Patient Registration

Patient: _____

Date of Birth: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Email: _____

Race: _____ Ethnicity: _____

Mother/Guardian: _____

Primary Phone: _____ Secondary Phone: _____

Father/Guardian: _____

Primary Phone: _____ Secondary Phone: _____

Insurance Company: _____

Address: _____ City: _____ Zip: _____

Member ID: _____ Phone: _____

Primary Care/Referring Physician: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Practice Name: _____

Pharmacy: _____ Phone: _____

Address: _____

Parent/Guardian Signature: _____ **Date**: _____

If a parent or guardian cannot bring the patient to the appointment, a signed letter stating the name of the person bringing the patient and that person's valid ID must be presented at check-in.

Office Policies and Procedures

If you have an emergency call 911 or go to the nearest emergency room. If you have any questions or concerns please call our office at 407-218-4444

The doctors and staff at Kids Neuro Care would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By singing you confirm that you have read this policy and understand the following:

Offices hours:

Orlando Monday – Thursday 8:00 am – 5:00 pm
Friday- 7:00 am- 3:00 pm
St. Cloud Tuesday- Wednesday 8:00 am- 1:00 pm

Consent: I, hereby, give consent for Kids Neuro Care to provide the necessary treatment discussed. I authorize use of information to coordinate and manage my child's healthcare and receive payment for services.

Authorizations: It is your responsibility to make sure you have authorization from your health insurance. You must contact your primary care physician or your insurance company prior to your appointment.

Cancellations/No Shows: We will not make appointments for patients who excessively cancel/no show to appointments. **You must call our office 48 hours prior to your appointment to reschedule or the FOLLOWING FEES WILL APPLY:**

AMB EEG No-Show Fee:	$125.00	Office Visit No-Show Fee:	$30.00
LTM EEG No-Show Fee:	$125.00	EEG No-Show Fee:	$75.00

Payment for Denied Services: You will be responsible for payment of services that are **NOT** covered by your insurance. Furthermore, it is your responsibility to notify our office prior to your appointment if your insurance plan has changed. It is also your responsibility to request and obtain referrals/authorizations through your PCP if required by your insurance carrier.

Payment for Services: Your copayment and any prior balance is due at the time of service unless otherwise prearranged prior to the appointment. You will receive an invoice if the balance in your account exceeds $10.00. Any unpaid balance that exceeds 90 days is subject to 1.5% interest per month being applied.

Medical Records: Medical Records such as EEG's, Labs, MRI's and other test results can be provided for a fee of $1.00 per page. Forms requested for the Doctor to fill out will be a $15.00 flat fee and $25.00 for FMLA. You will need to fill out a Medical Release form provided by Kids Neuro Care for any and all other records to be forwarded to other Physicians, Attorneys, School etc.

Prescriptions: Bring a list of current medications including dosing and frequency being given to the patient to the appointment and request any prescription refills needed during the appointment. If a refill is needed before the next appointment, call the office during business hours. If your child has not been seen in our office within the past three months, we will **NOT** fill prescriptions without a return visit appointment being scheduled. At appointments, the patient's prescription will be filled to last until the next scheduled appointment.

Insurance: I understand it is my responsibility to know my insurance coverage and benefits including contracted laboratories and hospitals where my child may receive care. It is my responsibility to provide the office with the necessary information to file claims and to notify the office of any insurance coverage changes prior to visits. I authorize payment of medical benefits directly to Kids Neuro Care for services rendered.

Mail: Kids Neuro Care may send me mail or email that assists the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, patient statements, and school forms.

Medical Release: I authorize any holder of medical records for my child to release to Kids Neuro Care, independent laboratories, and insurance carriers information needed for treatment, claims processing, and payments. I permit a copy of this authorization to be used in place of the original.

Conduct not allowed in our office:

- Not showing up for your appointment without prior cancellation 3 consecutive times.
- Not complying with recommended treatment.
- Using profanity against our staff or patients.
- Recording consultation is NOT allowed.
- Refuse to pay your balance.

  These conducts may result in the termination of our services to the patient

If you have any questions about the above information, please do not hesitate to ask us.

Patient: _____

Parent/Guardian name: _____

Parent/Guardian Signature: _____ **Date:** _____

New Patient Medical History Questionnaire

Child's Name: _____ **D.O.B:**_____

Help us to get to know your child better, please answer these questions to the best of your ability.

Main Reason(s) for Visit: _____

Past Medical History

Medication Allergies	
Serious Illness/Surgeries	
Head injuries	
Hospitalizations	

Birth History

Were any of the following concerns during pregnancy?

___No problems ___Abnormal Bleeding ___High Blood Pressure ___ Early Labor
___Diabetes ___ Tobacco use ___ Alcohol/substance use ___Trauma

Birth weight _____lbs_____oz	Vaginal ___ C-section____
Born early or late? _____ weeks	Discharged home in 2-3 days ___Y ___N
Problems during delivery? ___Y ___N	Newborn Jaundice _____Y _____N

Developmental History

Any worries about abnormal or slow development	**___Yes ___No**
Has your child ever lost developmental skills?	**___Yes ___No**
Has the child received any therapy for developmental delays?	**___Yes ___No**
Does your child receive special classroom modifications?	**___Yes ___No Current Grade_____**

Family History

Any family members with any of the following conditions:

__Epilepsy/Seizures	__Autism	__Migraines	__Brain tumor	__Aneurysm
__Multiple Sclerosis	__Muscle/nerve disorder	__ Birth Defects	__Bleeding Disorder	__Neurofibromatosis
__Learning Disability	__Tics/Tourette	__ Stroke	__Psychiatric Disorder	__ADD/ADHD

Current Medications

_____ _____ _____

_____ _____ _____

Review of Systems **(Please indicate if any of these are problems for your child)**

Confusion Y / N	Headaches Y /N	Dizziness Y / N	Blurred Vision Y / N
Numb/Tingling Y / N	Double Vision Y / N	Nausea/Vomiting Y/N	Ringing in ears Y/ N
Poor balance Y/N	Trouble walking Y / N	Stiffness Y / N	Drooling Y / N
Weakness Y / N	Clumsiness Y / N	Swallowing issues Y/N	Speech Difficulty Y/N
Seizures/Convulsions Y/N	Memory Problems Y/N	Mood Changes Y / N	Unable to sleep Y / N
Altered taste/smell Y/N	Change in appetite Y/N	Weight Loss/Gain Y/N	Excessive sleepiness Y/N
Fatigue Y / N	Nose bleeds Y / N	Fainting Spells Y / N	Involuntary Movements Y/N
Staring Spells Y /N	Loss of control bladder or bowel Y / N	Frequent belly pains Y/N	Chronic diarrhea or constipation Y / N
Low Back pain Y / N	Neck Pain Y / N	Joint pain/swelling Y/N	Tremors Y / N
Anxiety Y / N	Depression Y/ N	Disruptive behavior Y/N	Poor attention in school Y / N

If patient is older than 3 years old: Is your child RIGHT or LEFT handed.