21150 Biscayne Blvd, suite 201
Aventura, Fl 33180
Phone: 305-936-9393
Fax: 305-936-9650

4302 Alton Road, suite 430
Miami Beach, Fl 33140
Phone: 305-673-9990
Fax: 305-936-9650

Dear New Patient:

We are honored that you have chosen First Choice Neurology to provide you your neurological care.

To help prepare you for your upcoming visit, please read the enclosed information.

1. To make your visit as efficient as possible, please complete the attached **Patient Registration Form** and **Medical History Questionnaire** and bring them with you to your appointment. We will also need a copy of your **driver's license** and **insurance card(s)**.

**If your insurance requires a referral from your primary physician, please call them ASAP to obtain your referral and bring a copy with you. We cannot see you without a referral in place at time of your visit.*

2. Please bring a list of all medication that you use, their dosage and frequency, and the name of prescribing doctor.

3. Our collection policy: Our Physicians at First Choice Neurology participate in a variety of insurance plans. As a courtesy to our patients we file all claims. You will be expected to pay your co-payment and/ or deductibles at each visit. If you have any questions about insurance or account, please feel free to contact us.

We hope this letter of introduction will help make your visit with us as pleasant and efficient as possible. If you have any questions, please do not hesitate to contact us. Again, thank you for allowing us to participate in your care.

Sincerely,

Dr. Jeffrey Gelblum, Dr. Raul Grosz, and staff

Your Name:_____ Today's Date:_____

Doctor you are seeing today:_____

Your email Address:_____

Date of birth:_____ Age:_____ Social Security#:_____

Address:_____

City: _____ State:_____ Zip Code:_____

Home#: _____ Cell#:_____ Work#:_____

Sex: F or M Marital Status: S M Wid Sep Div Spouse's Name :_____

Emergency Contact:_____ Telephone:_____

**** What is the best method of contact and/or confirming appointment? _____****

Medical Providers:

Primary Doctor's Name:_____

Telephone #:_____ Fax:_____

Referring Physician's Name:

_____

Telephone #:_____ Fax #: _____

Employer information:

Employer Name: _____Telephone#:_____

Employee address: _____
City:_____ State: _____ Zip Code:_____

Occupation:_____

Insurance1: If Today's Visit Is Due To An Automobile Accident, Please Advise The Staff!
Type: HMO - PPO - POS - MEDICARE - W/C- AUTO

Insurance Name:_____ Telephone#:_____

ID#:_____ Group#: _____

Insurance 2:

Type: HMO - PPO - POS - MEDICARE - W/C- AUTO

Insurance Name:_____ Telephone#:_____

ID#:_____ Group#: _____

IF W/C AND AUTO ACCIDENTS:

CLAIM #:_____ ADJUSTER NAME: _____

TELEPHONE#:_____ DATE OF ACCIDENT:_____

Office Policies You Should Know

A. Please alert our office of any insurance or address changes.
B. We are not Medicaid providers; if your secondary insurance is Medicaid you will be responsible for your annual Medicare deductible.
C. Test done outside our office (**Blood, CT-Scan, MRI, ect)** may take up to two weeks or longer fore results. If you have not received a call back in two weeks please call our office.
D. Co-payments, Co-insurance and deductible are due at the time of service; otherwise your appointment will be rescheduled.
E. Please be aware that we are not your insurance company; therefore, we have limited insurance benefit information. If you have any questions about insurance benefits please contact the 1-800number on the back of your insurance card. Thank You.
F. If you are an HMO patient you will need an authorization or referral from your primary care physician or referring physician for every visit. It is patient responsibility to bring their referral to our office on the date of their appointment. Without the referral patient will be responsible for all services.
G. If you are here due to a car accident we will need the claim number from your car insurance, claim address, and the phone number to the claim representative. Your health insurance does not cover these charges until your car insurance has processed the charges.
H. We welcome your suggestion or complaints about our office. You may submit any suggestions or complaints by mail at 21150 Biscayne Blvd suit 201, Aventura Fl,33180 ATTN: Office Administrator or by e-mail at **cvgarcia@fcneurology.net**
I. For any medication refill please have the pharmacy send an electronic request to the physician at least 72 hours in advance.
J. If you would like a copy of these policies please ask the clerks.
K. Thank you for choosing our Physicians

Patient Signature: _____ Date:_____

Financial Agreement/ Assignment of Benefits:

I hereby authorize payment to be made directly to First Choice Neurology/ Neuroscience Consultants, LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, service and treatment incurred by the patient. If there is a fee that is not covered by the insurance, this is payable by the patient. The patient also agrees to pay for all Deductibles, Co-Payment, Co-Insurance, and NON-Covered services. After receipt of a statement, if payment is not received by the next billing cycle, it is subject to a monthly finance charge. If an accounted referred to an outside agency for collection, the patient agrees to pay all cost related to such action. An account will be referred to a collection service if no payment has been received within 90 days of service.

Patient or Guardian Signature:

_____

Date:

_____

FIRST Choice NEUROLOGY

Patient Referral Responsibility

If the patient's Primary Care Doctor (PCP) refers them to Dr. Jeffrey Gelblum & Dr. Raul Grosz and their insurance requires a referral, it is patient responsibility to be sure the PCP has called the referral in to the insurance carrier. We can no longer have these referral faxed over to out facility from your PCP due to we are not really receiving them in timely manner and then the patient's appointment's are either being reschedule or delayed. To avoid this from happening we are requesting that ALL patient's take responsibility for their own referral to bring with them to their doctor's appointment.

Patient is responsible for obtaining referrals for continued care services that your neurologist provider may request with regards to your treatment plan,(i.e a MRI, CT scan, ect).

Thank you for your understanding and choosing our physicians Dr. Jeffrey Gelblum & Dr. Raul Grosz.

_____ _____

PRINT DATE

_____

SIGNATURE

AUTHORIZATION TO DISCUSS MEDICAL TREATMENT

I, _____

give full authorization to discuss my medical treatment, medications diagnosis, and/or financial information with the following Physicians and/ or family members only. I understand that my medical care will not be discussed with anyone that is not on this list.

_____ _____
Relation

_____ _____
Relation

_____ _____
Relation

_____ _____
Relation

_____ _____
Relation

_____ _____
Patient Signature Date

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CONFIDENTIAL MEDICAL RECORDS RELEASE

In order to offer you the best quality of patient care we need authorization to obtain medical record (i,e, Lab Report, MRI Report, Progress Notes, ect) that have been performed at other centers. By giving us consent doctors will be able to do comparison reading.

Patient Name: _____ D.O.B:_____

I hereby authorize Dr. Jeffrey Gelblum &/or Dr. Raul Grosz and its representatives to contact my physicians and other health care providers to obtain medical records pertaining to my present medical condition.

I hereby authorize Dr. Jeffrey Gelblum &/or Dr. Raul Grosz and its representative to discuss the implication of my condition for the purpose of evaluating rehabilitation potential and formulating an approved program of rehabilitation service.

This authorization shall expire (1) year from the date written below, or as extended by me. Dr. Jeffrey Gelblum &/or Dr. Raul Grosz shall retain original signed copy of this consent in its file. A true and correct copy shall be considered sufficient authorization to release the requested information

I authorize _____ to release the following documents and to be sent to Dr. Jeffrey Gelblum & Dr. Raul Grosz Via Fax (305) 936-9650.
_____

_____ _____
Patient Signature Witness Signature

_____
Date

1. **What is your neurological complaint today**_____?

2**. Current Medications (include dose and frequency):**

_____ _____

_____ _____

_____ _____

3. **Pharmacy:**

Name_____
Address/Zip: _____
Phone Number: _____

4. **List any other neurologist seen in the past**_____

5. **Your Past Medical History** (Circle if appropriate. **ADD OTHERS** not listed.)

Cancer or Blood Disease: (List Type)

Heart and Blood Vessels: Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, Heart Attack, Hypertension, Peripheral Vascular Disease, High Cholesterol

Lungs: Asthma, Emphysema, Bronchitis

Kidney: Kidney Stones, Prostate Enlargement, Renal Failure

Psychiatric/ Emotional: Depression, Anxiety, Alcohol, or Drug Addiction/ Treatment

Gastrointestinal: Ulcer, Liver disease, Reflux disease

Endocrine/ Hormonal: Diabetes (Type 1 or 2), Thyroid Disease (Hypo or Hyper)

Neurological: Dementia, Parkinson's, Epilepsy, Migraine, Head Trauma, Stroke, Neuropathy

Last date and reason of hospitalization or Surgery: _____
_____

Name: _____Date:_____ ECW# (Office staff Only)_____

6. **Allergies:**

a. Name of medication _____ Type of Reaction _____

_____ _____

b. Non- Medication Allergies:

(Circle if present) Iodine Seafood
Latex Other (Specify)
_____

7**. Family Medical History**: (Please indicate any neurologic/cardiologic or other pertinent diseases in your family.)

Father: Living or Deceased (Circle One)
Mother: Living or Deceased (Circle One)
Sibling/Others: _____

8**. Social History**: Single – Married – Widowed – Divorced – Separated

Type of work_____ Type of Exercise _____

Number of children_____ Alcohol use_____ Drinks per Day_____

9. **Review of Symptoms**

General: ___FEVER
___WEIGHTLOSS

EYES: ___BLURRED VISION
___EYE PAIN

ENT: ___DECREASED HEARING
___RINGING IN EARS

CARDIOVASCULAR: ___CHEST PAIN
___PALPITATION/ HEART RACING

RESPIRATORY: ____SHORTNESS OF BREATH
_____ COUGH
_____WHEEZING

GASTROINTESTINAL:
___ ABDOMINAL PAIN
___ CHANGE IN BOWEL HABITS
___ NAUSEA

GENITOURINARY: ___FREQUENT URINATION
___URINARY INCONTINENCE

MUSCULAR/SKELETAL: ___MUSCLE PAIN
___SWOLLENJOINTS

SKIN: ___ CHANGE IN HAIR OR NAILS
___ RASH

PSYCHIATRIC: ___ANXIETY
___DEPRESSION
___SUICIDAL THOUGHTS

ENDOCRINE: ____TEMPERATURE INTOLERANCE
____EXCESSIVE THIRST

HEMATOLOGIC: ___EASY BRUSING
___SWOLLEN GLANDS

TOBACCO USE: ____ YES ____NO

Height _____ Weight _____ Blood Pressure_____

10. Sleep Complaints

- Do you snore? _____
-Are you overly sleepy during the day? _____
-What time do you wake up in the morning? _____
-How many times do you wake up at night and for what reason? _____
-Does the need to move your arms or legs prevent sleep? _____

Name:_____Date:_____ ECW#(Office staff only)_____

Name of patient: _____

Patient date of birth: _____

Acknowledgement of Receipt of Notice of Privacy Practice

I acknowledge that I have received a copy of providers Notice of privacy practices with the effective date of April-2010.

_____ _____

Patient Signature Date

_____

Relationship to Patient

Documentation of Good Faith Efforts To Obtain Patient's acknowledgement that they received provider's Notice of Privacy Practice

(For use when acknowledgement cannot be obtained from the patient)

The patient presented to the office/hospital on [insert date _____] and was provided with a copy of Covered Entities Notice of Privacy practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the notice. However, such acknowledgement was not obtained because:

- □ Patient refused to sign
- □ Patient was unable to sign or initial because:
  _____
- □ The patient had a medical emergency, and an attempt to obtain the Acknowledgement will be made at the next available opportunity.
- □ Other reason *(describe below)*
  _____

Signature of employee completing Form_____ Date_____

Notice of Privacy Practice for Protected Health information
Effective Date: April 2010

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully!

The office/hospital is permitted by federal privacy laws to make use and disclosed of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our service to you. Such information may include documenting your symptoms, examination and test results, diagnosis, treatment. It also includes billing documents for those services.

Examples of Use of Your Health Information for treatment purposes are:

- A nurse obtains treatment information about you and records it in a health record.

- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/ She will share the information with such specialist and obtain his/ her input.

Examples of use of your health information for payment purposes:

We submit request for payment to your health insurance company. The health insurance company (or other business associate helping us obtain payment) requests information from us regarding medical care given. We will provide information from us regarding medical care given. We will provide information to them about you and the care given.

Your Health Information Rights

The health and billing records we maintain are the physician property of the office/ hospital. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office/ hospital – we are not required to grant the request, but we will comply with any request granted.

- Request a restriction on disclosure of medical information on a health plan for purpose of carrying out payment or health care operations (and is not for purposes of carrying out treatment; and the PHI pertains solely to a health care service for which the provider has been paid out of pocket in full –we must comply with this request.

- Obtain paper copy of the current Notice of Privacy Practice for Protected Health Information ("Notice") by making a request at our office/ hospital.

- Request that you will be allowed to inspect and copy your health records billing record- you may exercise this right by delivering the request to our office/ hospital.

- Appeal a denial of access to your protected health information, except in certain circumstances.

- Request that your health care record be amended to correct incomplete or incorrect information by delivering request to our office/hospital. We may deny your request if you ask us to amend information that.

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
    - Is not part of the health information kept by or for the office/ hospital.
    - Is not part of the information that you would be permitted to inspect and copy; or,
    - Is accurate and complete.

If your request is denied, you will be informed of the reason of the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office/ hospital.

- Obtain accounting disclosures of your health information as required to be maintained by law by delivering a request to our office/ hospital. An accounting will not include uses and disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in

payment for such care; or, uses or disclosures made in a facility to notify family or other responsible for your care of your location, condition, or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office/hospital, except to the extent information or action has already been taken.

- Elect to opt out of receiving further fundraising communication from office/ hospital.

If you want to exercise any of the above rights, please contact Carolina V. Garcia Office Administrator (21150 Biscayne Blvd, Suite #201, Aventura, Fl 33180),in person or in writing, during regular business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office/hospital is required to:

- Maintain the privacy of your health information as required by law;

- Provide you with a notice as our duties and privacy practices as to the information we collected and maintained with you;

- Abide by the term of this notice;

- Notify you if we cannot accommodate a requested restriction or request; and

- Accommodate you reasonable request regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provision in our privacy practices and access practices and enact new provisions regarding to protect health information we maintain. If our information practices change, we will amend our notice. You are entitled to receive a revised copy of the notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have a questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Carolina V. Garcia Office Administrator 305-936-9393.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Carolina V. Garcia. You may also file a complaint by e- mailing it to the Secretary of Health and Human Service, Whose e-mail address is:

CVGARCIA@FCNEUROLOGY.NET

- We cannot, and will not require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/ hospital.

- We cannot, and will not, retaliate against you for filling a complaint with the Secretary of the Health and Human Services.

Other Disclosures and Uses

Directory

- Unless you notify us that you object, we will use and disclose your name, location, general condition, and religious affiliation in a hospital directory. This information may be provided to members of clergy and, except for religious affiliation, to other people who ask for you by name.

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object , we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Food and Drug Administration (FDA)

- We may use and disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post- marketing surveillance information to enable product recalls, repairs or replacement's.

Workers Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your protected health to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As Authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability: to report reactions to medication or problems with products; to notify a person who may have been exposed to a disease or who is at risk for contacting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
- Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and health care services are provided either to conduct an evaluation relating medical surveillance of the work place or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Correctional Institutional

- If you are in an inmate of a correctional institutional, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order. Or in case involving Felony prosecution or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal Law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/ Administrative Proceedings

- We may disclose you protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety a person or the public.

For specialized Government Function

- We may disclose your protected health information for specialized government functions as authorized by law, such as to armed forces personnel, for national security purposes, or to public assistance program personnel.

Coroners, Medical Examiners, and Funeral Directors

- We May release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of covered entities to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, beside those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in the notice under "Your Health Information Rights".

Website

- If we maintain a website that provides information about our entity, this Notice will be on our Website.