ORLANDO EPILEPSY CENTER

PATIENT REGISTRATION

☐ Existing Patient ☐ New Patient

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

Social Security # (last 4-digits): _____ Marital Status: _____

Address: _____ Email: _____

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

Emergency Contact Name: _____ Emergency Phone: _____

Primary Care Physician Name: _____

Referred By: _____

Reason for Visit: _____

PERSON RESPONSIBLE FOR THE BILL

Name: _____ DOB: _____ Sex: ☐ Male ☐ Female

Relationship to Patient: _____

PRIMARY INSURANCE

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

Insurer's Employer Name: _____ Insurer's DOB: _____

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: _____

Signature of Insured or Authorized Person

Updated 01/14/2026 - F47 - V3

OUR MONITORING UNIT LOCATIONS 407 704 8380 / 407 704 8572

226 W Michigan St, Orlando FL 32806

6985 Wallace Rd, Orlando FL 32819

OUR OFFICE LOCATIONS 407 652 6000 / 407 203 3015

12617 Narcoossee Rd, Suite 112, Orlando FL 32832

2881 Delaney Ave, Orlando FL 32806

805 Oakley Seaver Dr, Suite 103, Clermont FL 34711

821 E Oak St, Kissimmee, FL 34744

1300 City View Center, Oviedo 32765

www.orlando-epilepsy.com

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.

_____ Date: _____

Signature of Patient or Personal Representative

_____ Relationship to Patient: _____

Printed Name of Patient or Personal Representative

_____ Job Title: _____

Name of Witness Employee

_____ Date: _____

Signature of Witness

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. There is a $25.00 fee for any detailed work letter (work restrictions). If a work/school note is requested for day of appointment (date, time and return next day) there will be a $0 fee. Allow 7 - 14 business days for completion.

PATIENT FINANCIAL POLICY AGREEMENT

Orlando Epilepsy Center

Consent to Communications. By supplying phone numbers (including my mobile phone number), email address and any other personal contact information, I authorize Orlando Epilepsy Center, or any business associate vendor of Orlando Epilepsy Center, including billing and collection agencies, to contact me at any of the numbers or email addresses I provide using email, text messages, an automatic telephone dialing system, using pre-recorded voice or other 3rd party automated outreach and messaging system, as well as to use my protected health information, or other personal or identifying information, during such contact for any administrative or healthcare matter, including billing and collection. I consent to Orlando Epilepsy Center, or any of its business associate vendors, including billing and collection agencies, contacting me via unencrypted email and text messages. I also agree that they may leave detailed messages on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me. Any email address I provide will be my personal email address and not an employer provided email address. To opt out of or modify any of these communications, please contact Orlando Epilepsy Center at any Time.

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.

My email address: _____ Date: _____

My mobile phone number: _____

_____ _____

Responsible party/patient signature Resnonsible party/patient name

ORLANDO EPILEPSY CENTER

MEDICAL RECORDS REQUEST / RELEASE

(To have records sent to Orlando Epilepsy Center from another Office)

Patient name: _____ DOB: _____

Social Security # (last 4 digits): _____

I authorize Orlando Epilepsy Center to request / release my health information, from my physician:

Physician/Practice Name: _____ Phone #: _____

Address: _____ Fax: _____

I authorize Orlando Epilepsy Center to request / release the following information:

☐ Labs ☐ Medication List ☐ Office Notes ☐ Imaging Reports ☐ Procedure Reports ☐ All Records ☐ Other:

☐ From: _____ To: _____

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 3 years 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 informantion may receive compensation (either directly or indirectly) for doing so.

_____ Date: _____

Signature of Patient

_____ Date: _____

Print Name of Representative

_____

Signature of Authorized Representative:

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

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

www.orlando-epilepsy.com

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: _____

Patient or Legally Authorized Individual Signature

_____ Time: _____

Print Patient's Full Name

_____ Date: _____

Witness Signature

ORLANDO EPILEPSY CENTER

MEDICATION LIST

☐ Clermont ☐ Lake Nona ☐ Kissimmee ☐ Orlando ☐ Oviedo

Patient Name: _____ DOB: _____

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

Policy Acknowledgment Form

Patient Name:_____ **DOB:**_____

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 $50.00 fee for all missed/cancelled Established Patient and 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 / DMV/ Letter / Work Note

- There is a S35.00 fee for the completion of forms requested by patients "no exceptions".
- There is a $25.00 fee for any detailed work letter (work restrictions).
- If a work/school note is requested for day of appointment (date, time and return next day) there will be a $0 fee.

NOTE: Please allow 10 days for the completion of any forms.

Initials

Prescription Refills / Prior Authorizations

- All prescription 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:**_____

Signature of Patient or Personal Representative

Orlando Epilepsy Center Telehealth Policy

(This document expires 3-years from date signed)

1. **Telehealth/telemedicine** involves the use of electronic communications that enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive audio and telecommunications technology. Additionally a brief physical exam may take place via video/audio. However, it should be recognized that there are limitations in such that a comprehensive hands-on neurological exam cannot be performed during a telehealth examination and this may limit the health care provider in having all a complete assessment necessary to make a full and accurate diagnosis.
2. **Risks, benefits and alternatives:** The benefits of telemedicine include having access to medical specialists without having to travel physically into the office. I understand that there are risks and consequences from telemedicine, including, but not limited to the possibility despite reasonable efforts on the part of the healthcare provider that the transmission of my medical information could be disrupted or distorted by technical failures; The transmission of my medical information could be interrupted by unauthorized persons, and the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand the telemedicine based services and care may not be as complete as face to face services. As the patient, I agree to accept responsibility for following up with my healthcare providers recommendations slash including further diagnostic testing such as lab testing, imaging, and in office consultation. The alternative to telemedicine consultation is a face to face visit with the health care provider which is also available at any time at Orlando Epilepsy Center.
3. I understand that my insurance plan may not encompass telehealth services or that coverage of these services may change over time. In cases where my insurance plan does not cover any expenses which have been incurred, I will be personally liable to give cover these expenses.
4. I may withhold or withdraw my consent to the telemedicine consultation at any time before and or during the consult without affecting my right for future care or risking the loss or withdrawal of any program as to which I would otherwise be entitled.
5. The laws that protect the confidentiality of medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my consultation is generally confidential.
6. I agree not to record or share the content of my telehealth visit unless previously agreed upon. I agree to conduct this visit in a private space without any other attendees present unless an alternative arrangement is agreed to by me and my provider. I also agree that the telehealth visit must be conducted on simultaneous audio and visual connection and I must remain on video for the duration of the consultation.
7. I understand that telehealth services can only be provided to patients, including myself who are currently residing in the state of Florida at the time of service.
8. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to a provider's office or to existing 911 emergency services in the community.
9. l agree with Orlando Epilepsy Center policy that I must come in for a face to face consult by my third visit. Further determination on eligibility for continued telehealth visits will be made at the face to face visit.
10. I agree that in order to proceed with my new patient consultation my new patient paperwork and this consent must be completed and submitted prior to the consultation. Failure to do so would jeopardize the guarantee of completing consultation for that day.

By signing below I agree to that I have read, understood, and will adhere to the terms outlined above.

Signature of Patient or Representative: _____ Date of signature _____

Relationship of Representative to Patient _____