NEUROLOGIC ASSOCIATES OF CENTRAL BREVARD

Patient Demographics:

Patient Name: _____ _____ _____
(First) (Middle initial) (Last)

Social Security Number: _____ Date of Birth: _____
(For registration purposes only) (mm/dd/yyyy)

Gender: ❑ Male ❑ Female

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American ❑ Caucasian

Language: ❑ English ❑ Spanish ❑ Other: _____

Hand Dominance: ❑ Ambidextrous ❑ Left Hand Dominate ❑ Right Hand Dominate

Address: _____ Home Phone: _____

_____ Cell Phone: _____

City: _____ State: _____ Work Phone: _____

Zip: _____ Email Address: _____

Do you have a power of attorney: ❑ Yes ❑ No If yes (Name) _____
(If yes please provide us with a copy at the time of your visit.)

Emergency Contact:

Name: _____ Home Phone: _____

Relationship: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Pharmacy Information:

Pharmacy Name: _____ Street / Intersection: _____

Pharmacy Phone Number: _____

Insurance Information:

****Primary**** Insurance Name: _____

Policy / Member ID: _____

****Secondary**** Insurance Name: _____

Policy / Member ID: _____

Is your insurance provided directly to you or through a spouse, parent or other person?

❑ Self ❑ Spouse ❑ Parent ❑ Other

Please list name if other than self: _____

Please list birth date if other than self: _____
(mm/dd/yyyy)

Please list social security number if other than self: _____

Occupation:

Are you retired? ❑ Yes ❑ No

Please list pre-retirement occupation: _____

Name of employer: _____

Job Title: _____ Full Time: ❑ Yes ❑ No / Part Time: ❑ Yes ❑ No

Social History:

Do you smoke? ❑ Yes ❑ No ❑ Never

If the answer is YES or QUIT,

When did you quit? _____

How many cigarettes do you smoke a day? _____

Total number of years you have smoked? _____

Do you chew tobacco? ❑ Yes ❑ No ❑ Never

If you answer YES or QUIT,

When did you quit? _____

How much do you chew a day? _____

Total number of years you have chewed? _____

Do you drink alcohol (including beer or wine)? ❑ Yes ❑ No ❑ Never

Number of drinks per week? _____

Type of alcohol? _____

Chief Complaint: (Give a brief description of the nature of your visit – for example, left knee pain)

_____

_____

Please describe how your injury occurred: _____

_____

_____

Referring Doctor (who referred you here): _____

Primary Care Doctor: _____ Phone #: _____

Have you ever had this problem before? ❑ Yes ❑ No

Were you seen in the emergency room for your complaint? ❑ Yes ❑ No, Date: _____

What hospital were you seen in? _____

Were x-rays, CT Scans, or MRI taken: ❑ Yes ❑ No

Were medications prescribed? ❑ Yes ❑ No, if yes what medications were prescribed?

_____

Have you been treated by another physician for your complaint? ❑ Yes ❑ No

If yes, what's the doctor's name: _____Date: _____

Have you seen a pain management physician? ❑ Yes ❑ No

If yes, what's the doctor's name: _____Date: _____

Have you had any diagnostic studies for your complaint? ❑ Yes ❑ No
❑ CAT scan ❑ X-Ray ❑ Bone scans ❑ MRI ❑ EMG ❑ EEG

When? _____ Where? _____ Date: _____

Is this complaint related to a:

Workers' Compensation claim? ❑ Yes ❑ No, Date of injury: _____

Motor Vehicle Accident? ❑ Yes ❑ No, Date of injury: _____

Personal Injury? ❑ Yes ❑ No, Date of injury: _____

Is there an attorney involved? ❑ Yes ❑No ❑ Not Yet Name of attorney: _____

Review of symptoms (systems): (circle any that you have recently experienced)

Cardiovascular:
- ❑ Bleeding problems
- ❑ Chest pain
- ❑ Circulation problems
- ❑ Palpitations
- ❑ Ankle swelling
- ❑ Hypertension
- ❑ Lightheadedness
- ❑ Other: _____

Constitutional:
- ❑ Fatigue/ Weakness
- ❑ Itching
- ❑ Skin changes / problems
- ❑ Weight gain(unexplained)
- ❑ Weight loss(unexplained)
- ❑ Hair loss

E.N.T.:
- ❑ Ear discharge
- ❑ Hearing loss
- ❑ Nose bleeds
- ❑ Runny nose
- ❑ Sore throat
- ❑ Difficulty swallowing
- ❑ Hoarseness
- ❑ Difficulty speaking
- ❑ Ringing in the ears

Endocrine:
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ Hot flashes
- ❑ Excessive thirst
- ❑ Excessive sweating
- ❑ Other: _____

Eyes:
- ❑ Blurred vision
- ❑ Eye pain
- ❑ Failing vision
- ❑ Vision loss
- ❑ Double vision
- ❑ Vision loss
- ❑ Sudden vision loss
- ❑ Blind spots

Gastrointestinal:
- ❑ Abdominal pain
- ❑ Appetite loss
- ❑ Blood in stool
- ❑ Diarrhea
- ❑ Constipation
- ❑ GI bleeds
- ❑ Heart Burn
- ❑ Nausea
- ❑ Painful bowel mvmts
- ❑ Vomiting
- ❑ other: _____

Genitourinary:
- ❑ Painful urination
- ❑ Difficulty urinating
- ❑ Retention of urine
- ❑ Excess urination
- ❑ Frequent urination
- ❑ Leakage of urine
- ❑ Sexual difficulties
- ❑ Other: _____

Musculoskeletal:
- ❑ Mid Back Pain
- ❑ Muscle Cramps
- ❑ Neck Pain
- ❑ Low Back Pain
- ❑ Difficulty Walking
- ❑ Extremity Numbness
- ❑ Extremity pain
- ❑ Extremity Weakness
- ❑ Low Back Pain
- ❑ Stiffness
- ❑ Joint Pain
- ❑ Joint Swelling

Respiratory:
- ❑ Cough / Shortness of breath

Neurological:
- ❑ Trouble focusing
- ❑ Trouble sleeping
- ❑ Shaking / Tremors
- ❑ Dizzy spells
- ❑ Memory loss
- ❑ Migraines
- ❑ Headache
- ❑ Weakness
- ❑ Balance issues
- ❑ Loss of smell or taste
- ❑ Head pain
- ❑ Numbness or Tingling
- ❑ Daytime sleepiness
- ❑ Concentration issues

Psychiatric:
- ❑ Anxiety
- ❑ Depression
- ❑ Un-explained sadness
- ❑ Inappropriate laughter
- ❑ Uncontrolled crying
- ❑ Visual hallucinations
- ❑ Auditory hallucination
- ❑ Panic attacks
- ❑ Personality changes

Family History

(Check problem and indicate who was diagnosed: Mother = M, Father = F, Sibling = S, Grandparent = G)

❑ Adopted

Disorder	Who
Alcohol Liver Disease	❑ M ❑ F ❑ S ❑ G
Bleeding Disorder	❑ M ❑ F ❑ S ❑ G
Mental Disorder	❑ M ❑ F ❑ S ❑ G
Diabetes Type 1	❑ M ❑ F ❑ S ❑ G
Diabetes Type 2	❑ M ❑ F ❑ S ❑ G
Heart Disease	❑ M ❑ F ❑ S ❑ G
Stroke	❑ M ❑ F ❑ S ❑ G
Anesthetic Complications	❑ M ❑ F ❑ S ❑ G
Rheumatoid Arthritis	❑ M ❑ F ❑ S ❑ G
Osteoarthritis	❑ M ❑ F ❑ S ❑ G
Lupus	❑ M ❑ F ❑ S ❑ G
Alzheimer's	❑ M ❑ F ❑ S ❑ G
Parkinson's	❑ M ❑ F ❑ S ❑ G

❑ Cancer

Type: _____ ❑ M ❑ F ❑ S ❑ G
Type: _____ ❑ M ❑ F ❑ S ❑ G
Type: _____ ❑ M ❑ F ❑ S ❑ G
Type: _____ ❑ M ❑ F ❑ S ❑ G
Type: _____ ❑ M ❑ F ❑ S ❑ G

Care Team

(Please list the name of your doctor and specialty)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Past Surgical History (Please Print) ❑ NO PAST OPERATIONS

General Surgery

- ❑ Gall Bladder: (Year) _____
- ❑ Appendectomy: (Year) _____
- ❑ Breast Surgery: (Year) _____
- ❑ CABG: (Year) _____
- ❑ Caesarean Section: (Year) _____
- ❑ Carotid Endarterectomy: (Year) _____
- ❑ Cataract Extraction: (Year) _____
- ❑ Cholecystecomy: (Year) _____
- ❑ Colon Resection: (Year) _____
- ❑ Pacemaker implant: (Year) _____
- ❑ Vagus nerve stimulator: (Year) _____
- ❑ Gastric Bypass: (Year) _____
- ❑ Heart Procedure/Surgery: (Year) _____
- ❑ Hernia Repair: (Year) _____
- ❑ Hysterectomy: (Year) _____
- ❑ Lung Surgery: (Year) _____
- ❑ Prostate Surgery: (Year) _____
- ❑ Tonsillectomy: (Year) _____
- ❑ Tubal Ligation: (Year) _____
- ❑ Deep brain stimulator: (Year) _____
- ❑ Other: _____
- ❑ Other: _____

Orthopedic Surgery

- ❑ Arthroscopy: (Year) _____
- ❑ Ankle: ❑ LT ❑ RT (Year) _____
- ❑ Elbow: ❑ LT ❑ RT (Year) _____
- ❑ Hand: ❑ LT ❑ RT (Year) _____
- ❑ Finger: ❑ LT ❑ RT (Year) _____
- ❑ Hip: ❑ LT ❑ RT (Year) _____
- ❑ Knee: ❑ LT ❑ RT (Year) _____
- ❑ Shoulder: ❑ LT ❑ RT (Year) _____
- ❑ Wrist: ❑ LT ❑ RT (Year) _____
- ❑ Ankle Replacement: ❑ LT ❑ RT (Year) _____
- ❑ Carpal Tunnel Release: ❑ LT ❑ RT (Year) _____
- ❑ Hip Replacement: ❑ LT ❑ RT (Year) _____
- ❑ Knee Replacement: ❑ LT ❑ RT (Year) _____
- ❑ Shoulder Replacement: ❑ LT ❑ RT (Year) _____
- ❑ Back Surgery: ❑ Cervical ❑ Thoracic ❑ Lumbar

  Year_____ Year _____ Year _____
- ❑ Implants/Hardware (pins, rods, screws, plate):

  Which Body Part: _____

Past Medical History

As you review the following list, please check any problems or conditions, that you have been diagnosed with or treated for in the past. If you do not have any of the problems listed in the section please leave blank.

General Health ❑ *None*
- ❑ Good general health
- ❑ Cancer
- ❑ Celiac disease (Gluten sensitivity)
- ❑ Lupus
- ❑ Thyroid problems (High or Low)
- ❑ Diabetes
  - ❑ Type1 / year diag _____
  - ❑ Type2 / year diag _____
- ❑ Cancer

Type: _____year_____
Type: _____year_____
Type: _____year_____
- ❑ Other: _____

Ears, Nose, Mouth, Throat ❑ *None*
- ❑ Significant dental disease
- ❑ Recurrent ear infections
- ❑ Loss of hearing/deafness
- ❑ Ringing in ears / tinnitus
- ❑ Recurrent sinus infections
- ❑ Recurrent sores in mouth
- ❑ Leukoplakia
- ❑ Dry mouth
- ❑ Cold sores
- ❑ Other: _____

Eyes ❑ *None*
- ❑ Retinal detachment
- ❑ Retinal disease
- ❑ Macular degeneration
- ❑ Lazy eye (Strabismus)
- ❑ Diabetic eye disease
- ❑ Floaters
- ❑ Dry eye
- ❑ Other: _____

Gastrointestinal ❑ *None*
- ❑ Bleeding from stomach or bowels
- ❑ Esophageal problems
- ❑ GERD
- ❑ Ulcers
- ❑ Irritable bowel syndrome
- ❑ Hemorrhoids
- ❑ Diverticulitis
- ❑ Colitis
- ❑ Other: _____

Genitourinary ❑ *None*
- ❑ Recurrent UTI(s)
- ❑ Female: irregular period
- ❑ Female: #pregnancies_____
  #miscarriages_____
- ❑ Kidney stones
- ❑ Male: prostate disease
- ❑ Sexually transmitted diseases
- ❑ Dysuria
- ❑ Other: _____

Heart and Lungs ❑ *None*
- ❑ Heart attack
- ❑ Heart failure
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Irregular heart beat
- ❑ Palpitations
- ❑ Atrial fibrillation
- ❑ Any implanted devices
- ❑ Other: _____

Pulmonary ❑ *None*
- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ TB
- ❑ Pulmonary fibrosis
- ❑ Chronic bronchitis
- ❑ Pulmonary hypertension
- ❑ Pneumonia
- ❑ Other: _____

Neurological ❑ *None*
- ❑ ALS
- ❑ Brain aneurysm
- ❑ Tremors
- ❑ Weakness
- ❑ Ataxia
- ❑ Bells palsy / facial drooping
- ❑ Cluster / tension headaches
- ❑ TBI (traumatic brain injury)
- ❑ Spinal cord injury
- ❑ Dementia
- ❑ Epilepsy
- ❑ Stroke / TIA
- ❑ Neuropathy / Radiculopathy
- ❑ Migraines
- ❑ Syncope
- ❑ Seizures
- ❑ Multiple sclerosis
- ❑ Parkinson's disease
- ❑ Paralysis
- ❑ Vertigo
- ❑ Other: _____

Allergy ❑ None
- ❑ Drug allergies
- ❑ Food allergies
- ❑ Hay fever or environmental
- ❑ Other: _____

Orthopedic ❑ *None*
- ❑ Inflammatory arthritis
- ❑ Osteoarthritis
- ❑ Disc disease
- ❑ Gout
- ❑ Fibromyalgia
- ❑ Muscle disease
- ❑ Scoliosis
- ❑ Spinal stenosis
- ❑ Bursitis
- ❑ Osteoprosis
- ❑ Vertebral fracture
- ❑ Other: _____

Skin ❑ *None*
- ❑ Rosacea
- ❑ Hypersensitivity
- ❑ Melanoma
- ❑ Eczema
- ❑ Other: _____

Sleep ❑ *None*
- ❑ Sleep apnea
- ❑ Snoring
- ❑ Sleepwalking
- ❑ Nightmares
- ❑ Insomnia
- ❑ Other: _____

Psychiatric ❑ *None*
- ❑ ADD / ADHD
- ❑ Anxiety
- ❑ Depression
- ❑ Bipolar
- ❑ Schizophrenia
- ❑ Personality disorder
- ❑ Eating disorder
- ❑ OCD
- ❑ PTSD
- ❑ Psychosis
- ❑ Other: _____

NEUROLOGIC ASSOCIATES OF CENTRAL BREVARD
NOTICE OF PRIVACY PRACTICES

Acknowledgement Form

(*Only sign this portion if*) I have received the notice of privacy practices and I have been provided the opportunity to review it. There is a copy posted in the waiting room for you convenience but we will provide you with one only at your request.

Patient Name: (first) _____ (last) _____DOB: _____

Signature: _____ Date: _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

____ Home Telephone
____ O.K. to leave message with detailed information
____ Leave message with call-back number only

____ Written Communication
_____ O.K. to mail to my home address
_____ O.K. to mail to my work/office address
_____ O.K. to fax to this number

____ Work Telephone
____ O.K. to leave message with detailed information
____ Leave message with call-back number

_____ Other_____

Patients Signature: _____ Date: _____

Print Name: _____ Date Of Birth: _____

The privacy rules generally require healthcare providers to take reasonable steps to limit the use or disclosure of any requests for PHI to minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization request by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

RECORD OF DISCLOUSER OF PROTECTED HEALTH INFORMATION

DATE	PERSONS NAME	RELATIONSHIP	WHAT TYPE OF RECORDS

(WHAT TYPE OF RECORDS) A = ALL; T = TREATMANT RECORDS; P = PAYMENT RECORDS

CONSENT TO MEDICAL PROCEDURES: The undersigned consents to the procedures which may be performed in the course of evaluation and / or treatment rendered to the patient under the general and special instructions of Dr. Roberto Mixco.

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION: In consideration of services rendered, I hereby transfer and assign **Neurologic Associates of Central Brevard, Inc** all right, title, and interest in any payment due for services rendered as provided for in the above mentioned insurance policy or policies. I further assign all right to the payment due for medical services rendered to **Neurologic Associates of Central Brevard, Inc**. I hereby authorize the release of any part of the patient's record (including psychiatric, alcohol, and drug abuse information) necessary to process any claim for services rendered.

FINANCIAL AGREEMENT: The undersigned agrees, whether he signs as agent, or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself to pay any monies owed for services rendered. We will submit claims to your insurance company and will assist you in any way we reasonably can to get your claims paid. In the event any insurance company rejects in full, or in part, any portion of the claim for services rendered to the patient, due to controverting or said claim by the insurance company, or due to being a "non-covered" service, or for any reason whatsoever, the undersigned agrees to accept full financial responsibility of any portion of the bill which remains unpaid. It is understood that **Neurologic Associates of Central Brevard, Inc.** will act in accordance to the guidelines for participating physicians with Medicare, Blue Cross Blue Shield, Aetna, or any other companies that Neurologic Associates participates within the acceptance of insurance claims. Should the account be referred to any attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

ATTENTION MEDICAID PATIENT'S: Effective 8/12/17 we stopped participating with straight Medicaid. We do not participate with any Medicaid HMO's. If you desire to be seen at our practice, we require that you complete an ABN (Advanced Beneficiary Notice) that you understand that we do not participate with any Medicaid product and that you will be responsible for our bills. If you wish to see someone who participates with Medicaid we will be happy to send a referral if one is required for you to be seen elsewhere.

POLICY FOR SCHEDULING APPOINTMENTS: It is understood that should the patient be unable to keep any scheduled appointment that has been set for evaluation and / or testing in the course of treatment, the office **must be contacted** and given reasonable advance notice of **48** hours to cancel any appointment, not including weekends. Canceling or rescheduling late means you may incur a fee of $35 if notice is not given in the 48 hr time period not to include non working hours (ie. Before 9am, after 5pm, holidays or weekends). The office hours are Monday thru Friday (with the exception of holidays) 9:00 a.m. and 5:00 p.m.

The undersigned agrees that he / she has read the foregoing and is the patient, or is duly authorized by the patient as his / her general agent, parent, or guardian, to execute the above and accepts its terms.

Signature: _____ Print Name: _____ Date: _____

(Please check one) Relationship: Patient_____ Agent_____ Parent_____ Guardian_____

Witness signature: _____Date: _____

Current medications

*****Please include over-the-counter medications*****

(Please print)

	Name of Drug:	Dosage:	Frequency/Duration
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Allergies to Medication/Foods

	Name of Medication/Food	Reaction
☐	None	
1.		
2.		
3.		
4.		
5.		
6.		
7.		

PRESCRIPTION REFILLS

IF YOU **NO SHOW** FOR YOUR SCHEDULED APPOINTMENT OR DO NOT GIVE A 48-HOUR CANCELLATION NOTICE, WE WILL **NOT** AUTHORIZE A PRESCRIPTION REFILL UNTIL YOUR NEXT SCHEDULED APPOINTMENT!!!!! IF YOU NO SHOW FOR A SECOND APPOINTMENT, YOUR CHART WILL BE REVIEWED AND YOU MAYBE DISCHARGED FROM THE PRACTICE!!!!

Signature: _____ Date: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION
INCLUDING HIV, PSYCHIATRIC AND SUBSTANCE ABUSE

1. I hear by authorize _____ to release information including, any psychiatric or psychological information, infections or contagious information (including HIV/AIDS confidential information, and/or information about drug or alcohol abuse or treatment from the health record(s) of:

Patient name: _____ DOB: _____SSN:_____

Patient address: _____

Covering period(s) of treatment from: _____to_____

2. Information to be released: **COMPLETE RECORD**_____**OTHER**_____

3. Information to be released to: **Neurologic Associates of Central Brevard (Dr. Roberto Mixco)**
1395 N. Courtenay parkway Suite # 106
Merritt Island, FL 32953
Phone: (321) 452-1224 Fax: (321)-453-7784

4. Purpose of disclosure:_____

5. I hear by release_____ and its employees, agents, offices and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this consent for release of medical information.

6. I understand that this consent for release of medical information is subject to revocation by the undersigned at any time except, to the extent that action has already taken by neurologic associates of central Brevard in reliance upon this consent. Unless otherwise stated below, this consent shall automatically expire ninety (90) days from the date set forth below, or upon the following date, even or condition:_____

7. I have read and understand the consent for release of medical information, and have voluntarily and knowingly signed such consent.

8. I further understand that there may be charges associated with copying of these medical records and agree to pay charges as conditioned by Florida statute.

SIGNATURE OF PATIENT: _____***DATE:***_____

<u>If additional consent is necessary from a person authorized to give consent other than the patient:</u>

Signature of Patient's Representative: _____

Relationship to Patient: _____DATE:_____

Witness: _____DATE:_____

CONTRACT FOR CONTROLLED SUBSTANCES

Between Patient: _____ and Doctor: Roberto Mixco M.D.

The Florida Legislature has laws governing the prescription of controlled drugs. These drugs include all narcotics (such as codeine, hydrocodone and oxycodone), sleeping aids, benzodiazepines (such as valium, Xanax and Ativan), and ADHD medications (such as Concerta, Metadata, Ritalin, and Vyvanse).

To comply with these laws, I acknowledge and agree to the following:

1. Prescriptions for most controlled substance medications can only be written for a 30 day supply.

2. I agree that only my physician will prescribe controlled substance medication. I will not obtain or use any controlled substances from a source other than my physician. I will instruct my other physicians to confer with my physician for any changes or need for additional controlled substance medication. If it is discovered that other providers are prescribing medications for me, my physician reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

3. Refills must be written (i.e., they cannot be faxed or phoned in). I will need to come in and pick up the prescription. All medicine should be filled at the same pharmacy, when possible. The pharmacy I have selected is:(name/phone)_____

4. My physician's office requires a 24 - 48 hour notice to refill prescriptions. Prescriptions can only be refilled during normal business hours. They will **NOT** be refilled at night or on weekends. I may be asked to provide proof of identity to pick up my prescription.

5. I must be seen by my doctor every 1 - 3 months to continue to get refills.

6. My physician's office is not responsible for any controlled substance medications that have been misplaced, lost or stolen. Controlled substances cannot be refilled before the renewal date.

7. Random urine drug screens may be part of my treatment plan. I agree to have them done on the day my physician requests it and I understand the there is a handling fee of $20 that my insurance will not cover and will be my responsibility.

8. If I do not follow these policies, my physician will not be able to continue to prescribe these medications for me.

9. It is a crime to obtain narcotics under false pretenses. This could include getting medications from more than one doctor, misrepresenting myself to obtain medications, using them in a manner other than prescribed or diverting the medications in any other way (selling). If my physician has reason to believe that I have violated this agreement, the physician has the right to notify and cooperate with law enforcement. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to my records.

10. My physician has the right to discontinue controlled substance medications and discharge me from care if any of the following occur. • I trade, sell, misuse or share medication with others; • The clinic discovers I have broken any part of this agreement; • I do not consent to urine tests when asked; • My urine shows the presence of medications that my physician is not aware of, the presence of Illegal drugs or does not show medications that I am receiving a prescription for; • I get controlled substances from sources other than Neurologic Associates of Central Brevard (Dr. Roberto Mixco); • I exhibit any aggressive behavior toward the physicians or staff; • I consistently miss appointments.

I hold Neurologic Associates of Central Brevard harmless from any liability in the event I am dismissed from the practice for failure to abide by this agreement. I have read and understand the above policy.

Patient signature: _____ Date: _____

ATTENTION!!!!

OFFICE POLICY STATES THAT IF YOU DO NOT GIVE US AT LEAST A 48 HOUR NOTICE TO CANCEL YOUR APPOINTMENT SCHEDULED WITH OUR OFFICE YOU WILL BE CHARGED A $35 FEE FOR LATE CANCELING OR NO SHOWING YOUR APPOINTMENT. WE ALSO CALL YOU THE DAY BEFORE YOUR APPOINTMENT TO CONFIRM YOU WILL BE HERE. THIS IS A COURTESY THAT WE PROVIDE TO YOU. THIS IS NOT YOUR OPPORTUNITY TO CANCEL YOUR APPOINTMENT WITHOUT BEING CHARGED IT IS YOUR RESPONSIBILITY TO KEEP TRACK OF YOUR APPOINTMENTS.

TESTING LATE CANCEL/NO SHOW FEES:

EEG'S: $50 LATE CANCEL/NO SHOW FEE &

NERVE CONDUCTIONS: $75 CANCEL/NO SHOW FEE

Name: _____

Signature: _____ Date: _____