ORLANDO EPILEPSY CENTER

PATIENT REGISTRATION

☐ Existing Patient ☐ New Patient

PATIENT INFORMATION

Patient Name: Sex: ☐ Male ☐ Female

Age: DOB: MM/DD/YYYY 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: MM/DD/YYYY Previous Similar Symptoms? ☐ Yes/When: MM/DD/YYYY ☐ No

Emergency Contact Name: Emergency Phone #

Referred By:

PERSON RESPONSIBLE FOR THE BILL

Name: Sex: ☐ Male ☐ Female

Relationship to Patient: DOB: MM/DD/YYYY

PRIMARY INSURANCE

Insurer's Name: Insurer's Sex: ☐ Male ☐ Female

Insurer's Employer Name: Insurer's DOB: MM/DD/YYYY

Primary Insurance Company Name:

Policy Number: Group Number:

Insurance Company Address:

Insurance Company Phone Number:

SECONDARY INSURANCE

Insurer's Name:

Secondary 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.

Date: MM/DD/YYYY

Signature of Insured or Authorized Person:

Updated 25/08/2022 - F47 - V1

OUR MONITORING UNIT LOCATIONS
407 704 8380
407 704 8572

- Downtown 226 W Michigan St, Orlando FL 32806
- Dr Phillips 6985 Wallace Rd, Orlando FL 32819

OUR OFFICE LOCATIONS
407 652 6000
407 203 3015

- Lake Nona 12617 Narcoossee Rd, Suite 112, Orlando FL 32832
- Downtown 2881 Delaney Ave, Orlando FL 32806
- Clermont 805 Oakley Seaver Dr, Suite 103, Clermont FL 34711
- Kissimmee 821 E Oak St, Kissimmee, FL 34744
- Oviedo (coming soon) 1300 City View Center, Oviedo 32765

www.orlando-epilepsy.com

ORLANDO EPILEPSY CENTER

MEDICATION LIST

☐ Clermont ☐ Lake Nona ☐ Kissimmee ☐ Orlando

Patient Name | DOB MM/DD/YYYY

Allergies

Pharmacy Name | Pharmacy Phone Number

Mail Order Pharmacy Name | Mail Order Pharmacy Number

Note: 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

HOW DO YOU FEEL? - ¿CÓMO TE SIENTES?

Patient Name | DOB

Instructions: Circle the answer that best describes how you felt over the past week.
Instrucciones: Señala la respuesta que mejor describa como te has sentido 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? ¿Sienes que su vida esta vacia?	☐ 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 parle del tiempo?	☐ Yes - Si ☐ No
8	Do you often feel helpless? ¿Te sientes a menudo indefenso?	☐ 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 algo?	☐ 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 mayoria?	☐ Yes - Si ☐ No
11	Do you think it is wonderful to be alive now? ¿Crees que es maravilloso estar vivo?	☐ 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

ORLANDO EPILEPSY CENTER

HEALTH CHECK LIST

☐ Clermont ☐ Lake Nona ☐ Kissimmee ☐ Orlando

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
- ☐ Ear aches

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

CONSENT FOR TREATMENT

(THIS DOCUMENT EXPIRES 3-YEARS FROM DATE SIGNED)

TO THE PATIENT - Consent for Care and Treatment: *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 or Patient or Personal Representative

Date: MM/DD/YYYY

Printed Name of Patient or Personal Representative

Relationship to Patient

Name of Witness Employee

Job Title:

Signature of Witness

Date: MM/DD/YYYY

ORLANDO EPILEPSY CENTER

PATIENT FINANCIAL POLICY AGREEMENT

Thank you for choosing Orlando Epilepsy Center (OEC) as your healthcare provider. We are committed to your treatment being successful and we appreciate your trust in us. The following statement is our Financial Policy, which you are required to read, agree, and sign prior to your treatment being rendered.

- **Self-Pay Patients:** Payment 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 insurance company, we must have complete and **CURRENT** information, a copy of your insurance card and your signature on file.
- **Insurance:** By signing below, you authorize OEC to bill your insurance carrier. I**T 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 your 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 a 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 providers. 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.
- **Request for Medical Records:** Please allow 7 to 10 business days for processing of all medical records request. Patient must complete Records Release Authorization form for each request.
- **Returned Checks:** Any returned check is subject to a bank fee that may range from $25 - $50
- **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 this requires the patient to complete a Financial Evaluation Form with proper supporting documentation (to include patient 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 your account be placed with an external collection agency.
- **FMLA/Disability/DMV Forms**: There is a $35.00 fee for the completion of forms requested by patients. Allow 7 - 14 business days for completion.

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

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

Email: Date: MM/DD/YYYY

Signature of Patient or Financially Responsible Person

Print Name

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 the following person:

Name:

Relationship: Phone:

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 or 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.

_____ Date: MM/DD/YYYY

Patient or Legally Authorized Individual Signature

_____ Time:

Print Patient's Full Name

_____ Date: MM/DD/YYYY

Witness Signature

ORLANDO EPILEPSY CENTER

Policy Acknowledgment Form

Patient Name: **DOB:** MM/DD/YYYY

Initials

Request for Copy of Medical Records

- 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.

Initials

Notice of Missed or Cancelled Appointments

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

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

Initials

FMLA/ Disability Forms/ DMV Forms

- There is a S35.00 fee for the completion of forms requested by patients "no exceptions".

Initials

Prescription Refills/ Prior Authorizations

- 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 to10 business days to be processed.

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

Date: MM/DD/YYYY

_____
Signature of Patient or Personal Representative