Falcon Epilepsy Freedom Center

A Center of Excellence
For Seizure & Sleep Disorders

A Cleveland Clinic
&
Johns Hopkins
Alumni Group

Falcon Advanced Neurology & Epilepsy Freedom Center
6000 Metrowest Blvd., Suite 104-105, Orlando FL 32835
Phone: (407) 365-3033 ● Fax: (407) 365-3034
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New Patient Forms

Patient Name: _____DOB: _____ Age: _____

Address: _____ SS#:_____-_____-_____

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Phone Number: _____ Email: _____

Emergency Contact Name: _____Phone: _____ Relationship: _____

Insurance: _____ ID: _____ (attach Copy)

Referring Physician Name: _____Phone: _____

Chief Complaint:

_____

Symptoms:

_____

Recent hospital visit **Y/N?** _____ Hospital: Approx. Date:

Please bring prior medical records and images on CD if possible.

Review of Systems (Circle all that apply):

General: __Fatigue, __ Fever, __Weakness, __Weight loss, ____ Wt gain, ___Night Sweats.

Head:___ Pain, Injuries: _____, Dizziness._____

Eyes: ___ Blurry vision, ___ Double vision, ___ Eye pain,

Ears / Nose / Throat: ___ Hearing loss, ___ Ear-ache, ___Discharge, _____ Ringing, ___

Vertigo, Loss of Smell, ___ Obstruction, ___ Sinusitis ___ Swallowing, ___ Frequent (Ear/Nose/Throat) infections.

Respiratory: ___ Shortness of breath, ___ cough, ___ chest pain, ___ wheezing, ___ Asthma,

___ COPD, ___ Emphysema, ___ Pulmonary Hypertension.

Cardiovascular: __ Murmur, ___ Congestive Heart Failure (CHF), ___Arrhythmia,

___ Heart Attack _____ Coronary Artery Disease (CAD), __ swelling of: ankles/feet/hands.

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Gastrointestinal: ___ Loss of appetite, ___ Diarrhea, ___ Constipation, ___ Bloody Stool

___ Vomiting, ____ Reflux, ____ Abdominal Pain.

Skin: ___ rash, _ Itching, ___ Skin discoloration, ___ Change in hair or nails

Musculoskeletal: _ Joint pain, __ Joint stiffness, _ joint swelling, _ Neck Pain,___ Back Pain, ___Limb Pain.

Neurologic: ___ Headache, ___ Numbness, ___ Convulsions, ___ Tingling, ___ Choking,

___ Difficulty chewing, ___ Difficulty walking, ___ Frequent Falls, ___ Tremor ___

Memory Loss, ___ Confusion, ___ Trouble keeping focus, ___ Trouble with Multi-tasking.

Psychiatric: ___ Anxiety, ___ Mood swings, ___ Uncontrollable Fear, ___ Panic

Attacks, ___ Frequent Sadness, ___ Hallucinations, ___ Schizophrenia, ___ Depression.

Medical History:
___ Diabetes, ___ High Blood Pressure, High Cholesterol, Stroke, Dementia,

___ Peripheral Neuropathy, Diagnosed Seizures or Epilepsy, ___ Cancer, ___ Hepatitis,

___ Thyroid disease, ___ Osteoarthritis ___ Rheumatoid arthritis, ___ Blood disorder: specify
Other:

_____

_____

Surgical History:

_____

_____

Allergies/Symptoms:

_____

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Current Medications

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_____

_____

_____

Pharmacy: _____ Ph#:_____ City/State _____

Social History: ____Single ___Married ___Divorced ___Widowed ___Separated ___Partnered

Occupation: _____ Work hours AM/PM_____ Length_____

___ **Y**___ **N** Tobacco __ Amount per day _____

___ **Y**___ **N** Alcohol - Amount: _____

___ **Y**___ **N** Recreational Substances (Marijuana, Cocaine, Heroin, etc.) __ Past ___ Present

___ Never Amount:_____

___ **Y**___ **N** Caffeine (Tea Coffee Chocolate) Amount: _____

Are your symptoms interfering with activities of daily living? ___ Y ___ N Explain:

_____

_____

Family History of Illness (If no significant history write N/A on Illness):

Relative	Illness (es)	Alive/Deceased (Cause of death)
_____	_____	_____
_____	_____	_____

Sleep Disturbances:

___ Snoring, ___ Choking ___ Gasping ___ Non-restful sleep, ___Insomnia,

___ Excessive daytime sleepiness, ___ Unexplained frequent arousals from sleep,

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___ Witnessed apnea events, ____ Nocturia (Bedwetting), ___ Witnessed Sleepwalking.
__sleep paralysis, _hallucinations

Has a sleep study been done within the last 5 years? ___ Y ___ N: Where_____

Epworth Sleepiness Score (Circle only one, rate based on the chances of falling asleep during that activity):

SCALE: 0=no change of dozing 1= slight chance of dozing
2=moderate chance of dozing 3=high chance of dozing

Situation	**Scale**
Sitting and Reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a car for an hour	_____
Lying down to rest in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (without alcohol)	_____
Sitting for a few minutes in traffic	_____

Total_____/24

Height _____ Weight _____ Neck Size _____

I have answered all questions to the best of my abilities. I understand this will become part of my Medical Record governed by HIPAA guidelines. This form was completed and will be signed by Patient / Parent / Legal Guardian with consent for full treatment.

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Print Name: _____Signature: _____Date: _____

Reviewed by: _____Date:_____

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Consent to Perform Procedure

I, _____ authorize Falcon Medical Group, Inc / Falcon Sleep Center. to perform Polysomnographic (sleep study) procedures. These procedures will be used for diagnostic, therapeutic or research purposes.

Long term Video EEG monitoring and Polysomnographic procedures are non-invasive multi-channel recordings designed to record diagnostic physiologic parameters for neurological or sleep disorders. Monitoring leads are attached with tape or snap electrodes and medical crème. Minor skin irritation associated with the cleaning of the application sites and tape may be a side effect.
When Continuous Positive Airway Pressure (CPAP), Bi-level PAP or oxygen is indicated by policy during a sleep study, it may be applied to improve cardiac or respiratory events occurring during sleep. Common complications of CPAP and Bi-level is dry mouth; burning sensation in the nose, and skin irritation. With any procedure, there may be unforeseen or unexpected side effects experienced. Notify the technologist of any discomfort you experience during your procedure. I understand there is a possibility of reactions associated with tape.

Video/Audio Recording Consent

I hereby authorize Falcon Medical Group, Inc / Falcon Advanced Neurology, hereby by Company, its employees or agents, to digitally video and/or audio record me while under the care. I further authorize the use of any such photographs, video, and audio recordings be used by other physicians involved in my medical care. I understand that such photograph(s), audio recording(s) and/or video recordings may be used for clinical, research and/or medico-legal purposes. The Company and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings. Any recordings obtained during the course of the clinical care or study will be considered a protected portion of your medical record.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Informed consent / Insurance Verification & Billing

I hereby authorize the Company and or Falcon Sleep and Neurodiagnostics (facility), acting as Service agent for the **Medical Director, President & CEO Dr. Jaivir S. Rathore,** to contact my insurance carrier (shown below) in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by both Dr. Rathore and/or other medical staff providing treatments with or without his supervision. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will, within five days of receipt of this check, make payment in the amount of said check to the facility. The following also applies to the use of my insurance to cover the cost of services rendered:

Authorization to Release Medical Information for Billing/Payment

I hereby authorize the release of any information needed, including Medical Records regarding services provided by the Physician/Facility to process insurance claims and obtain payment from the insurance carrier.

Assignment of Insurance Benefits
I hereby irrevocably authorize assignment of payment of my benefits for the services rendered by the physician and the facility made directly to the facility.

Patient Name: _____Relationship to Patient: _____

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Signature: _____Date: _____

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Office Policies, Procedures, and Patient Responsibilities.

Please read carefully, initial next to the numbered policy, and sign to confirm that you have read all of the above and agree to uphold the terms defined.

1) _____All copays, co-insurance, and deductibles are to be collected prior to services being rendered. Any cost given is a contract of coverage in between the patient and the insurance carrier. We encourage our patients to become familiar with their benefits and responsibilities.
2) _____Scheduled appointments with the Doctor must be cancelled with 24hrs prior notice to the office (if a voicemail was left, will count after verification) or there will be a $75.00 late cancel/no-show fee. Procedure appointments such as routine and/or continuous Video EEGs require 48 hrs. prior notification or will incur a $250.00 no-show/late cancellation fee due at rescheduled date in addition to copay. If study falls on a Monday call to cancel/reschedule must be made by Thursday afternoon.
3) _____All forms (excludes: excuse notes) including FMLA, Disability, or any form that includes detailed/fillable information has a charge of $35.00 and up, due at drop-off. The form will be returned within 7-14 business days. The patient will be notified when ready.
4) _____For prescription refills please have your pharmacy fax over a prescription refill request unless it is a Scheduled II medication that requires a DEA compliant prescription. It is the patient's responsibility to notify the office at least 1 week prior to running out of medication. Changes in medications/dosages requires an office visit. Refills are given according to the follow up assigned by the doctor.
5) _____The patient is responsible for updating demographic information such as: address, phone number, updated driver's license or valid identification, and updated insurance cards.
6) _____The patient has a right to their medical records.
7) _____Some insurance carriers require authorizations/referrals prior to service. These may take 1-2 weeks to be completed by the insurance company or your Primary Care Physician; it is the patient's responsibility to follow up if no contact has occurred.
8) _____If an order has been submitted to a Durable Medical Equipment (DME) company and an attempt to contact is established it is the patient's responsibility to follow up on the status of order. Any delay longer than 6 months may result in starting over.
9) _____If full coverage was not extended on a medical claim and you receive a bill, we allow 30 days to remit payment for the balance in full from the date of the bill. On day 31, it will be sent to a collections agency where they will report to credit bureaus. If you are facing financial hardship please contact the office for a mutually reasonable payment arrangement.
10) _____I have been given a copy of the Summary of the Patient Bill of Rights and Responsibilities.

_____ _____

Print (Patient/Guardian) Signature D

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SUMMARY OF THE FLORIDA PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Florida law requires that your health care provider / facility recognize your and that you respect the health care provider's / facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider / facility. A summary is as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, sexual orientation, gender identity, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

For more detail please visit: https://www.flsenate.gov/laws/statutes/2011/381.026

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Medical Records Release Form

By signing this form, I (Patient Print)_____DOB:_____
authorize _____to release the following confidential health information

for continuation of care: (Facility/Doctors office)

Attn:_____
_____
Ph#_____
Fax#_____

To: Falcon Advanced Neurology & Epilepsy Freedom Center
Fax#:(407) 365-3034

- ☐ Complete Medical Record
- ☐ H&P (within the last year)
- ☐ Pathology/Lab Reports
- ☐ Radiology/Imaging Reports
- ☐ Operative Reports
- ☐ Other (Specify):_____

Date of Service:_____

Please fax all records attention Falcon Advanced Neurology & Epilepsy Freedom Center Jaivir S. Rathore, MD, FAES, to fax number (407) 365-3034.

Expiration Date:___/___/_____ (If left blank, authorization will expire 1 year from the date on signature line)

- I understand that declining to sign this form does not mean denial of care from the facility of provider; it may limit the coverage from insurance company for repeated testing or other rendered services out of the insurance policies governed timeframe.
- I have fully read, understood, and given a copy of the Patient Privacy Policy. This notice is in compliance with HIPAA and governed within such.
- I understand the patient has a right to revoke authorization for disclosure of protected health information. Submission of revocation must occur in the form of a written request to the practice's compliance officer.
- I understand that Florida Statute 456.057 (12), Makes it clear that any third party to

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whom records are disclosed is prohibited from further disclosing any information in the medical record without expressed written consent of the patient or legal representative.

Print: _____Signature: _____

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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to my agent identified in my durable power of attorney for health care named _____.

Authorization for release of PHI covering the period of health care (check one)

a. from (date) _____ to (date) _____ OR b. all past, present and future periods.

I hereby authorize the release of PHI as follows (check one)**:**

a. my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR

b. my complete health record *with the exception of the following information* (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

_____

In addition to the authorization for release of my PHI described in paragraphs 3 a and 3 b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ Relationship _____

Name _____Relationship _____

Name _____Relationship _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or

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_____, (date or event) at which time this authorization expires

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I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient Date

_____ _____

Witness (Staff) Date