Tampa Bay Neurology,Inc

Bharatkumar Patel,MD
8370 W.Hillsborough Ave. Suite#103, Tampa,FL 33615
Phone:813-336-3337 Fax:813-336-3338

WELCOME
My staff and I would like to welcome you to our office. We work as a team with goal of providing thorough medical care. We are always working to improving our care in any way possible. We will work with you to ensure you will receive the best quality of care.

APPOINTMENTS
If canceling an appointment, please allow 24 hour notice. If not, and if you NO SHOW for your appointment you will be charged $45.00 for clinical and $100 for diagnostic visit. Multiple no shows may result in being discharged from our practice. Your cooperation in this matter would be appreciated. It is the patient's responsibility to bring pertinent medical records and films to our office for a review. **PLEASE ALSO BRING PHOTO ID AND INSURANCE CARDS TO APPOINTMENT.**

PRESCRIPTIONS
lf you wish to refill a prescription that you are already taking, **YOU MUST CALL TWO WEEKS PRIOR TO RUNNING OUT.** Request for prescriptions refills will be responded to only during office hours. You can not have medications refills for a condition that you are not currently being treated for.

FINANCIAL POLICY
Payment of all medical care is due at the time of service. If you have a health plan we will be glad to bill them directly. Deductibles will be billed when they become due or when insurances notifies us. Co-payments are due at the time services are rendered. **The Patient and/or Guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status.** Patient is responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs. **There will be a $30.00 charge for all checks returned with non-sufficient funds. There may be a variable administrative charge for items such as completion of the medical forms, parking disability permit, physician letters etc.**

FOR ALL PATIENTS (ESPECIALLY HMO)
Patient is responsible for bringing a referral for each visit (New and Follow-up) to our office. You must contact your primary care physician to obtain a referral. Please bring it with you or have the primary care office fax it to us prior to your appointment. If a referral is not available, the patient is responsible for the bill, and be expected to pay for the service rendered that day. It is also the patient's responsibility before making an appointment, to confirm with their insurance company whether Dr.Bharatkumar Patel is covered as an IN-NETWORK PROVIDER for their plan.

SEIZURE/SYNCOPE PATIENTS
Do not drive and/or operate any machinery, or work in dangerous situations or places until cleared by Dr. Bharatkumar Patel and Florida DMV (Department of Motor Vehicles).

EMERGENCIES
CALL 911 FOR AN EMERGENCY

I hereby Certify that, I have read,Understand and Agree with the above.

Patient/Guardian Signature _____ **Date** _____
Patient Name _____ **DOB** _____

Tampa Bay Neurology,Inc

Bharatkumar Patel,MD

(Please Print)

Patient Registration Form

Patient Information **Today's Date** _____

Patient's Name (Last)_____ (First)_____ (MI)_____ Sex: Male / Female

Address _____ City/State/Zip_____

Soc. Sec. # _____Date of Birth MM_____/DD_____/YYYY_____ Age_____

Preferred Language _____ Race_____ Marital Status _____

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Home Phone_____ Work Phone _____ Cell Phone_____

Employer_____Occupation_____

Referring Physician/Agency _____ Phone _____Fax _____

PCP or Family Physician _____Phone _____Fax _____

In Case of Emergency, please notify: Name _____ Phone _____Relationship_____

Responsible Party ☐ Self ☐ Spouse ☐ Parent ☐ Other

Responsible Party Name:_____ Phone:_____

Date of Birth:MM_____/DD_____/YYYY_____ SS# _____

Reason for today's visit ☐ Illness ☐ Auto Accident ☐ Job Injury ☐ Other Injury

Date of Accident _____**Date of Injury**_____

Insurance Information (Please provide your photo ID and Insurance cards to front desk)

1. Worker's Compensation Co. Name _____Claim Number_____

   Adjustor's Name_____Phone_____ Fax_____

   Auto Insurance Co. Name_____Claim Number _____

   Attorney Name_____Phone_____Fax_____

2. Primary Health Ins. Co. _____

   Insured's Name _____DOB _____ Soc. Sec. #_____

   Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

   Policy #_____Group # _____

3. Seconday Health Ins. Co._____

   Insured's Name _____DOB _____ Soc. Sec. #_____

   Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

   Policy #_____Group # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that even though I may have insurance coverage, I am ultimately responsible for payment of services rendered. I also authorize Tampa Bay Neurology,Inc or insurance company to release any information required to process my claims.

Patient/Responsible Party Signature _____ **Date** _____

Tampa Bay Neurology,Inc

Bharatkumar Patel,MD

History Intake Form

Patient's Name_____ DOB_____ DOS_____

PAST MEDICAL HISTORY

Please list all your medical problems, including such things as heart, lung and kidney problems and medical problems such as Diabetes, Cancer, High blood pressure,High Cholesterol, Stroke,Head Trauma, Spinal Trauma, etc.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

PAST SURGICAL HISTORY

Please list all of your previous surgeries, including minor surgeries, along with the year and surgeon who did the operation.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

MEDICATIONS

Please list all medications you are taking, including over-the-counter medicines such as aspirin, etc., along with the dose and frequency of medication. **(Bring medicine bottles to appointment)**

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____
11. _____ 12. _____

ALLERGIES

Please list all allergies to medications and the reaction you have with the medicine.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

SOCIAL HISTORY

How many children do you have? _____ Are they healthy? _____

If not healthy, what diseases do they suffer?_____

Have you ever or do you now smoke? _____ If so, how long and how much? _____

If you were a previous smoker, when did you stop and how long did you smoke? _____

Do you drink alcohol? _____ If so, how much and how frequently? _____

If you drank alcohol previously, when did you stop and how long did you drink? _____

Do you now or have you ever used illegal drugs? _____

Patient/Guardian Signature _____ **Date** _____

Tampa Bay Neurology,Inc

Bharatkumar Patel,MD

History Intake Form

Patient's Name_____ DOB _____ DOS_____

FAMILY HISTORY

Is your mother alive? _____ If not, of what and at what age did she die? _____ Is your father alive? _____ If not, of what and at what age did he die? _____

How many brothers? _____ and sisters _____ do you have?

Please list their medical problems _____

_____

Has anyone in your family suffered a cancer or a neurological disease? Please list:_____

_____

_____

REVIEW OF SYMPTOMS

Please circle all that apply to you or that you notice

General	Recent weight loss, recent weight gain, weakness, fatigue, fever
Skin	Rashes, lumps, sores, itching, dryness, changes in nails, changes in hair
Head	Headache, head injury
Eyes	Visual loss, pain, redness, double vision, excessive tearing
Ears	Hearing loss, ringing in ears, earaches, ear infections, drainage from ears
Nose & Sinuses	Nasal stuffiness, nasal discharge, nosebleeds
Mouth & Throat	Bleeding gums, loss of teeth, sore tongue, sore throat, sores on gums, sores inside mouth
Neck	Lumps in neck, “swollen glands”, goiter
Breasts	Lumps, pain or discomfort, nipple discharge
Respiratory	Cough, coughing up blood, wheezing, asthma, bronchitis
Cardiac	Heart trouble, heart murmurs, chest pain, palpitations, rheumatic fever
Gastrointestinal	Swallowing troubles, heartburn, nausea, vomiting, vomiting of blood, change in bowel habits, rectal bleeding, abdominal pain, liver troubles
Urinary	Frequent urination, burning with urination, incontinence, stones, infection
Peripheral Vascular	Leg cramps, varicose veins, clots in legs
Neurological	Blackouts, seizures, tremors, involuntary movements, dizziness,gait disturbance
Hematological	Anemia, easy bruising, excessive bleeding, transfusion reactions in past
Endocrine	Thyroid trouble, excessive sweating, diabetes, excess thirst, excess hunger
Psychiatric	Nervousness, tension, depression, any history of psychiatric problems
Musculoskeletal	Back pain, bone/ joint symptoms
Immunological	Environmental allergies, Food allergies

Patient/Guardian Signature _____ **Date** _____

Tampa Bay Neurology,Inc
Bharatkumar Patel,MD

Patient 's Name_____DOB_____

Acknowledgement of Consent To Treatment, Authorization and Assignment of Benefits, Privacy Statement

Consent To Treatment

By signing below, I voluntarily agree to the following provisions of this form: Consent to Treatment

I allow Tampa Bay Neurology,Inc (the "Practice") to provide health care services to me that may be deemed to be routine or otherwise necessary. I consent to evaluation and treatment that the assigned healthcare provider may deem necessary. This may include diagnostic, radiology and laboratory procedures, and medication administration.

I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by Tampa Bay Neurology,Inc, and its physician as is necessary in their judgment.

I understand that this consent form will be valid and remain in effect as long as I (he/she) attend Tampa Bay Neurology,Inc.

This form has been explained to me and I understand its contents. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

_____ _____

(Signature of Patient / Legal Representative of Patient) Date

Authorization and Assignment of Benefits

Lifetime authorization to release information and assignment of benefits (financial agreement).

I hereby authorize the release of any medical or other information necessary to process any and all claims (Insurance claims) for reimbursement on my behalf for services rendered by Tampa Bay Neurology,Inc.

I authorize payment of medical benefits to Tampa Bay Neurology,Inc. I authorize payment of government benefits to the physician (entity) and any payments related to crossover medigap insurers. I request that payment of authorized secondary insurance be made to me or on my behalf to the above entity.

I understand I am financially responsible for all charged whether or not they are covered by my insurance. In the event of default, I agree to pay all cost of collection, and reasonable attorney fees.

I certify that the information that I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered effective and valid as the original.

_____ _____

(Signature of Patient / Legal Representative of Patient) Date

Privacy Statement

I acknowledge receipt of the **HIPAA Notice of Privacy Practices** pamphlet from Tampa Bay Neurology,Inc. I understand that it is my responsibility to read the information provided therein.

_____ _____

(Signature of Patient / Legal Representative of Patient) Date

_____

(Printed Name of Patient / Legal Representative of Patient)

_____ _____

Witness Employee Signature Witness Employee Printed Name

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ASSIGNMENT OF BENEFITS, LIEN, LETTER OF PROTECTION, A SPECIAL POWER OF ATTORNEY

To whom it may concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to Bharatkumar Patel, M.D. d/b/a Tampa Bay Neurology,Inc (Assignee) such sums as may be due and owing Assignee for services rendered me, both by reason of accident or illness, and by reason or any other bills that are due Assignees, and to withhold such sums from my disability benefits, medical payments benefits, No Fault benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said Assignee. I hereby further give an irrevocable lien to judgment, or verdict which may be paid to me as a result of the injuries or illness for which I have been treated by Assignee. This is to act as an assignment of my rights and benefits to the extent of the Assignee's services provided, and is in accordance with Florida Statute 627.736.5.

In the event my insurance company obligated to make payments to me upon the charges made by the Assignee for its services refuses to make such payments, upon demand by me or the Assignee, I hereby assign and transfer to Assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize Assignee to prosecute said cause of action either in my name or in Assignee's name, and further, I authorize Assignee to compromise, settle or otherwise resolve said claim or cause of action as it sees fit.

I direct my attorney to notify Bharatkumar Patel, M.D. d/b/a Tampa Bay Neurology,Inc of any settlement, judgment or verdict by certified mail at 8370 W.Hillsborough Ave, suite#103,Tampa, FL 33615. Bharatkumar Patel, M.D. d/b/a Tampa Bay Neurology,Inc will notify my attorney of all amounts due and owing. I irrevocably direct my attorney to pay or escrow for payment the total amount due at the time of closing or distribution for the past consideration of receiving medical services. If there is a dispute as to whether Bharatkumar Patel, M.D. d/b/a Tampa Bay Neurology,Inc is entitled to such escrowed funds, I irrevocably direct my attorney to enter said proceeds into the registry of the Court with jurisdiction and notify Bharatkumar Patel, M.D. d/b/a Tampa Bay Neurology,Inc by certified mail. I also direct my attorney to notify Bharatkumar Patel,M.D. d/b/a Tampa Bay Neurology,Inc in case he/she withdraws or is discharged, immediately by certified mail. The Assignee has relied on these promises in providing medical services to me.

I understand that I remain personally responsible for the total amounts due the Assignee for its services. I further understand and agree that this Assignment, Lien and Authorization does not constitute any consideration for the Assignee to await payments and they may demand payment from me immediately upon rendering services as their option.

I authorize the Assignee to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned Assignee be given Special Power of Attorney to endorse/sign my name on any and all checks and claim forms for payment of my bill.

I hereby give permission to the Assignee to administer treatment and perform such general procedures as prescribed by Bharatkumar Patel, M.D. d/b/a Tampa Bay Neurology,Inc which are deemed necessary in the diagnosis and/or treatment of my condition.

Patient/Guardian Signature _____ Date _____

Patient Name _____ DOB _____

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Patient Name _____ SS# _____ DOB _____

AUTHORIZATION TO RELEASE, RECEIVE,OR EXCHANGE INFORMATION

I authorize Tampa Bay Neurology,Inc, its Physician (Bharatkumar Patel. M.D.) and clinic staff to:

EXCHANGE, RECEIVE, AND/OR RELEASE TO:

ALL PHYSICIANS AND ANY OTHER HEALTH CARE PROVIDERS

ANY AND ALL NECESSARY MEDICAL RECORDS NEEDED FOR ON GOING HEALTHCARE.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary. I understand that if that organization authorization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

I understand that this consent shall be valid for a period for 1 year from the date of authorization and may be revoked at any time upon written notice, except to the extent that the information has already been released in reliance upon this authorization.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

I further understand that the confidentiality of this information may be protected by Federal Regulations, prohibiting any further disclosure of this information without specific written authorization of the undersigned, or as otherwise regulated.

_____ _____

Signature of Patient/Legal Representative Date

DESIGNATED RELATIVE

I Authorize Discussion of My general Medical Condition and Diagnosis (including treatment, payment, and healthcare operations) with ( ) Spouse ( ) Children ( ) Other
Please list the family members or significant others, if any, whom WE MAY Inform about Your Medical Conditions, and/or in Case of an Emergency:

Name_____Relationship_____Phone _____

Name_____Relationship_____Phone _____

Name_____Relationship_____Phone _____

_____ _____

Signature of Patient/Legal Representative Date

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AUTO ACCIDENT PATIENT QUESTIONNAIRE

Patient Name _____ DOB _____

Date of Accident: _____

Were you wearing a Seat Belt? _____

Were you the Driver or Passenger? _____

If Passenger, were you in the front or back seat? _____

Describe the accident in your own words: _____

_____

_____

_____

Were you struck in the front, rear, driver side or passenger side of the vehicle? _____

_____

Were you knocked unconscious? _____ If yes, How Long? _____

Did you feel immediate Pain? YES/ NO Where? _____

Did you go to the hospital? YES/ NO What Hospital _____

Were x-rays taken? YES *I* NO Medication Given? _____

What was your Diagnosis? _____

Have you been treated by another physician since the accident? _____

Name of Physician: _____

Treatment: _____

Did you have symptoms prior to the accident? _____

Are the symptoms improving, getting worse or the same? _____

Have you been in an auto accident before? _____

Date and Injury: _____

_____

Patient/Guardian Signature: _____ **Date** _____