PEDIATRIC NEUROLOGISTS OF PALM BEACH

NEW PATIENT REGISTRATION / DEMOGRAPHICS

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____

Sex: ☐ Male ☐ Female Address: _____

City: _____ State: _____ ZIP: _____

PARENT / LEGAL GUARDIAN 1

Name: _____ DOB: _____

Guardian status: ☐ Biological Parent ☐ Legal Guardian

Relationship to child: _____

Best Phone: _____ Alternate Phone: _____

Email: _____

Employer / Occupation: _____

PARENT / LEGAL GUARDIAN 2

Name: _____ DOB: _____

Guardian status: ☐ Biological Parent ☐ Legal Guardian

Relationship to child: _____

Best Phone: _____ Alternate Phone: _____

Email: _____

Employer / Occupation: _____

MEDICAL DECISION-MAKING AUTHORITY

Who has the right to make medical decisions for the child? ☐ Mother ☐ Father ☐ Both

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____

Policyholder Name: _____ Policyholder DOB: _____

Secondary Insurance (if applicable): _____ Member ID: _____

Policyholder Name: _____ Policyholder DOB: _____

PARENT / LEGAL GUARDIAN CERTIFICATION

I certify that I am the parent/legal guardian of the patient and that the information provided above is accurate to the best of my knowledge.

Parent/Legal Guardian Name (print): _____

Signature: _____ Date: _____

PEDIATRIC NEUROLOGISTS OF PALM BEACH

HEALTH & DEVELOPMENTAL HISTORY

Patient Name: _____ Date of Birth_____ Today's Date _____

Guardian status: ☐ Biological Parent ☐ Legal Guardian Gender ☐ male ☐ female ☐ other_____

Who has the right to make medical decisions for the child? ☐ Mother ☐ Father ☐ Both

Primary Care Provider (PCP): _____

PARENT CONCERNS

Please briefly describe your child's symptoms/concerns and the reason for today's visit:

_____

_____

_____

REVIEW OF SYSTEMS

Please check any that apply:

☐ Fevers/Night sweats	☐ Heart racing/pounding	☐ Abdominal pain
☐ Weight gain (how much _____)	☐ Chest pain	☐ Nausea/vomiting
☐ Weight loss (how much _____)	☐ Exercise intolerance	☐ Blood in stools
☐ Fatigue	☐ Persistent cough	☐ Recurrent diarrhea
☐ Hearing loss	☐ Shortness of breath	☐ Constipation
☐ Vision problems	☐ Apnea	☐ Headaches
☐ Painful urination	☐ Feeling excessively hot/cold	☐ Dizziness/fainting
☐ Blood in urine	☐ Excessive drinking	☐ Depression
☐ Bone/joint pain/swelling	☐ Excessive urinating	☐ Suicidal thoughts/plans
☐ Rashes	☐ Bruises/bleeds easily	☐ Hallucination

PREGNANCY & BIRTH HISTORY

Pregnancy complications (check all that apply):

☐ None	☐ Gestational diabetes	☐ Maternal recreational/illicit drug use
☐ Infection during pregnancy	☐ Bleeding	☐ Tobacco use
☐ Multiple pregnancy	☐ High blood pressure / Preeclampsia	☐ Alcohol use
☐	☐ Seizures	☐ Maternal prescription drug use

☐ Other: _____

How many weeks pregnant at delivery: _____ Birth weight: ____ lbs___ oz APGAR scores ____(1 min) ____(5 min)

Delivery: ☐ Vaginal ☐ Cesarean If Cesarian, why?_____

Complications after birth: : ☐ infection/sepsis ☐ required mechanical ventilation : ☐ seizures ☐ hypoxic/ischemic injury

☐ Other_____

NICU stay: ☐ No ☐ Yes If yes, how long? _____ Cooling treatment: ☐ No ☐ Yes

DEVELOPMENTAL HISTORY

Please provide the approximate age your child reached each milestone:

Rolled over	Sat independently	Walked	First words
_____	_____	_____	_____
First phrases	**Toilet trained**	**Early Intervention**	**Developmental regression**
_____	_____	☐ No ☐ Yes	☐ No ☐ Yes

SCHOOL HISTORY

School: _____ Grade: _____

School setting: ☐ Regular classes ☐ Gifted ☐ ESE ☐ Self-contained ☐ Homeschool ☐ Other: _____

Repeated a grade: ☐ No ☐ Yes Grade: _____ Current grades: ☐ A ☐ B ☐ C ☐ D ☐ F

PEDIATRIC NEUROLOGISTS OF PALM BEACH

SLEEP HISTORY

Bedtime: _____
Wake-up time: _____
How long does it take to fall asleep_____
Wakes at night? ☐ No ☐ Yes, if Yes, for how long_____
☐
unpleasant, restless feelings in legs relieved by walking/movement
☐ restless sleeper

☐ Snores
☐ Pauses/stops breathing/gasps in sleep
☐ Nightmares / night terrors / sleepwalking
☐ Difficulty getting up/still very tired in the morning
☐ Excessive sleepiness during the day

MEDICAL HISTORY

Please list al past and current medical conditions, hospitalizations and surgeries

_____

_____

_____

Please list any other medical specialists your child sees

_____

_____

CURRENT MEDICATIONS

☐ No current medications

Medication: _____ Strength: _____ Dose/Frequency: _____
Medication: _____ Strength: _____ Dose/Frequency: _____
Medication: _____ Strength: _____ Dose/Frequency: _____
Medication: _____ Strength: _____ Dose/Frequency: _____
Medication: _____ Strength: _____ Dose/Frequency: _____

ALLERGIES

☐ No known allergies Allergies: _____

FAMILY HISTORY

	Age	Occupation	Medical Problems
Mother:	____	_____	_____
Father:	____	_____	_____

Please check any that apply and list the relationship to the child:

☐ Seizures / Epilepsy _____
☐ Migraines/Headaches _____
☐ Neuromuscular Disorders _____
☐ Learning Disability/Dyslexia _____
☐ Cardiac arrhythmias _____
☐ Stroke before age 50 _____
☐ Heart attack before age 50

☐ Tics or other involuntary movements_____
☐ Autistic Spectrum Disorder _____
☐ Developmental Delay Intellectual Disability _____
☐ Fainting easily _____
☐ Multiple Sclerosis _____
☐ Unexplained Sudden Death _____
☐ Bipolar Disorder/schizophrenia _____

Other: _____ Relationship: _____

PARENT / LEGAL GUARDIAN SIGNATURE

I certify that the information provided in this health history is complete and accurate to the best of my knowledge.

Parent/Legal Guardian Name (print): _____

Signature: _____ Date: _____

PEDIATRIC NEUROLOGISTS OF PALM BEACH

CONSENTS, AUTHORIZATIONS & FINANCIAL AGREEMENT

Patient Name: _____ DOB: _____

PARENT / LEGAL GUARDIAN AUTHORITY

I certify that I am the child's parent or legal guardian and have the legal authority to consent to medical evaluation and treatment for this child. I agree to notify Pediatric Neurologists of Palm Beach of any change in custody, guardianship, or medical decision-making authority.

Relationship to child: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

PROXY CONSENT

I authorize the person(s) listed below to accompany my child to appointments and, when permitted by law and practice policy, to receive information and participate in decisions related to routine care on my behalf.

Authorized person: _____ Relationship: _____

Authorized person: _____ Relationship: _____

☐ I do not authorize a proxy at this time.

TELEHEALTH CONSENT

I consent to receive health care services through telehealth when offered by Pediatric Neurologists of Palm Beach. Telehealth may involve the use of electronic communications to allow the patient and health care provider to interact when they are in different locations.

I understand that telehealth has potential benefits, including improved access to care and reduced travel, but also has limitations and risks. These may include technical problems, interruptions, limitations of a remote examination, and risks to the privacy or security of electronic communications.

I understand that I may withhold or withdraw my consent to telehealth at any time without affecting my right to future care or treatment. I may ask questions about telehealth and may request an in-person visit when clinically appropriate. I understand that telehealth may not be appropriate for every medical condition and that emergency symptoms may require in-person or emergency evaluation.

I understand that reasonable safeguards will be used to protect the confidentiality of my child's health information and that applicable privacy laws continue to apply to telehealth services.

FINANCIAL AGREEMENT

I understand that I am responsible for providing current and accurate insurance information and for notifying the practice of insurance changes. I authorize Pediatric Neurologists of Palm Beach to submit claims for covered services and to receive payment directly from my insurance carrier when applicable.

I understand that copayments, deductibles, coinsurance, non-covered services, and other patient-responsibility amounts are due as required by my insurance plan and practice policy. Insurance authorization or verification of benefits is not a guarantee of payment.

I understand that I am ultimately responsible for charges not paid by my insurance carrier, except where prohibited by law or by contractual agreement.

MISSED APPOINTMENTS / LATE CANCELLATIONS: A $25 fee will be charged for a missed appointment or an appointment cancelled without at least 24 hours' notice. This fee is the patient's/parent's responsibility and is not billed to insurance.

ACKNOWLEDGMENT & SIGNATURE

By signing below, I acknowledge that I have read and understand the sections above and agree to the applicable terms. I certify that I have authority to sign for the patient.

Parent/Legal Guardian Name (print): _____

Signature: _____ Date: _____

Relationship to Patient: _____

PEDIATRIC NEUROLOGISTS OF PALM BEACH

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Patient Name: _____ DOB: _____

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of Pediatric Neurologists of Palm Beach's Notice of Privacy Practices. The Notice describes how health information about the patient may be used and disclosed and how I may access this information.

I understand that Pediatric Neurologists of Palm Beach may revise its Notice of Privacy Practices as permitted by law and that the current Notice will be available upon request.

Parent/Legal Guardian Name (print): _____

Relationship to Patient: _____

Signature: _____ Date: _____

FOR PRACTICE USE ONLY

If the patient's parent/legal guardian did not sign this acknowledgment, document the reason below:

☐ Parent/legal guardian declined to sign

☐ Other: _____

Staff initials: _____ Date: _____

PEDIATRIC NEUROLOGISTS OF PALM BEACH

Advance Beneficiary Notice of Non-Coverage (ABN)

Notifier: Pediatric Neurologists of Palm Beach

Patient Name: _____ Date: _____

Insurance plans do not cover all services even if they are considered medically necessary.

If your insurance does not pay for the services listed below, you will have to pay. Please READ the following and ask questions if you do not understand before signing.

Please choose 1 OPTION:

☐ 1) I want the services ordered and want my insurance BILLED for a final decision on payment. If my insurance does not pay, I will pay the balance in full and appeal directly with my insurance carrier.

☐ 2) I want the services and DO NOT want my insurance billed. I will pay now in full and will not have the option to appeal in the future. I will receive the below discounted rate.

☐ I refuse the services listed and understand and accept the risk of declining services/tests that may be harmful to my child's/my health.

Please be aware these are our self pay rates and your insurance rate may be higher. We can only offer this rate if you choose option #2. Otherwise you will be billed your insurance allowable, option #1.

SERVICE DESCRIPTION / SELF-PAY RATE

1. Office Visit NEW	$375
2. Office Visit Follow up	$200
3. APRN Follow Up	$120
4. Neuropsych CARS2	$250
5. ☐ EEG, 1 HOUR	$575
6. ☐ EEG, 2 HOURS	$700
7. ☐ EEG Monitoring/Video 24 hr	$1600
8. ☐ Polysomnogram	$1300
9. ☐ Polysomnogram, w/ CPAP	$1675
10. ☐ Polysomnography w/ MSLT	$1950

Signature: _____ Date: _____

Printed Name: _____

12959 Palms West Drive, Suite 120, Loxahatchee, FL 33470 | 150 SW Chamber Court, Suite 203, Pt St Lucie, FL 34986
Phone 561-753-8888 | Facsimile 561-795-5004 | www.pedineurologists.com