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Dear Parents,

Welcome to our practice. If you have been a previous patient, we would like to thank you for your continued support. Our physicians and staff are honored to participate in the care of your child. To provide the absolute best care possible, we ask your assistance with understanding the following policies:

1. The physician or nurse practitioner will not be able to see you if you if arrive more than 20 minutes past your scheduled time. In turn, we will make every effort to see you at your scheduled time. We spend the time necessary with every family and we apologize in advance if there are delays.
2. It is our policy to confirm every appointment. Please be aware, there is a $35 broken appointment fee if you do not give us 24 hours' notice. Please make sure we have your best contact information on file.
3. Health Care Cost Verification- we will do our best to verify your out of pocket expenses with your insurance company prior to your appointment. Please be aware, we receive an estimate of cost provided by **your insurance carrier**. As we state in our financial agreement, it is your responsibility to be aware of your benefits (deductible, coinsurance, etc.). We encourage parents to call their carrier for a cost estimate prior to any visits/tests being performed.
4. Medication Refills- Federal guidelines/Insurance carriers require quarterly office visits for patients receiving stimulants. The refills must be picked up in person (by a parent/guardian with an ID) or can be electronically sent in to a pharmacy that has capabilities to accept. We cannot mail.
   ALL MEDICATION REFILLS SHOULD BE REQUESTED 1 WEEK IN ADVANCE. OUR OFFICE WILL NOT REFILL MEDICATIONS AFTER HOURS OR ON THE WEEKENDS. Pharmacies can usually provide a few days of emergency supply for seizure medications.
5. The provider will not be able to call a parent if they were unable to attend a visit. Please plan to be present if you would like to discuss the plan of care.
6. Please allow at least 1 week for letters/forms and medical records request. There is a charge for records to be copied and mailed.
7. Parents or legal guardian are required to accompany their child to the initial visit and should accompany their child to each appointment. Proof of guardianship will be required. The child (patient) must be present at every visit. Patients without proper documentation will not be seen and another visit will be scheduled at the earliest available date.

Patient Name: _____

Signature _____ Date _____

New Patient Information (Please fill out completely) **Patient must be present for all appointments.**

Last Name_____ First Name_____ M.I._____
Social Security#_____ Date of Birth____/____/_____ Sex ___M___F
Address_____City_____State_____Zip_____
Home Phone#_____ Referring Physician PCP _____MD
Emergency Contact_____ Phone#_____
Home email address_____ Pharmacy_____

Guardian Information ___ Biological Parent ___ Legal Guardian**

(*You must present proof of parental rights and/or legal guardianship prior to being seen by providers.)

Mothers Name_____
Date of Birth_______________
Social Security#_____
Address (if different than patient)
_____City_____
State_____ Zip_____
Cellular phone#_____
Employer _____

Fathers Name _____
Date of Birth_____________
Social Security#_____
Address (if different than patient)
_____City_____
State_____ Zip _____
Cellular Phone#_____
Employer _____ _____

Primary Insurance Information:
Primary Insured. Mother / Father/Other _____ Relation to patient
Insured SS# _____ Date of Birth ____________
Insurance Company_____
Contract# _____Group#_____

(Please provide us with a copy of your insurance card and driver's license and referral if required: NO FAXES WILL BE ACCEPTED).

Assignment and Release:
I the undersigned certify that my dependent has insurance coverage with the above insurance company and assign payment directly to Pediatric Neurologists of Palm Beach for services rendered. I understand I am financially responsible for all charges not paid by the insurance. I hereby authorize this facility to release any information necessary to secure the payment of benefits; I also authorize the use of this signature on all insurance claim submissions.

Signature _____Date_____

By signing I attest that I am the legal guardian for this child and able to make medical decisions.

Pediatric Neurologists of Palm Beach

Patient History

Date of Visit _____

Patient's Name	Date of Birth	Gender: ☐ Male ☐ Female
Primary Care Physician	Age	School Grade
Primary Language	Guardians are: ☐ Biological ☐ Legal Guardians *	
Which parent has rights to make medical decisions? ☐ Mother ☐ Father ☐ Both		

** **(You must present proof of parental rights and/or legal guardianship prior to being seen by providers.)**

Please describe the chief medical problem(s) for which you brought your child to see us.

_____

_____

_____

_____

List the names of other specialists previously/currently seen for this or other problems.

_____

_____

WOULD YOU LIKE TO DISCUSS ANYTHING WITHOUT YOUR CHILD PRESENT? ☐ Yes ☐ No

PAST MEDICAL HISTORY (List all past and current medical problems, including surgeries)

ALLERGIES (REACTION): _____

MEDICATIONS (List current medications doses and times)

NAME	DOSE	NAME	DOSE

Does your child have LONG LASTING (WEEKS OR MONTHS), FREQUENT OR PERSISTENT

	YES	NO		YES	NO		YES	NO
Fevers/ Night sweats			Headaches			Diarrhea		
Weight Loss			Hearing loss			Constipation		
Weight Gain			Visual problems			Vomiting		
Bed Wetting			Chest Pain			Abdominal pain		
Staring Spells			Palpitations			Joint swelling		
Aggression			Fainting			Palpitations		
Dizziness			Depression			Excessive thirst		
Rashes			Hallucinations			Fatigue		

BIRTH HISTORY

Please circle all that apply to your pregnancy, labor and delivery

PREGNANCY COMPLICATIONS

vaginal/placental bleeding pre-eclampsia gestational diabetes maternal seizures

maternal drug use other _____

DELIVERY

Full term Preterm Vaginal C-section Vacuum Forceps

BORN AT _____weeks gestation

BIRTH WEIGHT _____ lbs._____oz.

AFTER BIRTH TREATMENTS

Ventilator Oxygen Phototherapy Antibiotics Blood Transfusion

AGE AT WHICH DISCHARGED FROM THE HOSPITAL AFTER BIRTH

_____Days _____Weeks _____Months

DEVELOPMENTAL HISTORY

At what age was your child able to?

SIT ALONE	WALK	FIRST WORDS	SENTENCES	TOILET TRAINED

SCHOOL HISTORY

SCHOOL	REGULAR CLASSES	REPEATED GRADES	GRADES	PT /OT	SPEECH THERAPY
	☐Yes ☐No	☐Yes ☐No	A B C D F	☐Yes ☐No	☐Yes ☐No

SLEEP HISTORY

WEEK DAYS		HOW LONG TO FALL ASLEEP?	SEEMS RESTED ON AWAKENING?	SNORES/STOPS BREATHING?
BED TIME	WAKES UP AT			
			☐Yes ☐No	☐Yes ☐No
RESTLESSNESS, LEG PAIN OR DISCOMFORT?		WAKES FREQUENTLY?	NAPS DURING THE DAY?	EXCESSIVE SLEEPINESS?
☐Yes ☐No		☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

FAMILY HISTORY

Name	Age	Occupation	Medical History
Mother			
Father			

Does the child live with a step-parent? ……..☐Yes ☐No
Are both parents still living? …… ☐Yes ☐No
Have any children died? …… ☐Yes ☐No

Are there any family members other than the child being seen today who have:

Seizures/Convulsions…….…….…….…….. ☐Yes ☐No
Headaches…….…….…… ☐Yes ☐No
Frequent fainting…….…….……..…… ☐Yes ☐No
Abnormal movements ……,……..…… ☐Yes ☐No
Intellectual disability……..…….……...…...…… ☐Yes ☐No
Learning problems ……..…… ☐Yes ☐No
Mental illness……..…… ☐Yes ☐No
Diabetes……..…… ☐Yes ☐No
Heart disease or stroke at a young age (< 35 years old) ..……..…… ☐Yes ☐No

Please list any other significant medical or neurological problems in the family:

_____

_____

_____

Has your child ever been in counseling? .....……..…… ☐Yes ☐No
Is your child easy going/happy?…… ☐Yes ☐No
Has your child ever expressed suicidal thoughts? ..……...…… ☐Yes ☐No
Does your child have frequent mood changes? ..... ☐Yes ☐No

I certify that I have reviewed the above information supplied by me and that it is true and complete to the best of my knowledge

Name of the person filling out the form	Relationship to patient	Signature	Date

Name_____ **Date**_____

Do you/your child have significant. frequent or persistent:

Constitutional			
Fevers, night sweats	O Yes	O No	Fiebres o sudor nocturno
Recent weight change	O Yes	O No	Cambios de peso recientes
Fatigue	O Yes	O No	Fatiga
Cardiovascular			
Chest pain	O Yes	O No	Dolor de pecho
Palpitations	O Yes	O No	Palpitaciones
Shortness of breath	O Yes	O No	Dificultad para respirar
Endocrine			
Frequent urination	O Yes	O No	Orina frecuente
Feeling excessively hot/cold	O Yes	O No	Sentimiento de calor o frio
Allergy/Immunology			
Congestion	O Yes	O No	Congestion
ENT			
Decreased hearing	O Yes	O No	Perdida auditiva
Ringing in the ears	O Yes	O No	Sonido en los oídos
Visual problems	O Yes	O No	Problemas visuales
Gastrointestinal			
Abdominal pain	O Yes	O No	Dolores abdominales
Blood in stool	O Yes	O No	Sangre en la materia fecal
Constipation	O Yes	O No	Estreñimiento
Diarrhea	O Yes	O No	Diarrea
Vomiting	O Yes	O No	Vomito
Genitourinary			
Blood in urine	O Yes	O No	Sangre en la orina
Difficulty urinating	O Yes	O No	Dificultad al orinar
Rheumatology			
Bone/joint pain/swelling	O Yes	O No	Dolor en los huesos
Rashes/skin lesions	O Yes	O No	Irritacion en la piel
Hematologic			
Easy bruising/bleeding	O Yes	O No	Moretones con facilidad
Musculoskeletal			
Leg cramps	O Yes	O No	Calambres en las piernas
Painful joints	O Yes	O No	Dolor en las articulaciones
Neurologic			
Headache	O Yes	O No	Dolor de cabeza
Dizziness	O Yes	O No	Mareos
Fainting	O Yes	O No	Fatiga
Tingling/Numbness	O Yes	O No	Adormecimiento
Balance difficulty	O Yes	O No	Dificultad en equilibrio
Psychiatric			
Depressed mood	O Yes	O No	Depresion
Suicidal thoughts	O Yes	O No	Pensamientos de suicidio
Substance abuse	O Yes	O No	Abuso de substancias
Auditory/visual hallucinations	O Yes	O No	Alucinaciones, ruidos.

Consent by Proxy for Non-Urgent Pediatric Care/Release of Information

Name of Child: _____

Date of Birth/Social Security #: _____

Address: _____

City, State, Zip Code: _____

Contact Number: _____

Primary Email address: _____

I, _____hereby authorize Pediatric Neurologists of Palm Beach to allow the below individuals to assist in the care and treatment of my child including the discussion of medication and possible medication changes in my absence:

Name: _____ Relationship to Patient _____ DOB: _____ Phone: ___

Name: _____ Relationship to Patient: _____ DOB: _____ Phone: ___

Name: _____ Relationship to Patient: _____ DOB: _____ Phone: _____

By authorizing the above individuals, I hereby agree to abide by all the financial responsibility associated with the care and treatment of my child. I will be responsible to pay Pediatric Neurologists of Palm
Beach for the following:

1. Any co-payments as set by my insurance carrier

2. Any unsatisfied deductible or termination of coverage

3. Any amount my insurance carrier deems my responsibility

4. Any amount considered non-covered by my insurance carrier

_____ _____

Parent/Guardian Signature Date

I, the undersigned certify that I have legal medical decision-making authority

_____ Parent/Guardian Printed Name

Revised 2 2016

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other _____

_____

_____ _____

Patient Signature Date

_____ _____

Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made; F=Fax; P=Phone; E=Email; M=Mail; O=Other

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Advance Beneficiary Notice of Non-Coverage (ABN)

Notifier: Pediatric Neurologists of Palm Beach
Patient Name_____ Date_____

Insurance plans do not cover all services even some that you or your provider have good reason to think you need.

If your insurance does not pay for the services listed below, you may 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:

Office Visit NEW	$ 375
Office visit Follow up	$ 216
APRN Follow Up	$ 146
Neuropsych Test (computerized)	$ 220
Neuopsych Test ADOS	$ 900
EEG, 20 min	$ 450.00
☐ EEG, 41-60 min	$ 600.00
☐ EEG, Over 1 hour	$ 700.00
☐ EEG Monitoring/Video 24 hr	$ 1600.00
☐ EEG Monitoring w/o Video 24hr	$ 865.00
☐ Polysomnogram, >6year	$ 975.00
☐ Polysomnogram, <5year	$ 975.00
☐ Polysomnogram, w/ CPAP	$ 1100.00
☐ Multiple Sleep Latency TEST	$ 650.00

X_____ Date:_____

Printed Name: _____ _____

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