Neurointerventional Associates, P.A.

Serious Illness Demands Extraordinary Care

Name (Mr./Ms./Mrs.) ____________________

Address: ____________________

____

City: __________ State __________ Zip __________ Email: __________

Phone (Home): __________ Cell: __________ Social Security Number: __________

DOB: __________ Age: __________ Primary Care Doctor: __________ City/State: __________

☐ Married ☐ Single ☐ Other: __________ Spouse/Parent Name: __________

Employer: __________ Spouse/Parent SS# __________ Occupation: __________

**** It is usual and customary to pay for services as rendered unless otherwise arranged****

I do authorize Dr. Nasser Razack to furnish my insurance company a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury, if requested by them. I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him services rendered to me. **I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for services rendered to me.**

This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment. I have read and agree to be bound by the terms of this assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare the entire balance due and payable. These assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient's Signature

Date: __________

NEUROINTERVENTIONAL ASSOCIATES P.A. PERSONAL HISTORY FORM

Patient Name __________ Referred by __________ Date __________

Family doctor __________ Date of Birth __________ Height __________ Weight __________

Right or Left handed (circle one) __________ Medical problems I'm seeing a Neurointerventional Radiologist for: __________

____

Past Medical History (check those that apply)

☐ Heart Attack	☐ Asthma	☐ Diabetes	☐ GERD/Reflux
☐ Migraines/Sinus Headaches	☐ Anemia	☐ Right/Left Cataract Surgery	☐ Stroke
☐ Coronary Artery Disease	☐ High Blood Pressure	☐ COPD/emphysema	☐ Anxiety
☐ Seizures	☐ Ulcer	☐ Head Trauma	☐ Cancer
☐ Depression	☐ Thyroid Disease	☐ High Cholesterol	☐ Arthritis

Other medical problems: ____________________

Surgeries or hospitalizations: ____________________

Review of Systems (check those that apply to YOU):

1.CONSTITUTIONAL:

- [ ] fevers - [ ] loss of appetite - [ ] night sweats - [ ] weight loss - [ ] weight gain

2.EYES:

- [ ] blurry vision - [ ] vision loss - [ ] double vision - [ ] redness - [ ] eye pain

3.EAR/NOSE/THROAT:

- [ ] snoring - [ ] hearing loss - [ ] ringing in ears - [ ] earache - [ ] sinus trouble

4.CARDIOVASCULAR:

- [ ] palpitations - [ ] chest pain - [ ] fainting - [ ] legs swelling - [ ] unable to lie flat

5.RESPIRATORY:

- [ ] cough - [ ] shortness of breath - [ ] hay fever

6.GASTROINTESTINAL:

- [ ] ingestion - [ ] nausea - [ ] vomiting

7.GENITAL/URINARY:

- [ ] frequent urination - [ ] incontinence - [ ] nighttime urination urgency - [ ] bedwetting

8.NEUROLOGIC:

- [ ] sleepiness - [ ] tremors - [ ] headaches - [ ] dizziness - [ ] numbness

9.PSYCHIATRIC:

- [ ] restlessness - [ ] lack of sleep - [ ] depression - [ ] anxiety - [ ] forgetfulness
- [ ] loss of consciousness

10.ALLERGY:

- [ ] hay fever - [ ] sinus headaches - [ ] hives

11.ENDOCRINE:

- [ ] irregular menses - [ ] fatigue - [ ] hot/cold intolerance

12.MUSCULOSKELETAL:

- [ ] neck pain - [ ] back pain - [ ] leg pain - [ ] joint pain - [ ] osteoporosis

13.HEMATOLOGIC:

- [ ] easy bleeding - [ ] blood clots - [ ] blood transfusion

14.SLEEP:

- [ ] restless legs - [ ] nocturnal choking - [ ] leg cramps - [ ] insomnia

15.DAILY ACTIVITIES: Are you experiencing any of the following?

1.Difficulty with bathing, dressing or feeding yourself?

- [ ] No - [ ] Yes

2.Difficulty getting out of chairs or bed?

- [ ] No - [ ] Yes

3.Decrease in movement or in arm/leg strength ?

- [ ] No - [ ] Yes

4.Balance problems or had a fall in the last 30 days?

- [ ] No - [ ] Yes

5.Use a wheelchair, walker or cane?

- [ ] No - [ ] Yes

6.Choke on food, liquids or pills?

- [ ] No - [ ] Yes

7.Difficulty communicating your needs to others?

- [ ] No - [ ] Yes

8.Decrease in the loudness of your voice or ability to speak clearly?

- [ ] No - [ ] Yes

PERSONAL HISTORY FORM

Testing: Have you had any of these tests? (Check those that apply)

MRI/MRA

- [ ] No - [ ] Yes - If so, of what/where/when?

CT/CTA

- [ ] No - [ ] Yes - If so, of what/where/when?

Ultrasound

- [ ] No - [ ] Yes - If so, of what/where/when?

Angiogram

- [ ] No - [ ] Yes - If so, of what/where/when?

Medications: (List both prescription & over the counter)

Medication name/ strength

Times per day

Who prescribed

Medication allergies:

None:

Social History: (check those that apply)

Occupation

- [ ] Retired - [ ] Unemployed - [ ] Disabled - [ ] Student - [ ] Homemaker

Marital Status:

- [ ] Single - [ ] Married - [ ] Disabled - [ ] Widowed - [ ] Divorced - [ ] Separated

I Live

- [ ] Alone
- [ ] With Spouse
- [ ] With Children
- [ ] With Parents
- [ ] Own Home
- [ ] Group Home
- [ ] Senior Apartment
- [ ] Assisted Living
- [ ] Nursing Home

Smoker

- [ ] No
- [ ] Yes - packs per day

Alcohol

- [ ] No
- [ ] Yes - drinks per week

Caffeinated Beverages

- [ ] No
- [ ] Yes - cups per day

Recreational Drugs

- [ ] No
- [ ] Yes - what kinds and how often?

Exercise

- [ ] No
- [ ] Yes - Type and how often?

Living Will

- [ ] No
- [ ] Yes - Full Resuscitation / Do Not Resuscitate / No Vent GenMedCare

Are you at risk for AIDS?

- [ ] Yes
- [ ] No

Date quit

____

Family History: Check applicable disease/condition any of your immediate family members may be suffering from: *

- [ ] Heart Disease
- [ ] High Cholesterol
- [ ] Cancer
- [ ] High Blood Pressure
- [ ] Thyroid Disease
- [ ] Dementia
- [ ] Seizures
- [ ] Diabetes
- [ ] Muscle Weakness
- [ ] Alcoholism
- [ ] Stroke
- [ ] Parkinson's Disease
- [ ] Aneurysm
- [ ] Alzheimer's
- [ ] Migraine
- [ ] Multiple Sclerosis
- [ ] Restless Legs
- [ ] Learning Disorders
- [ ] Sleep Apnea

Mother: Living Age

____

Father: Living Age

____

Deceased Age

____

Deceased Age

____

Authorization to speak to a family member:

- [ ] No
- [ ] Yes Who ?

Reviewed by:

____

Doctor's signature

____

Release of Information

Although HIPAA allows this office to use health information for treatment, payment, and to conduct health care operations, some insurance companies require a signed authorization. Please read and sign the statement below so that we may assist you in obtaining payment for your charges.

I, ______________________ , authorize Neurointerventional Associates, P.A., to release all medical information (including psychiatric, alcohol or drug abuse, HIV or communicable diseases) requested by my health insurance carrier, Medicare or its intermediaries, Medicaid, automobile insurance, or any third-party payers.

I authorize Neurointerventional Associates, P.A., to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct my insurance company or health plan administrator to release such information to Neurointerventional Associates, P.A.

I agree that these provisions will remain in effect until I provide written revocation to Neurointerventional Associates, P.A.

I authorize Neurointerventional Associates, P.A. to act as my agent in helping me obtain payment from my insurance companies. I understand that I am responsible for my bill. I hereby assign any and all insurance benefits owed to or received as a result of the injury or medical condition that necessitated treatment by the physicians of Neurointerventional Associates, P.A. from any insurance policy, whether such policy is owned by me or not.

Witness

Date

Signature of Patient/Guardian

Date

NEUROINTERVENTIONAL ASSOCIATES, P.A. PATIENT CONSENT

REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment as may be deemed necessary or advisable in the judgment of my physician or other provider. These may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or services rendered to the patient under the general and special instructions of the patient's physician. This facility has the right to refuse to treat you if you refuse to sign this consent, or if at any time you choose to revoke this consent.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment directly to this facility of any insurance benefits otherwise payable to me for services, at a rate not to exceed this facility's regular charges for such services.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collection, the undersigned agrees to pay reasonable collection and attorney fees for the collection expense.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical records and related information from this facility to authorized representatives of my third party payor or physician related to my care. I authorize the review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

The undersigned certifies that he/she has read the foregoing and received a copy thereof, and is the patient, or is duly authorized by the patient as patient's general agent, to execute the above and accepts its terms.

Patient (please print name)

Date Relationship

If the patient did not sign, please state reason:

NEUROINTERVENTIONAL ASSOCIATES, P.A. HIPPA CONSENT FORM

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operation per HIPPA Regulations

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

• A basis for planning my care and treatment;
• A means of communication among the health professionals who contribute to my care, such as referrals;
• A source of information for applying my diagnosis and treatment information to my bill;
• A means by which a third-party payer can verify services billed were actually rendered; and
• A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

• The right to review the "Notice" prior to acknowledging this consent;
• The right to restrict or revoke the use or disclosure of my health information for other uses or purposes; and
• The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions:
**I request the following restrictions to the use or disclosure of my health information:

****Please tell us with whom we may discuss your protected health information:**
(EX: Spouse [name], Children [names], Other relatives [names], Friends or Caregivers [names])

****Messages or Appointment Reminders:**

May we leave a message at your home using doctor's/practice's name? ○ Yes ○ No

May we leave a message at your work using doctor's/practice's name? ○ Yes ○ No

Messages will be of a non-sensitive nature, such as appointment reminders.

I understand that as part of treatment, payment or health care operations, it may become necessary to disclose health information to another entity (i.e. referral to other healthcare providers). I consent to such disclosure for these uses as permitted by law.

☐ **I fully understand and accept the information of this consent.

Patient/Guardian Signature   Date   Printed Name of Person Signing

*If other than the patient (Patient Name) ______________________ is signing,

are you the legal guardian, custodian, or have Power of Attorney for this patient for treatment and payment of healthcare operations?   ○ Yes ○ No

FOR OFFICE USE ONLY

Consent form received and reviewed by ______________________

☐ Consent form signature refused by patient

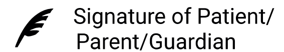
If patient is unable to sign consent form, state reason here. ______________________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's HIPAA Privacy Notice:

By subscribing my name below, I acknowledge that

has provided a copy of the HIPAA Privacy Notice, and that I have read (or had the opportunity to read if I so chose) and understand my rights and ask questions regarding my rights and receive answers to my satisfaction, and agree to its terms.

Name of Patient   Date    Signature of Patient/ Parent/Guardian

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain details of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: ______________________

Last four digits of his/her SSN or password (required): ______

Print Name: ______________________

Last four digits of his/her SSN or password (required): ______

Print Name: ______________________

Last four digits of his/her SSN or password (required): ______

I, Parent/Guardian (print)______________________ , acting on behalf of my minor son/daughter

Name of Patient ______________________ as legal Personal Representative in all matters. If representative is a court appointed legal guardian, a copy of court documents must be provided and kept in medical records.

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home / Cell Telephone Number:

☐ OK to leave message with detailed information ☐ Leave message with call back numbers only

Written Communication Address: ______________________________

______________________________ ☐ OK to mail to address listed above

E-mail me at: ______________________________ Work Telephone Number: ______________________________

☐ OK to leave message with detailed information ☐ Leave message with call back numbers only

Fax Communication: ______________________________ ☐ OK to Fax to the number listed above

Other: ______________________________

Date Relationship

AUTHORIZATION TO VERBALLY RELEASE MEDICAL OR BILLING INFORMATION TO INDIVIDUALS/FAMILY MEMBERS AND/OR OTHER ENTITIES

(This form does NOT permit the release of copies of the medical chart, office notes, or paper records)

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your healthcare provider or staff of ______________________________ or our billing company to discuss your medical or billing information with members of your family or other individual that you designate, we must obtain your authorization prior to doing so. Signing this form will only give consent to verbally release information and does not include permission to release copies of your medical records.

I authorize ______________________________ to verbally release any or all information concerning my medical care to the following individuals.

Name ______________________________ Name ______________________________

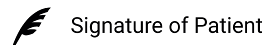
Relationship to Patient ______________________________ Relationship to Patient ______________________________

Name ______________________________ Name ______________________________

Relationship to Patient ______________________________ Relationship to Patient ______________________________

Patient Name ______________________________

Date of Birth ______________________________



Date

FORT MYERS MEDICAL CENTER

3949 EVANS AVE

300-B

FORT MYERS, FL 33901

Release Authorization

Radiologic Materials and Date

Patient Name: ______________________

Date of Birth: ______________________

Phone: ______________________

PLEASE SPECIFY WHICH DOCTOR/HOSPITAL THESE IMAGES ARE GOING TO:

Doctor: ______________________

Hospital/Clinic: ______________________

I acknowledge that, under Florida Law, the images that Dr.Razack possesses are the property of Dr. Razack and that I have only the right of access to view these images at the office during a scheduled appointment.

Due to my need to have my physician view these images, I have asked Neurointerventional Associates, P.A.

______________________ To have a copy of my images on CD for my physician.

______________________ To borrow these films for a short duration, which Neurointerventional Associates, P.A. has agreed to temporarily provide these under the condition that I agree to return all the images within thirty (30) days. I further promise to inform the physician to whom I am providing these original images to insure their safekeeping, and not to loan or forward them to any other individual without notifying Neurointerventional Associates, P.A.

Signature Date

Patient ☐ Yes Patient Representative ☐ Yes Permanent Transfer ☐ Yes

Check the appropriate box/boxes for type of images received:

☐ CT ☐ Diag ☐ IR ☐ Nuclear ☐ Mammo ☐ MRI ☐ Ultrasound ☐ All

MR#: ______________________ Jacket Location: ______________________

Staff signature or initial: