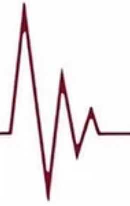
NeuroTek Inc.



Neurological Office & Diagnostic Testing Center

Board Certified Neurology
Dr. Victor Maquera, MD
Amanda Hall, APRN
1210 Kingsley Ave. Orange Park FL 32073
Email: Neurotekoffice@gmail.com

PERSONAL INFORMATION: ***DATE:*** ____________________

BIRTH SEX (CIRCLE): MALE FEMALE CURRENT GENDER: ____________________

FIRST NAME: ____________________ MIDDLE I.:______ LAST NAME:____________________

DATE OF BIRTH:____________________ SEX: ___ MALE ___ FEMALE

ADDRESS:____________________

CITY:____________________ STATE:__________ ZIP: ____________________

HOME PHONE: ____________________ WORK PHONE: ____________________

CELL PHONE:____________________ EMAIL: ____________________

Patient's Pharmacy of Choice: ____________________
Name of Pharmacy Street Address of Pharmacy Phone of Pharmacy

Primary Care Physician (Name and Phone #) ____________________

PATIENT'S SOCIAL SECURITY NUMBER: __________ - ____ - __________

TRICARE ONLY SPONSORS SOCIAL SECURITY NUMBER: __________ - ____ - __________

SPOUSE INFO *(MUST FILL OUT IF THEY ARE YOUR EMERGENCY CONTACT):*
IS YOUR SPOUSE A PATIENT AT THIS CLINIC? ___ YES ____ NO

FIRST NAME: ____________________ MIDDLE I.:______ LAST NAME:____________________

PHONE: ____________________ EMAIL: ____________________

EMERGENCY CONTACT INFO:
IS YOUR SPOUSE YOUR EMERGENCY CONTACT ? ___ YES (IF YES, NO NEED TO FILL OUT BELOW) ____ NO

FIRST NAME: ____________________ MIDDLE I.:______ LAST NAME:____________________

HOME PHONE: ____________________ WORK PHONE: ____________________

CELL PHONE:____________________ EMAIL: ____________________

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Neurotek, Inc. When you schedule an appointment with Neurotek, Inc. we set enough time aside to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our appointment.cancellation/no show policy below:

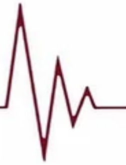
- Patients who are more than 15 minutes late for their scheduled appointment time **will** be rescheduled.
- Effective January 1, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office **with at least 24 hours notice** will be considered a "No Show" and **charged a $25.00 fee.**
- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office **with at least 24 hours notice a second time** will be **charged a $50.00 fee.**
- **If a third** no show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Neurotek, Inc.
- Any new patient who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and IS **DUE at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience circumstances please contact our office manager, who may be able to waive the No Show Fee. You may contact Neurotek, Inc. 24 hours a day, 7 days a week at the phone below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message. Messages left will be considered acceptable.

NEUROTEK, INC. 904-276-1663

I HAVE READ AND UNDERSTAND THE MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY & AGREE TO ITS TERMS.

______________________________	______________________________
SIGNATURE	**RELATIONSHIP TO PATIENT**
______________________________	______________________________
PRINTED NAME	**DATE**



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ASSIGNMENT OF BENEFITS

I, ____ HEREBY INSTRUCT AND DIRECT MY INSURANCE COMPANY PURSUANT TO FLORIDA STATUTE S.S.627.422 TO PAY BY CHECK OR DRAFT MADE OUT TO AND MAILED DIRECTLY TO:

NEUROTEK
DR. VICTOR MAQUERA
1210 KINGSLEY AVE
ORANGE PARK, FL 32073

FOR PROFESSIONAL OR MEDICAL SERVICES, AND ANY REIMBURSEMENTS OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED BY HIM. THE PAYMENT IS NOT TO EXCEED MY INDEBTEDNESS TO THE ABOVE PROVIDER.

I HEREBY ASSIGN ALL RIGHTS AND BENEFITS THAT I HAVE UNDER MY GROUP HEALTH, HMO PLAN, INDIVIDUAL HEALTH, PIP, DISABILITY OR ANY OTHER HEALTH OR MEDICAL PLAN OR POLICY OR REIMBURSEMENT PLAN THAT MAY PAY PATIENT BENEFITS FOR SERVICES AND TREATMENT THAT I HAVE RECEIVED OR WILL RECEIVE FROM THE ABOVE NAMED PROVIDER OR PROVIDERS WHO WORK FOR/UNDER STATED COMPANY NAME OF NEUROTEK, INC.

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY INSTRUCT AND DIRECT YOU TO MAKE THE CHECK PAYABLE TO ME AND THE ABOVE NAMED PROVIDER AND MAIL IT TO THE ADDRESS INDICATED ABOVE.

THE ASSIGNMENT INCLUDED BUT IS NOT LIMITED TO ALL RIGHTS TO COLLECT BENEFITS DIRECTLY FROM MY INSURANCE COMPANY OR HMO FOR THOSE SERVICES AND TREATMENTS THAT I HAVE RECEIVED AND ALL RIGHT TO PROCEED AGAINST MY INSURANCE COMPANY OR HMO IN ACTION INCLUDING LEGAL SUIT IF FOR ANY REASON MY INSURANCE COMPANY OR HMO FAILS TO MAKE PAYMENT OR BENEFITS THAT ARE DUE TO THE ABOVE NAMED PROVIDER/PROVIDERS/COMPANY. THIS ASSIGNMENT ALSO INCLUDES THE RIGHT TO RECOVER ANY ATTORNEY FEES AND COSTS FOR SUCH BROUGHT BY THE PROVIDER AS MY ASSIGNEE.

I ALSO AGREE THAT THE ABOVE MENTIONED PROVIDER BE GIVEN POWER OR ATTORNEY TO ENDORSE/SIGN MY NAME ON ANY AND ALL CHECKS FOR THE PAYMENT OF SERVICES PROVIDED BY HIM/HER.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY. ALL SELF PAY PATIENTS ARE EXPECTED TO PAY FOR SERVICES IN FULL AT THE TIME OF SERVICES ARE RENDERED. ULTIMATELY PAYMENT RESPONSIBILITY RESTS WITH YOU THE PATIENT.

I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION PERTINENT TO MY CASE OR CLAIM TO DR. VICTOR MAQUERA OR ANY ATTORNEY INVOLVED WITH THE CASE. A PHOTOCOPY OF THE ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I HEREBY AUTHORIZE THE ABOVE NAMED PROVIDER TO FILE ANY INFORMAL COMPLAINTS THAT ARE NECESSARY TO THE INSURANCE COMMISSIONER'S OFFICE OR ANY OTHER AGENCY OR COURT THEY DEEM APPROPRIATE ON MY BEHALF.

SIGNATURE OR PATIENT OR GUARDIAN____________________________________**DATE**____________________

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CONSENT PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS

I, ______________________________ consent to the use or disclosure of my protected health information by NeuroTek, Inc. and Dr. Maquera for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conducting health care options. I understand that diagnosis or treatment of me by Dr. Maquera's office and NeuroTek, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

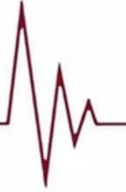
I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. NeuroTek, Inc. is not required to agree to the restrictions that I may request. However, if NeuroTek, Inc. agrees to the restrictions that I may request, the restriction is binding on Dr. Maquera and NeuroTek, Inc.

I have the right to revoke the consent , in writing, at any time,except to the extent that NeuroTek, Inc. has taken action in reliance to this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review NeuroTek, Inc.'s and Dr. Maquera's Notice of Privacy Practices prior to signing this document. NeuroTek, Inc. and Dr. Maquera's Notice of Privacy Practices can be provided to me at any time. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations by NeuroTek, Inc. and Dr. Maquera's Office. The notice of Privacy Practices for NeuroTek, Inc. and Dr. Maquera's Office is also provided at 1210 Kingsley Ave Orange Park Fl 32073. The notice of Privacy Practices also describes my rights and the duties of NeuroTek Inc. and Dr. Maquera's Office with respect to my protected health information. NeuroTek Inc. and Dr. Maquera's office reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling NeuroTek Inc.'s office and requesting a revised copy to be mailed to my address on file or by asking for one at the time of my appointment.

______________________________________ ________________________
Patient Signature Date



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RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications (ie. narcotics, tranquilizers, and barbiturates) are useful in relieving pain, thus improving function and/or ability to work. They have a high potential for misuse and are, therefore, closely controlled by local, state, and federal government. Because my physician is prescribing controlled substance medications to help manage my pain, I agreed to the following conditions:

1) I am responsible for the controlled substance medications prescribed to me. If my prescription is lost, misplaced, stolen, or if I "run out early", I understand that it will not be replaced.
2) Refills of controlled substance medications:
   a) Will be made only during regular office hours Monday through Friday, as well as in person, once a month, during a scheduled office visit. Refills will not be made during nights, weekends, or during holidays.
   b) Will not be made if I "run out early", Lose a prescription, spill, or misplace by medication.
   c) Will not be made as an "emergency", such as Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least 24 hours ahead if I need assistance with a refill.
3) I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is my responsibility to comply with the laws of the state while taking the prescribed medications.
4) I understand that if I violate any of the above conditions, my prescription for controlled substances will be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the reckless use of non-prescribed illicit (illegal) drugs, I may also be reported to all my physician's, medical facilities, and appropriate authorities.

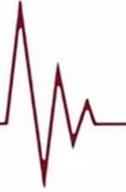
I have been fully informed by my physician and his staff regarding psychological dependence (addiction) of controlled substance medications. I know that some individuals may develop a tolerance to the medications, necessitating a dose increase to achieve desired effect, and that there is a risk of becoming physically dependent on that medication. This will occur if I am on the medication for several weeks. Therefore, when I need to stop taking medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I, ___________________________________, have read this contract, which has been explained to me by my physician. In addition, I fully understand the consequences of violating this agreement.

Patient Signature _____________________________________ Date__________________

Witness Signature _____________________________________ Date__________________

NeuroTek Inc.



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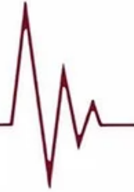
PERMISSION TO SHARE HEALTH INFORMATION
NOTIFICATION OF FAMILY MEMBERS AND/OR FRIENDS.

I have authorized providers and office staff at Neurotek, Inc. to discuss my health information with the following list of persons who may call on my behalf.

NAME	RELATIONSHIP

______________________________ ______________________
Patient Signature DOB

______________________________ ______________________
Witness (Staff) Signature Date



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PAYMENT POLICY

It is our policy to bill your insurance carrier(s) as a courtesy to you, although you are responsible for the entire bill at the time of service. We will file primary and secondary insurance if the information for the filing is given at the time of service. You will be responsible for any balance not paid by your insurance.

We realize, however, that it is not always possible for our patient to pay the full amount at the time of service. We offer the following methods of payment:

1) Cash or check for the total charges at the time of service.
2) All major credit cards.
3) File insurance with your percentage or co-payment due at the time of service.

If we have not yet received payment from your insurance company within 80 days, you will be requested to make payments of the entire bill and seek reimbursement from your insurance company. If you have any questions, please ask a staff member.

________________________________ ____________________
Patient Signature DOB

________________________________ ____________________
Witness (Staff) Signature Date

REVIEW OF SYMPTOMS – Are you currently experiencing the following (Please circle each as appropriate):

Constitutional:
Night sweats
Recurrent fevers
Recent unintentional weight loss

Eyes:
Double vision
Injuries
Glaucoma

Ears, nose, throat:
Hearing loss
Nasal discharge
Throat redness or swelling

Cardiovascular:
Chest pain or pressure
Arrhythmia or palpitations
Leg swelling

Respiratory:
Asthma
Shortness of Breath
Chronic cough

Gastrointestinal:
Abdominal pain
Nausea/vomiting
Heartburn

Genitourinary:
Recurrent urinary tract infections
Blood in urine
Frequent urination

Musculoskeletal:
Joint pain or swelling
Arthritis
Restricted motion

Integumentary:
Rashes
Sores
Blisters

Neurological:
Fainting spells or blacking out
Numbness/tingling
Headache

Psychiatric:
Anxiety
Depression
Hallucinations

Hematologic:
Anemia
Easy bleeding
Clotting disorder

HEIGHT:__________
WEIGHT:_________

PATIENT NAME:______________________

PATIENT SELF-ASSESSMENT (Please answer the following to the best of your ability).

1. *Reason for Visit:* ____
2. Do you have back pain? YES / NO
3. Do you currently take pain medication? YES / NO
4. Do you experience chronic headaches or migraines? YES / NO
5. Do you ever feel dizzy, lightheaded, or have black out spells? YES / NO
6. Do you experience memory loss? YES / NO
7. Have you ever had a stroke? YES / NO
8. Have you ever had a seizure? YES / NO
9. Do you have numbness or tingling in the arms or legs? YES / NO
10. Do you have any pain or swelling in the arms or legs? YES / NO

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PATIENT SELF QUESTIONNAIRE

PATIENT NAME:______________________________

Current Medications (list medication, dosage, and frequency OR write none):

1)____
2)____
3)____
4)____
5)____
6)____
7)____
8)____
9)____
10)____

Past Medical History (list current health problems/diagnoses such as diabetes, anxiety, high blood pressure, etc.):

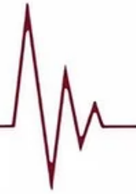
1)____
2)____
3)____
4)____
5)____

Prior Surgeries (previous surgery types OR write "non" if not applicable):

1)____
2)____
3)____
4)____
5)____

Do you smoke cigarettes? Yes or No Frequency:_______________________

Do you drink alcohol? Yes or No Frequency:_______________________



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RECORDS RELEASE AUTHORIZATION

CIRCLE: To or From

____

____
FAX NUMBER

____
ADDRESS CITY ST ZIP

Release TO/FROM:
NEUROTEK INC.
1210 Kingsley Ave. Orange Park FL 32073
Phone: 904-276-1663 Fax: 904-276-2469

Patient to Fill Out:
I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE MY RECORDS:

The complete medical records and best results in your possession, concerning my illness and/or treatment from the first visit to the last visit. This authorization includes the release of records relating to any drug or alcohol treatment,

Last Four of SSN #:______________________________________

Name:____DOB:______________

Address:____
City State Zip

Signature: ______________________________________ Date:______________________
(if relation, state relationship)

Witness: ______________________________________ Date:______________________