COMPREHENSIVE
NEUROLOGY
OF THE PALM BEACHES

Your Name: _____ Date:_____

Your Email Address: _____Date of Birth: _____

Age: ____ Sex: F or M Social Security #: _____ Marital Status: S M Wid Div

Address: _____

City: _____ State: _____ Zip Code: _____

Cell #:_____ Home#:_____Work#:_____

Emergency Contact:_____ Telephone #_____

Medical Providers:

Primary Doctor's Name: _____

Telephone #_____Fax: _____

Referring Physician's Name: _____

Telephone #_____Fax: _____

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Office Policies you should know:

A. **Please alert our office of any insurance, address changes or phone number changes.**
B. We are not Medicaid providers; if your secondary insurance is Medicaid you will be responsible for your annual Medicare deductible.

C. Tests done outside our office (Blood, X-ray, CT-Scan, MRI, etc) may take up to 2 weeks or longer for results. If you have not received a call back in two weeks, please call our office. You are responsible for the co-payments, deductibles and coins for those services.
D. Co-payments, co-insurances and deductibles 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 your insurance benefits, please contact the 1-800 numbers listed on your ID 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 your responsibility to make sure the referral is faxed, mailed, and/or brought to our office by the date of your appointment. Without the authorization/referral, you will be responsible for all services. New patient visits for cash are $500 self-pay and follow-up visits are $200 self-pay.
G. For medication refills please ask the pharmacy fax us the request to 561-246-3338 at least 72 hours in advance.
H. New patient appointments and NCV/EMG and EEG appointment that is canceled or no showed without 48 hours notice the patient will be charged $100 rescheduling fee or not rescheduled.
I. If you would like a copy of these policies, please ask the clerks.
J. Thank you for choosing our physicians.

Patient Signature: _____ Date: _____

THANK YOU

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Financial Agreement / HMO Patient Notice Assignment of Benefits:

I hereby authorize payment to be made directly to Neuroscience Consultants LLP/Jennifer Buczyner, MD 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 noncovered 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. An account will be referred to a collection service if no payment has been received within 90 days of service.

You are responsible for obtaining a referral /authorization for your visits and or testing in our offices from your primary care physician or claims adjuster.

Patient or Guardian:_____ Date:_____

HIPPA FORM

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.

_____	_____
Name/Relation	Name/Relation
_____	_____
Name/Relation	Name/Relation
_____	_____
Name/Relation	Name/Relation
_____	_____
Name/Relation	Name/Relation

Patient or Guardian:_____ Date:_____

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Name of Patient: _____Patient Date of Birth:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of APRIL-2010

_____ _____

Signature of Patient/Patient Representative Date

_____

Relationship to Patient

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's
Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment 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 acknowledgment will be made at the next available opportunity.
- ☐ Other reason (describe below):
  _____

Signature of Employee Completing Form: _____ Date:_____

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Patient Request for Release of Protected Health Information

By signing this document, I authorize Comprehensive Neurology to **receive** my medical records

Doctor name/Facility name

FAX#

To disclose my protected health information to the doctor listed below. Please mail disc with imaging to the address provided. 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:

Comprehensive Neurology of the Palm Beaches
Jennifer Buczyner, MD
601 University Blvd
Suite# 102
Jupiter, Fl 33458
Fax to 561-246-3338

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#:_____

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Patient Intake Form

Dr. Jennifer Buczyner, Ariel Le PA & Kaymie Poldo NP
601 University Blvd
Suite # 102
Jupiter, Fl 33458

Name: _____

Reason for Visit: _____

Referring Doctor: _____

Primary Care Doctor if Different than Referring Doctor: _____

Pharmacy (Please include address, phone and/or fax): _____

Past Medical History:

High blood pressure	Y/N	Stroke	Y/N
Seizures	Y/N	High Cholesterol	Y/N
Headaches	Y/N	Heart Disease	Y/N
Cancer	Y/N		
Diabetes	Y/N		

Other Medical Problems:

_____

_____

Surgeries:

_____

Have you had any recent Hospitalizations? If so, where?

_____

Family History, are parents current alive or deceased? What was the cause of death if deceased?

_____

Are you right or left handed? Please circle: R L

Please list all medications that you're are currently taking. Please list

Name	Strength	Frequency (times per day)

Medication Allergies:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____

Patient Signature Date Physician Signature Date