IDEAL NEUROLOGY
CLINIC

PERSONALIZED, COMPASSIONATE CARE

Welcome to the Ideal Neurology Clinic!

We are honored to be involved in your neurology care, and we look forward to working with you to ensure you reach your highest potential. We understand that having concerns about your nervous system can be scary. It's our goal to be a partner with you in this time and to provide support.

We strive to meet or exceed your expectations and provide personalized care. A great deal of information is on our website so you can better understand our practice and know what to expect.

To prepare for your first visit, please use this checklist as a guide. We look forward to working with you!

New Patient Checklist

- Please *bring* the following completed forms to your initial visit. This will ensure a complete evaluation. Dr. Chalfin will review them at the time of your visit. For privacy, forms sent ahead of time are not reviewed.
- We operate under a "therapist" model, meaning a certain amount of time is dedicated to each visit. You may be asked to return if an assessment is not completed in the allotted time.

  - ❑ Completed Registration Form
  - ❑ Completed Questionnaires (including Headache, Seizure, Memory, and/or Tremor Questionnaires as relevant to your situation)
  - ❑ Signed Office, Financial, and Cancellation Policies Form
  - ❑ Signed Credit Card Authorization Form
  - ❑ Any and all medications and supplements I take regularly
  - ❑ Copies of prior evaluations including doctor's notes, hospital discharge summaries, laboratory studies, MRI/CT scans (discs appreciated), EEGs, EMGs/Nerve Conduction Studies, and PT/OT/ST assessments

If you have any questions, do not hesitate to ask. I am looking forward to meeting with you.

Warmly,
Renata Chalfin, M.D.

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E-mail: rchalfin@idealneurology.com • Web: https://www.idealneurology.com

Patient Registration Form

Today's Date: ________________________________ DOB: ________________________

Name:___________________________________ Age: _______ R or L handed M F

What should I call you? (First Name, Nickname, Dr., Mr., Mrs., etc.) ___________________________

Primary Care Physician Name: ________________________________ Phone: ________________

SSN: ________________________________ Marital Status: S M Se D W

Address: ____

Cell Phone: ___________________ Home Phone: ___________________ Other:_______________

Email: ____

Employer: ___________________ Address:____

Pharmacy Name and Cross-Streets: ___________________________ Phone:_________________

How do you prefer to be contacted for appointment reminders? Text Email Voice None

Responsible Party (if different than patient)

Name:____DOB:______________________

SSN: _____________________________________

Address: ____

Cell Phone: ___________________ Home Phone:__________________ Other:_________________

Email: ____

Employer: ___________________Address:____________________________________

Emergency Contact

Name:______________________________________Phone #:_____________________________

Address: ____________________________________Relationship:_________________________

Email:____

Consent To Treatment

The undersigned, as patient or guardian of patient, authorizes Dr. Chalfin to evaluate the above-named patient and provide treatment. I authorize release of medical information that may be necessary for continuity of care, for reimbursement from insurers, and as needed for investigations. I assign all medical benefits payable for services to the Ideal Neurology Clinic, PLLC. I permit a copy of this authorization to be used in place of the original. I have reviewed, accepted, and will comply with office policies. I have received the privacy practices. I accept financial responsibility for all charges regardless of insurance, except where prohibited by law.

Patient/Guardian Signature: ____

Date: ____________________________________

Disclosure of Medical Information

I give Dr. Chalfin permission to discuss my medical condition with the following people: (names)

Spouse/Significant Other: ____

Parent(s):____

Sibling(s):____

Children: ____

Other: ____

Place a star next to the one person you would like to make medical decisions on your behalf if you are unable.

Other *medical providers* I would like to receive a copy of my medical notes (include contact info):

I may change this at any time by notifying the office and following up with a written notification.

Patient/Guardian Signature: ____

Date: ________________________________

If you have an advanced directive (living will), please give us a copy. If you would like to create one, the Florida form is here: http://www.caringinfo.org/files/public/ad/Florida.pdf Otherwise:

If I am hospitalized with a terminal condition or am not expected to regain significant functional recovery as determined by my treating physicians, **I DO / DO NOT wish to be resuscitated.**

Primary Care Physician Name: _______________________________ Phone:_______________

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CONSENT TO OBTAIN PATIENT MEDICAL RECORDS

Patient's Name: ____
Last First Middle

Date of Birth: ____

I consent to the medical records of the above named patient to be released to:

Ideal Neurology Clinic, PLLC
rchalfin@idealneurology.com
fax: (561) 898-1710 | phone: (561) 961-8575
P.O. Box 880761
Boca Raton, FL 33433

The records may be emailed, faxed, or mailed. This authorization applies to all healthcare information for the purpose of continued healthcare.

I understand that my express consent is required to release any healthcare information if I have been tested, diagnosed, and/or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release **all** health information relating to such diagnosis, testing, or treatment.

______________________________________ ________________
Signature of patient or guardian Date signed

Relationship to patient: ______________________________

Patient Phone number: ______________________________

General Questionnaire for All Patients – Reason for Visit

Who recommended this evaluation, and why?

What concerns do you have? What goals do you have for this consultation?

How long have you had these concerns? Have you seen any other physician for this problem? Have you received any diagnoses?

What have you tried that has worked or not worked?

Please circle the following tests you have had and make sure you bring **all results** with you to your appointment.

CT/MRI of the brain
CT/MRI of the spine
CT/MRI of neck
Carotid ultrasound
MRA/CTA of the blood vessels
Electroencephalogram (EEG, brain wave study)
EMG/Nerve Conduction study
Lumbar puncture (spinal tap)
Neuropsychological testing
Sleep study

Anyone in your family with similar problems?

Do you experience any other symptoms?

General Questionnaire for All Patients - Health History

Name:______________________________________ Today's Date:_______________

Height:____________________ Current weight:_______________

When filling out the following, please consider your *current* health status as well as your medical *history*, *even if* issues are *resolved.*

Have you **ever** had any of these medical issues? (circle)

Abuse/trauma	Head/neck injury/Concussion	Lung problems
Anxiety	Headaches/Migraines	Meningitis/encephalitis
Arrhythmia/Atrial fibrillation	Heart attack/heart problems	Multiple sclerosis
Autoimmune disease	High blood pressure	Osteoporosis
Birth injury/developmental issue	High cholesterol	Pregnancies
Blood clots	HIV/other infection	Seizures/Epilepsy
Cancer	Kidney disease	Sleep apnea
Depression	Liver disease	Stroke
Diabetes	Loss of consciousness	Thyroid disease

Please explain (include dates):

Any other medical problems?

Surgeries? (include dates):

Have you been hospitalized for anything besides surgery?

List allergies:

____

List current medications: (can attach a list or continue on the back). Please include pain medications, over the counter medications, vitamins, herbal supplements, etc.

Medication Name   Pill strength   # pills   Frequency of doses

1.____

2.____

3.____

List **family members** who have had the following: (M= mother, F = father, B = brother, S = sister, etc)

Alcohol or substance/drug addiction:	Memory problems/Alzheimer's disease:
Anxiety, depression or suicide:	Multiple sclerosis:
Blood clots:	Premature death:
Cancer (include type):	Seizures:
Diabetes:	Stroke:
Headaches:	Thyroid problems:
Heart attack/problems:	Other illnesses:

Who lives at home? Describe your home life: ____

Spouse/Significant Other:____

Children's Names:____

Where are you from originally?______________________ Ethnicity?______________

Religion/spirituality?______________________________Rabbi/priest/clergy:_____________________

What's the highest level of education you had?____

Previous/current occupation:__________________________ Satisfied?_________________________

Sleep quality?______________________ How many hours?____

What are your exercise habits?________________________ Diet?_____________________________

How much caffeine do you consume?______________________ Any energy drinks?_______________

How's your stress level?____

What are your stressors?____

How do you relieve stress?_______________________What do you do for fun?___________________

Health risks:

1. Do/did you use tobacco? Yes No Type?____

Amount?__________________________How many years?______Quit date:________________

2. Do/did you drink alcohol? Yes No Type? ______________________________________

Amount?__________________________How long? _____________Quit date:_______________

3. Do/did you use street drugs or other substances? Yes No Type/route?_______________

____Quit date:_______________

4. Any other bad habits or addictions? ____

5. How many sexual partners have you had in the last 12 months? ______In your lifetime? ____
   Do you use any sexual protection?____________________

6. Exposures: Have you ever been exposed to chemicals, or traveled to any places where there are risks of infection? ____

7. Do you have firearms in your home? Y | N Locked & unloaded? Y | N

8. Do you *or anyone in your life* have concerns about your driving safety? Y | N
   Explain (accidents? tickets? getting lost?)____
9. Do you need assistance paying bills, doing household chores, getting dressed/showering, eating, toileting, etc? Do you use any medical equipment?

Vaccines up to date? Y | N Flu shot? Y | N Pneumonia shot? Y | N Shingles shot? Y | N

Date and result of last: (NL = normal; ABNL = abnormal)

Eye exam	NL | ABNL	Mammogram	NL | ABNL
Dental exam	NL | ABNL	Pap smear	NL | ABNL
Hearing exam	NL | ABNL	PSA	NL | ABNL
Cardiac stress test or EKG	NL | ABNL	Sleep study	NL | ABNL
Colonoscopy	NL | ABNL		

General Questions – Share if you are willing

What are your health goals?

What is your life purpose?

Anything else you wish to share?

Ladies:

OB/Gynecologist name____Phone___________________

Age of first menstrual period_________ Date of last menstrual period_____________________________

Are you planning to become pregnant? Y | N When? _______________

What form(s) of birth control do you use?____

How many pregnancies have you had? ________________________ Are you breastfeeding? Y | N

Review of Systems

(circle any symptoms in the last month)

General/Constitutional
Weight +/- ____lbs
Change in appetite
Fatigue
Fever/chills
Night sweats

Ophthalmologic
Vision loss
Blurry vision
Double vision
Eye pain
Eyelids drooping

HEENT
Pain/Difficult swallowing
Pain/Difficulty chewing
Loss of smell
Hearing loss
Ringing in ears
Snoring
Dry mouth
Change in voice

Respiratory
Shortness of breath
Cough
Bloody sputum

Cardiovascular
Chest tightness
Palpitations/Irregular Heartbeat
Leg swelling

Gastrointestinal
Abdominal pain
Difficulty controlling bowels
Nausea/vomiting
Diarrhea
Constipation
Blood in stool
Black stools

Genitourinary
Frequent urination
Leaking urine
Painful urination
Unable to urinate
Sexual dysfunction
Vaginal bleeding

Hematology
Easy bruising
Prolonged bleeding
Blood clots

Musculoskeletal
Back pain
Neck pain
Joint pain
Muscle pain
Weakness
Spasticity

Skin
Moles
Color changes
Rash

Neurologic
Dizziness
Balance difficulty
Change in handwriting
Change in voice
Difficulty speaking
Difficulty with coordination
Falls
Headache
Language difficulty
Loss of consciousness
Memory loss
Numbness/tingling
Seizures
Speech changes
Tremor
Walking difficulty

Psychiatric
Abnormally elevated mood
Anxiety
Depressed mood
Difficulty concentrating
Difficulty sleeping
Hallucinations
Irritability
Mood swings

Endocrine
Heat intolerance
Cold intolerance
Excessive thirst

None of the above.

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Office, Financial, and Cancellation Policies

Patient Name: ____ DOB: _______________

Ideal Neurology Clinic is a private practice dedicated to providing personalized care for patients and their loved ones. Discussing and understanding financial and patient responsibilities is an important step in our partnership, and one that helps to ensure an aligned and sustainable medical relationship.

Please read this thoroughly and ask Dr. Chalfin any questions that you may have.

Patient Visits:

- I understand that Ideal Neurology Clinic participates in select insurance plans as listed on the website. Dr. Chalfin is an out-of-network provider for all other insurance plans.
- I understand that my insurance coverage is a contract between me and my insurance carrier, and that I am responsible for determining my insurance's coverage for services, as well as the amounts of any copays, coinsurance, and deductibles.
- I understand that I am responsible for knowing if referrals are necessary for insurance reimbursement, and for obtaining those referrals.

For participating insurance plan holders:

- I understand services will be submitted to my insurance plan. Copays, coinsurance, and deductibles are my responsibility and will be accepted at the time of service.
- I understand my insurance company will send an Explanation of Benefits (EOB) to both me and your office showing what my total patient responsibility is. If I disagree with the patient responsibility amount owed, it is my responsibility to contact my insurance carrier immediately.
- I understand that some services may not be reimbursed by my insurance plan, and I agree to pay any balances not covered by my insurance plan as outlined in the Fee Schedule.
- I acknowledge that my insurance card must be available at the time of services, or I will be charged the direct-pay rate.

For all other health insurance policy holders:

- I agree to pay for each visit in accordance with the published fee schedule.
- I understand payment is due at the time of service.

_______ Patient or Guardian's Initials

Payment Policy:

- Ideal Neurology Clinic uses a secure, third-party appointment booking program. This company stores your credit card payment information, and only the last four digits of your credit card number can be seen.
- I understand that copays and other out-of-pocket expenses will be charged at the completion of my appointment to the credit card I have put on file.
- I understand that out-of-pocket expenses incurred between visits will be charged to the credit card on file immediately. These expenses include, but are not limited to: no-show/late

cancellation fees, telephone encounters, refills, and forms fees.
- If my participating insurance policy is subject to deductibles and/or co-insurances that cannot be collected at the time of service, I understand that Ideal Neurology Clinic will charge my credit card on file any outstanding balances as outlined on my Explanation of Benefits (EOB).
- I am responsible for understanding my insurance policy's benefits and if referrals or prior authorizations are required.
- I understand that credits on my account will be returned to the credit card on file.
- I agree to update my credit card on file when needed. I will receive a statement in the event my credit card cannot be charged. There will be a **$25 statement fee** added.

_______ **Patient or Guardian's Initials**

Cancellation Policy:
- I understand I will be charged $50 if I cancel less than 48 hours prior to my appointment time, or after 11am on Fridays for Monday appointments.
- I understand that I will be charged 50% of the visit fee if I cancel within 24 hours of my appointment time, or if I no-show for my appointment without cancellation.
- I understand multiple late cancellations or no-shows will result in dismissal from the practice.

_______ **Patient or Guardian's Initials**

Late Arrival Policy:
- Dr. Chalfin wants all patients to have the opportunity to be seen for his/her entire scheduled visit time. Thus, she operates under a "therapist" model, meaning each appointment has a dedicated length of time.
- I understand that arriving late for my appointment may result in my visit being truncated to allow for others to be seen on time.
- I also understand that a shortened visit may result in an incomplete assessment, and I may need to return for further assessment.
- I also understand that if I arrive late for the visit, I may not be seen, and will still be required to pay the late cancellation fee of 50% of the visit.

_______ **Patient or Guardian's Initials**

Telephone and Email Policy:
- I understand that I will often be asked to schedule an appointment if issues or questions arise between scheduled appointment times.
- I understand that the best way to discuss my care is in a scheduled office visit to allow for examination as necessary. I agree to pay an out-of-pocket encounter fee of $50 per 15-minute increment or fraction thereof if I require non-emergent telephone communication between office visits regarding my care.
- I understand that there are inherent privacy concerns in communicating by email, and I will use

the patient portal for any general, non-urgent questions. For more involved matters, I will schedule either an office visit or a telephone encounter.

_______ Patient or Guardian's Initials

Laboratory Results, Refill, Forms, and Paperwork Policy:

- I agree to come to my follow-up appointments or schedule a telephone encounter so I can discuss the results of any of my laboratory results and what they mean to my care.
- I agree to request all refills at the time of my visit. I understand that if I cancel or reschedule an appointment, I may run out of my required medication. I agree to pay $50 for any refill request between appointment times.
- I understand that requesting paperwork and form completion is best done during my appointment. I agree to pay the out-of-pocket fee of $50 for any letters, forms, or other paperwork that require completion by Dr. Chalfin outside of scheduled appointment times. I understand that I can avoid this charge by scheduling an appointment and bringing the forms with me to the office visit.

_______ Patient or Guardian's Initials

Hospital/Emergency Policy:

- I understand that Dr. Chalfin does not go to the hospital. She may recommend I go to the Emergency Room if I am having symptoms of an emergent condition or need to be seen urgently, but my care will be under the hospital physicians.
- Though Dr. Chalfin will make every best effort to communicate with my treating doctors, it is ultimately my responsibility to own my records and carry the names and contact information of my doctors to the ER.

_______ Patient or Guardian's Initials

Controlled Medications/Marijuana Policy:

- Dr. Chalfin does not prescribe opiates or medical marijuana for the treatment of chronic pain, or benzodiazepines for the treatment of chronic anxiety or insomnia. She does not take over the prescribing of these medications from another physician.
- I understand that Dr. Chalfin is required by law to review my prescription refill habits through the Prescription Monitoring Program, even if she is not prescribing me a controlled substance.
- I also understand that Dr. Chalfin always communicates with prescribing physicians about my treatment plan if it is related, even if she is not also prescribing me controlled substances.
- If such medications are required for treatment of my condition, I agree to bring in my medication bottles to each visit for pill counts. Random urine drug screens will also be performed at or

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between office visits to ensure compliance. Any unwillingness to participate in pill counts or drug screens will result in discontinuation of the prescription. Any diversion or abuse of prescribed medications will result in dismissal from the practice.

_______ Patient or Guardian's Initials

Attorneys:

- In the event Dr. Chalfin is required to work with an attorney, or is required to appear in court, the current hourly rate, billed by the quarter hour, will be charged, based on the most recent Attorney Fee Schedule.

_______ Patient or Guardian's Initials

Privacy Practices:

This clinic abides by federal privacy regulations and keeps my protected health information (PHI) confidential. We will safeguard your information and generally only share your information with your verbal or written permission. Exceptions to this include for the purposes of treatment, payment, or healthcare operations, as well as if you are a danger to yourself or others; and if we are obligated to comply with an investigation. You can request a digital copy of your records at no charge.

Violence and Threats

Any threats or aggressive or violent behavior directed toward staff, other patients, or neighboring businesses will result in dismissal from the practice.

Updates

We will update these policies from time to time. You may review the latest policies on request.

I have read and agree to the above financial, billing, and office policies.

____

Patient or Guardian Signature | Name | Date

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CREDIT CARD ON FILE AUTHORIZATION FORM

Today's Date: ___________________

Patient's Name: ____ Date of Birth: _______________

At Ideal Neurology Clinic, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover for which you are liable. This includes, but is not limited to, co-payments, coinsurance, and payments toward your deductible.

Your credit card information is kept confidential and secure. With the exception of payments due at the time of service per our Financial Policies, payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Card Information:

Card Type (circle): Visa Mastercard Discover Amex Other

Name on Card: ____ Billing Zip Code: ____________

Card Number: ____

Expiration Date: ____ CVV/Security Code: ____________

Cardholder Signature: ____

I authorize and request Ideal Neurology Clinic to charge my credit card, indicated above, for balances due for services rendered that are my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Ideal Neurology Clinic.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Ideal Neurology Clinic in writing and the account must be in good standing.

Patient or Guardian's Name (print): ____

Signature: ____ Date: __________________