By completing these forms you agree to the use of electronic signatures. Rev 11/5/2020

Forms can be printed/faxed to 561-795-5004 (secure) or saved/emailed to STAFF@PEDSNEURO.NET (sender to secure)

PNPB
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Palm Beach

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12959 Palms West Drive
Suite 120
Loxahatchee, FL 33470

5610 PGA Boulevard
Suite 203
Palm Beach Gardens, FL 33418

150 SW Chamber Court
Suite 203
Pt St Lucie, FL 34986

10301 Hagen Ranch Rd
Suite D903
Boynton Beach, FL 33437

Phone 561-753-8888
Facsimile 561-795-5004
www.pedineurologists.com

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 into 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/Guardian Name: _____

Signature _____ Date _____

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

Last Name_____ First Name_____ M.I._____
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_____
Address (if different than patient)
_____ City_____
State_____ Zip_____
Cellular phone#_____
Employer_____

Fathers Name_____
Date of Birth_____
Address (if different than patient)
_____ City_____
State_____ Zip_____
Cellular Phone#_____
Employer_____

Primary Insurance Information:
Primary Insured: Mother / Father/Other_____
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).

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.

Consent to treat:
I hereby authorize and request Edwin Liu MD PA/Pediatric Neurologists of Palm Beach to provide such medical care and administer such diagnostic care, medication prescriptions, including psychotropics and/or therapeutic treatments as in the judgement of the Physician/APRN in attendance and deemed necessary and advisable. **I consent to treatment via in office or TELEMEDICINE visits as scheduled with my appointment provider. I am aware those visits will be conducted via a state approved platform, currently doximity, healow or zoom. If there is any information I do not wish to share via telemedicine, I will inform my provider and share that information at my next in office visit.**

Attestation:
I hereby certify that I am the parent/guardian/legal custodian of the above-named patient. I have legal medical decision-making authority. I understand my child may be prescribed controlled substances and or psychotropics based on their diagnosis and I am consenting to that treatment if indicated. Should another party need to consent, I will notify my provider in writing and obtain signatures prior to treatment.

Patient/Guardian Signature_____ Date_____

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

Name: _____

Date of Birth _____

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

_____ _____

Patient/Guardian Signature Date

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

_____ Patient/Guardian Printed Name

Revised 2 2016

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

Pediatric Neurologists of Palm Beach

Patient Financial Agreement

We would like to take this opportunity to Thank-you for choosing Pediatric Neurologists of Palm Beach to provide your child's neurological care.

In an effort to try to contain the rising cost of healthcare, we have implemented this financial policy for you to review and sign. You may request a copy for your records and the original will be scanned to your chart.

INSURANCE BENEFITS AND COVERAGE

As a courtesy to you, our billing company will submit your insurance claim(s) for treatment rendered in the office. Please understand that your insurance policy is a contract between you and your insurance company. It is your responsibility to contact your insurance company to review your coverage and benefits. Ultimately, you are responsible for all costs incurred during the treatment with the exception of insurance payment adjustments. These adjustments are determined by the contract between the physician and the insurance company. If your insurance does not accept assignment of benefits and pays you directly, that payment must be made in full to us at the time of visit.

COPAYMENTS, DEDUCTIBLES AND COINSURANCE

Our office requires payment of any copayments at the time of service. In addition, if it is determined that you have a deductible or coinsurance, that will be also be collected at time of visit. The verification process does not always reveal this information. In that case, any deductible or co insurance amounts to be met will be billed to you once your insurance company has processed their portion of the claim and sent the Explanation of Benefits or EOB. While we make every effort to inform you of anticipated patient financial responsibility in advance, verification of benefits is not a guarantee of the amount you will owe. It is your responsibility to call your insurance company to determine this. Acceptable payment forms are cash, credit or debit.

UNINSURED PATIENTS AND NON-COVERED BENEFITS

Full payment is due at the time of service. In some instances a payment plan may be arranged on a case by case basis with our office. While we try to accommodate all of our patients, our office maintains strict guidelines regarding payment plans.

BALANCE AND STATEMENTS

You will receive a statement once a month if you have a balance. Failure to pay the balance by the 4th consecutive statement will result in your account being turned over to a collections company. The same would apply to patients with a payment agreement. Please be aware this can affect your credit rating. Also note there is a $50 NSF returned check fee.

REFERRALS

Referrals are required at time of visit. If a referral is required by your insurance company, please make sure to present it at your appointment. Failure to do so will result in your appointment being rescheduled. It is your responsibility to obtain the proper referral required by your insurance carrier

We are dedicated to providing your family with the highest level of neurological care. We will make every attempt to accommodate our patients whenever possible. If you have any questions or concerns, please contact our office manager and we will be happy to discuss them with you. Thank-you for your understanding.

Signature of patient/guardian Date Rev 1/2018

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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: _____

Rev 5/2019

Name_____ Date_____

Does your child have significant, frequent or persistent:

Constitutional		
Fevers, night sweats	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No
Excessive sleepiness	☐ Yes	☐ No
Cardiovascular		
Irregular heartbeat	☐ Yes	☐ No
Cyanosis		
Pulmonary	☐ Yes	☐ No
Apnea	☐ Yes	☐ No
Endocrine		
Excessive drinking/urinating	☐ Yes	☐ No
Allergy/Immunology		
Congestion	☐ Yes	☐ No
ENT		
Decreased hearing	☐ Yes	☐ No
Visual problems	☐ Yes	☐ No
Gastrointestinal		
Blood in stool	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Genitourinary		
Blood in urine	☐ Yes	☐ No
Rheumatology		
Bone/joint pan/swelling	☐ Yes	☐ No
Rashes/skin lesions	☐ Yes	☐ No
Hematologic		
Easy bruising/bleeding	☐ Yes	☐ No
Neurologic		
Irritability	☐ Yes	☐ No
Loss of strength	☐ Yes	☐ No

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)

Privacy Practices Documentation

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name _____ Birthdate _____

Signature _____ Date _____

To Be Completed by Front Office

Written acknowledgement could not be documented due to:
- ☐ Patient refused to sign
- ☐ Personal representative not available to sign
- ☐ Language, communication, or effects of disability impeded acknowledgement
- ☐ Emergency care impeded acknowledgement
- ☐ Other, please specify _____

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(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

Telemedicine Consent Form Florida

ENGLISH:

I understand that telemedicine is the use of electronic technology for communication for the purpose of providing healthcare services wherever the doctor and the patient are located.
I understand that the institution is based in Florida and likewise uses telemedicine to conduct a consultation with their patients.
I understand that with the use of telemedicine, the interaction shall be done through real-time audio-video communication.
I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA) also apply to telemedicine.
I understand that I will be responsible for any payments or coinsurances that apply to my telemedicine visit.
I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment; I have the right to access my information and to inspect my medical information that was transmitted through telemedicine; I have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent.
I understand any lawsuit airing out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states.
With the pronouncements above:
I authorize the Institution to provide me their diagnosis, observations, recommendations regarding my condition through telemedicine.
Whenever necessary, I authorize the Institution to consult with other physicians or specialists whom they believe to have full knowledge and skills that can address my case.
I have read and understood the information provided above, my rights, and obligations regarding telemedicine. I have had the opportunity to ask questions and all of which were answered to my satisfaction. Therefore, I hereby give my consent to the use of telemedicine for medical care.

SPANISH:

Entiendo que las visitas de telemedicina son de uso electronico technologico para poder cominicarse con el proposito de proporcionar servicos medicinales donde el doctor y paciente esten localizados.
Entiendo que las institucion se basa en al Estado de Florida y al igual usa Telemedicina para conducer consultas con los pacientes.
Entiendo que con el uso de telemedicina la interaccion entre doctor e paciente esta basada en tiempo real de comunicacion, por video y audio.
Entiendo que las leyes protejen la privacidad y confidencialidad al igual como la confidemcialidad de la informacion medica por medico de laLey responsabilidad y portabilidad de Seguro de salud (HIPPA- por sus siglas en ingles) que aplican a la telemedicina
Entiendo que sere responsable de algun pago o copagos que apliquen a una visita Telemedinal.
Entiendo que tengo el derecho de retener o retirar mi consentimiento para el uso de telemedicina en cualquier momento en el curso de cuidado medico, sin que afecte el derecho de ningun tratamiento en un future. Tengo el derecho de acceso a mi informacion medica para inspeccionar cualquiera de esa informacion que haya sido transmitida por telemedicina. Tengo el derecho de mi privicidad donde or cuando sea necesaria y busco el consentimineto en orden para relevar mi informacion a no ser que sea permitido po la ley revelar lo mismo sin que yo de mi consentimento.
Entiendo que alguna demanda legal ventilada de este acuerdo o servicio podria ser llevado a los cortes de el Estado de Florida con exclusion de otros estados.

Con los pronunciamientos mencionados arriba: Autorizo a la institucion a proveer un diagnostic, observacion, recomendacion medica al respect de la condicion basada al usar telemedicina. Donde sea necesario autorizo a la institucion a consultar con otros medicos y especialistas quien ellos creen tienen la capacidad e habilidades para abodar mi caso.
he leido y entendi esta informacion prevista mencionada arriba, mis derechos y obligaciones sobre la telemedicina. y entenaio la opottunidad de hacer preguntas en las cuales e obtenido respuestas con mi satisfaction. Por lo tanto, yo presento mi consenmiento de uso de telemedicina para el uso de cuidado medico.
Favor de marcar dentro de esta caja si algun representante a firmado este consentimeiento a favor del paciente.

PATIENT Name/ Nombre de el Paciente

First Name/ Nombre Last Name/ Apellido

- PARENT Signature/ Firme de el paciente o representante
- Date/ Fecha
- Submit/ Someter