SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.
1601 Clint Moore Road, Suite 120, Boca Raton, FL 33487
Phone - 561-939-0300 Fax – 561-939-0339

DIRECTIONS TO OFFICE

- ***DIRECTIONS TRAVELING SOUTH ON MILITARY TRAIL***: Head south on Military Trail until you get to Clint Moore Road. At Clint Moore Road, turn left, heading east, until you approach the traffic light at Broken Sound Parkway and turn left in to The Boca Clinic parking lot. If you reach Congress Avenue, you have passed our building.

- ***DIRECTIONS TRAVELING SOUTH ON I-95***: Head south on I-95 exiting off on Congress Avenue. Follow the exit ramp west to the Congress Avenue traffic light and turn left on Congress Avenue, heading south, until you get to Clint Moore Road. At Clint Moore Road, turn right, heading west, until you get to the traffic light at Broken Sound Parkway. Turn right in to The Boca Clinic parking lot. If you reach Military Trail, you have passed our building.

- ***DIRECTIONS TRAVELING NORTH ON MILITARY TRAIL***: Head north on Military Trail until you get to Clint Moore Road. At Clint Moore Road, turn right heading east until you approach the traffic light at Broken Sound Parkway. Turn left at this light in to the Boca Clinic parking lot. If you reach Congress Avenue, you have passed our building.

- ***DIRECTIONS TRAVELING NORTH ON I-95***: Head north on I-95 exiting at Congress Avenue. Follow the exit ramp west to the traffic light at Congress Avenue and turn left, heading south on Congress Avenue, until you reach Clint Moore Road. Turn right on Clint Moore Road, heading west, until you reach the traffic light at Broken Sound Parkway and turn right in to the Boca Clinic parking lot. If you reach Military Trail, you have passed our building.

SOUTH FLORIDA NEUROLOGY ASSOCIATES IS LOCATED BETWEEN THE FRONT AND EAST ENTRANCES TO THE BUILDING.

VALET PARKING IS AVAILABLE AT THE BOCA CLINIC BUILDING FOR A NOMINAL FEE.

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Patient Information Form

Name: ____ Sex: ____ M _____F

Home Phone: ________________ Work Phone:_________________Cell Phone:_____________

Email Address: ____

Home Address: ____________________ City/State: __________________ Zip Code: ________

Patient Social Security #: _________________________ Date of Birth:____________________

Driver's License #: _______________________ State: ______ Exp. Date: __________________

Marital Status: Married Divorced Legally Separated Single

Full Time Student: Yes No Name of School: _____________________________________

Nearest relative not living with you: _____________________ Phone:___________________

Nearest friend not living with you: ______________________ Phone: ___________________

Emergency contact:_________________________________ Phone:___________________

Whom may we thank for referring you to us?____________________ Phone:_______________

Who is responsible for this bill? ____

Name of referring/primary physician: ____

Did you sustain an injury at work?

□Yes □No

Are you covered under an employer or union policy?

□Yes □No

Are your injuries accident related?

□Yes □No

Is your spouse or other family member employed?

□Yes □No

Are you currently employed?

□Yes □No

Do you have a secondary insurance policy?

□Yes □No

Have you ever served in the military?

□Yes □No

Are you covered under any other health care plan?

□Yes □No

Have you made any changes to your choice of Medicare options in the last open enrollment period?

Y N

Are you enrolled in a Medicare Advantage Plan?

Y N

I am a new patient to this practice and am in a pre-existing provision with my insurance carrier.

Y N

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Medical Insurance Information:

Name of Insured: ____

Relationship to Patient: ____

Policyholder Date of Birth: _______________Policyholder Social Security #: __________________

Insurance Carrier Name, Address, Phone #:

____

____

Identification card present upon encounter: Yes No

Secondary Medical Insurance

If information is same as the information above indicate with "Same as and indicate which policyholder is applicable" in the appropriate data fields. Leave blank if you do not have a secondary policy.

Name of Insured: ____

Relationship to Patient: ____

Policyholder Date of Birth: _______________Policyholder Social Security #: __________________

Insurance Carrier Name, Address, Phone #:

____

____

Identification card present upon encounter: Yes No

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature:____

Date: _____________________

SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.

PATIENT MEDICAL HISTORY

Name ________________________________ **Age** ______ **Left or Right Handed (circle)**

Primary/Referring Physician ______________________ **Phone** ______________________

Chief Complaint (Why are you here?) ________________________________

Describe briefly the history of your problem: ________________________________

____

Please mark "X" if you have had any of the following:

__Back Pain	__Diarrhea	__Hearing Loss	__Pains	__Tremors
__Bladder Changes	__Dizziness	__Fever	__Palpitations	__Uncoordination
__Blurred Vision	__Double Vision	__Memory Loss	__Paralysis	__Unsteadiness
__Confusion	__Fainting	__Muscle Wasting	__Ringing in Ears	__Weight Loss/Gain
__Constipation	__Involuntary Movements	__Neck Pain	__Edema	__Sleep Disturbance
__Convulsion	__Headaches	__Numbness	__Tingling	__Loss of Appetite
__Rash	__Depression	__Insomnia	__Cough	__Shortness of Breath
__Chest Pain	__Anemia	__Loss of Smell		

Allergies: ________________________________

Past Medical History (please list all medical problems) ________________________________

____

____

Do you have a pacemaker or defibrillator? ___Yes ___No Which?________________

Hospitalizations/Surgeries (Dates & Reasons): ________________________________

____

Please mark "X" next to any conditions that you have now or have had in the past:

__Diabetes __High Blood Pressure __Head Injury __High Cholesterol __Heart Disease

__Seizures __ Stroke __Other (Explain):________________________

Please list all medications including vitamins, supplements & herbal medicines that you are currently taking with dosages:

____

____

Family Medical History (Please list medical problem and family member affected): ________________________

____

Do you smoke? ___Yes ___No If yes, how much? ____________ For how long? ________________

Do you drink alcohol? ___Yes ___No If yes, how much? __________ How often? ________________

Do you use Marijuana, Cocaine and/or any unprescribed drugs? ___Yes ___No If yes, which ones? ______________

Ethnicity? ___Hispanic or Latino ___ NOT Hispanic or Latino Race: ________________________

Occupation (Please indicate if retired.) ________________________________

Additional comments or specific questions: ________________________________

____

I have answered the questions truthfully and to the best of my knowledge, without intent to falsify information. I understand that incorrect information I may have provided could affect recommended treatment and ultimately affect the course and outcome of my medical condition.

________________________ ____________ ________________________

Patient's Name (Print) Date Patient's Signature

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CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (narcotics, tranquilizers and barbiturates) can be very useful in the treatment of headaches and other pain syndromes. Unfortunately, they also have a high potential for abuse and misuse and are closely supervised by the local, state, and federal governments.

Dependence upon the regular intake of analgesics can easily lead to "rebound" headaches, as well as confusion, forgetfulness, and excessive drowsiness. This occurs when the brain becomes accustomed to the chemicals in the analgesics and expects those same chemicals within a certain time frame. When the analgesics are withheld, a withdrawal effect can occur. **Headache therapy usually cannot commence without an inpatient or outpatient withdrawal of the patient experiencing drug abuse headache**. Withdrawal is only the first step towards the successful treatment of the patient suffering with headache.

I agree to enter into the following contract with the health care providers of South Florida Neurology Associates, P.A.:

1. I am responsible for my controlled substance medications. If the prescription or medication is lost, misplaced, or stolen, or I use it sooner than prescribed, I understand that it will not be replaced.
2. I will not request nor accept controlled substance medication from any other physician or individual while I am receiving such medications from South Florida Neurology Associates, P.A. The exception would be if I were hospitalized and under the care of another physician.
3. Refills of controlled substance medication:
   a. Will be made during office hours only 10:00 AM to 4:00 PM, Monday through Friday, once a month. **Refills will not be made at night, on holidays, nor on weekends.**
   b. Will not be made if I "run out early." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount left.
   c. Will not be made as an "emergency." I will call at least 24 hours ahead if I need assistance with a controlled substance medication prescription.
   d. I understand that if I violate any of the above conditions, my relationship with South Florida Neurology Associates, P.A. will be terminated. I understand that I may be reported to the Drug Enforcement Agency (DEA), other physicians, and local medical facilities.

I have read and agree to the terms of the CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS of South Florida Neurology Associates, P.A as signed and witnessed below.

______________________	______________________	________
Name of Patient (printed)	Signature of Patient	Date
______________________	______________________	________
Name of Witness (printed)	Signature of Witness	Date

SOUTH FLORIDA NEUROLOGY ASSOCIATES, P.A.

CONSENT to the USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION for TREATMENT, PAYMENT, or HEALTHCARE OPERATIONS

I understand that as part of my healthcare, South Florida Neurology Associates, P.A. ("SFNA") originates and maintains health records describing my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves many purposes to many other healthcare professionals and healthcare related operations.

I understand and have been provided with the opportunity to review our Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that SFNA reserves the right to change their notice and practices and prior to implementation will provide me the opportunity to review them. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that SFNA is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that SFNA has already taken action in reliance thereon.

I authorize the following person(s) or class of person(s) to receive my health information:

____

____

I request the following restrictions to the use or disclosure of my health information:

____

____

Please use the other side of this form if more space is needed

______________________________________ ______________________

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

______________________________________ ______________________

PRINT PATIENT NAME DATE

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone ______________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone ______________________
  - ☐ O.K. to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ O.K. to mail to my home address
  - ☐ O.K. to mail to my work/office address
  - ☐ O.K. to fax to this number ______________
- ☐ Other ______________________

______________________________ Patient Signature

______________ Date

______________________________ Print Name

______________ Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for *PHI* to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures or TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key; T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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Assignment of Benefits Form

Patient:____Phone: ______________________________

Address:____

City, State, Zip:____

ID#:_____________________________________Group#:_______________________________________

I, ____, understand that services rendered to me by **South Florida Neurology Associates, PA** are my financial responsibility and that the provider will bill my insurance company ____________________________, as a courtesy. I authorize my insurance company to pay my benefits directly to **South Florida Neurology Associates, PA** 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 haves 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 ________________________________(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 the payment to **South Florida Neurology Associates, PA** within 48 hours. I agree that if I fail to send the payment to **South Florida Neurology Associates, PA** 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 patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to 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 the provider 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.

Dated______________________________Witness ______________________________________

____

Signature of Patient/Guardian/Policyholder

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FINANCIAL AGREEMENT FORM

We, the staff of **South Florida Neurology Associates, PA** thank you for choosing us as your medical provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact Mishelle Mostun at 561.939.0300 x 6308.

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. **If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.**

We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa, and in-state checks). A $35.00 service fee will be charged for all returned checks.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Medicare

We are Medicare providers and therefore we accept the Medicare allowable for covered services. We are NOT, however, necessarily on any other Medicare “advantage” or HMO plans. You will be responsible to pay the deductible (if it has not already been met for the year) AND the 20% Medicare co-payment if you do not have a secondary insurance.

Auto Insurance

We will need a copy of your medical insurance card(s) even if you are covered under an auto claim. Any remaining balance will be billed to your health insurance (only those we participate with) once your auto insurance benefits have been exhausted. Be advised that if we are a non-participating provider with your health insurance, you will be required to pay the entire balance and file a claim to seek reimbursement. ***Note that it is in your best interest to stay within your health insurance network for best coverage. Contact your insurance company to find a provider in your network.*

Workers Compensation

Our office does **NOT** work with Workers Compensation.

Participating Insurance Plans

If our office participates with your insurance plan, you will be expected to pay your deductible and co-payment at the time services are provided. Call your insurance company to see if we are on their participating panel.

Non-Participating Insurance Plans

You will be expected to pay in full for your services at the time of the visit**. Please be advised that we are not obligated to take any contractual adjustments and you will be responsible for all charges at the time of service.** Testing orders will be given to you in prescription form to take to your participating primary care physician so arrangements can be made so the services can be covered in your network. If you choose to have the testing done in our office, you will be required to pay at the time of service and you can request an itemized bill to file your own insurance claim.

At times, non-participating providers send claim checks directly to the policy holder. In the event you receive a check for services rendered, it is your responsibility to forward the check to South Florida Neurology Associates, P.A. Please endorse the back of the check on the first line. On the second line, please write "Pay to the order of South Florida Neurology Associates, P.A.”

Patient’s Initials: ________________________

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Miscellaneous Forms, Additional Information, and Authorizations

We will provide all necessary information to have your benefits released.

Missed Appointments

We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee can be applied. These fees are typically $25.00. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files, and or summaries.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature of Insured or Authorized Representative: ____

Date: ________________

South Florida Neurology Associates, P.A.
Diplomates, American Board of Psychiatry and Neurology

Frederick J. Boltz, M.D.
Marc H. Feinberg, M.D.
Scott E. Blumenthal, D.O.
Joannes J.A. Paul, M.D.
Naadira F. McClain, D.O.
Stuart N. Keiran, M.D.
Caleene R. Goodis, A.P.R.N.

Doctor's Lien

To: (Fill in Attorney Name Here)

Re: Medical Reports and Doctor's Lien for (Fill in Patient Name Here)

Date of Loss: (Fill in date of accident here)

Doctor,

I do hereby authorize the above doctor to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owed to him for medical service rendered to me, both by reason of this accident and by reason of any other bills that are due to his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered me and that this agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. And I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

(FILL IN DATE) (PATIENT SIGNATURE)

________________________ __________________________
Date Patient Signature

The undersigned being attorney of record for the above patient does herby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor above named.

(NOT NEEDED) (NOT NEEDED)

________________________ __________________________
Date Attorney's Signature

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NOTICE OF EMERGENCY MEDICAL CONDITION

The undersigned licensed medical provider, hereby affirms:

1. The below injured patient, has in the opinion of this medical provider, suffered an **Emergency Medical Condition**, as a result of the patient's injuries sustained in an automobile accident that occurred on ________________ (Date of Accident).
2. The basis for the finding of an **Emergency Medical Condition** is that the patient has sustained acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: a) serious jeopardy to patient health; b) serious impairment to bodily functions; or c) serious dysfunction of a bodily organ or part.

I hereby attest that I am a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464, and that the above facts are true and correct.

____________________________	____________________________	____________________________
Name (PRINT or TYPE)	Signature of medical provider	Date

The undersigned injured person or legal guardian of such person affirms:

1. The symptoms I reported to the medical provider are true and accurate

2. I understand the medical provider has determined I sustained an Emergency Medical Condition as a result of the injuries I suffered in the care accident.

3. The medical provider has explained to my satisfaction the need for future medical attention and the harmful consequences to my health which may occur if I do not receive future treatment.

Injured patient receiving this diagnosis or legal guardian of said injured patient:

____________________________	____________________________	____________________________
Name (PRINT or TYPE)	Signature of injured patient/guardian	Date

Frederick J. Boltz, M.D.
Marc H. Feinberg, M.D.
Scott E. Blumenthal, D.O.
Joannes J.A. Paul, M.D.
Naadira F. McClain, D.O.
Stuart Kieran, M.D.

South Florida Neurology Associates, P.A.
Diplomates, American Board of Psychiatry and Neurology

RELEASE OF INFORMATION AUTHORIZATION FORM

I, ____, Date of Birth: _______/ _______/_________
(Patient's Name)

hereby authorize SOUTH FLORIDA NEUROLOGY ASSOCIATES to:

☐ Release protected health information to:

☐ Receive protected information from:

☐ Share protected health information with:

Name of Facility/Individual: ____

Address:____

____

Phone:____________________________________Fax:____________________________________

Records Desire: ___ Office Notes ___ Diagnostic Tests ___ Medication List
___ Labs ___ Other: ____

****

It is understood:

- That the recipient of the protected health information under this authorization should not re-disclose the information without a written authorization.
- Health Care Provider will not condition the provision of care or receipt of benefits on the signing of the authorization.
- Patient will receive a copy of the completed authorization form upon request.
- Patient may revoke this authorization by requesting in writing.

This authorization expires: (choose one)___ 30 days from above date
___ 1 year from above date
___ immediately after this request is fulfilled

______________________________ ______________________________
Patient's Signature Patient's Date of Birth

______________________________ ______________________________
Printed Patient's Name Patient's Address

____
Date

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