NEUROLOGY of Central Florida

ALICIA V CABRERA, MD

## NEW PATIENT INFORMATION

Name: _____

Date of Birth: _____ /_____ /_____ Social Security: _____

Address: _____

_____

Phone Number/Home: _____ -_____ -_____ Cell: _____ -_____ -_____

Primary Care Physician: _____

Pharmacy: _____

Email Address: _____

Insurance/Primary: _____

Insurance/Secondary: _____

## MEDICATIONS

An up-to-date list of medications must be available and with you at all times for your appointment. Please list all medications you are taking, including vitamins, over-the-counter medicines and herbal supplements.

| Medications | MG | #times/day | Medications | MG | #times/day |
|---|---|---|---|---|---|
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***PLEASE BUBBLE ONLY THOSE THAT APPLY***

***PAST MEDICAL HISTORY***

O Cancer (specify type) _____
O Tuberculosis
O Thyroid disease
O Diabetes Type I or II
O Heart Attack
O Coronary Heart Disease
O Atrial fibrillation
O High cholesterol
O High blood pressure
O Sleep apnea
O Blood clots in legs
O COPD
O Kidney failure
O Liver disease
O Anxiety Disorder
O TIA
O Stroke
O Carotid stenosis
O Neuropathy
O Migraines
O Parkinson's Disease
O Tremors
O Dementia or Alzheimer's
O Multiple Sclerosis
O Myasthenia Gravis
O Other medical condition(s):
_____
_____

***SURGICAL HISTORY***

O Tonsillectomy
O Appendectomy
O Cholecystectomy
O Coronary Artery Bypass Graft
O Carotid Endarterectomy
O Pacemaker
O Back surgery
O Hysterectomy total/partial
O Mastectomy L or R
O Prostate surgery
O Other surgeries:
_____
_____

***MEDICATION ALLERGIES***

_____ _____
_____ _____
_____ _____
_____ _____

***FAMILY HISTORY***

Father Living? O YES or O NO
List medical conditions: _____
_____
Mother Living? O YES or O NO
List medical conditions: _____
_____

***SOCIAL HISTORY***

**Tobacco Status**:
O Current smoker
O Former smoker
O Non-smoker

**Do you consume alcoholic beverages?**
O YES or O NO
If yes, how many cups/day? _____

**Do you drink caffeinated beverages?**
O YES or O NO
If yes, how many cups/day? _____

**Do you have children?**
O YES or O NO
If yes, how many? _____

**What is your marital status?**
O Married O Single
O Widowed O Partner

**Do you work?**
O YES or O NO
If yes, what is your occupation? _____
_____

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If no, are you ___retired, ____disabled, or ____unemployed?

## ***SYMPTOMS***

***PLEASE CHECK ONLY THOSE SYMPTOMS YOU ARE EXPERIENCING AT THIS TIME***

### ***General/Constitutional***

Fatigue__
Weight change__
Frequent colds__
Nasal/seasonal allergies__
Sinus congestion__

### ***Allery/Immunology***

Hives__
Rash__
Itching__
Sneezing__

### ***Ophthalmologic***

Cataract__
Double vision__
Blurred vision__
Loss of vision__

### ***ENT***

Hearing loss__
Ringing in ears__
Nosebleed__
Dizziness__
Difficulty swallowing__

### ***Endocrine***

Cold intolerance__
Heat intolerance__
Diabetes__
Frequent urination__

### ***Respiratory***

Shortness of breath
- At rest__
- With exertion__

Sputum production__
Wheezing__

### ***Cardiovascular***

Chest pain:
- At rest__
- With exertion__

Difficulty lying flat__
Irregular heartbeat__
Palpitations__

### ***Hematology***

Easy bruising__
Swollen glands__

### ***Gastrointestinal***

Abdominal pain__
Change in bowel habits__
Constipation__
Diarrhea__
Heartburn__
Blood in stool__

### ***Genitourinary***

Frequent urination__
Painful urination__
Difficulty urinating__

### ***Musculoskeletal***

Painful joints__
Swollen joints__
Joint stiffness__
Weakness__
Muscle aches__
Sciatica__
Shooting arm pain__
Shooting leg pain__

### ***Peripheral vascular***

Blanching of the skin__
Cold extremities__
Pain/cramping in legs after exertion__
Ulceration of feet__

### ***Skin***

Dry skin__
Discoloration__
Skin lesions__

### ***Neurologic***

Balance difficulty__
Fainting__
Falls__
Gait abnormality__
Headache__

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Tingling/numbness__
Memory loss__
Pain__
Seizure__

Tremor__
Anxiety__
Depression__
Hallucinations__

**MEDICAL INFORMATION RELEASE FORM**

**HIPAA RELEASE FORM**

Patient Name: _____ Date of Birth: _____/_____/_____

**RELEASE OF INFORMATION**

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____ phone #: _____

[ ] Child(ren)_____ phone #_____

[ ] Other _____ phone #: _____

[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

_____

**MESSAGES**

Please call [ ] my home [ ] my work [ ] my cell number: _____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (day) _____between (time) _____

Signature: _____ Date: _____/_____/_____

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**AUTHORIZATION FOR**
**RELEASE OF PROTECTED HEALTH INFORMATION**
**PURSUANT TO HIPAA**

I, or my authorized representative, request that information regarding to my care and treatment be released as set forth below:

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that:

- When my information is used or disclosed pursuant this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA Privacy Rule.
- I have the right to revoke this authorization in writing by notifying Neurology of Central Florida, LLC; except to the extent that the practice has already acted in reliance upon this authorization.
- Signing this authorization is voluntary. I do not have to sign this authorization in order to receive medical treatment from the medical provider to whom this authorization is provided.
- I may obtain a copy of this information for a reasonable fee.
- This authorization will remain in effect for one year.

Name and address of provider who shall release information:

Name and address of person or provider to whom this information will be sent:
**Alicia Cabrera, MD 405 W Central Parkway Altamonte Springs FL 32714** **P: (407) 790-4990**
**F: (407) 790-4862**

Specific information to be released:
___Medical Record for certain dates of service (list dates of service below)

_____ Include: (indicated by initializing)
____Alcohol/Drug treatment
____Entire Medical Record ____Mental Health Information
____HIV/AIDS
_____

Authorization to discuss HEALTH INFORMATION
____By initializing here___ I authorize Neurology of Central Florida, L.L.C to discuss my health information with my attorney, or a government agency, listed here _____

REASON FOR RELEASE OF INFORMATION:
___At the request of individual ___Continuity of care ___Insurance/disability ___Legal action ___Personal use ___Other

_____ _____
Signature of patient, guardian, or authorized representative Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMTION

**Required information**:
Patient name: _____
Address: _____
_____
Date of birth: _____SSN: _____

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**MEDICAL RECORDS RELEASE AND INSURANCE ASSIGNMENT POLICY**

I. Responsibility for accountant – I agree that should the amount of the insurance benefits be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due for the professional service if the expense is not covered by my insurance policy.
II. Collection Information – I understand that my portion of all fees are due at the time treated unless previous arrangements have been made. I will be billed for my portion of any fees unpaid at the time of service. Any amounts which are 60 days past due will be eligible to be turned over to a collection agency unless previous arrangements have been made. There will be a $25.00 charge for any returned check.
III. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACEOF THIS ORIGINAL WHICH IS ON FILE AT THE PHYSICIAN'S OFFICE
IV. Release of Information – I authorize the physician examining and/or treating me to release to any third party (such as an insurance company or governmental agency) any medical information and records concerning diagnosis and treatment when requested for use in determining claim for payment.
V. Physician Insurance Assignment – I authorize payment directly to the physician examining or treating me for surgical and/or medical benefits. Any service for which assignments are not accepted, are acknowledged to be my full and complete financial responsibility.
VI. Release of Information – I authorize Neurology of Central Florida, LLC to release my medical records to any other healthcare providers involved in my continuing care and treatment

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I. By signing this document, I acknowledge that I have received a copy of Neurology of Central Florida LLC. Notice of Privacy Practices as required by the privacy regulations created as results of Health Insurance Portability and Accountability Act of 199 (HIPAA)
II. I will retain for future reference and assist in my care

**OFFICE POLICIES**

In an effort to clarify office policies for our patients, please read and understand the following policies. Hopefully this will reduce concerns and anxieties about your medical care in this practice

I. Please allow us 48-72 hours for prescription refills. They will only be filled Monday-Friday 8:00 a.m. – 5:00 p.m. Have your pharmacy contact our office for refills. For prescriptions to be refilled, you must have been seen within one year.
II. Under most circumstances, please allow 7-10 business days to schedule MRI testing. Rarely, more urgent testing may be required and your doctor will notify you of this fact.
III. Disability forms will take 7-10 business days to complete. You will be charged $50.00. In addition, we do not fill out functional capacity evaluations which many carriers require. You will be referred to a physical therapist and may need to pay for this out-of-pocket.
IV. If you need to cancel or reschedule an appointment, we require a 48-hour notice or a fee of $75.00 for follow-up appointments and $100.00 for tests (ANS, EEG, EMG, and VEP) will be charged.
V. Request from patients for letters in regards to work, insurance, or other matters will take from 5-10 business days.
VI. The patient is aware that he/she should follow the doctor's medically necessary recommendations to see/have the required testing, laboratory work-up, referral to other physicians/facilities, and/or follow up appointment(s). He/she further understands that the failure to comply with medical recommendations may lead to adverse health outcomes and/or limits the physician's ability to diagnose and treat his/her condition.

**NOTICE TO HMO, PPO, AND COMMERCIAL INSURANCE PAYMENTS**

Typically, insurance companies will pay only for those services they deem to be "reasonable and necessary". If for any reason an insurance company determines our services do not meet their criteria, they may deny payment to this practice. In this case, charges for those services become the responsibility of the patient. We will work with our patients to appeal any such findings in a denial. If payment is still denied subsequent to any appeals, the patient shall become responsible for payment. By signing, you acknowledge that your insurance company may deny payment to this practice for services. In such case, you agree to be personally responsible for payment:

Services rendered:

-EMG/NCS -Infusion -Nerve block -ANS
-ENG -EEG routine -VEP
-24hr Ambulatory EEG -Botox -Prolonged ambulatory video EEG
-Skin biopsy for ENFG -Lumbar puncture -Prolonged video EEG monitor (2-12hr)

**Billing Department Phone Number: 954-507-4624**