

SMIRNOFF NEUROLOGY

729 CR 466, LADY LAKE, FL 32159

PH: 352-633-2164 FAX: 352-205-8149

Welcome to Smirnoff Neurology. We look forward to meeting you. Attached are the forms you will need for your new patient appointment. Please fill out all forms completely and return them to the office at least 2 days prior to your appointment. 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 fax number of the requested physician.**

Please note that we do not do any DISABILITY EVALUATIONS, ACCIDENT RELATED CASES, OR WORKERS COMPENSATION CASES.

Co-pays and deductibles are collected at the time of visit.

We accept Visa, MasterCard, Discover, or Cash only at the first appointment.

We are located at the corner of County Road 466 and Rolling Acres Road, in the medical complex SUMMIT OF LADY LAKE.

We are caddie-corner to the American Legion and directly across from the plant nursery.

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PH: 352-633-2164 FAX: 352-205-8149

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Referring Dr: _____ Family Dr: _____

SS# _____

Sex: Male Female Are you Hispanic? Yes No

Are you: Right handed Left handed

Are you retired? Yes No

Current/Previous occupation: _____

Highest degree of education: _____

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my family member(s) or caretaker(s) 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 doctor to discuss my medical information in anyway 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: _____

Signature stays on file unless patient changes status.

_____ Date _____

SMIRNOFF NEUROLOGY

INSURANCE INFORMATION

It is your responsibility to provide accurate and up-to-date 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 a non-payment for services, or your insurance denies coverage, you will be invoiced directly and payment is expected immediately.

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.

CONSENT FOR TREATMENT AND FINANCIAL AGREEMENT

I consent to examination and treatment necessary or desirable to the care of the patient, including, but not restricted to whatever medicine, laboratory, diagnostic tests, or other studies that may be used by the attending physician or qualified designate. I also acknowledge full responsibility for the payment of such services. 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.

CANCELLATION POLICY

I am aware that Smirnoff Neurology has a late cancellation and no show policy that states that a patient that does not give at least 24 hours notice when they are unable to keep an appointment with our office will be charged a fee of \$75.00 per occurrence, and \$100.00 for any scheduled tests. Any appointment scheduled for Monday requires a phone call no later than 8:30 am to avoid the fee. If you are out of town at your scheduled appointment time, we require a 48 hour notice. I am also aware that this fee will be due before seeing the physician at my next appointment.

PRIVACY NOTICE

I have received a copy of Smirnoff Neurology Privacy Notice.

By signing below, I acknowledge that I understand and agree to each of the above notices. I also understand that I can not make any changes to the above policies.

Patient Signature: _____ Date: _____

SMIRNOFF NEUROLOGY NEW PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

REASON FOR THIS CONSULTATION: _____

I HAVE HAD THIS PROBLEM FOR HOW LONG: _____

TESTS THAT I HAVE HAD FOR THIS PROBLEM: _____

WHAT MEDICATIONS HAVE YOU TRIED: _____

SOCIAL HISTORY

DO YOU DRINK ALCHOL? YES OR NO HOW MANY DRINKS PER DAY? _____

DO YOU CURRENTLY SMOKE? YES OR NO HOW MANY PACKS PER DAY? _____

ARE YOU A FORMER SMOKER? YES OR NO

FAMILY HISTORY

(CIRCLE ALL THAT HAVE OCCURRED AND IN WHICH BLOOD RELATIVE)

DIABETES: _____

CANCER: _____

HYPERTENSION: _____

HEART DISEASE: _____

STROKE: _____

MIGRAINE: _____

TREMOR: _____

PARKINSON'S DISEASE: _____

SURGERIES

(PLEASE LIST ALL SURGERIES AND PLEASE INCLUDE DATES)

PAST MEDICAL HISTORY

NAME _____ DOB _____

PLEASE CIRCLE ALL THAT APPLY

CARDIOVASCULAR:

HIGH BLOOD PRESSURE LOW BLOOD PRESSURE A-FIB CHEST PAIN HEART ATTACK
HEART DISEASE STENTS LEG SWELLING EMBOLISM BRADYCARDIA HYPERLIPIDEMIA
PACEMAKER

RESPIRATORY:

SHORTNESS OF BREATH ASTHMA EMPHYSEMA COPD CHRONIC BRONCHITIS
WHEEZING SLEEP APNEA CPAP _____ YES _____ NO

GASTROINTESTINAL:

ULCER HEPATITIS _____ A _____ B _____ C GALLBLADDER DISEASE

GENITOURINARY:

PROSTATE DISEASE

ENDROGINE:

DIABETES INSULIN DEPENDENT _____ YES _____ NO

HEMATOLOGIC:

EASY BRUISING EASY BLEEDING ANEMIA BLOOD CLOTS

MUSCULOSKELETAL:

NECK PAIN BACK PAIN ARTHRITIS OSTEOPOROSIS FIBROMYALGIA

NEUROLOGIC:

STROKE TIA SEIZURES HEADACHES DIZZINESS UNSTEADY GAIT TREMOR
PARKINSON'S MULTIPLE SCLEROSIS DEMENTIA COGNITIVE IMPAIRMENT SYNCOPPE

PSYCHOLOGICAL:

DEPRESSION ANXIETY DRUG ABUSE ALCOHOL ABUSE BIPOLAR

CANCER:

WHAT TYPE? _____

CHEMO? _____ RADIATION? _____

OTHER:

Patient name _____ DOB _____

REVIEW OF SYSTEMS

(Please circle all that apply to you or that you notice)

General: Fatigue, fever, recent weight loss, recent weight gain, excessive perspiration

Head: Headache, dizziness, cognitive impairment, migraines

Eyes: Glaucoma, macular degeneration, double vision, blurred vision, eyelid droop, dry eye vision loss (R / L),

Ears: Hearing loss (R / L), ringing in ears

Nose: Chronic sinusitis, loss of smell, nosebleeds

Throat: Swallowing difficulty, voice changes

Cardiovascular: Atrial fibrillation, pacemaker, palpitations, leg swelling, recent heart attack

Respiratory: Cough, shortness of breath, wheezing, asthma, bronchitis

Gastrointestinal: Loss of appetite, nausea, vomiting, diarrhea, constipation

Urinary: Incontinence, urinary infections, urgent bladder, difficulty urinating

Musculoskeletal: Muscle pain, joint pain, joint stiffness, leg pain with walking, spasms, weakness, leg/foot cramps

Integumentary: Nail changes, rashes, psoriasis

Neurological: Problems with ADLs, bowel dysfunction, double vision, problems with concentration, loss of memory, dizziness, gait problems, loss of balance, loss of facial sensation, loss of taste, loss of smell, loss of vision, migraines, numbness, pain, burning of skin, headaches, seizures, stroke, syncope, tingling, tremor, vertigo

Psychiatric: Depression, anxiety, insomnia, nervousness, obsessive compulsive, psychosis, schizophrenia, drug abuse, alcohol abuse, bipolar disease, hallucinations, agitation

Hematologic/lymphatic: Easy bleeding, easy bruising, blood clots, DVT, phlebitis, transfusion, lymphoma/leukemia, anemia

NAME _____ DOB _____

DATE _____

**YOUR HEALTH AND WELLBEING IS OF UTMOST IMPORTANCE TO US.
PLEASE ANSWER THE QUESTIONS BELOW. THIS WILL HELP US, HELP
YOU.**

PLEASE CIRCLE YES or NO TO THE FOLLOWING QUESTIONS:

- YES NO Have you fallen in the past year?
- YES NO Are you afraid of falling?
- 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 pain or numbness in your legs or feet?
- YES NO Do you have confusion, feel depressed or have anxiety?
- 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 to your sleeping habits?
- YES NO Do you have a decreased interest in activities?

SMIRNOFF NEUROLOGY, PA

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed 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 your 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 be 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 or 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 or disclose your Health Information if we believe, in good faith, that the use of disclosure is necessary to prevent or lessen a serious or imminent threat to the health or 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 of 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 or 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 in your care or treatment. Except in emergency situation, you will be notified in advance and have the opportunity to verbally agree or object to his use and disclosures of 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 your 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 of 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 involved 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 than 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.