Fort Lauderdale Neurology, LLC

James L. Cimera, MD

DIPLOMATES, AMERICAN BOARD OF NEUROLOGY

Name (Last, First, MI): ____________________________________ Today's Date: ___________

Doctor: ___________________________Your Email Address: ____________________________

Date of Birth: _________________ Age:________ Social Security #:______________________

Address: ____

City: _________________ State: ______________ Zip Code:_____________________________

Home #:____________________ Cell#:__________________ Work#:______________________

Race:________ Ethnicity:_________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 #:________________

Employer Address: ____

City: ______________ State: _____ Zip Code: _________ Occupation: ________________

Insurance 1: If Today's Visit Is Due To An Automobile or Worker's comp 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: ____

ID#:______________________________ Group#: _______________________________

IF W/C AND AUTO ACCIDENTS:

Claim #:_________________________________ Adjuster's Name: __________________

Telephone#:______________________________ Date of Accident: __________________

I hereby authorize payment to be made directly to James L. Cimera, MD, LLC/Neuroscience Consultants LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered be the insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments, co-insurances 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 account is referred to an outside agency for collection, the patient agrees to pay all costs related to such action.

Patient or Guardian:____________________________________

Date:________________

Patient Financial Responsibility Policy

Thank you for choosing James L. Cimera, MD as a healthcare provider. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for her treatment and care. Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan. Payment is due at the time of service, and for your convenience, we accept cash, check, and most major credit cards at our office. While the filing of insurance claim is a courtesy that we extend to our patients, **it is your responsibility to**:

- ☐ Bring insurance card to each visit and notify our office of any changes to your insurance.
- ☐ Know your co-pay and be prepared to pay at each visit at check-in.
- ☐ Know your insurance company benefits and coverage.
- ☐ Determine if doctor(s) are network providers prior to first visit.
- ☐ To understand that we are a medical office not your insurance. If you have any questions or need to understand how your insurance processed or will process your claims please contact the 1800 number on your card.
- ☐ **NO SHOW APPOINTMENTS WILL BE CHARGE $30 NO SHOW FEE IF NOT CANCEL BY WITHIN 24 HOURS.**
- ☐ Pay for any amounts not covered by your insurance according to their fee schedule (i.e. If your diagnosis falls under a **pre-existing condition** and your insurance will not reimburse, **you are responsible for the payment**).
- ☐ **Patient is responsible for ALL necessary referrals & authorization**, if required from insurance. If we do not have your necessary referral at time of visit, patient is responsible for the bill without proper authorization/referral.

Patients may incur, and are responsible for the payment of additional charges at the discretion of Neuroscience Consultants, LLP Neurology: These charges *may* include (but are not limited to):

- Charge for returned checks
- Charge for missed appointment without 24 hours advance notice
- Charge for extensive phone consultations requiring diagnosis, treatment, or prescriptions.
- Charge for the copying and distribution of patient medical records.
- Charge for extensive forms completion (i.e. Disability Forms)
- If an account needs to be placed in collection due to delinquency, you will be responsible for any collection and/or attorney fees.

I have read, understand, and agree to the provisions of James L. Cimera, MD Statement of Patient Financial Responsibility. James L. Cimera, MD reserves the right to change or amend this statement at any time and at its discretion.

Signature of Patient (or Guardian): ______________________________ **Date:** __________

Printed Name: ____

Involvement of Care

Patient Name: ____Date of Birth:_______________

I hereby request that the following individual(s) be allowed to participate in my care or payment decision process. I understand that these individual(s) may be given health and/or payment information about me, if I am not available or unable to communicate. Heather N. Britton, LLC will act on this information until I revoke or amend the authorization in writing.

Name	Relationship	Date of Birth (if known)	Phone Number

My complete medical record can be released to above individual(s): YES: ____________ NO: ____________

If no, I hereby authorize the release of all my medical record with the **exception** of the following information:

Mental Health
Communicable Diseases (including HIV and AIDS)
Alcohol and/or Drug Abuse Treatment
Other, please specify:
____

Note: In the event this individual(s) is to be involved in healthcare decisions for this patient, a healthcare proxy must be completed in accordance with the related policy.

Authorization to Treat

1.) I, or the person acting on my behalf of the patient listed above, do herby authorize the rendering of such care, which may include diagnostic procedures and such medical treatment as deemed necessary by the physician or provider in charge of my care.
2.) I understand that the practice of medicine and surgery is not an exact science and that diagnoses and treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as the result of examination or treatment by this facility.
3.) It is customary, absent emergency or extraordinary circumstances, that no procedures are performed upon a patient unless he or she has had an opportunity to discuss with physician or provider in charge of their care to the patient's satisfaction. Each patient has the right to consent or refuse consent to any procedure or therapeutic course. No patient will be involved in any research or experimental procedures without his or her full knowledge and consent.
4.) This is a lifetime financial consent concerning outpatient service records, which shall continue in effect until I revoke it in writing. I authorize payment directly to James L. Cimera, MD, LLC/Neuroscience Consultants, LLP any benefits payable under the terms of my insurance/third party payer. I understand that I am finically responsible for any charges or remaining balances not covered by my insurance/3rd party payer. I authorize Neuroscience Consultants, LLP Neurology to release all pertinent medical information for purposes of obtaining payment for services rendered, reviewing or evaluating patient care, and/or preparing continuing care.

My signature below indicates I have also been provided with a copy of the Notice of Privacy Practices (HIPPA).

Signature: ____ Date: _____________________

Witness: ____ Date: _____________________

Patient Request for Release of Protected Health Information

By signing this document, I authorize:

____

To disclose my protected health information to the doctor listed below. I am specifically requesting MRI's, MRA's, CT Scans, Labs, Neurology consult notes, EEG, and any medical records that may pertain to the patient's condition be sent to:

James L. Cimera, MD
1211 SE 2nd Avenue
Ft Lauderdale, Fl 33316
Phones: 954-527-9303
Faxe: 954-527-0245

I understand that this information will become part of my medical record and may be released as part of that medical record.

Patient's Printed Name:___________________________________Date:___________________

Patient's/Guardian Signature:____

Patient's Date of Birth:_______________________________SS#:________________________

Guardian's Printed Name:___________________________________Relationship:_____________

Patient Health History Form

Patient Name:____
Pharmacy Name:_______________________________ Pharmacy Phone:_________________________
Pharmacy Address:____
Reason for today's visit:____
Height: _____________ Weight:________________ Handiness: Right / Left / Ambidextrous

Current Medications: NONE: ☐

1.	6.	11.
2.	7.	12.
3.	8.	13.
4.	9.	14.
5.	10.	15.

Current Allergies NONE: ☐

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Medical History NONE: ☐

- ○ ADD/ADHD
- ○ Alcoholism
- ○ Alzheimer's
- ○ Anemia
- ○ Anxiety
- ○ Arthritis
- ○ Asthma
- ○ Atherosclerosis
- ○ Bipolar disorder
- ○ BPH
- ○ Brain tumor
- ○ Cancer ________
- ○ Cataracts
- ○ Carpal tunnel syndrome(CTS)
- ○ Chronic back pain
- ○ Congestive heart failure(CHF)
- ○ COPD
- ○ Depression
- ○ Diabetes
- ○ DVT
- ○ Eczema
- ○ Emphysema
- ○ Endometriosis
- ○ Fibromyalgia
- ○ Fracture:________
- ○ Gallbladder disease
- ○ Gallstones
- ○ Genital warts
- ○ Glaucoma
- ○ Goiter
- ○ Gout
- ○ Headache(NOT MIGRAINES)
- ○ Heart attack
- ○ Heartburn
- ○ Hepatitis
- ○ Herpes
- ○ Hernia
- ○ Herniated disk
- ○ High blood pressure
- ○ High cholesterol
- ○ HIV/AIDS
- ○ Hyperthyroid
- ○ Hypothyroid
- ○ Inflammatory bowel disease
- ○ Irritable bowel syndrome
- ○ Kidney disease:
- ○ Liver disease
- ○ Mental illness:__________
- ○ Migraine
- ○ Multiple sclerosis
- ○ Obesity
- ○ Osteoporosis
- ○ Parkinson disease
- ○ Peptic ulcer disease
- ○ Seizure
- ○ Spinal cord injury
- ○ Stroke
- ○ Tuberculosis

Past Surgical History

NONE: ☐

○ Angio w/stent	○ D&C	○ Lumbar discectomy
○ Angioplasty	○ Gallbladder removed	○ ORIF
○ Appendectomy	○ Gastric bypass	○ Pacemaker
○ Arthrocentesis	○ Hysterectomy	○ Small bowel resection
○ CABG	○ Hemorrhoidectomy	○ Spinal fusion
○ Carotid endarterectomy	○ Hernia repair	○ Mastectomy
○ Carpal tunnel release	○ Hip replacement	○ TAH/BSO
○ Cataract extraction	○ Knee arthroscopy	○ Thyroidectomy
○ Cervical discetomy	○ Knee replacement	○ Tonsillectomy
○ Colostomy(NOT Colonoscopy)	○ Laminectomy	○ Tubal ligation
○ Craniotomy	○ LASIK	○ TURP
○ C-Section	○ Liver Biopsy	○ Vasectomy

OTHER:____

____

Family History

NONE: ☐

	Living(L) Deceased(D) Unknown(U)	Cause of Death	Medical Problems
Mother			
Father			
Siblings			

OTHER:____

Social History

Tobacco	Alcohol	Caffeine
○ Current	○ Yes	○ Yes
○ Former	○ No	○ No
○ Never	○ Former	
Type	Frequency	Type
○ Cigars	○ Occasional	○ Coffee
○ Chewing	○ Social	○ Soda
○ Cigarettes	○ Rare	○ Tea
		○ Chocolate

FIRSTChoice NEUROLOGY

REVIEW OF SYSTEMS: Please ***CIRCLE*** and provide brief details below for any positive symptoms or other symptoms not listed.

GEN	Weight loss	Weight gain	Fatigue	Headache	Fever
Eyes:	Visual loss	Double vision	Eye pain	Droopy lids	Blurry vision
ENT:	Hearing Loss	Ringing in ear	Loss of smell	Can't swallow	Dizzy
CV	Chest pain	Palpitations	Leg swelling	Fainting	High blood pressure
Respiratory:	Cough	Bloody sputum	Phlegm	Night sweat	Short of breath
GI:	Nausea	Vomiting	Constipation	Diarrhea	Black bowels
GU:	Pain urinating	Sexual problems	Bloody urine	Frequent urinating	Can't empty bladder
MS:	Joint pain	Muscle pain	Weakness	Back pain	Neck pain
Skin/Breast:	Rash	Change in color	Itching	Breast lump	Milk from breast
Neurological:	Tremors	Loss of balance	Memory loss	Numb or tingling	Speech problems
Endocrine:	Heat intolerant	Cold intolerant	Excess urine	Excess thirst	Always angry
Heme/Lymph:	Swollen glands	Pallor	Bleeding	Bruise easily	
Allergy/Sleep /Immune:	Allergies	Sleep too much	Insomnia	Snoring	Frequent infections
Psychiatric:	Confusion	Hallucinations	Depression	Nervous	Thoughts of harm
Details of positive symptoms:					

FIRSTChoice NEUROLOGY

Patient's Name: ________________________________

*Please answer the entire questionnaire below

	Several Days	**More than half the days**	**Nearly every day**	**Not at all**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself, being a failure, let yourself / your family down	☐	☐	☐	☐
7. Trouble concentrating on things such as reading or watching TV	☐	☐	☐	☐
8. Moving/ speaking slowly or being fidgety/ restless moving more than usual	☐	☐	☐	☐
9. Thoughts of being better off dead or hurting yourself in some way.	☐	☐	☐	☐

FIRSTChoice NEUROLOGY