SMIRNOFF NEUROLOGY

729 COUNTY ROAD 466, LADY LAKE, FL 32159

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

smirnoffdoc@yahoo.com

Welcome to Smirnoff Neurology. We look forward to meeting you. Attached are the forms you will need for your first appointment. Please fill out all forms completely and return them to our office at least 2 days prior to your appointment. Do not write "see attached".

Please bring the following to your appointment:

- Drivers License or State ID
- All Insurance Cards
- All prescription bottles. Please complete the attached medication list or provide a typed list of medications.
- 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. Credit and Debit cards are subject to a 3% service charge.

We are located at the corner of County Road 466 and Rolling Acres Road, in the medical complex The Summit of Lady Lake. We are caddie-corner to the American Legion and directly across from the plant nursery.

Please sign and date that you have read this coversheet in its entirety.

________________________________________ Date__________________

# SMIRNOFF NEUROLOGY

729 CR 466, LADY LAKE, FL 32159

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 if 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 that 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 MEDICATION LIST

PATIENT NAME ______________________________

PHARMACY NAME ____________________ PHARMACY TEL # ____________________

| MEDICATION LIST | DOSAGE | DIRECTIONS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

LIST OF MEDICATIONS YOU ARE ALLERGIC TO

| MEDICATION | REACTION |
|---|---|
| | |
| | |
| | |

# SMIRNOFF NEUROLOGY NEW PATIENT INFORMATION

PATIENT NAME:______________________________________________DOB:______________

REASON FOR THIS APPOINTMENT:______________________________________________

HOW LONG HAVE YOU HAD THIS PROBLEM?__________________________________________

WHAT TESTS HAVE YOU HAD FOR THIS PROBLEM?____________________________________

WHAT MEDICATIONS HAVE YOU TRIED?_____________________________________________

## SOCIAL HISTORY

DO YOU DRINK ALCOHOL? YES NO HOW MANY DRINKS PER DAY__________________

DO YOU CURRENTLY SMOKE? YES NO HOW MANY PACKS PER DAY__________________

ARE YOU A FORMER SMOKER? YES NO

## FAMILY HISTORY

PLEASE CIRCLE ALL THAT APPLY

| | | | | |
|---|---|---|---|---|
| DIABETES: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| CANCER: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| HYPERTENSION: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| HEART DISEASE/ATTACK: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| STROKE: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| MIGRAINES: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| TREMOR: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |
| PARKINSON'S DISEASE: | MOTHER | FATHER | GRANDPARENTS | SIBLINGS |

## SURGERIES

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

# 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 DO YOU USE A CPAP MACHINE YES NO

## GASTROINTESTINAL:

ULCER GALLBLADDER DISEASE HEPATITIS__________A_________B_________C

## GENITOURINARY:

PROSTATE DISEASE

## ENDROCINE:

DIABETES INSULIN DEPENDENT YES NO HYPOTHYROIDISM HYPERTHYROIDISM

## HEMATOLOGIC:

EASY BRUISING EASY BLEEDING ANEMIA BLOOD CLOTS

## MUSCULOSKELETAL:

NECK PAIN BACK PAIN ARTHRITIS OSTEOPORISIS/OSTEOPENIA FIBROMYALGA WEAKNESS

## NEUROLOGIC:

STROKE TIA SEIZURES HEADACHES DIZZINESS UNSTEADY GAIT TREMOR PARKINSON'S

MULTIPLE SCLEROSIS DEMENTIA COGNITIVE IMPAIRMENT SYNCOPE TRIGEMINAL NEURALGIA

## PSYCHIATRIC:

DEPRESSION ANXIETY INSOMNIA NERVOUSNESS OBSESSIVE COMPULSIVE PSYCHOSIS

SCHIZOPHENIA DRUG ABUSE ALCOHOL ABUSE BIPOLAR DISEASE HALLUCINATIONS AGITATION

# REVIEW OF SYSTEMS

NAME:__________________________________DOB:____________

PLEASE CIRCLE ALL THAT APPLY

FATIGUE FEVER RECENT WEIGHT LOSS RECENT WEIGHT GAIN EXCESSIVE PERSPIRATION

HEADACHE MIGRAINES DIZZINESS COGNITIVE IMPAIRMENT

MACULAR DEGENERATION DOUBLE VISION BLURRED VISION EYELID DROOP DRY EYES
VISION LOSS

HEARING LOSS RINGING IN EARS

CHRONIC SINUSITIS LOSS OF SMELL NOSEBLEEDS

SWALLOWING DIFFICULTY VOICE CHANGES

A-FIB PACEMAKER PALPITATIONS LEG SWELLING RECENT HEART ATTACK

COUGH SHORTNESS OF BREATH WHEEZING ASTHMA BRONCHITIS

LOSS OF APPETITE NAUSEA VOMITING DIARRHEA CONSTIPATION

INCONTINENCE URINARY INFECTIONS URGENT BLADDER DIFFICULTY URINATING

MUSCLE PAIN JOINT PAIN JOINT STIFFNESS LEG PAIN WHILE WALKING

MUSCLE SPASMS LEG/FOOT CRAMPS WEAKNESS

NAIL CHANGES RASHES PSORIASIS

PROBLEMS WITH ADL'S BOWEL DYSFUNCTION DOUBLE VISION CONCENTRATION PROBLEMS

LOSS OF MEMORY DIZZINESS VERTIGO GAIT PROBLEM LOSS OF BALANCE FALLS

LOSS OF FACIAL SENSATION LOSS OF TASTE LOSS OF SMELL LOSS OF VISION PAIN

NUMBNESS HEADACHES MIGRAINES SEIZURES STROKE SYNCOPE TINGLING TREMOR
STROKE

DEPRESSION ANXIETY INSOMNIA NERVOUSNESS OBSESIVE COMPLUSIVE PSYCHOSIS

SCHIZOPHRENIA DRUG ABUSE ALCOHOL ABUSE BIPOLAR DISEASE HALLUCINATIONS
AGITATION

EASY BLEEDING EASY BRUISING BLOOD CLOTS DVT ANEMIA LYMPHOMA LEUKEMIA

# HEALTH AND WELLBEING QUESTIONAIRE

NAME:______________________________________________DOB:________________

DATE:________________________

PLEASE CIRCLE **YES** OR **NO** TO THE FOLLOWING QUESTIONS:

YES NO HAVE YOU FALLEN IN THE PAST YEAR? HOW MANY TIMES?__________

YES NO ARE YOU AFRAID OF FALLING?

YES NO DO YOU EVER LOSE YOUR BALANCE, FEEL DIZZY OR LIGHTHEADED?

YES NO DO YOU 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 HAVE YOU GOTTEN CONFUSED OR LOST WHILE DRIVING?

YES NO DO YOU HAVE SERIOUS ALTERATIONS TO YOUR SLEEPING HABITS?

YES NO DO YOU HAVE A DECREASED INTEREST IN ACTIVITIES?

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name ~~ID#~~: ______________________ DATE:______________

| Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| **2.** Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| **3.** Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| **4.** Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| **5.** Poor appetite or overeating | 0 | 1 | 2 | 3 |
| **6.** Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| **7.** Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| **8.** Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| add columns | | + | + | |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL: ______

| **10.** If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people? | |
|---|---|
| Not difficult at all | ______ |
| Somewhat difficult | ______ |
| Very difficult | ______ |
| Extremely difficult | ______ |

Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD© is a trademark of Pfizer Inc.

A2663B 10-04-2005

# 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.