JOSÉ A GAUDIER M.D.P.A.
Neurology

Dr. José A.Gaudier, M.D.
Lacy Jernigan, A.R.N.P.

Patient Name: _____ Date of Birth: ___/___/_____ Sex: Male/Female

Address: _____City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone:_____ Work phone:_____

SSN:_____ Race:_____ Ethnicity: Hispanic/ Non-Hispanic Language: _____

E-mail: _____Pharmacy: _____Pharmacy Phone:_____

Occupation/Prior Occupation (if retired): _____Employer:_____

Marital Status: S M D W Spouse's Name: _____Spouse DOB: ___/___/_____

Spouse Phone Number: _____

Emergency Contact (other than spouse): _____ Phone Number: _____

Name of Primary Insurance:_____ Please circle: HMO / PPO

Name of Secondary Insurance:_____

Name of Referring Doctor: _____ Is this your Primary Care Doctor? YES / NO

If not, please list Primary Physician: _____

Please list all other physicians you see (cardiology, pulmonology, nephrology, etc.)

_____

Do you have a living will or advance directive? _____

Is this appointment related to a workman's compensation case?_____

Is this appointment the result of a motor vehicle accident?_____

PLEASE GIVE YOUR INSURANCE CARDS/LIVING WILL/ADAVANCE DIRECTIVE/PHOTO ID TO THE RECEPTIONIST SO THAT WE CAN MAKE A COPY FOR YOUR FILE

I certify that any information given by me is correct and herby authorize direct payment of benefits to Jose A. Gaudier, MD, PA for services rendered by my physician in person or any of his partners or under his/their supervision and understand that I am financially responsible for any balance not covered by my insurance company. In addition, I authorize release of any medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

_____ _____ _____
Patient Name (please print) Patient Signature Date

_____ _____ _____
Patient/Guardian (please print) *Patient/Guardian Signature* *Date*

An electronic or photocopy of these assignments and acknowledgements shall be valid as the original.

1740 S.E 18th Street Suite 1202, Ocala, Florida 34471 **Telephone (352) 732-8630** **Fax (352) 867-7895**

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Jose A. Gaudier, M.D., P.A. Financial Policies

We are committed to providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

Insurance Policy

It is the policy of Jose A. Gaudier, M.D., P.A. to file insurance as a courtesy to our patients; however, deductibles, co-payments and co-insurance are expected to be paid at the time of service. We do not accept responsibility for communications of collections from your insurance company. If we have not received payment from your insurance company within 60 days of the date of service, the responsibility for that payment will transfer to the patient and payment in full will be expected at that time.

If under circumstances, you are required to file your own insurance, you will be provided with the required information.

Self-Pay Accounts

If you do not have insurance, payment in full for all services is expected at the time the services are rendered.

All Accounts

Patients are informed that we may, at our discretion, refer an unpaid account to a collection agency or credit reporting agency. Any cost relating to the collection agency for lack of payment, you will no longer be seen in the office until your account is paid in full.

Referrals

All of our HMO patients requiring our services will need to have a referral/authorization depending on their health plan. This comes from the primary care physician. If our office does not have this at the time of your appointment, your visit will need to be rescheduled.

Missed Appointments

It is the policy of Jose A. Gaudier, M.D., P.A. to confirm appointments at least 24 hours prior to the date of the appointment. If a patient does not show up for a scheduled appointment and does not give at least 24 hours' notice that account may be billed a charge of $25.00. Three missed appointments without proper notification may results in being discharged from the practice.

Returned Checks

There will be a $35 returned check fee added on all returned checks.

I have read and understand the above policies of Jose A. Gaudier, M.D, P.A.

_____ _____

Patient Signature Date

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Acknowledgement of Receipt of "Notice of Privacy Practices"

I acknowledge that I have received a copy (see receptionist) of the Notice of Privacy Practices issued by Jose A. Gaudier, M.D, P.A. This notice describes how Jose A. Gaudier, M.D, P.A. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

By signing this acknowledgement, I agree that Jose A. Gaudier, M.D, P.A. may use and disclose my protected health information as described. This acknowledgement and authorization will remain in effect indefinitely unless it is revoked in writing by me except to the extent that Jose A. Gaudier, M.D, P.A. may have already used or disclosed the information. However, I also understand that by revoking this authorization that I might be jeopardizing the service that Jose A. Gaudier, M.D, P.A. will be able to provide to me.

_____
Patient Name (please print)

_____
Signature of patient

_____
Date

-OR-

_____
Signature of Personal Representative

_____
Relationship to Patient

_____
Date

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To our patients:

Due to HIPAA regulations, we require the following information for your security:

Please list any people (family members, etc.) or the Power of Attorney that we have your permission to discuss your medical needs with, including copies of medical records, prescriptions, appointments, medical history and current concerns. If the person's name is not listed on the sheet, we will need a medical release form filled out for that person by either the patient or Power of Attorney.

Name	Relationship to patient

ABOUT OUR PRACTICE

Our office hours are from 8:00 AM to 5:00 PM, closed from 11:30 AM to 1 PM for lunch, and 8AM to 12PM on Fridays.
As neurologists, our practice is limited to the diagnosis and management of neurological conditions. We do not perform surgery but will refer you to a surgeon if you condition indicates. We recommend that you keep a regular follow up with your primary doctor, who could be either a family practice physician or an internal medicine physician.
Please remember that some unattended neurological conditions may result in irreversible or permanent medical consequences. It is important that you comply with your physician's recommendations. If you do not understand them, please ask for clarification. Further, it is your responsibility to reschedule any missed appointments at your earliest convenience. In addition, tests requested by our group of physicians (including but not limited to laboratory or radiological exams) are important in order to provide adequate diagnosis and monitor your health. Failure to obtain these tests or follow your physician's directions may result in delaying proper therapies leading to potentially irreversible neurological conditions.

I understand the above statement and will keep my appointment or be responsible to reschedule them at my earliest convenience, including laboratory and other testing appointments and agree to comply with my physician's recommendations. By signing this consent form, I have not waived any of my patient legal rights.

_____ _____

Patient Signature Date

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(Please answer all questions completely)

Previous Surgeries:	**Approx date: (mm/yy)**	**Medical Conditions:**
1._____	_____	High Blood Pressure ___ High Cholesterol___
2._____	_____	Heart Disease___ Heart attack ___ Diabetes___
3._____	_____	Stroke (CVA) ___ Mini-Stroke (TIA) ____
4._____	_____	Cancer (type, year diagnosed, treatment, etc) ____
5._____	_____	_____
6._____	_____	Other: _____

Have you been hospitalized in the past year? (ER or admitted) YES / NO

Date: _____ Hospital:_____ Reason:_____

Date: _____ Hospital: _____Reason:_____

Family History: (Blood relatives only please)

Father: Living / Deceased	Mother: Living / Deceased	Brother(s): Living / Deceased	Sister(s): Living / Deceased
Age:_____	Age:_____	Number living: _____	Number living: _____
If deceased, at age: _____	If deceased, at age:_____	Number deceased:_____	Number deceased:_____
Cause:_____	Cause:_____	Cause:_____	Cause: _____
		Cause:_____	Cause: _____

Children:

Age:_____ M / F	Age:_____ M / F	Age: _____ M / F	Age:_____ M / F
If deceased, at age:_____	If deceased, at age:_____	If deceased, at age: _____	If deceased, at age:_____
Cause:_____	Cause:_____	Cause: _____	Cause: _____

Additional:_____

Social History:

Are you a current tobacco smoker? YES / NO How many cigarettes per day? _____ For how long? _____

How soon after you wake up do you smoke your first cigarette?_____ Interested in Quitting? YES NO MAYBE

Are you a former smoker? YES / NO When did you quit? _____ How long did you smoke for?_____

Do you currently drink alcoholic beverages? YES / NO If yes, (please circle) 1 2 3 4 5 6 7 per DAY / WEEK / MONTH / YEAR

Caffeinated beverages: _____ cups per day (coffee, tea, soda, etc.)

Have you used drugs other than those for medical reasons in the past 12 months? If so, please list:_____

What is your highest level of education?_____

Present Illness:

Briefly, describe your present symptoms: _____

_____

Approximate date when symptoms began: _____ Previous treatment for this problem: _____

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Medication List

Please fill out and bring to your appointment.

Drug Allergies:_____

_____

Medication Name	Dosage	Directions (daily, twice daily, etc.)

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