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: _____

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

Financial Policies

We are happy that you have chosen Dr. Unger as your neurologist and we strive to give you the best medical care. We understand that in addition to needing to feel comfortable with your physician, you may have concerns about eh financial policies of our practice.

Our office collects co-payments/co-insurance at the time services are rendered. Any amount not collected at the time of service may be subject to a $25.00 service fee. We accept cash and all major credit cards. **WE DO NOT ACCEPT PERSONAL CHECKS.**

For all services rendered to minor patients, we will ask the accompanying adult for payment including any past due balances. We will not get involved in arrangements between divorced parents or custodial agreement's.

In order to accurately and efficiently bill your insurance, we MUST see your insurance card and photo ID at each visit. If you do not have your insurance card and/or photo ID at the time of the visit, the visit may be expected to be paid in full.

If your visit is auto or workman's compensation related we must be informed immediately or the charges will be the responsibility of the patient. We will **NOT FILE WORKERS COMPENSATION** to a patient's major medical insurance. The charges for auto related visits will be billed to your auto insurance initially and as a courtesy to your major medical insurance (if we are in network) after PIP is exhausted. We must have the following information prior to billing your auto insurance: auto insurance company, claim number, adjuster's name, phone number and fax number. All balances are the responsibility of the patient. **WE DO NOT ACCEPT LETTERS OF PROTECTION FROM ATTORNEYS.**

Any services that we file with your primary insurance company that are not responded to after 90 days from the date of service may be transferred to the 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 the payment is forthcoming from them. Filing with a secondary insurance is a courtesy and any secondary insurance that has not paid within 90 days after primary payment was made will be the patient's responsibility. We will NOT resubmit claims to secondary insurance companies.

Any balances not paid within 90 days will be forwarded to our collection agency unless prior arrangements have been made with our office and/or our billing company. The collection fee will be the responsibility of the patient. This includes collection agency fees, interest, etc. **PLEASE NOTE ONCE AN ACCOUNT HAS BEEN SENT TO THE COLLECTION AGENCY, YOU WILL NEED TO CONTACT THEM DIRECTLY, WE ARE UNABLE TO NEGOTIATE ANY ACCOUNT ARRANGEMENTS ONCE THE ACCOUNT IS IN COLLECTIONS. WE CANNOT SCHEDULE OR SEE PATIENTS IN COLLECTION STATUS. COLLECTIONS MUST BE CLEARED PRIOR TO THE PATIENTS ARRIVAL FOR HIS/HER APPOINTMENT. PATIENTS WITH A HISTORY OF BEING IN COLLECTIONS MAY BE DISCHARGED FROM THE PRACTICE.**

A monthly statement will be sent to you from our billing company detailing unpaid charges. If you have any questions regarding your statement, please call the billing company directly. The billing company phone number will be listed on your statement. If you have any questions regarding items that have not been paid by your insurance company, please call your insurance company directly.

NON-COMPLIANCE WITH THIS FINACIAL POLIY MAY RESULT IN BEING DISCHARGED FROM THE PRACTICE.I have read and understand the financial policies of the practice and agree to be bounded by these terms. I understand that such terms may be amended at will by the practice at any time.

Patient Name _____

Patient Signature _____ Date _____

Neurology Institute of Melbourne
Office Policies

APPOINTMENTS: As a courtesy, we allow 15 minutes for lateness. After 15 minutes, we reserve the right to reschedule the appointment, and you will be billed a "missed appointment" fee. We have a reminder call program in place, also as a courtesy, whereby all of the patients are called 2-3 days prior to 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 the appointment. If you do not call and cancel a scheduled appointment at least 24 hours in advance, not including weekends, you will be charged a missed appointment fee. Do not leave a message with the answering service. You must call and directly speak with our office staff at least 24 hours before to cancel an appointment. If you do not call and cancel your appointment at least 24 hours in advance, you create a vacancy in our schedule which would have been otherwise filled by another sick patient. Failure to keep scheduled appointments may result in being discharged from the practice. For this reason, it is our policy to charge the missed appointments as follows:

$100 FOR MISSED FOLLOW UP APPOINTMENT
$200 FOR EACH MISSED TEST (EMG/NCS STUDY)

INSURANCE: We accept many private insurances, **NOT** including Health First, Humana, Medicaid, Florida Blue Select and all HMO commercial/Medicare plans to name a few. Many insurance companies that we are in network with are writing plans we are **NOT** in network with. Insurance companies are constantly changing their network of participating physicians. Therefore, it is the responsibility of the patient to contact their insurance company directly to verify that Dr. Unger is a network provider for that plan. If any reason your insurance company or health plan refuses payment, you are responsible for the balance of payment services rendered, including any and all service charges, interest fees, and missed appointment fees. It is also the patient's responsibility to provide proof of current insurance cards and a valid photo ID at each appointment. **Scanned photo copies are not considered valid proof.** If this information is not available, please make arrangements with the receptionist to utilize a private pay option to be paid at the time of the appointment. There is a discount for private pay patients that do not have medical insurance. All payments are due at the time of service and we do not bill private pay patients. For all private pay patients, payments must be cash or credit card, **NO PERSONAL CHECKS.** We do not accept Medicaid of any kind. All co-payments must be paid at the time of service or a $25.00 service charge will be billed.

MEDICAL RECORDS: All request for medical records must be in writing and can take up to 14 business days to process. Medical records to/from another physician may be requested by completing a form in our office. As a courtesy, we provide the first copy of you medical record at no charge. Our office charges for reproducing additional copies of medical records at $1 per page for the first 25 pages and $0.25 for each additional page. Payment for these records must be paid in advance with cash or credit card. Forms submitted to Dr. Unger to be completed can take up to 2 weeks. The fee for these forms are as follows:

$75.00 FOR THE FIRST PAGE
$50.00 FOR EACH ADDITIONAL PAGE

FILM RE-READ FEE: In order to provide you with the best medical care, Dr. Unger reads **ALL** films (MRI/CT) including those that 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 company deny payment for these services, your maximum responsibility will not exceed $50.00 per scan.

NON-COMPLIANCE WITH THESE OFFICE POLICES MAY RESULT IN DISMISSAL FROM THIS PRACTICE.
I have read and understand the financial policies of the practice and agree to be bounded by these terms. I also understand and agree that such terms may be amended at will be the practice at any time.

Patient Name _____

Patient Signature_____ DATE _____

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: _____

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: _____

(Forms reviewed with patient)

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

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)