COVID-19 (CORONAVIRUS) Screening Questionnaire

Have you traveled outside the US within the last month? ☐ Yes ☐ No

Do you have any symptoms of dry cough, fever, shortness of breath or sore throat? ☐ Yes ☐ No

Have you had contact with someone with a confirmed diagnosis of COVID-19 or under investigation of COVID-19? ☐ Yes ☐ No

Have you had contact with someone who is ill with respiratory illness? ☐ Yes ☐ No

Have you had contact with someone who has traveled internationally within the past 14 days? ☐ Yes ☐ No

If you have marked YES to any of the above question, please postpone your appointment for at least 14 days after the start of your symptoms

Have you been vaccinated? ☐ Yes ☐ No

If YES, which vaccine was given? Please circle which vaccine:

Pfizer, Moderna or Johnson and Johnson

Print Patient Name: _____

Patient Signature: _____ Date: _____

Contact your healthcare provider (PCP) if your symptoms get worse

Thank you for your understanding

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PATIENT'S NAME: _____

PATIENT SOCIAL HISTORY:

USE OF ALCOHOL:	☐	NEVER	MODERATELY	☐
USE OF TOBACCO:	☐	NEVER	MODERATELY	☐
USE OF DRUGS:	☐	NEVER	MODERATELY	☐

OCCUPATIONAL HISTORY:

CURRENT EMPLOYMENT:

LEVEL OF EDUCATION:

QUESTIONS OR COMMENTS:

FAMILY MEDICAL HISTORY:

	AGE	DISEASE	CAUSE
FATHER			
MOTHER			
OTHER			
OTHER			

ALLERGIES:

PATIENT'S PAST MEDICAL HISTORY:

Diabetes	☐	NO	YES	☐
Hypertension	☐	NO	YES	☐
Cancer	☐	NO	YES	☐
Stroke	☐	NO	YES	☐
Heart Problems	☐	NO	YES	☐
Convulsions	☐	NO	YES	☐

Other:

PREVIOUS HOSPITALIZATION/ SURGERIES:

MEDICATIONS:

Endocrine Symptoms:

EXCESSIVE THIRST	☐	YES	NO	☐
TEMP. INTOLERANCE	☐	YES	NO	☐

OTHER: _____

Hematologic Symptoms:

EASY BLEEDING	☐	YES	NO	☐
EASY BRUISING	☐	YES	NO	☐

OTHER: _____

Skin Symptoms:

RASH	☐	YES	NO	☐
ITCHING	☐	YES	NO	☐
CHANGE IN COLOR	☐	YES	NO	☐

OTHER: _____

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**Please circle the responses that best fit your symptoms. **

Constitutional Symptoms (Affecting whole body)

FATIGUE	YES	NO
FEVER	YES	NO
WEIGHT CHANGE	YES	NO

OTHER: _____

Eye Symptoms:

EYE DISEASE	YES	NO
GLASSES/CONTACTS	YES	NO
BLURRY VISION	YES	NO
SEEING DOUBLE IMAGES	YES	NO

OTHER: _____

Cardiovascular Symptoms:

CHEST PAIN	YES	NO
COLD EXTREMITIES	YES	NO
PALPITATIONS	YES	NO
SHORTNESS OF BREATH	YES	NO
VARICOSE VEINS	YES	NO

OTHER: _____

Otolaryngeal Symptoms:

BLEEDING GUMS	YES	NO
DRAINAGE	YES	NO
EARACHE	YES	NO
HEARING LOSS	YES	NO
HOARSENESS	YES	NO
JAW PAIN	YES	NO
MOUTH SORES	YES	NO
SINUS PAIN	YES	NO

OTHER: _____

Gastrointestinal Symptoms:

ABDOMINAL PAIN	YES	NO
CHANGE IN BOWEL HABITS	YES	NO
CONSTIPATION	YES	NO
DIARRHEA	YES	NO
LOSS OF APPETITE	YES	NO
NAUSEA	YES	NO

Respiratory Symptoms:

COUGH	YES	NO
SHORTNESS OF BREATH	YES	NO
ASTHMA	YES	NO
WHEEZING	YES	NO

OTHER: _____

Genitourinary Symptoms:

BLOOD IN URINE	YES	NO
FREQUENT URINATION	YES	NO
INCONTINENCE	YES	NO
PAINFUL URINATION	YES	NO
SEXUAL DIFFICULTY	YES	NO

OTHER: _____

Psychiatric Symptoms:

ANXIETY	YES	NO
CONFUSION	YES	NO
DEPRESSION	YES	NO
FEELING NERVOUS	YES	NO
INSOMNIA	YES	NO
MEMORY LOSS	YES	NO

OTHER: _____

Musculoskeletal Symptoms:

BACK PAIN	YES	NO
DIFFICULTY WALKING	YES	NO
JOINT PAIN	YES	NO
JOINT STIFFNESS	YES	NO
MUSCLE CRAMPS	YES	NO
NECK PAINS	YES	NO

OTHER: _____

Neurological Symptoms:

DYSHAGIA	YES	NO
DIZZINESS	YES	NO
HEADACHE	YES	NO
LIGHT HEADED	YES	NO
NUMBNESS	YES	NO
SEIZURES	YES	NO
TREMOR	YES	NO
WEAKNESS	YES	NO

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Patient's Name: _____ Home Phone Number: _____

Work Phone: _____ Cell Phone: _____

Home Address: _____

City/State Zip Code

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐ Date of Birth: _____

Email Address: _____

Would you like access to our Patient Portal? YES NO

Emergency Contact

Name: _____ Phone Number: _____

Pharmacy

Name: _____

Address/Zip: _____

Phone Number: _____

Medical Providers

Physician's Name: _____ Phone Number: _____

Fax: _____

Referring Physician Name: _____

Phone Number: _____ Fax Number: _____

Insurance Information:

Type: HMO PPO POS MEDICARE W/C AUTO

Insurance name: _____ Phone Number: _____

ID # _____ Group Number: _____

If W/C AND AUTO

Claim Number: _____ Adjuster Name: _____

Phone Number: _____ Date Of Accident: _____

We ask all patients to show their insurance cards and driver's license so that we can make copies of them. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any services rendered. I have read all the information of this sheet and have completed the answers above. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature Date

_____ _____

Parent Signature (if minor) Date

NEUROSCIENCE

RECORDS RELEASE AUTHORIZATION

TO: _____

DOCTOR OR HOSPITAL

_____

ADDRESS

I HEREBY AUTHORIZE AND REQUEST YOU TO REALEASE TO:

-DESIGN NEUROSCIENCE CENTER

[ ] KESTER NEDD, D.O

[ ] SREEPADMA SONTY, M.D.

[ ] BRUCE RUBIN, M.D.

[ ] IVELISSE RAIMUNDI, PSY.D

[ ] OMAR BAEZ, M.D.

[ ] ISAAC TOURGERMAN, PSY.D

[ ] CARLOS OLIU, M.D.

[ ] PAMELA YOUSSEF, M.D.

DESIGN NEUROSCIENCE CENTER
8875 NW 23RD ST
DORAL, FL 33172
PHONE: 305-653-5155
FAX: 305-653-5513

THE COMPLETE HISTORY OF RECORDS IN YOUR POSSESION, CONCERNING MY ILLNESS AND/OR TREATMENT DURING THE PERIOD:

FROM: _____ TO: _____

NAME: _____ DATE: _____

ADDRESS: _____

DOB: _____ SS# _____

SIGNATURE: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), for your physician or staff of DESIGN NEUROSCIENCE CENTER to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization before doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the lay stipulates that these rules may be waived.

☐ **I DO NOT authorize Design Neuroscience center to release any information concerning my medical care to any individual except as set forth above.**

☐ **I DO authorize Design Neuroscience center to release any information concerning my medical care to the following individual(s):**

_____	_____
Name- Please Print	**Name- Please Print**
_____	_____
Relationship to Patient	**Relationship to Patient**
_____	_____
Phone Number	**Phone Number**
_____	_____
Patient Signature	**Date**

Design Neuroscience Center has my permission to leave a voicemail message regarding my health information or my results at my phone # _____. Please initial ☐ YES ☐ NO

Design Neuroscience Center

HIPPA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____

(PRINTED NAME)

_____ Date_____

(SIGNATURE)

Office Policies:

We strive to give our patients quality care at affordable rates. We also have very qualified insurance personnel that are always willing to help answer any questions/concerns that you may have.

1.) **Please make sure to notify our front office of any changes in the status of your insurance policy that would affect coverage during your treatment.**

2.) **We will verify coverage and benefit information before your appointment; however, your insurance is your responsibility. We encourage you to be aware of your insurance policy requirements and limitations for specialty office visits and therapy as you will become responsible if they do not pay in a timely manner, or if they deny payment for various reasons.**

3.) **All co-pays, coinsurance, and deductibles are expected to be paid when services are rendered.**

4.) **The patient is responsible for obtaining and maintaining referrals required by your insurance company. You will also need to notify our office if precertification is required for any appointments. Failure to obtain a referral or precertification will result in denial of your claim and you will be responsible for your bill.**

5.) **If you are here due to a car accident, we will need the claim number from your car insurance, claim address and the phone number to the claim representative.**

6.) **The patient is ultimately responsible for charges incurred regardless of the insurance involved.**

7.) **For any medication refills please have the pharmacy fax us the request to 305-653-5513 at least 72 hours in advance**

Our staff will do all that we possibly can to make this as convenient as possible. If there is something about our policy or your insurance that you do not understand, let us know and we will try to help.

I have read and I understand the financial policies of Design Neuroscience Center and agree to abide by these terms.

Patient's Signature **Date**

8875 NW 23rd Street, Doral, Florida 33172
Telephone (305) 653-5155, Fax (305) 653-5513.

Design Neuroscience Center

GENERAL CONSENT FOR TREATMENT

I, the undersigned patient or _____ (name of authorized representative acting on behalf od patient) consent to undergo all necessary test, treatments and other procedures in the course of the study, diagnosis and treatment of my illness(es) by the medical staff and other agents and / or employees of DESIGN NEUROSCIENCE CENTER, including medical and graduate level students.

☐ I further understand that this is a teaching facility, and that training doctors and others, is one of the activities of the clinic, and I agree to cooperate to the best of my ability,

☐ I hereby grant to members of the medical staff and other medical researchers, access to my medical records for purpose of bona fide research, However, my records may not be identified as pertaining to me specifically, without my expressed permission.

_____ _____

Signature of Patient Date

DISCLOSURE & ACKNOWLEDGEMENT FORMS

I hereby attest and affirm that:

The services set forth in the medical bills on this date were rendered.
I understand that I have a right and an affirmative duty to confirm the services for which I am being billed, or are being billed to my insurance carrier, have actually been rendered.
I was not solicited by any person to seek any serviced from the above-named medical provider.
The physician, other licensed professional, clinic or other medical institution rendering services, for which payment is being claimed, have explained the services rendered to me.
I understand that, if I notify the insurer in writing of a billing error, I may be entitled to a certain percentage of the reduction in the amounts paid by my motor vehicle insurance.

_____ _____

Signature of insured patient or guardian Date

_____

Witness

Design Neuroscience Center

NON-COVERED SERVICES

INSURANCE DISCLAIMER:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a service is not reasonable or necessary, or that a service is not covered under your plan, or MAXIMUM ALLOWED HAS BEEN EXHAUSTED your insurer will deny payment for that service. Ex: Therapeutic injections/ Blocks.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally responsible for payment. In addition to this, I am fully aware that I am responsible for any co-payment, deducible, or coinsurance that my insurance applies to my charges.

_____ _____

Print Name Signature

Insurance Grace Period

As per Florida Blue:

"any claims that are incurred during in the members first month of grace period will be processed according to the terms of the members contract". "Claims incurred during the second and third month of grace period will be pended until full premium is paid by the member. If premium is paid in full by the end of the grace period, all claims will be processed". "If premium is not paid in full by the end of the grace period any claims incurred may be denied and provider may seek reimbursement directly from the member."

☐ I have read and understand the above statement regarding my insurance being in grace period. I agree that if any claims incurred while in the grace period are denied I will be responsible for complete payment.

_____ _____

Print Name Signature

_____ _____

Date Witness

Design Neuroscience Center

Assignment of Benefits Form

Patient Name: _____ **Date** _____

I hereby instruct and direct _____ **Insurance Company to pay by check made out and mailed to: Design Neuroscience Center**

OR

if my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows to:
Design Neuroscience Center *8875 NW 23 ST, Doral, Florida 33172*

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I declare that I am a claimant and/or insured who has signed below and I have constituted and appointed the above captioned medical provider and/or it's; employees and/or billing agent(s) (hereafter "medical provider"), and I grant the medical provider authority to execute ALL HCFA forms necessary in the processing of my medical insurance claims.

BY SIGNING BELOW, I HAVE READ, UNDERSTOOD, AND AGREED TO ALL OF THE ABOVE

_____ _____
Patient Printed Name **Date**

_____
Patient (Claimant and/or insured Signature

_____ _____
Witness Printed Name **Witness Signature**

Design Neuroscience Center

Form Charge Statement

Company policy for Design Neuroscience Center patients with regards to Forms or Letters which require your providing Doctor to state your medical status or functional ability will incur cost/charge to you the patient at the office managers discretion.

1. Standardize Temporary Disability Forms and FMLA Forms ... $100.00
2. Immigration Letter/ Citizenship Form $200.00
3. Jury Duty Accommodations Letter $25.00

Please be advised that this Document serves as a notification of company policy to which your acknowledgement is required by signature.

I _____, here by acknowledge this document as a formulary policy by Design Neuroscience Center and verify that any letter of accommodation for my medical condition can and will be charge a fee as specified above.

_____ _____

Patient Signature Witness