ATIT NEUROLOGY
Vikram M. Atit M.D., P.A.
Telephone: (727) 937-4600
Fax: (727) 937-3312

NEW PATIENT INFORMATION

Date: _______________

Patient: (Last Name) ______________________ (First Name) __________________ (MI) ______

Address: ____

City: _______________________________ State: __________________ Zip: __________________

Home Phone: _______________________________ Cell Phone: ____________________________

Social Security Nbr: _________ - ___________ - __________ Date of Birth: ____ / ____ / _____

Marital Status: S M D W SEP HT: ___________ WT: ____________

Personal Email: ____

Primary Care Physician: ____

Referring Physician: ________________________ Reason for Visit: __________________________

Notify in case of Emergency: ____________________________ Relationship: _________________

Address: ____ City: _________________________

State: __________________ Zip: _____________________ Tel: _____________________________

Pharmacy: _________________________ City: __________________ Tel: ____________________

Mail order or specialty pharmacy: ____

Telephone: ___________________________________ Fax: _________________________________

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MEDICAL HISTORY FORM

Date: _______________

Patient: (Last Name) _____________________ (First Name) _________________ (MI) ______

Do you have any of the following? (Please circle all that apply)

General Health:

Change in appetite Fatigue Night Sweats Sleep Disturbance Weight gain or Loss Lbs: ___

Ophthalmologic:

Blurred vision (RT Eye) (LT Eye) Flashes of light Floaters in the visual field Eye Pain (RT) (LF)

Ears / Nose / Throat:

Hearing Loss Decreased sense of Smell Difficulty Swallowing Dry Mouth Ringing in Ears

Cardiovascular:

Irregular Heartbeat Palpitations Fluid accumulation in Legs Skin Color turning Blue

Gastrointestinal:

Constipation Diarrhea Heartburn Nausea Vomiting Rectal Bleeding

Musculoskeletal:

Joint Stiffness Leg Cramps Muscle Cramps Painful Joints Swollen Joints Weakness

Peripheral Vascular:

Cold Sensation in Hands Feet Pain in Hands Feet Decreased Sensation in Hands Feet

Podiatric:

Ankle Swelling (RT) (LF) Burning in Feet (RT) (LF) Foot Numbness (RT) LF) Foot Pain

Skin:

Dry Skin Rash Skin Lesion Hives Itching Sun Sensitivity Skin Cancer

MEDICAL HISTORY FORM

Neurologic:

Balance Difficulty   Lack of Coordination   Difficulty Speaking   Dizziness   Fainting

Gait Abnormality   Headache   Irritability   Strength Loss   Loss of Use of Extremity   Pain

Lower Back Pain   Memory Loss   Seizure   Tics   Tremors   Temporary Loss of Vision

Tingling / Numbness Where? ____

Psychiatric:

Anxiety   Depressed Mood   Eating Disorder   Substance Abuse   Suicidal Thoughts

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MEDICAL HISTORY FORM

Date: _______________

Patient: (Last Name) _____________________ (First Name) _________________ (MI) ______

Do you Smoke? (Please circle all that apply)

Current Smoker   Ex Smoker   Non Smoker   If Smoker or Ex How Long? _____________

Do you Drink? (Please circle all that apply)

Daily   Weekly   Monthly   Socially   Never

Medication:

Allergies: ____

Please list current medications including strength and dose:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____
14. ____

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PERMISSION FOR TREATMENT AND RELEASE OF HEALTHCARE INFORMATION

I, the undersigned, hereby voluntarily consent to medical care, diagnostic treatment, random drug testing, and or minor surgical treatment by Dr. Vikram M. Atit, and his staff deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the release of any of my past/current medical records that are needed for my treatment from any other healthcare providers. I grant permission to view external prescription history and to use Baycare eHX to access all my health records.

Signature: ____ Date: _________________________

AUTHORIZATION AND ASSIGNMENT

I request that the payment of authorized Medicare/Insurance be made either to me on my behalf for any services furnished by Dr. Vikram M. Atit. I authorize any holder of medical information about me to release to CMS/Insurance carriers and its agents any information needed to determine their benefits related to services. I hereby authorize Dr. Vikram M. Atit to furnish information to medical providers, Medicare/Insurance carriers and pharmaceutical companies/pharmacies concerning my medical condition, illness and treatment to determine the benefits for related services. I hereby authorize my Insurance carriers / Medicare to make payment directly to: Dr. Vikram M. Atit for medical / diagnostic / surgical benefits payable for the services rendered. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of and professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for and returned checks. I understand that Medicare and/or other insurance carriers do not cover all services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to this physician's office for services. I certify that the information I have given here is true and correct to the best of my knowledge. I will also notify you of any changes in my status of changes in the above information.

Signature: ____ Date: _________________________

DESIGNATED RELATIVE

I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with: ( ) Spouse ( ) Children ( ) Other: ____

Please list family members or significant others, if any, whom we may inform of your medical condition.

Name: ____ Phone Number: ______________________________

Name: ____ Phone Number: ______________________________

Signature: ____ Date: _________________________

PRIVACY NOTICE

I have read / received a copy of Dr. Vikram M. Atit's office privacy notice.

Signature: ____ Date: _________________________

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FEE SCHEDULE

The following fees will be applied for additional services as outlined below. These fees must be paid prior to receiving requested paperwork or appointment with the provider.

Simple form: $35 (example: Disabled Parking Permit)

FMLA and Disability Forms: $150.00

DMV Medical Driving Eval Forms: $75.00

Please note: All forms require a minimum of 10-days to complete after documents presented to the office and fee is collected. Please plan accordingly as we cannot rush documentation.

Medical Records Fee(s): Service charge of $19.99, then $1.00 per page for the first 25 pages and $0.25 per page for all remaining pages. Record requests must be given with a 14-day notice prior to the date they will be needed.

There is no charge for sending records to another provider or healthcare facility. However, a release is required prior to us sending these records.

Missed Appointment Fee: To cancel an appointment, we require a 24-hour notice. All appointments that are cancelled with less than 24-hour notice, will be assessed a fee of $40.00; this will include late cancellations and no-shows.

Additionally, after 3 no-shows to a scheduled appointment the patient is at risk of being discharged from the practice.

Late Arrival Fee: $20.00 – Arriving to the office on time allows our providers to stay on time with their schedules. If you arrive more than 15 minutes after your scheduled appointment time, you will be assessed a $20.00 fee that will be due prior to seeing the provider.

Frequent Re-scheduling Fee: We will allow 3 reschedules for an appointment. If you request additional reschedules, a $20.00 fee will be assessed.

Copayment and/or Deductibles: These are due at the time of the appointment, prior to seeing the provider. The copayment is the same for the visit, whether seeing a physician, nurse practitioner or a physician assistant. If you have not met your deductible for the year, you will be required to pay our cash rate for the appointment. In the event of an overpayment, the additional amount will be applied to your account as a credit.

Signature: ______________________________________ Date: ________________________

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CONTROLLED SUBSTANCE POLICY

Atit Neurology is not a pain management office and we do not treat chronic pain conditions with controlled substances. However, there are some medications for neurological conditions that are considered a Schedule II-controlled substance.

Please read the following guidelines and initial beside each one that you understand and agree.

_____ If you are prescribed a Schedule II-controlled substance at any time during your care by Atit Neurology, you will be required to be seen on a monthly basis as refills are not allowed by Florida State Law. Refills will be authorized *after your monthly appointment* and will be sent electronically to the pharmacy of your choice.

_____ EFORSCE database will be checked at frequent intervals throughout you care and if it is found you are obtaining duplicate medication from a different provider, you will be discharged from this practice.

_____ Random urine drug screenings both for metabolism of medication and compliance may be ordered. These will be required to be completed prior to any additional refills.

_____ Inappropriate use of any controlled substance or any medication prescribed by this office can result in immediate discharge from the practice.

_____ Paper Prescription – If for some reason a paper prescription is required for a controlled substance, you will be subject to a fee of $10.00 UNLESS it is an office problem requiring the paper prescription.

Please Note that due to changing State and Federal regulations that this document may change at which time you will be required to review agree and sign a new document prior to your medications being prescribed.

Signature: ____ Date: _________________________

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: ______________________________ Date of Birth: _____ / _____ / _______

Previous Name: ______________________________ Last 4 of SSN: _____________________

I request and authorize the following Healthcare Providers and/or establishments to release healthcare information for the above named patient.

____

____

____

Please release the following records:

- ☐ Healthcare information regarding the following treatment, condition or dates:

  ____

  ____

- ☐ All Healthcare information
- ☐ Most recent progress notes, labs and diagnostics.

- ☐ Other: ____

Please send the records to the following:

ATIT NEUROLOGY
1011 Us Hwy. 19 Holiday, Florida 34691
Telephone: (727) 937-4600
Fax: (727) 937-3312
Secure Email: vik@atitneurology.com

Signature: ______________________________________ Date: ________________________

(A copy of this release will be kept on file for one year to facilitate record retrieval and continuity of care.)