Neurology Clinic, Inc.

1333 Pine Street
Melbourne Florida 32901
321 984 9400 fax 321 984 0150

WE ARE TWO BLOCKS WEST OF HOLMES REGIONAL HOSPITAL - CORNER OF PINE ST. & MICHGAN AVENUE

APPOINTMENT WITH ______CAITLIN FEATHERSTON, APRN ______ DAVID J PACKEY, MD

ON: ____________________________________ at ____________________AM PM

****ARRIVE 20 MINUTES PRIOR TO YOUR APPOINTMENT TIME WITH COMPLETED PAPERWORK****

**** FOR GPS SYSTEM USE : PLEASE USE COMPLETE ADDRESS INCLUDING ZIP CODE OTHERWISE, YOUR GPS WILL BRING YOU TO AN INCORRECT LOCATION****

******PLEASE NOTE: we single book our patients and therefore we have a strict scheduling policy. YOU MUST ARRIVE FOR YOUR APPOINTMENT WITH COMPLETED PAPERWORK 20 MINUTES PRIOR TO YOUR ABOVE SCHEDULED TIME.***

Accepting an appointment is considered verbal consent to the office policies as follows:

1. WE MUST RESCHEDULE ANYONE ARRIVING 10 MINUTES OR MORE AFTER SCHEDULED APPOINTMENT TIME *or arriving at scheduled time **without** completed paperwork.*
2. Missed (no show) appointments are subject to a $75.00 no show fee. Patients that miss, cancel, or reschedule 3 consecutive appointments will not be allowed to schedule any further appointments.
3. Test results are discussed in scheduled follow-up visits only. Results are NOT given over the phone. Test results, continued treatment and management are discussed and therefore the follow-up is considered a full appointment and billed as such.
4. Prescription refills are to be first requested by patient via their pharmacy. Due to federally regulated prescribing laws we do NOT provide refills if patient has not been seen in office as dictated by our provider or within 12 months of previous visit. Special circumstances may be considered by provider. Refill requests are addressed within 24 hours (excluding weekends and holidays). Patients are responsible for compliance.
5. All co-pay, co-insurance, deductible, or fee balances are due at time of service. *Botox patients: account balance must be paid in full AT or BEFORE next injection appointment.
6. Form processing fee of $25.00 is assessed for our completion of documents for DMV/Life insurance/FMLA, and other forms at discretion of management. Fee is due at time of submission and must be paid by cash/credit/debit only. NO CHECKS.
7. Any authorization required by insurance is patient's responsibility to confirm requirements by insurance and that, if needed, is in effect at time of service.

Signing below acknowledges receipt of these policies. Failure to comply may result in discharge from practice.

Patient (or *Guardian) Signature____

*if Guardian Signs: Patient Name_________________________________DOB________

Date _____________ Witness Signature ________________________________

David J. Packey, Ph.D., M.D. Jill W. Miller, M.D., Ph.D. Caitlin Featherston, APRN

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 ________

IN ORDER TO COMPLY WITH INSURANCE DOCUMENTATION GUIDELINES
THIS INFORMATION MUST BE OBTAINED AT EACH PATIENT VISIT

Patient Name ______________________________ Date ________________
Date of Birth ________________ Primary Care Doctor ________________
What pharmacy do you currently use (Name/Address)? ______________________________
____
____

Do you need any medications refilled today? YES / NO
Reason for today's visit: ______________________________

Are you currently having or have experienced within the last 30 DAYS?

General:								
Covid	yes	no	**Respiratory:**			**Genitourinary:**		
fevers	yes	no	shortness of breath	yes	no	frequent urination	yes	no
chills	yes	no	cough	yes	no	unable to control bladder	yes	no
rash	yes	no	sleep apnea / CPAP	yes	no	kidney stones	yes	no
fatigue	yes	no	**Gastrointestinal:**			difficulty voiding	yes	no
sleep problems	yes	no	constipation	yes	no	**Neurological:**		
weight gain/loss	yes	no	diarrhea	yes	no	headache	yes	no
Eyes:			vomiting	yes	no	dizziness / fainting	yes	no
eye pain	yes	no	nausea	yes	no	lightheadedness	yes	no
vision loss	yes	no	abdominal pain / cramp	yes	no	weakness	yes	no
blurring	yes	no	swallowing problems	yes	no	numbness / tingling	yes	no
double vision	yes	no	change in appetite	yes	no	balance problems	yes	no
Ear, Nose, Throat:			incontinence	yes	no	falls	yes	no
decreased hearing	yes	no	reflux	yes	no	memory changes	yes	no
ringing/buzzing in ears	yes	no	**Musculoskeletal:**			confusion	yes	no
nose bleeds	yes	no	back pain	yes	no	speech changes	yes	no
sore mouth or nose	yes	no	neck pain	yes	no	tremors	yes	no
hoarseness	yes	no	leg pain	yes	no	**Psychiatric:**		
Cardiovascular:			joint pain / swelling	yes	no	depression	yes	no
chest pain	yes	no	muscle cramps	yes	no	anxiety	yes	no
palpitation	yes	no	muscle weakness	yes	no	hallucinations	yes	no
irregular heart beat	yes	no	stiffness	yes	no	paranoia	yes	no

Females Only: Are you (circle) - Pregnant / Trying to become pregnant / Using birth control / Menopausal

Health Screening: In the last year have you had (circle all that apply) -
Colonoscopy Mammogram Pap Smear Flu Shot Pneumonia Shot
Covid Vaccine Shingles Vaccine

Smoking Status: (circle) - Non-smoker / Smoker (packs/day____) / Smokeless Tobacco / E-Cig user

____________OFFICE USE ONLY BELOW THIS LINE____________

HT ________ WT ________ Pulse________ O_2 Sat ________ BP ______/ ______ Reviewed by________

Neurology Clinic, P.A.

1333 Pine Street - Melbourne, FL 32901

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.