Neurology Institute of Melbourne
Patient Information

Is this visit related to a work injury or an auto accident? **YES** **NO**

Has this visit been scheduled through Vocational Rehabilitation? **YES** **NO**

Name: _____ Birthdate: _____

Permanent Address: _____

Mailing Address: _____ _____

Home #: _____ Work #: _____ Cell #: _____

SSN: _____ Marital Status: _____

Email Address: _____

Primary Insurance Company: _____

Insured's Name: _____ Birthdate: _____

Emergency Contact: _____ Phone #: _____

Nearest Relative (not living with you): _____ Phone #: _____

How did you hear about us?: _____ Primary Care Physician: _____

I hereby assign all medical benefits including major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plan to Neurology Institute of Melbourne, PA. This assignment remains in effect until revoked by me in writing.

Your portion of the office visit is due at the time of service. As courtesy to you, we will file your initial insurance claim. It is your responsibility to obtain authorization for all services. If for any reason your insurance company or health plan refuses payment, you are responsible for the balance of payment for services rendered, including any and all service charges or missed appointment fees.

Signature: _____ Date: _____

Neurology institute of Melbourne

Office Policies

(Please initial in each provided space)

Appointments

As a courtesy, we allow 15 minutes for lateness. After 15 minutes, we reserve the right to reschedule. We have a "reminder call" program in place, also as a courtesy, whereby all scheduled patients are called the workday before the appointment to confirm. It is your responsibility to make note of your appointments and arrive as scheduled; this policy is in effect even if we are unable to reach you by phone to confirm your appointment. As we do not double book appointments, if you do not cancel a scheduled appointment 24 hours in advance, you create a vacancy in our schedule which cannot be filled. For this reason, it is our policy to charge the following FEES.

$50.00 FOR A MISSED FOLLOW UP APPOINTMENT
$50.00 FOR AN APPOINTMENT YOU WALK OUT ON
$100.00 FOR A MISSED TEST (NERVE CONDUCTION, EMG, EEG)

Insurance

We accept most private insurances excluding Health First and HMO plans. **It is the patient's responsibility to contact the insurance company to verify that Dr. Unger is a network provider for that plan. If for any reason your insurance company or health plan refuses payment, you are responsible for the balance of payment for services rendered, including any and all service charges or missed appointment fees.**

It is also the patient's responsibility to provide proof of current insurance at the time of the appointment. Scanned or photographic copies of the insurance card is not considered valid proof. If this information is not available, please make arrangements with the receptionist to utilize the private pay option. There is a discount for private pay patients who do not have current insurance. Additionally, payment are due at the time of service or subject to a $25.00 administration service charge. This includes coinsurance payments for Medicare. PLEASE NOTE: WE DO NOT ACCEPT MEDICAID AT ALL. If you have any questions regarding billing, please contact our billing service company, Seabreeze Medical Billing 1-877-859-5650.

Medical Records

All requests for medical records must be in writing and may take up to 14 business days to process. All patients' accounts must be paid in full before medical records are released. Medical records to / from another physician may be requested by completing the form in our office. As a courtesy, we provide the first copy of your medical records at no charge. In accordance with Rule 64B8-10.333 Administrative Code, our office charges for reproducing additional copies of medical records for $1.00 per page for the first 25 pages, and $ .25 per page thereafter. Payments for records must be made in advance.

Forms and read fees

Forms: $75.00 for the first page, $25.00 for each additional page for forms generated outside of our office. This is due in advance.

Letters: $75.00 per letter written by Dr. Unger on behalf of the patient. This is also due in advance.

Also, in order to provide you with the best possible care, Dr. Unger reads ALL films (MRI, CT) including those that may have been read by another physician / facility. A read fee is charged for each scan, and we will submit this bill to your insurance company as a convenience to you. Should your insurance provider deny payment for this service, your maximum responsibility will not exceed $50.00 per scan.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

Release of information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- [ ] Spouse _____
- [ ] Child (ren) _____
- [ ] Child (ren) _____
- [ ] Child (ren) _____
- [ ] Other _____
- [ ] Other _____
- [ ] Other _____

[ ] Information is not to be released to anyone.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of the signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ Please **print** name of Patient

_____ Please **sign** as Patient / Guardian of Patient

_____ Legal Representative / Guardian

_____ Relationship of Legal Representative / Guardian

NEUROLOGY INSTITUTE OF MELBOURNE, PA
FINANCIAL POLICY

Patient Name: _____ DOB: _____

Welcome to Neurology Institute of Melbourne. We are happy you have chosen Dr. Unger as your Neurologist and we will strive to give you the best medical care. We understand that in addition to needing to feel comfortable with your Physician, many patients have concerns about the Financial Policy of our practice.

It is the policy of our office to collect co-payments/deductibles at the time services are rendered. Any amount due at the time of service that is not collected will be assessed at a $ 25.00 service fee. We accept cash, personal check and most major credit cards. A returned check fee of $25.00 will be assessed and you will be unable to make subsequent payments by check.

For all services rendered to minor patients we will look to the adult accompanying the patient or the parent/guardian for payment (including any past due balances). We will not get involved in arrangements made between divorced parents or custodial agreements.

Neurology Institute of Melbourne has agreed to file insurance for patients who participate in insurance plans. In order to do this as accurately as possible you MUST produce your insurance card at each visit. If you do not have this available payment in full is due at the time of the visit must. Any applicable credit amounts will be refunded to you once contracted insurance information is received and dates of service are paid by the insurance company.

If your visit is auto or worker's compensation related, we must be informed immediately. The charges for auto-related visits will be billed to your auto insurance company and, as a courtesy to your major medical carrier(s). All balances are the responsibility of the patient. We do not accept "Letters of Protection" from attorneys. We must have the following information for billing: auto insurance company, claim number, adjuster's name and phone number, and mailing address for billing.

Any services that we file with your insurance company that are not responded to after 90 days from the date of service may be transferred to patient balance which will remain the responsibility of the patient until payment is received or written correspondence is received from the insurance company verifying that payment is forthcoming from them. Any balances not paid within 90 days will be forwarded to our collection agency unless prior arrangements have been made with our office. The account balance and additional 30% fee associated with collecting the debt will be the responsibility of the patient. WE CANNOT SCHEDULE OR SEE PATIENTS IN COLLECTION STATUS. COLLECTION STATUS MUST BE CLEARED PRIOR TO THE PATIENT'S ARRIVAL FOR ANY SUBSEQUENT VISIT.

A monthly statement will be sent to you by our billing company, Seabreeze Medical Billing, detailing unpaid charges. If you have any questions regarding items which have not been paid by your insurance, we ask that you contact your insurance company or employer as benefit packages vary by employer and policy.

Non-Compliance with this Financial Policy may result in dismissal from the practice.

I have read and understand the financial policy of the practice and agree to be bound by its terms and agree that such terms may be amended at will by the practice.

Printed Name of Patient: _____ Date: _____

Signature of Patient or Guardian: _____

NEUROLOGY INSTITUTE OF MELBOURNE
NEW PATIENT HEALTH HISTORY FORM

Name: _____ DOB _____ Today's Date _____

ARE YOU HERE FOR CONDITIONS RELATED TO A MOTOR VEHICLE ACCIDENT? **YES** **NO**

IS THE CASE STILL OPEN? **YES** **NO**

Please list ALL of your **medications and dosages** including **vitamins** and **over the counter products.**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list ALL **allergies to medications** and their **reactions.**

MEDICATION _____ REACTION _____

MEDICATION _____ REACTION _____

MEDICATION _____ REACTION _____

MEDICATION _____ REACTION _____

FAMILY HISTORY: Please indicate the relation of any **family members** diagnosed with the following conditions. If no relative had the condition, please circle "**NONE**"

Alzheimer's Disease: _____ None

Dementia: _____ None

Lou Gehrig's Disease (ALS): _____ None

Migraines: _____ None

Multiple Sclerosis: _____ None

Neuropathy: _____ None

Parkinson's Disease: _____ None

Psychiatric Disorders: _____ None

Strokes: _____ None

Seizures: _____ None

MAJOR ILLNESSES: Please circle any of the following illnesses with which you have been diagnosed or prescribed treatment.

Acid Reflux	Headache	Other Arrhythmias
Anemia	Heart Disease (CAD)	Parkinson's
Arthritis	Hepatitis	Peripheral Vascular Disease
Asthma	Herpes Infection	Rheumatoid Arthritis
Atrial Fibrillation	High Cholesterol	Pneumonia
Benign Prostatic Hyperplasia	History of Chicken Pox	Polio
Bipolar Disorder	History of Mono	Female Reproductive Problems
Blockage's in heart	HIV / AIDS	Prostate Cancer
Carpal Tunnel	Hypertension	Psych Disorders
Cataracts	Kidney Disease	Schizophrenia
COPD	Kidney Failure	Seizures
Depression	Kidney Stones	Sinus Infections
Diabetes	Liver Disease	Spine Problems (Neck / Back)
Diverticular Disease	Lupus	Stroke
Emphysema	Memory Loss	Syphilis
Fibromyalgia	Meningitis	Thyroid Nodules
Frequent UTI's	Multiple Sclerosis	Thyroid Problems (HYPO / HYPER)
Glaucoma	Neuropathy	Tuberculosis
Gonorrhea	Osteoarthritis	Ulcer

Cancer (please explain): Type _____ Year _____

Treatment _____ Remission? **YES** **NO**

HABITS: Please circle the appropriate answer.

Smoking:	current (cig____ / day)	current (smokeless ____ / day)	NEVER
	current (vape ____ / day)	former (quit ____ years ago)	
Drug use:	current (#____ / day)	former (quit ____ years ago)	NEVER
	TYPE: _____		
Alcohol:	regular (# ____ / day)	occasional (# ____ / month)	NEVER

Please list ALL **surgeries** and **approximate dates.**

PROCEDURE _____ DATE _____

PROCEDURE _____ DATE _____

PROCEDURE _____ DATE _____

PROCEDURE _____ DATE _____

PROCEDURE _____ DATE _____

PROCEDURE _____ DATE _____

New Patient Review of Symptoms: Please check all that apply

GENERAL WELL BEING

___ Fever
___ Weight Loss (>10lbs)
___ Excess Fatigue
___ Recurrent Nausea / Vomit
___ Night Sweats

DERMATOLOGICAL

___ Eczema or Psoriasis
___ Dermatitis
___ Dry or Scaling skin
___ Rashes
___ Changes in skin color
___ Changes in moles
___ Skin Cancer
___ Breast pain or swelling
Date of last mammogram ____

OPTHALMOLOGIC

___ Burry vision
___ Eyesight worsening
___ Double vision
___ Eye pain
___ Eyes water or burn
___ Cataracts
___ Other eye problems
___ Wear glasses / Contacts
___ Date of last exam: _____
___ Infections
___ Injuries
___ Glaucoma
___ Cateracts
___ Blurred vision
___ Trouble focusing
___ Recent change in vision

EARS, NOSE, MOUTH & THROAT

___ Wear hearing aids
Date of last hearing exam ____
___ Hearing Loss
___ Ear Infection
___ Ear Pressure
___ Ringing in ears
___ Pain in ears
___ Balance disturbance
___ Itching in ears
___ Nasal congention
___ Nasal drainage
___ Nosebleeds
___ Sinus infections / problems
___ Sinus headaches
___ Throat infections
___ Difficulty swallowing
___ Lip or mouth sores
___ Sore throats

RESPITORY

___ Chronic cough
___ Emphysema
___ Bronchitis
___ Asthma
___ Chronic obstruction
___ Pulmonary Disease
___ Shortness of breath
___ Oxygen use at home
___ Pneumonia
___ Lung cancer
___ Tuberculosis
___ Blood in saliva
___ Date of last chest X-ray _____

CARDIOVASCULAR

___ Chest pain
Date of last EKG _____
___ Heart attack
___ High blood pressure
___ Low blood pressure
___ Irregular heartbeat
___ Heart murmur
___ Arm and leg swelling
___ High cholesterol

DIGESTIVE

___ Blood in vomit
___ Indigestion
___ Nausea / vomiting
___ Jaundice
___ Abdominal pain
___ Altered bowel habits
___ Ulcers or Gastritis
___ Colon, liver, stomach cancer
___ Hepatitis

GENITOURINARY

___ Urinary tract infection
___ Painful urination
___ Blood in urine
___ Difficulty urinating
___ Incontinence
___ Kidney stones
___ Prostate cancer
___ Endometriosis
___ Uterine, ovarian or cervical cancer

MUSCULOSKELETAL

___ Broken bones
List: _____
___ Arm or leg weakness
___ Joint pain or swelling
___ Back pain
___ Arthritis

HEMATOLOGIC

___ Anemia
___ Hemophilia
___ Easy bleeding / bruising
___ Swollen glands

IMMUNOLOGIC

___ Environmental allergies
___ Hay fever
___ Food allergies
___ Immune system problems
___ Connective tissue disease
___ Frequent colds / infections

PSYCHIATRIC

___ Anxiety
___ Depression
___ Manic / Depression
___ Schizophrenia
___ Considering suicide / homicide
___ Panic attacks
___ Sudden mood swings
___ Emotional difficulties
___ Insomnia
___ Other psychiatric problems
___ Under psychiatric care
___ Desiring psychiatric care

NEUROLOGICAL

___ Confusion
___ Difficulty concentrating
___ Dizziness
___ Hallucinations
___ Headache
___ Lethary
___ Memory problems
___ Personality change
___ Spells
___ Clumsiness
___ Facial numbness - tingling
___ Numbness - arms (L/R/B)
___ Numbness - legs (L/R/B)
___ Poor balance
___ Poor coordination
___ Speech difficulty
___ Stiffness
___ Trouble walking
___ Weakness - arms (L/R/B)
___ Weakness - legs (L/R/B)
___ Choking
___ Difficulty chewing
___ Difficulty tasting
___ Drooling
___ Hoarseness
___ Incontinence - bowel
___ Incontinence - bladder
___ Nausea
___ Pain
___ Vomiting
___ Blurred vision
___ Decreased hearing
___ Double vision
___ Dysphagia
___ Fainting spells
___ RInging in the ears
___ Trouble with smells
___ Vertigo / Dizziness
___ Sexual dysfunction
___ History of coma
___ History of cardiac arrest

NEUROLOGY INSTITUTE OF MELBOURNE **DR. RICHARD M. UNGER, JR., M.D.**

NAME: _____ **DATE:** _____

PAIN ASSESSMENT

Do you have pain in the following areas:

If you answered yes, please continue. **If you do not answer it will be assumed that there is nothing to make your pain worse.**

Is the pain in your **NECK**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **THORACIC SPINE** (between your shoulder blades)? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **LOWER BACK**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **FEET/LEGS**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **HANDS/ARMS**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **FACE**? YES NO Is the pain: INTERMITTENT CONSTANT

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Is the pain in your **JOINTS**? YES NO Is the pain: INTERMITTENT CONSTANT

Which Joints? _____

On a scale of 1-10, 10 being the worst what is your pain level: **1 2 3 4 5 6 7 8 9 10**

Is the pain: SHARP DULL BURNING STABBING THROBBING **What makes the pain worse?** _____

Patient Signature: _____ Physician Signature: _____

(Form reviewed with patient)

NEUROLOGY INSTITUTE OF MELBOURNE DR. RICHARD M. UNGER, JR., M.D.

NAME: _____ DATE: _____

MEMORY (COGNITIVE) ASSESSMENT

Can you handle **DRIVING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **COOKING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **FINANCES** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **MEDICATIONS** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **FEEDING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **DRESSING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **BATHING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Can you handle **TOILETING** on your own: **YES** **NO** Do you need assistance?: **YES** **NO**

If yes, explain: _____

Patient Signature: _____ Physician Signature: _____

(Form reviewed with patient)

NEUROLOGY INSTITUTE OF MELBOURNE DR. RICHARD M. UNGER, JR., M.D.

NAME: _____ DATE: _____

HEADACHE ASSESSMENT

Do you get headaches? **YES** **NO** If yes, please fill out the form below.

What side is your headaches? **RIGHT** **LEFT** **BOTH SIDES**

On a scale of 1-10, 10 being the worst what is your headache pain level: **1 2 3 4 5 6 7 8 9 10**

Where are your headaches located on your head? **FRONT** **BACK** **SIDE** **EYES** **FACE** **TEMPLES**

How often do you experience headaches? _____ How Long do the headaches last? _____

How long have you had headaches? _____

What type of pain is the headaches? **SHARP** **DULL** **THROBBING**

Do you have any of the following (circle all that apply):
LIGHT SENSITIVITY **SOUND SENSITIVITY** **SMELL SENSITIVITY** **NAUSEA/VOMITING**

Are your headaches sudden or gradual in onset? **SUDDEN** **GRADUAL**

Do you have an aura (warning before headache) such as flashing lights? **YES** **NO**

Do you have other symptoms with the headaches? **VISUAL DISTURBANCE** **SPEECH DISTURBANCE** **FOCAL WEAKNESS/NUMBNESS** PLEASE CLARIFY: _____

What do you take for your headaches when they occur to get them to go away?

_____

List all preventative (daily) medications you are currently taking.

_____ _____

List all preventative (daily) medications you have taken for headaches in the past.

_____ _____

Since last visit has the frequency of the headaches increased or decreased? **INCREASED** **DECREASED** **SAME**

Any change in the type of headaches since last visit? _____

Patient Signature: _____ Physician Signature: _____
(Form reviewed with patient)

NAME: _____ **DATE:** _____

PARKINSON'S ASSESSMENT

Do you have Parkinson's disease? **YES NO**

If yes, what year were you diagnosed? _____

Do you have a DBS (Deep Brain Stimulator)? **YES NO**

When was it implanted? _____ By Whom? _____

What medication are you taking for Parkinson's? **LIST DOSAGE AND TIME(S) OF DAY TAKEN**

Sinemet (carbidopa / Levodopa) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Sinemet CR (long acting Carbidopa / Levodopa) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Mirapex (Pramipexole) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Requip (Ropinerol) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Neupro (Rotigotine) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Azilect (Rasagiline) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Eldepryl (Selegiline) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Symmetrel (Amantidine) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Comtan (Entacapone) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Artane (trihexyphenidyl) ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Apokyn (Apomorphine) Injecton ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Tasmar (Tolcapone) Injection ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Rytary ____**MG Exact Time(s) of day taken / how many pills each dose**_____

Does the medication control your symptoms from dose to dose? **YES NO**

If not, what symptoms are you experiencing in between doses? _____

Do you have dyskinesia (uncontrolled abnormal snake like movement)? **YES NO**

Do you experience hallucinations or delusions? **YES NO**

Do you get episodes of lightheadedness when you stand up? **YES NO**

Do you have memory loss? **YES NO** If so, how long? _____

Patient Signature: _____ Physician Signature: _____

(Form reviewed with patient)