Child Neurology Center of Northwest Florida
400 Gulf Breeze Parkway, Suite 300
Gulf Breeze, FL 32561
Phone: (850) 932-5055

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Doctor/Patient Services Agreement

Welcome, your appointment is on:_____ at:_____

Neurology Treatment: We specialize in the care of infants, children, and adolescents with neurological disorders. We also treat some adults for specific disorders.

Appointments: We have a strict 15 minute late policy. Patients that arrive 15 minutes after their appointment will need to be rescheduled. A 24-hour notice is required to cancel an appointment.

Insurance Authorization: It is the responsibility of the patient to ensure prior insurance authorization for all follow-up appointments and procedures.

Professional Fees: Payment is due in full at the time of services, unless prior arrangement has been made. Payment of insurance deductible and insurance co-pays are due at time of service. As a courtesy we will file for all insurance companies. Payment is due in full by the 30th of the month. Please contact our billing office at 850-932-5055 option 7 for questions regarding your bill.

Contacting the Office: Phone calls are answered from 8am to 4pm, Monday through Friday.

Emergencies: For medical emergencies please call 911 or go to your local emergency room.

Consent: I authorize my insurance benefits to be paid directly to Child Neurology Center; realizing I am responsible for non-covered services. I authorize the release of pertinent medical information to insurance carriers.

Your signature below indicates that you have read the agreement and agree to its terms.

Responsible Party Patient Name Patient DOB

Patient Demographics

Patient Name:_____
Address:_____
Social Security Number:_____ Date of Birth:_____ Age:_____
Race:_____ Ethnicity:_____Language:_____ Sex:_____

Preferred Contact Method:
Home:_____ Work:_____ Cell:_____
Emergency Contact:_____Relationship:_____Phone:_____
Email:_____

Guarantor Information

Name:_____
Address:_____
Social Security Number:_____ Date of Birth:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____

Referring Physician Information

Referring Physician:_____ Phone:_____
Address:_____

Insurance Information

Primary Insurance:_____
Member ID Number:_____ Group Number:_____
Subscriber Name:_____Subscriber DOB:_____

Secondary Insurance:_____
Member ID Number:_____ Group Number:_____
Subscriber Name:_____Subscriber DOB:_____

Authorization to pay benefits to physicians; I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my provider, Child Neurology Center of Northwest Florida when they accept assignment. I authorize to release medical information to my provider, Child Neurology Center of Northwest Florida, to release any information necessary for my course of treatment.

_____ _____
Signature of Patient (patient representative) Date

Adult Patient History

Patient Name:_____ Date of Birth:_____

Please complete this section for all people who currently live in the same home as the patient named above:

Full name	Relationship	Age	Job	Education level

Who has legal custody of the patient (if applicable)?_____
Relationship (if applicable):_____
Who is the primary doctor?_____ Phone:_____

List any other doctors that the patient sees:

Name of doctor	Address	Phone number	Specialty

Preferred Pharmacy:_____ Phone Number:_____

Reason for this visit:_____
_____
_____
_____

Patient History:

Please list all current medications:

Medication name	Amount(MG or ML)	How often	Time of day taken	What for

Please list any hospital stays that patient has had (if any):

Date of stay	Name of hospital	Reason for hospital stay

Please list any surgeries that patient has had (if any):

Date of stay	Name of hospital	Reason for surgery	Surgery performed

Does the patient have any of the following medical problems? If so describe them here.

System	Type of problem
Breathing	
Heart/blood vessels	
Skin	
Psychiatric/emotional	
Eyes/ears/nose/throat	
Stomach/intestines	
Kidneys/bladder	
Blood	
Immune system/infections	
Muscles/bones	
Seizures/head injury	
Brain/nerves	
Reproductive (women)	Last menstrual period? Number of pregnancies? Number of children?
Prostate (men)	
Other	

Does the patient have any allergies?

Allergy	Reaction

Please list any medication the patient has taken in the past:

Medication name	Reason	Date started	Date stopped	Why stopped

Please check the boxes below and write either mom or dad's side of the family has these problems:

- ☐ Headaches:_____
- ☐ Weak muscles:_____
- ☐ ADHD/ADD:_____
- ☐ Strokes:_____
- ☐ Brain or nerve problems:_____
- ☐ Cerebral Palsy:_____
- ☐ Seizures:_____
- ☐ Psychiatric:_____
- ☐ High B/P:_____

Please attach a recent photograph of the patient if available.

Patient/Parent/legal guardian signature:_____ Date:_____

Relation to patient:_____

MD/ARNP Signature:_____ Date:_____

Standard Authorization of Use and Disclosure of Protected Health Information

Child Neurology Center of Northwest Florida, P.A.
400 Gulf Breeze Pkwy, Suite 300
Gulf Breeze, FL 32561
Phone: 850-932-5055 Fax: 850-932-1404

The health information covered under this authorization:
Neurology office notes
EEG reports
MRI/CT scans
Laboratory results

Persons whom the above health information will be used and disclosed to:

Name of Person/Organization	Contact Number
Name of Person/Organization	Contact Number
Name of Person/Organization	Contact Number
Name of Person/Organization	Contact Number

Expiration date of this authorization expires 1 year after the date signed. This authorization can be terminated by the patient or the patient's representative at any time. To terminate or revoke this authorization the patient or patient's representative must complete a written revocation; which can be given by contacting the HIPAA compliance officer.

Potential for Re-disclosure; Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient (print)	Date of Birth
Signature of Patient	Date Signed
Signature of Patient Representative and Relationship to Patient	Date Signed