SMIRNOFF NEUROLOGY

729 County Road 466
Lady Lake, FL 32159
Ph: 352/633-2164 Fax: 352/205-8149

Welcome to Smirnoff Neurology. Attached are the forms you will need for your new patient appointment. Please fill out all forms completely. Do not write "see attached."

In addition to these forms please bring the following to your appointment:

1. Drivers License or State ID
2. All Insurance Cards
3. All prescription bottles. Please complete the attached medication list or provide a typed list of medications.
4. Any test results that are relevant to your visit. If you need to request records, please do so in advance. Records release forms are available in our office. You will need to provide the address, phone number, and fax number of the requested physician.

Please note that we do not do disability evaluations, accident related cases or workers compensation cases.

We accept Visa, MasterCard, or Cash only at the first appointment. Co-pays and deductibles are collected at the time of visit. There is a $3.00 fee to use a credit or debit card.

WELCOME.....WE LOOK FORWARD TO MEETING YOU!

SMIRNOFF NEUROLOGY

729 County Road 466, Lady Lake, FL 32159

Patient Name: _____DOB:_____Age:_____

Address:_____

City:_____ State: _____Zip:_____

Home Phone:_____Cell Phone:_____

SS#:_____Sex: Male Female

Marital Status: Single Married Widowed Divorced Separated Other

Highest Level of Education:_____Race:_____

Hispanic? Yes or No E-mail address:

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family members or caretakers may ask questions about my medical condition over the telephone or in person. I understand it is a breach of physician-patient confidentiality for my doctors to discuss my medical information in any way with anyone without my expressed written consent. By signing this form I am designating the parties listed below to be able to discuss my medical condition with *Smirnoff Neurology*.

1. Name:_____Relationship:_____
2. Name:_____Relationship:_____
3. Name:_____Relationship:_____
4. Name:_____Relationship:_____

Patient Signature_____Date_____

*Signature stays on file unless patient changes status

SMIRNOFF NEUROLOGY

INSURANCE INFORMATION

It is your responsibility to provide accurate and up-to-date medical insurance information and to notify us immediately of any changes in your insurance coverage. Please note that you are personally responsible for all charges incurred. To the extent that if you fail to provide timely or accurate insurance information resulting in non-payment for services, or your insurance denies coverage, you will be invoiced directly and payment is expected immediately.

Patient Signature_____Date_____

*Prior authorizations are required for all HMO plan

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Smirnoff Neurology to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to Smirnoff Neurology all payments for medical services rendered to me or my dependents.

Patient Signature_____Date_____

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

I consent to examination and treatment necessary or desirable to the care of the patient mentioned, including, but not restricted to whatever medicine, laboratory, x-ray, or other studies that may be used by the attending physician, his nurse, or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay for them at the time of service. I understand that the charges made by professional services may not be covered in full by insurance, although insurance may be filed. I understand that the patient or the responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment, I agree to pay all costs of collection, including reasonable attorney fees.

Patient Signature_____Date_____

CANCELLATION POLICY

I am aware that Smirnoff Neurology has a late cancellation and no show policy that states that patients who do not give at least 24 hours notice when they are unable to keep an appointment with the doctor will be charge a fee of $75.00 per occurrence, and $100.00 for any tests scheduled. I am also aware that this fee will be due before seeing the physician at my next appointment.

Patient Signature_____Date_____

PRIVACY NOTICE (Reference Forms Given)

By signing below, I hereby acknowledge receipt of Smirnoff Neurology Privacy Notice.

Patient Signature_____Date_____

SMIRNOFF NEUROLOGY MEDICATION LIST

NAME: _____

PHARMACY NAME: _____ PHARMACY #: _____

DATE STARTED	MEDICATION NAME	DIRECTIONS	REASON FOR TAKING

LIST OF MEDICATIONS YOU ARE ALLERGIC TO

MEDICATION	REACTION

SMIRNOFF NEUROLOGY NEW PATIENT INFORMATION

PATIENT NAME: _____ DOB _____

I WAS REFERRED BY: _____ PRIMARY DR: _____

HAVE YOU EVER BEEN SEEN BY DR. SMIRNOFF IN THE HOSPITAL? YES OR NO

IF YES, WHEN? _____

REASON THAT I AM BEING SEEN TODAY: _____

_____

I HAVE HAD THIS PROBLEM FOR: _____ YEARS_____ WEEKS_____ MONTHS_____ DAYS

TEST THAT I HAVE HAD FOR THIS PROBLEM: _____

WHAT MEDICATIONS HAVE YOU TRIED: _____

SOCIAL HISTORY

(PLEASE CIRCLE THE ANSWER THAT APPLIES)

DO YOU DRINK?	YES	NO
HOW MANY DRINKS PER DAY		
DO YOU SMOKE?	YES How many PPD?	NO
ARE YOU A FORMER SMOKER?	YES	NO

FAMILY HISTORY

(Please check box that applies)

CONDITION	MOM	DAD	SIBLINGS	GRAND PARENTS
DIABETES				
CANCER				
HYPERTENSION				
STROKE				
HEART ATTACK				
MEMORY PROBLEMS				

SURGERIES

PLEASE LIST ALL SURGERIES TO INCLUDE DATE

Patient Name_____ DOB_____

Review of Symptoms- Check any of the following symptoms you have had within the ***past 2 months:***

GENERAL: Fatigue_____ Unexplained weight gain_____ Unexplained weight loss_____

Excessive perspiration_____

HEAD: Headache_____ Dizziness_____ Cognitive impairment_____

EYES: Double vision_____ Blurred vision_____ Macular degeneration_____ Glaucoma_____

EARS: Hearing loss_____ Ringing in ears_____

NOSE: Loss of smell_____

THROAT: Difficulty swallowing_____Voice changes_____

RESPIRATORY: Chest pain_____Palpitations_____Leg swelling_____

GENITOURINARY: Incontinence_____Urinary tract infections_____Urgent bladder_____

Difficulty urinating_____

RESPIRATORY: Shortness of breath_____Wheezing_____

GASTROINTESTINAL: Loss of appetite_____Nausea_____Vomitting_____Diarrhea_____Constipation_____

MUSCULOSKELETAL: Muscle pain_____Joint pain_____Joint stiffness_____Cramps_____

Weakness_____Leg pain while walking_____

INTEGUMENTARY: Rashes_____Psoriasis_____

NEUROLOGIC: Problem with activities of daily living_____Problem with concentration_____

Unsteady gait_____Numbness_____Tingling_____Pain_____Loss of memory_____

Seizures_____Stroke_____Syncope_____TIA_____Tremor_____Vertigo_____

PSYCHIATRIC: Depression_____Insomnia_____Anxiety_____Nervousness_____

Drug abuse_____Alcohol abuse_____Hallucinations_____Bipolar_____

HEMATOLOGIC: Easy bleeding_____Easy bruising_____Blood clots_____DVT_____

Transfusions_____Lymphoma/Leukemia_____

PAST MEDICAL HISTORY

NAME_____DOB_____

PLEASE CHECK ALL THAT APPLY

CARDIOVASCULAR:

HIGH BLOOD PRESSURE_____

LOW BLOOD PRESSURE_____

A-FIB_____

CHEST PAIN_____

HEART ATTACK_____

STENTS_____

LEG SWELLING_____

EMBOLISM_____

BRADYCARDIA_____

HYPERLIPIDEMIA_____

PACEMAKER_____

RESPIRATORY:

SHORTNESS OF BREATH_____

ASTHMA_____

EMPHYSEMA_____

COPD_____

CHRONIC BRONCHITIS_____

SLEEP APNEA_____

CPAP_____

WHEEZING_____

GASTROINTESTINAL:

ULCER_____

HEPATITIS_____A___B___C___

GALLBLADDER PROBLEMS_____

ENDROCINE:

DIABETES_____INSULIN_____YES_____NO

OBESITY_____

HYPOTHYROIDISM_____

HYPERTHYROIDISM_____

HEMATOLOGIC:

EASY BLEEDING_____

EASY BRUISING_____

ANEMIA_____

BLOOD CLOTS_____

ANTICOAGULATION_____

NEUROLOGIC:

STROKE_____

TIA_____

SEIZURES_____

EPILEPSY_____

HEADACHES_____

DIZZINESS_____

UNSTEADY GAIT_____

TREMOR_____

PARKINSON'S_____

MULTIPLE SCLEROSIS_____

ALS_____

DEMENTIA_____

COGNITIVE IMPAIRMENT_____

SYNCOPE_____

PSYCHOLOGICAL:

DEPRESSION_____

ANXIETY_____

DRUG ABUSE_____

ALCOHOL ABUSE_____

BIPOLAR_____

GENITOURINARY:

PROSTATE DISEASE_____

MUSCULOSKELETAL:

NECK PAIN_____BACK PAIN_____

ARTHRITIS_____OSTEOPOROSIS_____

FIBROMYALGIA_____

CANCER:

WHAT TYPE?_____CHEMO?_____RADIATION?_____

OTHER:_____

Name_____ DOB_____

Date_____

Your health and wellbeing is of paramount importance to us. Please answer the questions below. This will help us, help you. Thank-you.

Please circle YES or NO to the following questions:

Yes No Have you fallen in the past year?

Yes No Do you ever lose your balance, feel dizzy or lightheaded?

Yes No Do you ever feel dizzy or lightheaded when you first stand up?

Yes No Do you have confusion, feel depressed or have anxiety?

Yes No Do you have pain or numbness in your legs or feet?

Yes No Have you noticed a decline in your memory?

Yes No Have friends or family told you that you are forgetting things?

Yes No Do you get confused or more distracted than you used to?

Yes No Do you have serious alterations in your sleep habits?

Yes No Do you have a decreased interest in activities?

Yes No Are you afraid of falling?

SMIRNOFF NEUROLOGY, PA

PRIVACY NOTICE

This notice describes how medical information about you may be used and discloses and how you can get access to this information. Please review it carefully.

We are required under Federal Health Care Privacy Rules (the "Privacy Rules") to protect the privacy of your health information which includes information about your health history, symptoms, test results, diagnoses, treatment and claims and payment history(collectively "Health Information") . We are also required to provide you with this Privacy Notice regarding our legal duties, policies and terms in the Privacy Notice unless (and until) it is revised. We reserve the right to change the terms of the Privacy Notice and to make the new notice provision effective for the Health Information that we maintain and use, as well as for any Health Information that we may receive in the future. Should the terms of the Privacy Notice change, we will promptly distribute a revised copy of the notice to you.

PERMITTED USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

1. General Uses and Disclosures: Under the Privacy Rules, we are permitted to use and disclose you Health Information for the following purposes, without obtaining your permission or authorization:

- Treatment. We are permitted to use and disclose your Health Information in the provision and coordination of your health care. For example, we may disclose your Health Information to your primary health care provider, consulting providers and to other health care personnel who have a need for such information for your care and treatment.
- Payment. We are permitted to use and disclose your Health Information for the purposes of determining coverage, billing and reimbursement. This information may b released to an insurance company, third party payor or other authorized entity or person involved in the payment of your medical bills and may include copies or portions of your medical record, which are necessary for payment of your bill. For example, a bill sent to your insurance company may include information that identifies you, your diagnosis and the procedures and supplies used in your treatment.
- Health Care Operations. We are permitted to use and disclose your Health Information during our health care operations, including, but not limited to: quality assurance, auditing, licensing or credentialing activities and for educational purposes. For example, we can use your Health Information to internally assess our quality of care provided to patients.
- Uses and Disclosures Required by Law. We may use and disclose your Health Information when required to do so by law, including, but not limited to: reporting abuse, neglect and domestic violence: in response to judicial and administrative proceedings: in responding to a law enforcement request for information: or in order to alert law enforcement to criminal conduct on our premises or of a death that may be the result of criminal conduct.
- Public Health Activities. We may disclose your Health Information for public health reporting, including, but not limited to: child abuse and neglect, reporting communicable disease and vital statistics, product recalls and adverse events, or notifying person(s) who may have been exposed to a disease or are at risk of contracting or spreading a disease or condition.
- Abuse and Neglect. We may disclose your Health Information to a local, state or federal government authority, if we have a reasonable belief of abuse, neglect of domestic violence.
- Regulatory Agencies. We may disclose your Health Information to a health care oversight agency for activities authorized by law, including, but not limited to, licensure, investigations and inspections. These activities are necessary for the government and certain private health oversight agencies to monitor the health care systems, government program and compliance with civil rights.

- Judicial and Administrative Proceedings. We may disclose your Health Information in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal or in response to a subpoena, summons, warrant, discovery request of similar legal request.
- Law Enforcement Purposes. We may disclose your Health Information to law enforcement officials when required to do so by law.
- Coroners, Medical Examiners, Funeral Directors. We may disclose your Health Information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your Health Information to funeral directors, as necessary, to carry out their duties.
- Research. Under certain circumstances, we may disclose your Health Information to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your Health Information.
- Threats to Health and Safety. We may use of disclose your Health Information if we believe, in good faith, that the use of disclosure is necessary to prevent or lessen a serious of imminent threat to the health of safety of a person or the public, or is necessary for law enforcement to identify or apprehend an individual
- Specialized Government Functions. If you are a member of the U.S. Armed Forces, we may disclose your Health Information as
- required by military command authorities. We may also disclose your Health Information to authorized federal officials for national security reasons and the Department of State for medical suitability determinations.
- Inmates. If you are an inmate of a correctional Institution or under the custody of a law enforcement official, we may release your Health Information to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety, or the health or safety of others; or for the safety and security of the correctional institution.
- Worker's Compensation. We may disclose your Health Information to your employer to the extent necessary to comply with Florida laws relating to Worker's Compensation or other similar programs.
- Fundraising. We may use or disclose your Health Information to make a fundraising communication to you, for the purposes of raising funds for your own benefit. Included in such fundraising communications will be instructions describing how you may ask not to receive further communications.
- Marketing. We may use or disclose your Health Information to make a marketing communication to you that occurs in a face-to-face encounter with us or which concerns a promotional gift of nominal value provided by us.
- Appointment Reminders/Treatment alternatives. We may use and disclose your Health Information to remind you of an appointment for treatment and medical care at our office to provide you with information regarding treatment alternatives or other health-related benefits and services that may be on interest to you.
- Business Associates. We may disclose your Health Information to business associates who provide services to us. Our business associates are required to protect the confidentiality of your Health Information.
- Other Uses and Disclosures. In addition to the reasons outlined above, we may use and disclose your Health Information for other purposes permitted by the Privacy Rules.

2. Uses and Disclosures which Require Patient Opportunity to Verbally Agree of Object. Under the Privacy Rules, we are permitted to use and disclose your Health Information (i) for the creation of facility directories, (ii) to disaster relief agencies and (iii) to family members, close personal friends or any other person identified by you, if the information is directly relevant to that person's involvement if your care or treatment. Except in emergency situation, you will be notified in advance and have the opportunity to verbally agree or abject to his use and disclosures or your Health Information.
3. Use and Disclosures which Require Written Authorization. As required by the Privacy Rules, all other uses and disclosures of your Health Information (not described above) will be made only with your written Authorization. For example, in order to disclose your Health Information to a company for marketing purposes, we must obtain you Authorization. Under the Privacy Rules, you may revoke your Authorization at any time. The revocation of your Authorization will be effective immediately, except to the extent that: we have relied upon it previously for the use and disclosure of your Health Information; if the Authorization was obtained as a condition or obtaining insurance coverage where other law provides the insurer with the right to contest a claim under the policy or the policy itself;

or where your Health Information was obtained as part of a research study and is necessary to maintain the integrity of the study.

You have the following rights concerning your Health Information:

1. Right to Inspect and Copy Your Health Information. Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set maintained by us or for us. A "designated record set" contains medical and billing records and other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information that we maintain . For example, this right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for use in civil, criminal, or administrative proceedings. Where permitted by the Privacy Rules, you may request that certain denials to inspect and copy your Health Information be reviewed. If you request a copy or summary of explanation of your Health Information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage and any other associated costs in preparing the summary of explanation.
2. Right to request Restrictions on the Use and Disclosure of Your Health Information. You have the right to request restrictions on the use and disclosure of your Health Information for treatment, payment and health care operations as well as disclosure to persons involved in your care or payment for your care, such as family members and close friends. We will consider, but do not have to agree to such requests.
3. Right to Request an Amendment of Your health Information. You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by us or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement and a description of how you may file a complaint.
4. Right to an Accounting of Disclosures of Your health Information. You have the right to receive an accounting of disclosures of your Health Information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your Authorization; disclosures that are part of a Limited Data Set; incidental disclosures; disclosures to persons involving in your care or payment for your care; disclosures to correctional institutions or law enforcement officials, disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.
5. Right to Alternative Communications. You have the right to receive confidential communications to your Health Information by a different means or at a different location that currently provided. For example, you may request that we only contact you at home or by mail.
6. Right to Receive a Paper Copy of this Privacy Notice. You have the right to receive a paper copy of this Privacy Notice upon request, even if you have agreed to receive this Privacy Notice electronically.

If you want to exercise any of these rights, please contact our office. All requests must be submitted in writing.