Brain, Spine
& Sleep Institute
1120 Carlton Ave, Suite 1300
Lake Wales, Florida 33853
Ph: (863)676-6386
Fax: (863)676-6454

NEW PATIENT INTAKE FORM

Patient Name:_____ Date of Birth:_____ Today's date:_____

*Welcome to Brain, Spine & Sleep Institute. Please take a few minutes to **COMPLETELY** fill out the information below. By filling the form completely and accurately, you will assist greatly in providing high quality care to you. If you have any questions, please ask one our staff members.*

1. What is the reason for your visit today? _____

2. Do you suffer from any medical conditions or disease? Please check all that apply:

☐ High blood pressure	☐ HIV	☐ Schizophrenia
☐ COPD (emphysema)	☐ HEP C	☐ Dissociative Identity Disorder
☐ Congestive Heart failure	☐ Artificial Heart Valve	☐ PTSD
☐ Irritable Bowel Syndrome	☐ Headaches/Migraines	☐ Ceberal Palsy
☐ Sleep Apnea	☐ Heart Attack	☐ Brain Tumor
☐ Thyroid Problems	☐ Stroke	☐ Epilepsy/Seizures
☐ Diabetes	☐ Arthritis	☐ Hyperlipidemia (cholesterol disorders)
☐ Asthma	☐ Fibromyalgia	☐ Coronary artery disease (blockage in heart)
☐ Lupus	☐ Anxiety	☐ Atrial fibrillation (irregular heartbeat)
☐ Multiple Sclerosis	☐ Depression	☐ Cancer: type_____
☐ MRSA	☐ Bipolar Disorder	☐ Auto-immune disorder: type_____

☐ Other:_____

3. Have you had any surgeries? If yes, please tell us what kind:

_____

_____

4. Are you currently experiencing or have you recently experienced any of the following symptoms?

Please check all that apply:

□ Weight Loss □ Fever □ Shortness Of Breath □ Chest Pain □ Cough □ Nausea □ Vomiting □ Diarrhea

□ Abdominal Pain □ Fatigue □ Joint Pains □ Back Pain □ Weakness □ Muscle Aches □ Falls □ Seizures

□ Loss Of Balance □ Dizziness □ Tingling/Numbness □ Vision Changes □ Anxiety □ Depression

□ Suicidal Thoughts □ Hearing Voices □ Loss Of Memory □ Headaches/Migraines □ Sleep Disturbances

□ Restless Sleep □ Snoring

5. Do you smoke cigarettes? □ No □ Yes How Much?_____
6. Do you use other tobacco? □ No □ Yes
7. Do you drink caffeine? □ No □ Yes How Much?_____
8. Do you use Marijuana? □ No □ Yes
9. Do you use recreational drugs? □ No □ Yes *If yes, what kind:_____
10. Did you use recreational drugs in the past? □ No □ Yes
11. Do you drink alcohol? □ No □ Socially □ Heavy

12. Are there any diseases or conditions that run in your family?

Mother:_____

Father:_____

Other:_____

13. Do you suffer from any allergies? If yes, please explain:_____

_____

14. Do you have a DNR (Do Not Resuscitate) Order? Yes / No

*If yes please provide a copy to the front desk

15. Please list all your medications, including herbal and over the counter medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Hasan M. Mousli, M.D., Director

PATIENT INFORMATION

Name:_____

Date of Birth _____ Sex: Male / Female (Please circle one) Social Security # _____-_____-_____

Marital Status: Married/ Single/ Divorced/ Separated/ Widow(er) (Please circle one)

Mailing Address: _____

Residence Phone: _____ Cell Phone_____

Email Address:_____ Retired? Yes / No (Please circle one)

Employed? Yes / No (Please circle one) Occupation: _____ Work Phone:_____

Employer Name/Address:_____

BILLING INFORMATION

Person Responsible for paying bill: Patient Parent Spouse Other _____ (Please circle one)

Name (if different from above) _____ Date of Birth _____

Address (if different from above) _____

Residence Phone:_____ Cell Phone_____ Work Phone:_____

Occupation:_____ Employer Name/Address:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co. Name

Subscriber ID Number | Group Number | Policyholder's Name | Social Security #

Patient's relationship to policyholder (Please circle one) Self Spouse Child Other Date of Birth of Policyholder_____

SECONDARY INSURANCE

Insurance Co. Name

Subscriber ID Number | Group Number | Policyholder's Name | Social Security #

Patient's relationship to policyholder (Please circle one) Self Spouse Child Other Date of Birth of Policyholder_____

Person to Contact in Case of Emergency:

Name:_____

Address:_____

Phone Number: _____ Relationship: _____

Was this an accident? Yes ____ No _____ If so, indicate: Auto_____ Worker's Comp _____Other _____

Referring Physician: _____ Fax Number:_____

PLEASE COMPLETE ALL INFORMATION

Revised 11/2011

Brain, Spine, & Sleep Institute
1120 Carlton Ave, Suite 1300, Lake Wales, FL
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OUR FINANCIAL POLICY

Patient' Name:_____ **DOB:**_____/_____/_____

Thank you for choosing Brain, Spine, & Sleep Institute as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. Please let us know if you have any questions.

- We will verify your insurance coverage at every visit. It is the patient's responsibility to supply the most current insurance card/s. If inaccurate or untimely information given to the staff results in denial or non-coverage by your insurance company, the guarantor will be responsible for payment.
- Full payment is due at the time of service.
- We accept cash, Visa and MasterCard.
- Payment plans must be arranged in advance with the Patient Accounts Department.
- HMO & PPO patients requiring referral authorizations must make sure we have received all authorizations and referrals prior to making arrangements for health care or testing.
- When labs or other tests are ordered by our providers, you are responsible to check with your insurance company as to where you are authorized to have these studies done. We will not be responsible for any bill if you have a test done at the wrong location.

As a courtesy to our patients, we will submit claims to your primary and secondary insurance carrier for you. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. The patient is responsible to know the rules of their health plan.

I hereby authorize Brain, Spine, & Sleep Institute to release any medical information required in the course of examination and treatment and permit payment directly to them for any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage; this includes but is not limited to co-insurance, co-payment, deductible and non-covered services.

I have read, understood and agree to the Financial Policy (above.

_____ _____
Signature of Patient or Responsible Party Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice of Privacy Practices for Brain, Spine, & Sleep Institute. I have read it in its entirety and have had the opportunity to ask any questions. I also understand that I have the option to request a copy.

_____ _____
Name of Patient or Responsible Party (Please print) Relationship to Patient

_____ _____
Signature of Patient or Responsible Party Date

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made on my behalf to Brain, Spine, & Sleep Institute for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap (secondary insurance – if applicable) benefits be made on my behalf to Brain, Spine, & Sleep Institute for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these benefits payable for related services.

_____ _____
Signature of Patient or Responsible Party Date

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

I give permission for Brain, Spine & Sleep Institute to release my protected health information to the following person/s regarding my protected health information . This information includes but not limited to appointments, treatments, plan of care, billing information, etc.

Name if person to release information to:_____

Relationship: _____ Phone Number:_____

_____ _____
Signature of Patient or Responsible Party Date

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E-Prescribing Consent Form

ePrecribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. ePrescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribe program. These include:

- **Formulary and benefit transactions** — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Brain, Spine, & Sleep Institute can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Brain, Spine, & Sleep Institute to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature: _____

Print Name:_____

Relationship to patient:_____

Date of Birth:_____/_____/_____ Date:_____/_____/_____

Cancellation and No-Show Policy

Cancellation of Appointments:

- Patients are required to provide at least 24 hours' notice when canceling or rescheduling appointments.
- Cancellations can be made by calling our office or through our online patient portal.

No-Show Appointments

- A "no-show" appointment is defined as when a patient misses an appointment without canceling or providing prior notice.
- Patients who arrive 15 minutes or more after their scheduled appointment time will be considered a "no-show".

Late Arrivals

- If a patient arrives late for an appointment, the appointment will have be rescheduled.

Cancellation and No-Show Fees

- Patients who fail to cancel or reschedule appointments with less than 24 hours' notice or who do not show up for their appointments WILL be subject to a cancellation/no-show fee.
- The specific fee amount will be determined by our practice and is outlined in our Fee Schedule, which is posted in the reception area.

Repeated No-Shows

- Patients with a history of repeated no-shows or chronic cancellations without proper notice may be subject to additional actions, including:
    a) Termination of the provider-patient relationship.

Notification of Late Arrivals and No-Shows

- Our practice will send reminders and notifications about upcoming appointments to minimize the risk of no-shows.
- It is the patients responsibility to keep their contact information up-to-date to receive these notifications.

Exceptions and Appeals

- We understand that emergencies and unforeseen circumstances can occur. In such cases, please contact our office as soon as possible to discuss your situation.
- Patients may submit written appeals regarding cancellation/no-show fees or related actions to our practice manager for review. *Note: there is no guarantee request will be approved.

Questions or Concerns

- If you have any questions or concerns about this policy, please feel free to contact our office for clarification.

By continuing to receive care at Brain, Spine, & Sleep Institute, you acknowledge that you have read, understood, and agree to comply with this Cancellation and No-Show Policy. This policy is designed to ensure that all patients receive the care they need and to minimize disruptions to our scheduling process.

Hasan M. Mousli, MD
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Patient Acknowledgment: I acknowledge that I have read and understood the Cancellation and No-Show Policy outlined above, and I agree to comply with these guidelines.

Patient's Name (printed): _____ Date: _____

Patient's Signature: _____ Date: _____

Patient Code of Conduct

Brain, Spine, And Sleep Institute is a healing environment. To accomplish our mission to improve the lives of our patients, we will need to work together to provide a safe and healthy environment for our patients, staff, and visitors. Brain, Spine, And Sleep Institute expects all visitors, patients, and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of others.

As a patient visiting our practice, we expect the following:

- Please communicate all issues you wish to discuss with your provider at the time your appointment is scheduled so we can allot an appropriate amount of time for your appointment. If you wish to discuss additional issues, another visit may be necessary in order to ensure all patients are given the time and quality of care they deserve.
- If you need to cancel or reschedule an appointment, please contact the office at least 24 hours prior to your appointment.
- If you have any questions about your care, or if you are unhappy with the service received in our office, please contact our practice manager before you leave the office so that any concerns you have can be addressed.
- We have a zero-tolerance policy for any aggressive behavior directed toward our staff. We encourage you and all members of your support team to be respectful to your care team.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Please supervise any underage children accompanying you.
- End every visit with a clear understanding of your provider's expectations and treatment goals.
- Follow recommended treatment plans, consultations, and other follow-up care.

The following behaviors are prohibited:

- Possessing firearms or any weapon.
- Intimidating, harassing, physically assaulting, or threatening staff or other patients or visitors including use of profanity or aggressive language.
- Making threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication.
- Damaging business equipment or property.
- Making menacing or derogatory gestures.
- Making racial, cultural, or sexual slurs or other derogatory remarks.
- Refusing to follow any practice of public health and safety policies or regulations including wearing a mask when required.
- Videotaping, audiotaping or recording providers, staff members, patients, or visitors by any other means without prior authorization.

If you are subjected to any of these behaviors or witness inappropriate behavior, please report it to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Patient's Name (printed): _____ Date: _____

Patient's Signature: _____ Date: _____