Authorization to Release Health Information

Patient Name: _____ Date of Birth: _____

Vero Beach Neurology and Research Institute is willing to assist you in receiving your protected health information. To do this, you must authorize us to provide this information to persons by completing this form.

By authorizing the listed persons below, they will have access to all, of my health information, up to and including HIV, drug and alcohol, and psychiatric records. Vero Beach Neurology and Research Institute is permitted to release this information to the persons listed below.

Persons authorized to receive my medical information:

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

Name: _____Relationship: _____Phone: _____

You may notify me, or the parties listed above with normal test results, appointment reminders and other information regarding my health information as follows:

_____ Message on answering machine. Phone number: _____
_____ Message on work voicemail. Phone number: _____
_____ Message on cell phone. Phone number: _____
_____ Other. Phone number: _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Patient Signature: _____ **Date**: _____

PLEASE BE ADVISED WHEN PICKING UP ANY PAPERWORK OR PRESCRIPTIONS FROM YOUR DOCTOR YOU MUST PRODUCE YOUR DRIVERS LICENSE FOR VERIFICATION. IF YOU NEED SOMEONE OTHER THAN YOURSELF TO PICK UP YOUR PAPERWORK OR PRESCRIPTIONS THEY MUST BE LISTED ON THIS FORM.

I UNDERSTAND THE STATEMENT ABOVE AND ENSURE ALL PARTIES THAT ARE LISTED CAN PICK UP PAPERWORK OR OBTAIN MY PRESCRIPTION MEDICATION.

Signature: _____ **Date**: _____

Name of authorized Representative: _____Relationship: _____

VERO BEACH NEUROLOGY & Research Institute

Patient Name: _____ DOB: _____ Date: _____

Primary Care Physician: _____ Chief Complaint: _____

Current Local Pharmacy: _____ Current Mail Order Pharmacy: _____

LIST OF MEDICATIONS:

☐ No medications

****PLEASE PROVIDE NURSE A MEDICATION LIST IF NEEDED****

Name of Medication	Dosage	Frequency	Route
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral
_____	_____ mg	_____	☐ oral

Medical History

☐ Alzheimer's disease
☐ Arthritis
☐ Asthma
☐ Cancer: _____
☐ Congestive heart failure
☐ COPD
☐ Coronary artery disease
☐ Crohn's disease
☐ Deep venous thrombosis
☐ Degenerative joint disease
☐ Depression
☐ Diabetes:
☐ Drug abuse
☐ Elevated Cholesterol
☐ Fibromyalgia
☐ Gout
☐ Headache/Migraine
☐ High Blood Pressure
☐ Multiple Sclerosis
☐ Heart Attack/Myocardial Infarction
☐ Obesity
☐ Osteoporosis
☐ Parkinson's disease
☐ Peptic Ulcer Disease
☐ Psoriasis
☐ Kidney Disease
☐ Scoliosis
☐ Seizure disorder
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ Other: _____
☐ Other: _____

Surgical:

☐ Amputation
☐ Angioplasty
☐ Appendectomy
☐ Arthroscopy
☐ Back surgery
☐ Blood transfusion
☐ CABG/Heart Bypass
☐ Cardiac pacemaker
☐ Cardiac valve replacement
☐ Carpal tunnel release
☐ Cataract extraction
☐ Cholecystectomy (gallbladder)
☐ Colonoscopy
☐ Gastric bypass
☐ Hernia repair
☐ Hip replacement
☐ Hysterectomy
☐ Knee replacement
☐ Thyroid removal
☐ Tonsil removal (tonsillectomy)
☐ Other: _____

Allergies:

☐ No drug allergies
☐ Codeine
☐ Penicillin
☐ Sulpha
☐ Other: _____

Patient Name: _____ DOB:_____

Hospitalization (with in the last 1 year):

☐ NO ☐ YES:
Where: _____
Chief reason: _____

Family **MEDICAL History:**

Mother: 1. _____ Deceased/Alive
2. _____

Father: 1. _____ Deceased/Alive
2. _____

Other: _____

Tobacco Use:

☐ Non-smoker
☐ Current
- ☐ Cigarette: How many per day? _____
- ☐ Cigar
- ☐ Other: _____

☐ Former: How long ago did you stop smoking? _____years/months

Alcohol Use:

☐ Former
☐ Never
☐ Current
- ☐ Daily
- ☐ Weekly
- ☐ Other: _____

How many drinks: _____

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Patient Name: _____ DOB: _____

Height: ____ft. ____in. **Weight**: _____lb.

Pain scale: (please circle with 0 being no pain and 10 being worst pain):

0 1 2 3 4 5 6 7 8 9 10

Depression:

Do you or have you had symptoms of Depression in the last 2 weeks?

☐ No
☐ Yes

*****If YES, additional questions will be asked at time of examination *****

Advanced Directive:

☐ Advanced Directive is in place

☐ Advanced Directive HAS NOT been determined

Fall History:

☐ NO falls in the last 1 year
☐ Fallen in the last 1 year

____Number of falls in the last 1 year

☐ Injured
☐ Not Injured

Name: _____

Date: _____

General/Constitutional

Fatigue	O Yes	O No
Fever	O Yes	O No
Night sweats	O Yes	O No

Ophthalmologic

Blurred vision	O Yes	O No
Corrective lens	O Yes	O No
Eye Pain	O Yes	O No

Endocrine

Cold intolerance:	O Yes	O No
Heat intolerance	O Yes	O No

Gastrointestinal

Constipation	O Yes	O No
Diarrhea	O Yes	O No
Nausea	O Yes	O No
Vomiting	O Yes	O No

Musculoskeletal

Leg cramps	O Yes	O No
Weakness	O Yes	O No

Allergy/Immunology

Seasonal allergies:	O Yes	O No
Watery eyes	O Yes	O No
Rash:	O Yes	O No

ENT

Ringing in the ears:	O Yes	O No
Decreased hearing:	O Yes	O No

Cardiovascular

Chest pain	O Yes	O No
Irregular heartbeat	O Yes	O No
Palpitations	O Yes	O No

Genitourinary

Painful urination	O Yes	O No
Blood in urine	O Yes	O No
Frequent urination	O Yes	O No

Neurologic

Dizziness	O Yes	O No
Headache	O Yes	O No
Memory loss	O Yes	O No
Tingling/Numbness	O Yes	O No

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PATIENT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Date Of Birth: _____ Sex: ☐ Male ☐ Female

Social Security Number: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Alt Phone #: _____

Employer: _____

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

FINANCIAL RESPONSIBILITY
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

☐ **CHECK HERE IF "SELF" SKIP Below**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Date Of Birth: _____ Sex: ☐ Male ☐ Female

Social Security Number: _____

Home Phone #: _____ Cell Phone #: _____

Work Phone #: _____ Alt Phone #: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship:

- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other (Specify)

No-Show/Missed Appointment Agreement

Thank you for trusting your medical care to Vero Beach Neurology and Research Institute. We work diligently to maintain a high level of professional and personalized service. We strive to accommodate our patient's need for office visits in a timely manner. When a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of other patients.

Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Appointment Cancellation/No Show Policy:

- Effective October 1, 2020, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24-hours' notice** will be considered a **No Show** and charged a $50.00 fee for a provider appointment and a $100 fee for a testing/Neurodiagnostic appointment.

- If a third **No Show** or cancellation/reschedule without a 24-hour notice should occur, the patient will be at risk for dismissal from the care of Vero Beach Neurology and Research Institute.

- Any new patient who fails to show for their initial visit will require prior approval before rescheduling.

- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit and/or upon receipt of statement,** whichever occurs first.

By signing below, I have read and understand the Vero Beach Neurology and Research Institutes **No Show/Missed Appointment Guidelines** and agree to its terms.

Patient Printed Name Date of Birth Date

Patient Signature (or Parent/Guardian if minor) Relationship to Patient

Patient Agreement and Insurance Assignment

HIPAA: This organization complies with all HIPAA and other federal privacy regulations. A notice of privacy policies is available upon request. I acknowledge by signature below that I have been made aware of my rights to review or obtain a copy of the policies.

NOTICE OF THE HEALTH INFORMATION: All patient records remain the property of this practice. Records are centralized and may be accessed by the medical providers or employees as necessary function of their role within the organization. This organization does not release patient records unless necessary for purpose of medical treatment, obtaining payment, or supporting the day-to-day healthcare operations of the practice. Patient signature below provides the practice your consent to use and disclose my health information in accordance with the above statement.

AUTHORIZATION FOR RLEASE OF RECORDS: With my signature below, I consent to medical, surgical care and treatment as may be deemed necessary or advisable in the judgement of my doctor and other providers. Such medical and surgical care and treatment may be preformed at any organizational facility, including emergency treatments or procedures and medical administration, including but not limited to immunizations and injections.

PARTICIPANTS IN MEDICARE PART B: My signature below allows for the holder of medical or other information about me to be released to the Social Security Administration and the CMS First Coast SVC Optional or its intermediaries or carriers or the billing agent of this organization, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignments.

INSURANCE AUTHORIZATION: By signing this agreement, I assign the benefits payable for doctor services to the doctor and organization furnishing the services and authorize them to submit the claim to my health insurance as needed for payment of services. I authorize any holder of medical or other information about me for release to my insurance carrier that is needed for this or a related claim.

I have been advised that payment is due at the time of service. I understand that I will receive itemized statements of my account reflecting the balance pending with insurance and due from me. It remains the responsibility for final payment on my account, regardless of the payment or lack of payments by my insurance carrier. I accept these arrangements while continuing to receive care and services. I also understand that I am responsible in notifying this office when there are changes to my insurance. This authorization and assignment are to be continuing, remaining in force until revoked in writing by the undersigned. I also agree that the information below is correct.

Signature: _____ **Date**: _____
(Patient/Authorized Representative/Parent – if a minor)

Name of authorized Representative: _____ Relationship: _____

VERO BEACH NEUROLOGY & Research Institute

Authorization For Release Of Medical Record Information

Patient Name: _____ Date of Birth: _____

Phone(C): _____ Phone (H): _____

Address: _____ City/State/Zip: _____

I Authorize to Release My Medical Records to:

Doctor/Facility Name: _____ Address:_____

PH: _____ FX:_____

Please Release the Following:

[ ] Office Visits [ ] Radiology Reports Only
[ ] In-House Testing [ ] Lab Work
[ ] Additional:_____

RESTRICTIONS: Only medical records originated and ordered by Dr. S. James Shafer and Stacy Smith PA-C will be released unless otherwise requested. I understand that this authorization may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or Human Immunodeficiency (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office of Vero Beach Neurology and Research Institute (VBNRI). I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact VBNRI making disclosure.

I have read the and agree to the Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature: _____ **Date**: _____

Printed name of authorized representative: _____

Relationship:_____Telephone number of authorized representative: _____