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: _____

Requesting from:

DR/Facility Name: _____ PH: _____ FX: _____

DR/Facility Name: _____ PH: _____ FX: _____

DR/Facility Name: _____ PH: _____ FX: _____

Medical Records Requested (If applicable):

✓ Office Notes ✓ Testing Results ✓ Mail Imaging CD ✓ Lab Work

Please Fax/Mail to:

Dr. S. James Shafer / Stacy P. Smith PA-C

1040 37th Place Suite 201

Vero Beach Fl, 32960

PH: (772) 492-7051 FX: (772) 492-7048

RESTRICTIONS: 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. This information may be disclosed and used by following individual or organization: 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 health information management department. 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.

If I fail to specify an expiration date, event or condition, this authorization will expire 1 year from the date signed. 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 in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with tit 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 above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature: _____ Date: _____

Name of authorized Representative: _____ Relationship: _____

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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: _____

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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

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)

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PRINCIPAL CARE MANAGEMENT AGREEMENT FORM

As part of an ongoing effort to enhance care coordination for its beneficiaries, Medicare and Commercial Insurances are pleased to offer a **new chronic care management service** which will help us better coordinate your care Principal Care Management consists of non-face-to-face care services which our office will furnish to assist in coordination of your care among your different care providers and to help you better manage your chronic conditions. This service would be a complement to the face-to-face services you receive, such as office visits.

As part of this service **Vero Beach Neurology & Research Institute** will work with a team of healthcare providers at our practice to provide care management for your chronic conditions, such as to:

- Create a comprehensive care plan, which will be made available to you either in a written or electronic format and may be periodically revised.
- Coordinate and communicate with other health professionals outside of our practice who are also involved in your care. (Please note, this communication will be done in accordance with all state and federal privacy and security laws.)
- Help you manage care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals or other health care facilities.
- Have a member of **Vero Beach Neurology & Research Institute** care team, accessible 24 hours a day, 7 days a week to help you with any urgent chronic care needs and to coordinate with other healthcare professionals involved in your care. Your chronic care coordinator is name is **Beth, and you can reach her at 772-217-6001.**
- Review and track your key health information such problems, laboratory results, medications and medication allergies as well as help you know when to receive recommended preventive care services.

By signing this consent form, you agree to:

- Allow **Vero Beach Neurology & Research Institute** to bill Medicare or Commercial Insurances for Principal Care Management services on your behalf no more frequently than once a month. This service may be billed even if you do not come into the office that month. **Vero Beach Neurology & Research Institute** will not bill Medicare for Principal Care Management during months in which less than 30 minutes of non-face-to-face chronic care management is provided.
- Pay a copayment, if applicable, during the months in which this service is provided (Most secondary insurances will pay the copayment). Deductibles may also apply. Although there is a fee for this service, it may help you avoid the need for more costly face-to-face services that entail greater cost-sharing. The approximate cost is $12.00 - $50.00 (Commercial Insurances may charge copayments or deductibles), depending on the amount of time each month for Principal Care Management activities.

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- Authorize the electronic communication of your medical information with other treating providers as part of these care coordination efforts.

You have the right to stop receiving Principal Care Management services at any time (effective at the end of a calendar month) and can do so by notifying **Vero Beach Neurology & Research Institute** of your decision, at which point we will have you sign a Principal Care Management termination form.

I permit **Vero Beach Neurology & Research Institute** to bill my Medicare / Insurance for Principal Care Management services provided to me and understand I will be responsible for applicable co-payments and deductibles.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Effective 01/01/2024

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VERO BEACH NEUROLOGY
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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

Authorization to Release Health Information

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 following:

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 result, appointments 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.

PATIENT SIGNATRE _____ Date _____

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: _____