# *Neurology Clinic, Inc.*

*1333 Pine Street - Melbourne, FL 32901*
*Phone: (321) 984-9400 - Fax: (321) 984-0150*


## Welcome to the Neurology Clinic.

You have a scheduled appointment at the Neurology Clinic on

_____at _____,
with _____ Stephanie Newberry-Angell, ARNP / with ____ Dr. David Packey

**Our office is located at 1333 Pine Street, two blocks west of Holmes Regional Medical Center in Melbourne.**
We are in a sky-blue building with white trim, on the corner of Pine St. and Michigan Avenue
**Make sure you bring your actual insurance cards with you on your first visit.**
**Do not bring copies on your phone or email.**

## Office Policies

1. **If you arrive more than 10 minutes past your appointment you will be asked to reschedule.**
2. **If you do not show for your scheduled appointment or if an appointment is not cancelled at least 24- hour in advance, you will be charged a $75.00 fee.**
3. **The cancellation fee will need to be paid before you are seen.**
4. **If an appointment is missed or cancelled, we are unable to fill prescriptions for medications until a new appointment is made.**
5. **We are unable to schedule a new appointment if a patient has missed, rescheduled, or cancelled their appointment three consecutive times.**
6. **An office visit is required to receive lab and diagnostic test results. No results will be given by phone.**
7. **All co- payments, co-insurances, deductibles, and balances are due at the time of service.**
8. **ALL prescription refills should be called in to your pharmacy not the office. Our office will have refill request addressed within 24 hours. (excluding weekends and holidays)**

**By signing below, I acknowledge that I have read all of the above office policies. I understand that failure to comply with these policies will result in being discharged from this practice.**

Signature _____ Date_____


*David J. Packey, Ph.D., M.D.* *Jill W. Miller, M.D., Ph.D.* *Stephanie Newberry-Angell, ARNP*

# *Neurology Clinic, P.A.*

## PATIENT INFORMATION

Legal Name: (first)_____ (last) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Extension _____

Date of Birth _____ Gender _____ Marital Status _____

Last four digits of SS# _____ Occupation _____

Emergency Contact Name _____

Phone _____ Relationship _____

Spouse Name _____ Date of Birth _____

Check and date if appropriate: Injured on the Job ___ Auto Injury___ Date of Injury _____

**If proper insurance information is not provided on the date of service, our office is not responsible for filing back charges. If our account is turned over to our collection agency an additional fee, 25% of your total bill, will be added to your balance.**

Primary Insurance _____ ID# _____

Policyholder Name _____ Date of Birth _____ Relationship _____

Secondary Insurance _____ ID# _____

Policyholder Name _____ Date of Birth _____ Relationship _____

I hereby assign all medical benefits (money paid on my behalf for my medical care) to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private medical insurance , and any other health plans to Neurology Clinic, P.A. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. I authorize release to my insurance carrier, employer and / or referring health care provider any information needed, including diagnosis and records of any treatment or examination rendered to me to process the claim.

I authorize Neurology Clinic to obtain records from hospitals, health care providers, and pharmacies that will assist the health care providers at Neurology Clinic with my care.

Lifetime signature authorization: This authorization and assignment are to be continuing, remaining in force until revoked in writing by myself or legal representative.

Patient / Legal Representative _____

Witness _____ Date _____

If patient is a minor, provide parents name or legal representative and relationship.

Name _____ (circle) Parent Grandparent Guardian Other _____

**David J. Packey, Ph.D., M.D.** **Jill W. Miller, M.D., Ph.D.**

Name _____ Date _____

Primary Care Doctor _____ Referring Doctor _____

Pharmacy name and location _____

Tell us why you are here today: _____

**Medications with dosages, including vitamins and aspirin: list all (if none, please write NONE)**

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

**Allergies to medications, including type of reaction you have: list all (if none, please write NONE)**

1. _____
2. _____
3. _____
4. _____

**Surgeries / Hospitalizations: list all (if none, please write NONE)**

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

**Family Medical History: list any illness or disease past or present**

Father: _____

Mother: _____

Siblings: _____

Ages of your children: _____ [for WOMEN] # of pregnancies: _____

**Other Information:**

Age: _____ Last grade of school completed: _____ Are you RIGHT _____ or LEFT _____ handed?

Marital Status: _____ Employed _____ Retired _____ Disability _____ Unemployed _____

Do you drink alcoholic beverages? Yes ___ No ___ How many drinks daily? Beer ___ Wine ___ Alcohol ___

Do you drink caffeinated beverage? Yes ___ No ___ How many drinks daily? ___

Do you currently use any type of tobacco? Yes ___ No ___

If yes, what type of tobacco? _____ how much? _____ how often? _____

Have you used tobacco in the past? Yes ___ No ___ If yes, when did you quit? _____

Do you have: Living will? Yes ___ No ___

Legal health care proxy / surrogate? Yes ___ No ___

If yes, does your primary care doctor have a copy of these documents? Yes ___ No ___

_____**OFFICE USE ONLY BELOW THIS LINE**_____

BP _____ WT _____ HT_____ PULSE _____ HR _____ Reviewed By _____

Patient Name _____ DOB _____ Date _____

Are you currently having or have experienced within the last month?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **General:** | | | **Cardiovascular:** | | | **Skin:** | | |
| fevers | yes | no | chest pain | yes | no | rash | yes | no |
| chills | yes | no | palpitation | yes | no | itching | yes | no |
| sweats | yes | no | syncope | yes | no | dryness | yes | no |
| loss of appetite | yes | no | irregular heart beat | yes | no | **Neurological:** | | |
| fatigue | yes | no | **Respiratory:** | | | headaches | yes | no |
| sleepiness | yes | no | wheezing | yes | no | fainting spells | yes | no |
| weight gain loss | yes | no | excessive sputum | yes | no | weakness | yes | no |
| **Eyes:** | | | cough | yes | no | diziness | yes | no |
| eye pain | yes | no | sleep apnea | yes | no | tremors | yes | no |
| vision loss | yes | no | **Gastrointestinal:** | | | memory problems | yes | no |
| excessive tears | yes | no | constipation | yes | no | balance problems | yes | no |
| itching | yes | no | diarrhea | yes | no | falls | yes | no |
| blurring | yes | no | vomitting | yes | no | speech difficulty | yes | no |
| double vision | yes | no | nausea | yes | no | tics | yes | no |
| discharge | yes | no | abdominal pain | yes | no | drooling | yes | no |
| sensitive to light | yes | no | change bowel habits | yes | no | pain in limb | yes | no |
| **Ear, Nose, Throat:** | | | jaundice | yes | no | facial pain | yes | no |
| earache | yes | no | heartburn | yes | no | sudden loss of vision | yes | no |
| ear discharge | yes | no | reflux | yes | no | uncontrolled jerking | yes | no |
| ringing/buzzing in ears | yes | no | bloating | yes | no | change in handwriting | yes | no |
| decreased hearing | yes | no | hemorrhoids | yes | no | **Psychiatric:** | | |
| congestion | yes | no | **Musculoskeletal:** | | | depression | yes | no |
| nose bleeds | yes | no | back pain | yes | no | anxiety | yes | no |
| sore throat | yes | no | neck pain | yes | no | hallucinations | yes | no |
| hoarseness | yes | no | leg pain | yes | no | paranoia | yes | no |
| difficulty swallowing | yes | no | joint pain / swelling | yes | no | **Lymphatic:** | | |
| | | | muscle cramps | yes | no | abnormal bruising | yes | no |
| | | | muscle weakness | yes | no | abnormal bleeding | yes | no |
| | | | stiffness | yes | no | enlarged lymph nodes | yes | no |

**PAST MEDICAL HISTORY: Please CIRCLE all medical conditions that were diagnosed by a health care provider**

**CARDIOVASCULAR:** high blood pressure, high cholesterol, heart attack, heart murmur, pacemaker, atrial fibrillation congestive heart failure, heart valve problem/replacement, angina, peripheral vascular disease

**RESPIRATORY:** asthma, chronic bronchitis, emphasema, COPD, sleep apnea

**GASTROINTESTINAL:** ulcer, GERD, irritable bowel syndrome, gastric bypass/band/sleeve, liver problems / hepatitis

**ENDOCRINE:** diabetes, pitultary problems, hypothyroidism

**MUSCULOSKELETAL:** spinal stenosis, disc disease

**NEUROLOGICAL:** stroke, TIA, history of head trauma, seizures/epilepsy, Parkinson's disease, dementia, essential tremor, neuropathy, carpal tunnel syndrome

**CANCER DIAGNOSIS?** If YES - lung, breast, prostate, colon, brain, lymphoma/leukemia, OTHER _____

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Name _____ Date _____

**CONSENT FOR COMMUNICATION AND/OR DISCLOSURE OF PERSONAL HEALTH INFORMATION**

I understand that Neurology Clinic has a health information privacy policy. I can request the Neurology Clinic pamphlet 'Notice of Privacy Practices' should I want a copy.

I understand that I have the right to determine my preferred method of communication, and the right to restrict certain types of communication. I further understand that Neurology Clinic must honor this request as to the method of communication if reasonable. Neurology Clinic may not ask me why I want certain methods of communication.

**I give Neurology Clinic permission to contact me as follows:** (Check all that apply)

| | | | |
|---|---|---|---|
| For APPOINTMENT information | Home phone ____ | Cell phone ____ | At work ____ |
| For BILLING information | Home phone ____ | Cell phone ____ | At work ____ |
| For MEDICAL information | Home phone ____ | Cell phone ____ | At work ____ |

Can messages be left on your machine or voice mail for the above numbers? Yes____ No____

Please fill in as appropriate for what you checked above:

Home phone:_____
Cell phone: _____
Work phone: _____

**I give Neurology Clinic permission to speak to the person(s) named below:**

Name _____ Phone _____ Relationship _____
Name _____ Phone _____ Relationship _____

I understand that I have the right to object to the use and/or disclosure of my individually identifiable personal health information to other physicians or family members.
I object to the use and/or disclosure of my health information as follows: _____

_____

I understand that I may revoke this consent in writing, but that the revocation will not be effective to the extent that Neurology Clinic has already taken action in reliance on my earlier effective consent.

_____ _____

Signature of Patient or Legal Representative Signature of Witness

Date: _____

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## PATIENT PORTAL

Using a computer or tablet, patients can contact Neurology Clinic to obtain an appointment, send notes to the office staff, and have access to their medical records and test results.

This is all done via a patient portal, which is available for use by a patient only AFTER that patient provides their Email address. Once a patient gives their Email address to the office staff at Neurology Clinic, they will be given information on how to sign-up for the patient portal.

Name _____ Date_____

Email Address _____

Please be assured that Neurology Clinic will not sell or share patient Email addresses, and that the Email addresses will only be used by Neurology Clinic staff members to facilitate communication with patients.