Orlando Epilepsy Center

Consent for Treatment

**** THIS DOCUMENT EXPIRES 3-YEARS FROM DATE SIGNED ****

TO THE PATIENT - Consent for Care and Treatment Consent: *You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure involved. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner), and other health care providers or the designees as deemed necessary, to perform a reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). Waiver of Jury Trial; each party hereby irrevocably waives its right to trial by jury in any action or proceeding arising out of this agreement or the transactions relating to its subject matter.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient or Personal Representative	Relationship to Patient
_____	_____
Name of Witness Employee	Job Title
_____	_____
Signature of Witness	Date

Orlando Epilepsy Center

Patient Registration

☐ Existing Patient ☐ New Patient

PATIENT INFORMATION

Patient Name: _____

Age: _____ **Date of Birth:** _____ **Sex:** ☐ Male ☐ Female

Social Security # (last 4-digits): _____

Marital Status: _____ **Primary Care Physician Name:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____ **Office Phone:** _____

Email: _____ **Reason for the Visit:** _____

Date Symptoms Started: _____**Previous Similar Symptoms?** ☐ **Yes /When:** _____ ☐ **No**

Emergency Contact Name: _____ **Emergency Phone #**_____

Referred By: _____

PERSON RESPONSIBLE FOR THE BILL

Name: _____

Relationship to Patient: _____ **Date of Birth:** _____ **Sex:** ☐ Male ☐ Female

PRIMARY INSURANCE

Insurer's Name: _____

Insurer's Date of Birth: _____ **Insurer's Sex:** ☐ Male ☐ Female

Insurer's Employer Name: _____

Primary Insurance Company Name: _____

Policy Number: _____ **Group Number:** _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

SECONDARY INSURANCE

Insurer's Name: _____

Primary Insurance Company Name: _____

Policy Number: _____ **Group Number:** _____

I authorize release of any medical information necessary to process this claim. I authorize payment of medical benefits to Orlando Epilepsy Center.

Signature of Insured or Authorized Person: _____

Date: _____

Orlando Epilepsy Center

Medical Records Release Form

Patient Name: _____ Patient DOB: _____

I AUTHORIZE ORLANDO EPILEPSY CENTER TO REQUEST MY HEALTH INFORMATION, FROM:

Physician/Practice Name: _____ Phone Number: _____

Address: _____Fax Number: _____

I authorize Orlando Epilepsy Center to request the following information:

☐ **Labs** ☐ **Medication List** ☐ **Office Notes** ☐ **Imaging Reports** ☐ **Procedure Reports** ☐ **All Records**

☐ **My health information covering the period of healthcare dates TO: _____ FROM: _____**

☐ **Other: _____**

Except to the extent that action has already been taken in reliance upon this authorization. I understand that I may revoke this authorization at any time by giving written notice to Orlando Epilepsy Center. Unless revoked earlier, this authorization will expire in 1 year from the date signing below or upon. _____ **(Initials)**

I also understand that if a person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Signature of Patient: _____ Date: _____

Print Name of Representative: _____ Date: _____

Signature of Authorized Representative: _____

☐ **Parent** ☐ **Legal Guardian** ☐ **Court Order** ☐ **Other: _____**

Orlando Epilepsy Center
2881 Delaney Ave, Suite A
Orlando, FL 32806
Phone: (407) 704-8510 Fax: (407) 203-3015

Orlando Epilepsy Center

Patient Financial Policy Agreement

Thank you for choosing Orlando Epilepsy Center as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following statement of our Financial Policy, which you are required to read and sign. Our staff will address any questions that you may have; however, you will need to agree to and sign prior to your treatment being rendered.

- **Self-Pay Patients**: Payments in full is due at the time of service.
- **Patients with Insurance**: We will file your insurance claim for you. However, to work with your company, we must have complete and current information, a copy of your insurance card and your signature on file.
- **Insurance Benefits:** It is your responsibility to know your insurance benefits. Please contact your insurance company with any questions that you may have regarding coverage of specialty services.
- **Co-Payments, Co-insurances and Deductibles**: All patient balances are due at the time of service. We accept cash, check, credit cards (Visa, MasterCard, American Express, Discover, and Care Credit).
- **Non-Covered Charges:** Please understand there may be some charges for our services which you insurance company considers *non-covered* and may be excluded from your policy. Accordingly, you will be responsible for these charges.
- **Denied Claims:** Failure to present your current insurance information before services being rendered may result in denial of your claim and subsequent billing for unpaid services.
  - You are responsible for any charges that are denied by your insurance company.
- **Medicare**: We are participating Medicare provider. We will bill Medicare, for you, as well as any secondary insurance that you may have. However, that does not mean that all services are covered. Additionally, you are responsible for any co-payments, usually 20% of the allowed amount, as well as any unmet annual deductible. Medicare may allow a service but your secondary insurance provider may not; therefore, you will be responsible for that portion of the bill.
- **Missed Appointments**:
  There is a $25.00 fee for all missed/cancelled **established Patient** office visit with <u>less than 24-hour notice</u>.
  There is a $50.00 fee for all missed/cancelled **NEW Patient** office visit with <u>less than a 24-hour notice</u>.
  <u>NOTE</u>: This is an internal charge and cannot be billed to your insurance company.
- **Returned Checks**: Any returned check is subject to a $25.00 bank fee.
- **Special Financial Arrangements**: We offer monthly payment plans with balances to be paid off in **four** consecutive payments. We also offer financial hardship discounts but these require the patient to complete a Financial Evaluation Form with proper supporting documentation that documents the patient's income.
- **Past Due Accounts**: All past due accounts are subject to collection proceedings. All fees, including, but not limited to the maximum interest that is allowable by law, a 35% collection agency fee and awarded court fees will become your responsibility in addition to the patient balance should you placed with an external collection agency.

I have read, understand, and agree to the above Financial Policy.

_____ _____

Signature of Patient or Financially Responsible Person Date

_____

Print Name

Orlando Epilepsy Center

Policy Acknowledgment Form

Patient Name: _____ DOB: _____

_____ Request for Copy of Medical Records

(Initials)

- Please allow 7 to 10 business days for processing of ALL medical records requests.
- Patient must complete and sign a Medical Release Form for each request.
- Fee: $1.00 per page (pages 1-24), $0.25 per page (each remaining pages)

_____ Notice of Missed or Cancelled Appointments

(Initials)

- There is a $25.00 fee for all missed/cancelled **established Patient** office visit with <u>less than 24-hour notice</u>.
- There is a $50.00 fee for all missed/cancelled **NEW Patient** office visit with <u>less than a 24-hour notice</u>.

NOTE: This is an internal charge and cannot be billed to your insurance company.

_____ FMLA/ Disability Forms/ DMV Forms

(Initials)

- There is a $35.00 fee for the completion of forms requested by patients.

_____ Prescription Refills/ Prior Authorizations

(Initials)

- All prescriptions refills require 24 to 48 hour notice to our staff. Please allow 24 to 48 hours to process the medication request.
- Prior authorizations will take 7 to 10 business days to be processed.

I, _____ acknowledge receipt and acceptance of these policies.
(Patient Name)

_____ _____

Signature of Patient or Personal Representative Date

Orlando Epilepsy Center

Notice of Privacy Practices
Acknowledgement and Consent
(Consent to use PHI)

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Orlando Epilepsy Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

☐ I have received a copy of the Notice of Patient Privacy Policy.

☐ Orlando Epilepsy Center may share information with your family; **Name**: _____

Requesting a Restriction on the Use or Disclosure of Your Information
- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will not be in violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature, I give permission to leave a message on my answering machine and/or cell phone.

Cell Phone #: _____

By my signature below, I give my permission to use and disclose my health information.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Print Patient's Full Name Time

_____ _____
Witness Signature Date

Orlando Epilepsy Center

Medication List

Patient Name: _____ DOB: _____

Allergies: _____

Pharmacy Name: _____ Pharmacy Phone Number: _____

Mail Order Pharmacy Name: _____ Mail Order Pharmacy Number: _____

** Please allow us 24-48 business hours to refill your medications**

** Allow 7-10 business days to complete *Prior Authorization* for medications**

Medication Name	Dose	Directions

Orlando Epilepsy Center

Review of System Checklist

Patient Name: _____ DOB: _____

General:

- ☐ **Fatigue**
- ☐ **Weakness**
- ☐ **Problems Sleeping**
- ☐ **Weight Gain or loss**
- ☐ **Fever or chills**

Head:

- ☐ **Headaches**
- ☐ **Head Injury**

Ears:

- ☐ **Decrease hearing**
- ☐ **Ringing in the ears**
- ☐ **Earaches**

Eyes:

- ☐ **Vision Loss**
- ☐ **Flashing Lights**
- ☐ **Pain**
- ☐ **Glaucoma**
- ☐ **Blurry vision or double vision**
- ☐ **Cataracts**

Respiratory:

- ☐ **Cough**
- ☐ **Shortness of Breath**
- ☐ **Sputum**
- ☐ **Wheezing**
- ☐ **Coughing up blood**
- ☐ **Painful Breathing**

Urinary:

- ☐ **Frequency**
- ☐ **Blood in Urine**
- ☐ **Urgency**
- ☐ **Incontinence**
- ☐ **Burning and pain**

Musculoskeletal:

- ☐ **Muscle or Joint Pain**
- ☐ **Stiffness**

Neurological:

- ☐ **Dizziness**
- ☐ **Weakness**
- ☐ **Tremors**
- ☐ **Fainting**
- ☐ **Numbness**
- ☐ **Tingling**

Psychiatric:

- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Excessive Stress**
- ☐ **Nervousness**

Cardiovascular:

- ☐ **Chest Pain or discomfort**
- ☐ **Shortness of breath**
- ☐ **Tightness**
- ☐ **Swelling**
- ☐ **Palpitations**

Orlando Epilepsy Center

HOW DO YOU FEEL? (¿CÓMO SE SIENTES?)

Patient Name: _____ DOB: _____

Instructions: Circle the answer that best describes how you felt over the past week.
Instrucciones: Círcule la respuesta que mejor describa cómo se sintió durante esta semana.

1. Are you basically satisfied with your life? ¿Estás básicamente satisfecho con tu vida?	YES (SI)	NO
2. Have you dropped many of your activities and interests? ¿Ha abandonado muchas de sus actividades e intereses?	YES (SI)	NO
3. Do you feel that your life is empty? ¿Sientes que su vida está vacía?	YES (SI)	NO
4. Do you often get bored? ¿Te aburres a menudo?	YES (SI)	NO
5. Are you in good spirits most of the time? ¿Estás de buen humor la mayor parte del tiempo?	YES (SI)	NO
6. Are you afraid that something bad is going to happen to you? ¿Tienes miedo de que te vaya a pasar algo malo?	YES (SI)	NO
7. Do you feel happy most of the time? ¿Se siente feliz la mayor parte del tiempo?	YES (SI)	NO
8. Do you often feel helpless? ¿Te sientes a menudo desvalido?	YES (SI)	NO
9. Do you prefer to stay at home, rather than going out and doing things? ¿Prefieres quedarte en casa en lugar de salir y hacer cosas?	YES (SI)	NO
10. Do you feel that you have more problems with memory than most? ¿Siente que tiene más problemas de memoria que la mayoría?	YES (SI)	NO
11. Do you think it is wonderful to be alive now? ¿Crees que es maravilloso estar vivo ahora?	YES (SI)	NO
12. Do you feel worthless the way you are now? ¿Se siente inútil tal como está ahora?	YES (SI)	NO
13. Do you feel full of energy? ¿Te sientes lleno de energía?	YES (SI)	NO
14. Do you feel that your situation is hopeless? ¿Sientes que tu situación es desesperada?	YES (SI)	NO
15. Do you think that most people are better off than you are? ¿Crees que la mayoría de la gente está mejor que tú?	YES (SI)	NO

FOR CLINICAL STAFF ONLY: Total Score_____