erectile Dysfunction	
Memory problems	Diarrhea	Nocturia	
Neck/back/hand/foot pain	Nausea	UTI (recurring)	
Tingling	Vomiting	Void difficulty	
Numbness	**Hematology**	**Psychiatric**	
Loss of arm/leg strength	Anemia	Panic attack	
Fall	Bleeding disorder	Anxiety	
I Tremors	Cancer	Depression	
Balance issues	Bruise easily	Hallucinations	
Dizziness	Swollen glands	Suicide Idea	
Ophthalmology	**Genitourinary**	Stress/Tension	
Blurred vision	Urine incontinence	**Ear/Nose/Throat**	
Double vision	Urination at night	Swallowing pain	
Loss of vision	Impotence	Nosebleed	
Eye pain	Blood urine	**Constitutional**	
Endocrinology	Urine retention	HIV	
Type 2 diabetes	**Musculoskeletal**	STD	
Cold sensitivity	Neck pain	Hepatitis	
Excessive Sweating	Hand pain	Lyme Disease	
Heat sensitivity	Foot pain	Colds	
Cardiology	Back pain	Ear fullness	
Chest pain	Joint pain	Itchy eyes	
Irregular heartbeat	Joint stiffness	Seasonal allergies	
Leg swelling	Leg cramps	Stuffy/runny nose	
Leg pains	Shooting arm/leg pain	Congestion	
Respiratory	**Dermatology**		
Cough	Hives		
Shortness of breath	Rash		

The above information is true and correct to the best of my belief. I have added any other relevant medical information to the spaces provided.

Patient Signature: _____ **Print Name: _____**

Date: _____

Countryside Neurology, Inc

The following information is very important to your health. Please take your time to fill up the form fully and accurately. <u>Negative or normal if not circled or checked.</u>

Family History: Please Circle Those that Apply to You

Diabetes	brother	sister	mother	father
Heart Attack	brother	sister	mother	father
High Blood Pressure	brother	sister	mother	father
Stroke	brother	sister	mother	father
High Cholesterol	brother	sister	mother	father
Cancer	brother	sister	mother	father

Past Medical History: Please Circle Those that Apply to You

Diabetes	Heart Attack	Thyroid	Cancer
Brain Bleed	vertigo	Seizure	Fainting
High Blood Pressure	Stroke	Bleeding Ulcer	MS
Other:			

Past Surgical History: Please Circle Those that Apply to You

Aneurysm	Hysterectomy	Appendix	R L Hip	R L Knee
R L Foot	Carpal Tunnel	Prostate	Tonsils	Cataract
Please list additional				

Allergy

Penicillin □
Sulfa □
List others □

Social History

Tobacco	Present □	Past □	Never □
Alcohol	Present □	Past □	Never □
Illicit Drugs	Present □	Past □	Never □

Occupation:

Married □	Single □	Divorced □

Medications

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Over The Counter

1.	3.
2.	4.

The above information is true and correct to the best of my belief. I have added any other pertinent information medical information to the spaces provided.

Patient Signature: _____ **Print Name: _____**

Date: _____

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PATIENT NAME:_____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

1. The right to complain to this practice and to the Secretary of HHS, if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
2. The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
3. The right to receive confidential communications of protected health information.
4. The right to inspect and copy protected health information.
5. The right to amend protected health information.
6. The right to receive an accounting of disclosures of protected health information.
7. The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Patient Signature: _____ **Print Name: _____**

Relationship to patient (if signed by a personal representative of patient) _____

□ Reviewed by Dr. Khademi

Countryside Neurology, NC
2595 Tampa Road Suite V&W
Palm Harbor, FL -34684
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DEAR PATIENT

The completion of information/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in a tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs especially when multiplied over the large number of patients our practice services. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of forms as follows:

$30.00 per forms for completion of the following:

- **Credit care deferment forms**
- **Family medical leave act forms**
- **Private disability insurance forms**
- **School educational disability or limitation forms**

$50.00 for completion of any dictated letter describing medical care and limitations.

$100.00-$300.00 for any narrative report detailing diagnosis, treatment and future medical care including work capacity statements. (Functional capacity evaluation testing maybe necessary prior to or in addition to the narrative report).

In closing, thank you for your cooperation and understanding.

Patient Signature: _____ Date: _____

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ALTERNTIVE COMMUNICATION RELEASE FORM

I hereby authorize Countryside Neurology Inc., with regards to my protected health information to:

- **Call Me at Home _____**
- **Call Me at Work _____**
- **Speak only with me _____**
- **Speak only with the following:**
- **Name Relationship**

_____

_____

_____

_____

_____

- **Fax information to me at this fax number _____**
- **Send my information to the following address if different from home: _____ _____**
- **Leave appointment reminders and test results on my answering machine.____**
- **If you have any specific request, please clearly specify them to our staff.**

Patient or Guardian Signature: _____ Print Name: _____

Print Patient's Name _____

Witnessed by: _____ Date: _____

Countryside Neurology, NC
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Date: _____

To: _____

_____

_____

I hereby authorize you to release to:

Dr. Ardeshir Khademi M. D
Board Certified Neurologist

Please send all records/ tests listed above

_____
_____
_____
_____
_____
_____
_____
_____

_____

Print Name _____

Witness _____

Date of Birth _____

Signature _____

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Patient Name: _____
I hereby authorize payment of my medical and surgical insurance benefits to Dr. Khademi/Countryside Neurology Inc. I understand I am financially responsible for any charges whether or not paid by insurance. If my insurance company or health plan designates co- payment and/or deductibles, I agree to pay them to Dr. Khademi/Countryside Neurology Inc. I authorize Dr. Khademi/Countryside Neurology Inc. to release any information required to process all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

Beneficiary Name **Medicare ID#:**

I request that payment of authorized Medicare benefits to be made on my behalf to Dr. Khademi for services furnished me by Dr. Khademi/Countryside Neurology Inc. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the benefits payable to related services. I understand my signature requests that payment be made and authorized release of medical information necessary elsewhere on other approved claim forms: my signature authorizes releasing the information of the Medicare carrier, co-insurance, co-payment, and non-covered services. Co-insurance, co-payment and deductible are based upon the charge determination of the Medicare carrier. MEDIGAP.

If a Medigap policy of other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Dr. Khademi/Countryside Neurology Inc. I hereby authorize payment of my medical and surgical insurance benefits to Dr. Khademi/Countryside Neurology Inc. I understand I am financially responsible for any charges whether or not paid by my insurance. If my insurance company or health plan designates co-payments and/or deductibles, I agree to pay them to Dr. Khademi/Countryside Neurology Inc. I authorize Dr. Khademi/Countryside Neurology Inc. to release information required to process all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. I have been given the Notice of Privacy Practices Agreement as required in the HIPAA regulations.

Patient Signature: _____ **Date: _____**

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FINANCIAL PAYMENT POLICY

REGARDING INSURANCE: Our office participates with Medicare and many other managed care insurance companies. Should your insurance coverage be with one or more of these insurance companies, we will bill your insurance company along the guidelines of our contract. However, co- payments, co-insurances, and deductibles that have not been satisfied are the responsibility of the patient at the time services are rendered. If you have an insurance with which we do not participate, we ask that payment be made at time services are rendered and your insurance company will reimburse to you any amount due. As a courtesy to our patients, we will submit a claim to your insurance company.

By signing this form, you authorize the release of any information requested by insurance companies or liable third parties and assign any insurance benefits to Ardeshir Khademi, M.D. If the correct insurance information is not given to Ardeshir Khademi, M.D. or the proper referral is not provided to Dr. Khademi/Countryside Neurology Inc. then the patient will be responsible for the bill. You also authorize Ardeshir Khademi, M.D. to release to any other provider his/her office or medical facility any information necessary for referral purposes. These authorizations shall remain in force until written notice is given from the patient or responsible person.

CANCELLATION POLICY: Our office requires a twenty-four (24) hour cancellation of an appointment. If a twenty-four (24) cancellation is not made with our office staff, the patient or responsible party will be charged a fee of **$50.00.** For any patient not showing up for an appointment, the patient or the responsible party will be charged a fee of **$50.00.**

SPECIAL NEEDS: There are times when making a payment can be a financial hardship. It may be necessary to set up a payment plan for a patient who cannot comply with our financial policy. If you need special payment arrangements, please advise our Billing Coordinator or Office Administrator as soon as possible. Informing our patients about our financial policy assists us in providing the best service to our patients. Thank you for taking the time to read this policy statement. Should you have any further questions or comments, please contact our Billing Coordinator or Office Administrator.

I hereby understand the financial office policy of this office. I guarantee payment of all charges incurred for the account of the below patient.

Patient Signature: _____ **Date: _____**

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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Countryside Neurology, Inc. to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my insurance health carrier, Medicare, or other third-party payers. I authorize Countryside Neurology Inc. to release all medical information to my primary and secondary care physicians. I also authorize Countryside Neurology Inc. to contact my insurance company or health administration and obtain important insurance information concerning coverage and payments under my policy. I direct the insurance company or health plan administration to release such information to Countryside Neurology Inc.

I agree that these provisions will remain in effect until I provide written revocation to Countryside Neurology Inc. practice.

Patient or Guardian Signature: _____ Print Name: _____

Date: _____