



WEHMAN NEUROSURGERY

2014 S. Orange Ave, Suite 101
Orlando FL 32806
Phone (407)254-0005 Fax (407)254-0009

Acct#: _____

Date: _____ Time: _____

Last Name: _____ First: _____ MI: _____ SS#: _____

Home Address: _____ City _____ State/Zip _____

Home Phone: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Marital Status: _____ Spouse's Name: _____

Email Address: _____ Occupation: _____

Referring Physician: _____ Phone: _____

Family Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Alternate Phone: _____

HEALTH INSURANCE INFORMATION:

Primary Insurance: _____ Phone: _____

Policy Number: _____ Group Number: _____

Claims Address/City/Zip: _____

Policy Holders Name: _____ Relationship: _____

SS#: _____ D/O/B: _____

Secondary Insurance: _____ Phone: _____

Policy Number: _____ Group Number: _____

Claims Address/City/Zip: _____

Policy Holders Name: _____ Relationship: _____

SS#: _____ D/O/B: _____

I authorize the release of any medical information necessary to process the claims(s) rendered to me. I also authorized payment of medical benefits directly to Wehman Neurosurgery, LLC for services rendered to me. I understand that I will be responsible for all copays, deductibles and non covered services as determined by my Insurance Carrier. I accept full responsibility for any outstanding balance with Wehman Neurosurgery, LLC

Signature: χ _____ Date: _____

Page Two:

Last Name: _____ First: _____ MI: _____ SS#: _____

→ [] **Worker's Compensation:**

Date of Injury: _____ Case Manager: _____ Phone: _____

Claim Number: _____

Insurance Company: _____

Claim Address: _____

City: _____ State: _____ Zip: _____

→ [] **Auto Accident:**

Date of Injury: _____ Adjuster: _____ Phone: _____

Claim Number: _____ Policy Number: _____

Location of Accident: _____

Insurance Company: _____

Claim Address: _____

City: _____ State: _____ Zip: _____

→ [] **Attorney Information:**

Attorney's Name: _____

Firm Name: _____

Address: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Letter of Protection: [] Yes [] No

Patient History Form

NAME: _____ DOB: _____ AGE: _____

RIGHT _____ OR LEFT _____ HANDED BIRTH PLACE/NATIONALITY/RACE: _____

OCCUPATION: _____ EMPLOYER _____

WEIGHT TODAY _____ HEIGHT: _____ ANY RECENT WEIGHT LOSS: (YES/NO) HOW MUCH: _____

DO YOU SMOKE: _____ HOW MUCH PER DAY: _____ NO. OF YEARS: _____ DRUGS: _____

DO YOU DRINK ALCOHOL: _____ HOW MUCH: _____ HOW OFTEN: _____

LIST ALL SYMPTOMS OR COMPLAINTS RELATED TO TODAY'S VISIT:

ARE THE SYMPTOMS CAUSED BY AN AUTOMOBILE ACCIDENT: (YES/NO) WORK COMP INJURY: YES/NO

IF YES: DATE OF INJURY: _____ HAVE YOU RETAINED AN ATTORNEY: (YES/NO) IF YES: ATTORNEY

NAME _____ PHONE NUMBER: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING OVER-THE-COUNTER MEDICATIONS:

ARE YOU ALLERGIC TO: (IF YES, PLEASE LIST NAMES)

MEDICATIONS _____

FOODS _____ CONTRAST DYE _____ OTHER _____

HAVE YOU HAD ANY PROCEDURES OR SURGERY IN THE PAST: (YES/NO) IF YES PLEASE GIVE YEAR, TYPE OF SURGERY, SURGEON'S NAME, AND HOSPITAL NAME:

HAVE YOU OR RELATIVE HAD EXCESSIVE BLEEDING DURING SURGERY: (YES/NO) IF YES, PLEASE EXPLAIN AND STATE RELATIONSHIP: _____

HAVE YOU BEEN HOSPITALIZED FOR ANY PROBLEMS NOT MENTIONED ABOVE: YES/NO

IF YES, PLEASE STATE REASON, YEAR AND HOSPITAL: _____

ARE YOU CURRENTLY WORKING: YES/NO IF NO, IS THIS DUE TO YOUR PAIN: YES/NO:

ALL FIELDS MUST BE COMPLETED

NAME: _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING: IF YES, PLEASE CHECK.

- | | | |
|--|---|--|
| <input type="checkbox"/> MEASLES | <input type="checkbox"/> DIFFICULTY WITH URINATION | <input type="checkbox"/> LOW BLOOD PRESSURE |
| <input type="checkbox"/> MUMP | <input type="checkbox"/> DRIBBLE /BLOOD IN URINE | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> FREQUENCY & BURN URINATING | <input type="checkbox"/> HEART ATTACK |
| <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> KIDNEY AILMENTS OR STONES | <input type="checkbox"/> HEART DISEASE |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> ANEMIA/OR BLOOD DISEASE |
| <input type="checkbox"/> INFECTIOUS MONO | <input type="checkbox"/> ACCIDENT (DATE) _____ | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> ENCEPHALITIS | <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> POLIO | <input type="checkbox"/> LOSS OF CONSCIOUSNESS | <input type="checkbox"/> CHRONIC COUGH |
| <input type="checkbox"/> MENINGITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> WHEEZING |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> THYROID CONDITION | <input type="checkbox"/> SPITTING UP OF BLOOD |
| <input type="checkbox"/> GONORRHEA | <input type="checkbox"/> NERVOUS BREAKDOWN | <input type="checkbox"/> NIGHT SWEATS |
| <input type="checkbox"/> SYPHILIS | <input type="checkbox"/> PSYCHIATRIC TREATMENT | <input type="checkbox"/> DIZZINESS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DRUG POISONING/OVERDOSE | <input type="checkbox"/> PARALYSIS/WEAKNESS |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> EXPOSURE TO TOXINS | <input type="checkbox"/> NUMBNESS |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> EYE DISEASE | <input type="checkbox"/> TINGLING |
| <input type="checkbox"/> DIABAETES | <input type="checkbox"/> IMPAIRED SIGHT | <input type="checkbox"/> CHEST PAIN |
| <input type="checkbox"/> JAUNDICE | <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> PALPATIONS |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> SWELLING OF FEET |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> NAUSEA OR VOMITING |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> ULCER |
| <input type="checkbox"/> NEURITIS | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> STOMACH PAIN |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> BLOOD IN STOOL |

***WOMEN ONLY: ARE YOU PREGNANT: YES/ NO MENSTRUAL PERIODS ARE: REG IRREG NONE

SOCIAL HISTORY: MARITAL STATUS: _____ NUMBER OF CHILDREN: _____

FAMILY HISTORY: LIST AGE, HEALTH CONDITION FOR EACH MEMBER OR AGE AT AND CAUSE OF DEATH

PARENTS _____

BROTHERS/SISTERS _____

HAS ANY BLOOD RELATIVE EVER HAD: (IF YES, CHECK AND GIVE RELATIONSHIP)

- | | |
|--|--|
| <input type="checkbox"/> DIABETES _____ | <input type="checkbox"/> TUBERCULOSIS _____ |
| <input type="checkbox"/> HEART DISEASE _____ | <input type="checkbox"/> MENTAL ILLNESS _____ |
| <input type="checkbox"/> STROKE _____ | <input type="checkbox"/> EPILEPSY _____ |
| <input type="checkbox"/> KIDNEY PROBLEMS _____ | <input type="checkbox"/> HIGH BLOOD PRESSURE _____ |
| <input type="checkbox"/> ANEMIA _____ | <input type="checkbox"/> ARTHRITIS _____ |
| <input type="checkbox"/> HEADACHES _____ | <input type="checkbox"/> CANCER _____ |

PLEASE NOTIFY THE OFFICE OF ANY CHANGES IN MEDICATIONS OR MEDICAL HISTORY.

PATIENT SIGNATURE: _____ DATE: _____

REVIEWED BY: _____ DATE: _____

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FORM COMPLETION POLICY

Wehman Neurosurgery, LLC will begin charging for form completions. The first requested form from each patient will continue to be completed at no charge. We will continue to help our patients to the best of our ability but have found the need to charge for completion of additional forms. Each additional form will be completed at a charge of \$10.00 per form. This charge will be payable by the patient requesting completion and will not be billed to insurance companies, etc.

Requests will be completed in seven to ten business days and payment is due prior to or upon completion of the form.

MEDICATION REFILL POLICY

Do not wait until you are out of medication before your request is called in. Your doctor may be in surgery and may not be able to approve your refill on an emergency basis.

MEDICAL RECORDS RELEASE POLICY

You will need to sign a release form in order for our office to release any records to the doctor(s) of your choice. If your attorney(s) are requesting records then they must submit a records release to our office with your signature. Please allow one to two weeks for request to be processed.

If you as the patient are requesting a copy of your records, please be informed that the cost is \$1.00 per page. Please allow up to one week for your request to be processed.

NO SHOW/CANCELLATION POLICY

If it is necessary to cancel/reschedule your appointment, please do so prior to 24 hours of appointment to avoid a \$25 charge and to allow someone else to use that appointment time. The fee of \$25.00 is to be paid by the patient and is not billable to any insurance.

Signature

Print

Date



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LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL/PLAN DOCUMENTS:

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the previously listed company, and hereby assign and convey directly to Wehman Neurosurgery, LLC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and laboratory in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bringing suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor's expense.

This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signature of Patient

Date

I understand that I am entering into a contractual relationship with Wehman Neurosurgery, LLC for professional care. I understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Wehman Neurosurgery, LLC, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice.

Furthermore, should a meritorious medical malpractice claim or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use an ABMS board certified expert witness in the same or similar specialty. I agree that these expert witnesses will adhere to the guidelines and/or code of conduct defined by the specialty societies for expert witnesses in the area of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, I (the physician), agree to the same stipulations.

Physician Signature

Patient Signature



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AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

I hereby authorize the release or use of my individually identifiable health information (“protected health information”) and medical record information by Wehman Neurosurgery, LLC (from here forth referred to as “the Practice”) in order to carry out treatment, payment, or health care operations. You should review the Practice’s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of the Notice of Privacy Practices at any time. If we do make changes to the terms of the Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restrictions(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

I agree that the Practice may also disclose the following types of information contained in my medical record (**please initial the appropriate categories listed below**):

- HIV/AIDS Information
- Substance Abuse Information
- If Patient is under the age of eighteen (18), Pregnancy Information
- Mental Health Information
- Sexually Transmitted Disease Information

I agree and consent to the Practice releasing information to me in the following alternative manners (**please initial the appropriate categories listed below**):

Via email to the Patient’s designated e-mail address which is: (I am responsible for notifying the practice of any changes to my e-mail address.) _____

Via regular mail with any envelopes being marked personal/confidential and addressed to me.

Via telephone, if I contact the Practice and provide the appropriate information (including name, social security number and unique personal identifier).

Via fax to my designated fax number which is _____. At all times, you retain the right to revoke this consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective except to the extent that the Practice has already taken action based on the prior Consent.

The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form. If you (or authorized representative sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient, to sign this document verifying consent to the above terms.

Date: _____ Time: _____ am/pm

Signature of Patient or authorized representative’

Please Print Name

Authorized representatives’ relationship to Patient

Description of Authority to act on patient’s behalf.

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Wehman Neurosurgery, LLC would like to secure your acknowledgement of receipt of this Notice of Privacy Practices ("Notice"). Your acknowledgement or lack of acknowledgement of this Notice will not affect your medical benefits. You will continue to receive the same service as usual.

Please note that this acknowledgement applies only to you. Other members of your family who are on your medical benefits plan should make a separate acknowledgement that they have read the Notice of Privacy Practices.

Signed: _____ Date: _____

Print Name: _____

Witness: _____ Date: _____

Print Name: _____