NEUROLOGICAL SOLUTIONS

INITIAL: _____

Allan M Spiegel M.D P.A

31608 US HWY 19 N Palm Harbor, FL 34684-3723 | Ph: (727)787-7077 Fax: (727)786-6588

NAME: _____ **DATE:** _____/_____/_____

DATE OF BIRTH: _____/_____/_____ **AGE:** _____ **SEX**:_____ **MARITAL STATUS:**_____

PRIMARY PHONE NUMBER ***for appointment confirmations:*** cell/home/other_____

SECONDARY PHONE: _____ **EMAIL ADDRESS:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:**_____

EMPLOYER: _____ **PHONE:** _____

EMERGENCY CONTACT: _____ **PHONE:** _____

RELATIONSHIP: _____

PREFERRED PHARMACY: _____ **PHONE:** _____

PRIMARY CARE DOCTOR: _____ **PHONE:** _____

REFERRING DOCTOR: _____ **PHONE:** _____

REASON FOR SEEING DR. SPIEGEL TODAY:

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ **ID#**_____

SECONDARY INSURANCE:_____ **ID#**_____

I hereby authorize direct payment of medical/surgical benefits to Dr. Allan Spiegel for services rendered by him or under his supervision. I understand that I am financially responsible for any balances not covered by insurance. In the event of non-payment, I agree to pay all collection fees and attorney fees associated with bills.

I certify that the information given from me in applying for payment is correct. I authorize release of all records on request. I request payments of authorized benefits be made on my behalf.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Dr. Spiegel and any other Physician to release any medical or incidental information that may be necessary for medical care or financially beneficial applications.

The fee for a missed appointment is $75.00, to avoid please call to cancel 24 hours in advance

PATIENT SIGNATURE: _____ **DATE:** _____/_____/_____

INITIAL: _____

ADDITIONAL QUESTIONS:

Is your injury due to auto, work, or slip and fall?	YES	NO
Have you been involved in a car accident that has not been settled?	YES	NO
Are you pregnant now or are you breastfeeding?	YES	NO

CURRENT MEDICATIONS

Please be advised: It is our policy to request pharmacy profiles on all patients.

MEDICATION	DOSE	TIMES TAKEN PER DAY	MEDICATION	DOSE	TIMES TAKEN PER DAY

MEDICATION ALLERGIES (IF NONE, PLEASE MARK N/A - NOT APPLICABLE):

_____

_____

HABITS:

Smoke Cigarettes? YES NO If yes, how many per day? _____ For how long? _____

Former Smoker? YES NO When did you quit? _____

Drink Alcohol? YES NO How many drinks? _____ How often? _____

Addictive Drugs: YES NO If yes, which ones? _____

Right or Left Handed? RIGHT LEFT Who lives with you? _____

Your Occupation: _____ Height: _____ Weight: _____

DIAGNOSED MEDICAL CONDITIONS (IF NONE, PLEASE MARK N/A - NOT APPLICABLE):

_____

_____

_____

INITIAL: _____

FAMILY HISTORY

	Mother	Father	Sibling	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy/Seizures							
Diabetes							
Bleeding							
Alcoholism							
Cancer							
Migraine							
Thyroid							
Alzheimer's							
Stroke							
Mental Illness							
Tremors							
Multiple Sclerosis							
Hypertension							
Glaucoma							
Parkinson's							
Heart Disease							
Dementia							

SURGICAL HISTORY (IF NONE, PLEASE MARK N/A - NOT APPLICABLE):

_____

_____

_____

INITIAL: _____

REVIEW OF SYSTEMS

(indicate any problem with the following)

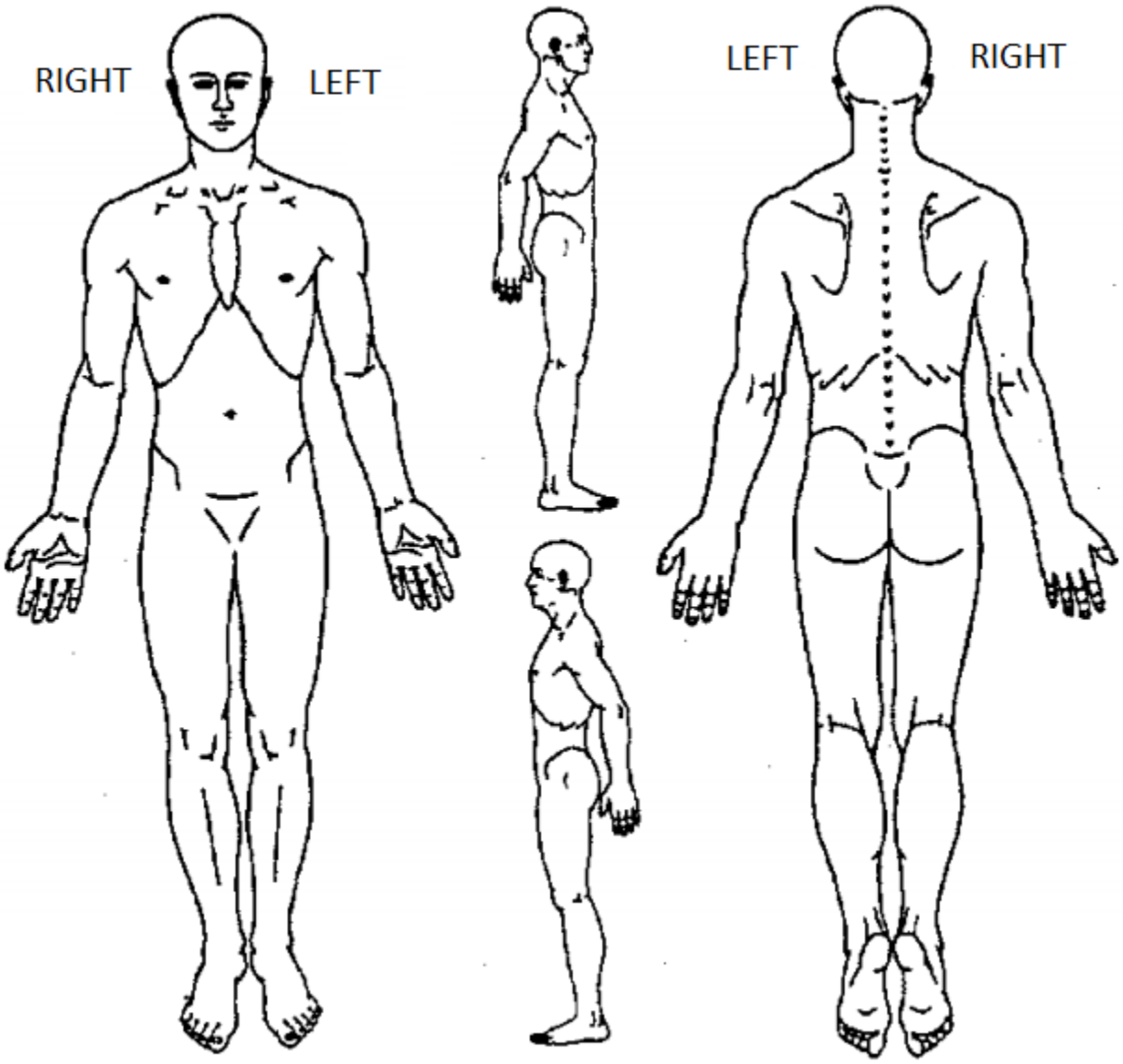
CONSTITUTIONAL	***Symptom***	***Yes***	***No***	**CARDIOVASCULAR**	***Symptom***	***Yes***	***No***
	Chills	_____	_____		Chest Pain	_____	_____
	Fever	_____	_____		High Blood Pressure	_____	_____
	Weight Loss	_____	_____		History of Heart Attack	_____	_____
	Decline in Health	_____	_____		Swelling of Legs	_____	_____
	Weakness	_____	_____		Palpitation	_____	_____
	Fatigue	_____	_____				
HEAD	***Symptom***	***Yes***	***No***	**GASTROINTESTINAL**	***Symptom***	***Yes***	***No***
	Dizziness	_____	_____		Abdominal Pain	_____	_____
	Headaches	_____	_____		Diarrhea	_____	_____
	Fainting	_____	_____		Vomiting	_____	_____
	Pain	_____	_____				
	Head Injury	_____	_____				
	Sweats	_____	_____				
EYES	***Symptom***	***Yes***	***No***	**MUSCULOSKELETAL**	***Symptom***	***Yes***	***No***
	Blurry Vision	_____	_____		Arthritis	_____	_____
	Double Vision	_____	_____		Muscle Cramps	_____	_____
	Unusual Sensation	_____	_____		Back Problems	_____	_____
	Vision Loss	_____	_____				
	Eye Pain	_____	_____				
ENT	***Symptom***	***Yes***	***No***	**PSYCHIATRIC**	***Symptom***	***Yes***	***No***
	MOUTH:				Behavioral Change	_____	_____
	Postnasal Drip	_____	_____		Memory Loss	_____	_____
	Tongue Burning	_____	_____		Depression	_____	_____
	Voice Changes	_____	_____				
	EARS:						
	Hearing Impairment	_____	_____				
	Ringing in Ears	_____	_____				
	Dizziness	_____	_____				
	THROAT/NECK:						
	Frequent Sore Throat	_____	_____				
	Tenderness	_____	_____				
RESPIRATORY	***Symptom***	***Yes***	***No***	**NEUROLOGICAL**	***Symptom***	***Yes***	***No***
	Asthma	_____	_____		Tingling	_____	_____
	Cough	_____	_____		Memory Loss	_____	_____
	Wheezing	_____	_____		Tremor	_____	_____
	Sputum	_____	_____		Numbness	_____	_____
	Shortness of Breath	_____	_____		Stroke	_____	_____
					Unsteady Gait	_____	_____

NAME:_____ **DATE OF BIRTH:** _____/_____/_____

INITIAL: _____

NAME:_____ **DATE OF BIRTH: _____/_____/_____**

PLEASE NOTE ANY PAIN, NUMBNESS, OR TINGLING SENSATION ON THE DIAGRAM BELOW



INITIAL: _____

Allan M Spiegel M.D P.A

Prescription Drug Policy

The law requires responsible usage of drugs by doctors and patients. If you accept a prescription from Dr.Spiegel, you are also accepting the responsibility to use the drug for yourself and only as prescribed. My responsibility is to prescribe the medications in an appropriate dosage and amounts, with clear instructions, I will also inform you of the reasons I am prescribing the drug, the expected benefits from its use, and the major precautions and side effects. I will answer any questions you have about the drug.

Drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs *(narcotics, pain medications, and tranquilizers)* require even more responsibility on your part. I will accept NO excuses for their loss or theft and will not order replacements. I will not prescribe them if you are using them other than exactly prescribed or receiving them from another source. I expect you to notify my office if you change drug stores, so that the order at the first store may be canceled.

Many drugs are appropriate for short-term use only. If and when I feel it is not in your best interest to continue on a medication I will tell you. If we cannot agree about your continued use of a substance, then I would require additional consultation with other specialists to help decide on the correct course of action.

My office requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you will need a refill, please call my office 24-48 hours prior so that my office staff will have ample time to ask me to review your chart and call your medication into your pharmacy.

Failure to follow these policies will force my office to terminate our professional relationship and may require me to file a report with the Department of Professional Regulation (DPR) or the local police.

If you are in agreement with all the information stated above, please sign on the line below.

_____ _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE **DATE**

_____

PRINT NAME

INITIAL: _____

Allan M Spiegel M.D P.A

Individual Consent

Consent to the Use and Disclosure of Individually Identifiable Health Information for Treatment, Payment, and/or Health Care Operations

I understand that as a part of my health care, Dr.Allan M. Spiegel receives, originates, maintains, discloses and uses individually identifiable health information, including, but not limited to, health records and other health information describing my health history, symptoms, examination and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. I understand that Dr.Spiegel and staff may use use this information to perform the following tasks:

- Diagnose my medical/psychiatric/psychological condition.
- Plan my care and treatment.
- Communicate with other health professionals concerning my care.
- Document services for payment/reimbursement.
- Conduct routine health care operations, such as quality assurance (the process of monitoring the necessity for, the appropriateness of, and the quality of care provided) and peer review (the process of monitoring the effectiveness of health care personnel)

I have been made aware of the location of the *NOTICE OF INFORMATION PRACTICES* that fully explains the uses and disclosures that Dr.Spiegel will make with respect to my individually identifiable health information. I understand that I have the right to review the *NOTICE* before signing this consent. Dr.Spiegel has afforded me sufficient time to review this *NOTICE* and has answered any questions that I have to my satisfaction. I also understand that Dr.Spiegel cannot use my individually identifiable health information other than as specified in this *NOTICE*. I also understand, however, Dr.Spiegel reserves the right to change this notice and the practices detailed therein prospectively (for uses and disclosures occurring after the revision).

I understand that I do not have to consent to the use or disclosure of my individually identifiable health information for treatment, payment, and health care operations, but that, if I do not consent, Dr.Spiegel may refuse to provide me health care services unless applicable by state or federal law requires Dr.Spiegel to provide such services.

I understand that I have the right to request restrictions on the use or disclosure of my individually identifiable health information to carry out treatment, payment, or health care operations. I further understand that Dr.Spiegel is not required to agree to the requested restriction but that, if it does agree, it must honor the restriction unless I request that it stop doing so or Dr.Spiegel notifies me that it is no longer going to honor the request.

I understand that I have the right to request restriction as to the method of communications to me. I further understand that Dr.Spiegel must honor this request if the *METHOD OF COMMUNICATION* is reasonable. I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Dr.Spiegel has already taken action in reliance on my earlier effective consent.

I give permission to the following people to speak to Dr. Spiegel about my medical condition *(please list first and last name)*:

1. _____ 2. _____

3. _____ 4. _____

_____ _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE **DATE**

INITIAL: _____

Allan M Spiegel M.D P.A

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

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 practices legal duties with respect to my protected health information. This 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 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 other 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 brief description of how I may exercise these rights in relation to:
    - 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 complaint.
    - The right to request restrictions on certain uses and disclosures of my protracted health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of The Notice of Privacy Practices from this practice upon.

I authorize this office to leave a voicemail message on my home phone, cell phone, or answering machine. This office reserves the right to change its Notice of Privacy practice 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 Practice upon request.

_____ _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE **DATE**

<u>*IF SIGNED BY A GUARDIAN</u>, *please indicate name and relationship to patient below:*

NAME:_____ RELATIONSHIP:_____

INITIAL: _____

Assignment of Benefits Form

Neurological Solutions
31608 US Hwy 19 N.
Palm Harbor, FL 34684
Ph:(727)787-7077

Patient:_____
ID #:_____
Group #:_____

I,_____, understand that services rendered to me by Allan M. Spiegel and his associates are my financial responsibility and that the provider will bill my health insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to Allan M. Spiegel and I understand that I will be fully responsible for any outstanding balance on my account. *THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.* This payment will not exceed my indebtedness to the above- mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by the health insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward payment to Allan M. Siegel within 48 hours. I agree that if I fail to send the payment to Allan M. Spiegel and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event a patient receives a check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to the provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

I authorize to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____/_____/_____
PATIENT OR GUARDIAN SIGNATURE **DATE**

_____ _____
PRINT NAME **WITNESS**

INITIAL: _____

********FOR FUTURE USE. PLEASE SIGN AND DATE AT BOTTOM. DO NOT FILL OUT FORM********

AUTHORIZATION TO USE AND OR DISCLOSE MEDICAL RECORDS

I authorize the person/facility below to use and or disclose a copy of the specific health and medical information identified below for:

PATIENT:_____ **DATE OF BIRTH:**_____/_____/_____

RELEASE RECORDS *FROM*:

PHYSICIAN/FACILITY: _____ FAX: _____

ADDRESS: _____ PHONE: _____

RELEASE RECORDS *TO*:

PHYSICIAN/FACILITY: _____ FAX: _____

ADDRESS: _____ PHONE: _____

FOR THE FOLLOWING PURPOSES:

_____ Continued medical care _____ Personal information _____ Legal

By checking the boxes below, I specifically Authorize the use and or Disclosure of the following:

- Please send the entire medical records (all information to above named recipient)
- Office notes and reports
- Imaging records
- Other:_____

*The following items must be initialed in the Use and/or Disclosure for other Health Information:

_____ HIV/AIDS related information and/or records of communicable diseases

_____ Mental health information and/or records

_____ Genetic testing information and/or records

_____ Drug/alcohol diagnoses, treatment, or referral information *(Federal regulations require a description of how much and what kind of information is to be disclosed): Describe:*_____

I understand that if the person or entity receiving the information is not a healthcare provider or health plan covered by Federal Substance Abuse Confidentiality Requirements. I understand that the person I am authorizing to Use and Disclose the information may not receive compensation for doing so. I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for my eligibility for benefits. I may inspect or copy any information to be Used and/or Disclosed under this Authorization. I understand that I may revoke this Authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this Authorization. Unless revoked earlier, this Authorization will expire in one year from the date of signing.

_____ _____/_____/_____

PATIENT OR GUARDIAN SIGNATURE **DATE**

_____ _____/_____/_____

PRINT PATIENT OR GUARDIAN NAME **DATE**

_____ _____/_____/_____

WITNESS **DATE**