PALMA SOLA NEUROLOGY ASSOCIATES

SANJAY YATHIRAJ, MD
2902 59TH STREET WEST SUITE D
BRADENTON, FL 34209
PHONE: 941-877-7007
FAX: 941-238-9119

New Patient Registration

Name (First, Middle, Last)	Date of Birth
Social Security Number	Sex
	M☐ F☐
Address	City
State	Zip Code
Home Number	Cell Number
Race/Ethnicity: Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other ☐ Declined ☐	
Email Address:	
Primary Care Physician:	
Pharmacy: Pharmacy Phone: Pharmacy Address:	

I agree that my Protected Health Information (PHI) may be shared with the following.

_____ _____
Full name Relationship

_____ _____
Full name Relationship

_____ _____
Full name Relationship

I understand that I can change any of the foregoing agreements at any time by giving written notice to Palma Sola Neurology Associates.

_____ _____
Signature Date

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Assignment of Benefits

In consideration of the treatment to be rendered to the patient by Palma Sola Neurology Associates, LLC I agree and consent to the following conditions:

1. **Consent to the use and disclosure of health information for treatment, payment, and healthcare operations:** The undersigned agrees that all records concerning the patient's treatment shall remain the property of Palma Sola Neurology Associates, LLC. The undersigned understands and agrees that such information is used for.
    a. The provision and coordination of the patient's healthcare which may require disclosure of all or any portion of the patient's medical record information to patient's attending physician, consulting physician, and or other healthcare providers who have a legitimate need for such information in the care and continuing treatment of the patient.
    b. Billing, claims management, medical data processing, reimbursement, and or for determining coverage with may necessitate disclosure of such information to any insurance company, third party payer, entity, and or entity representatives including quality assurance, utilization review, risk management, medical peer review, internal auditing, accreditation, certification, licensing, or credentialing activities of Palma Sola Neurology Associates, LLC.
    c. Medical research, legal, and or educational purposes.

    I further authorize any hospital, physician, or any healthcare provider who has attended me or furnished medical services, to disclose when requested to do so copies of hospital or medical records to Palma Sola Neurology Associates, LLC

    The information released may indicate the presence of a communicable or venereal disease, which may include but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, and or infection with the Human Immunodeficiency Virus.

    I understand that I may revoke at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing. I also understand that I have the right to examine and copy the information to be disclosed, unless deemed that such disclosures are not in my best interest.

2. **Payment Responsibility:** The undersigned understands that the patient or another person who specifically agrees to guarantee payment for the patient is responsible for the payment of all charges for services rendered at Palma Sola

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Neurology Associates, LLC to the patient that exceed any third-party coverage including applicable coinsurance payments, deductibles, and or all amounts for which payment has been denied by any third party.

3. **Assignment of benefits:** The patient hereby makes the assignment of benefits as set forth below:
    a. **Medicare:** The patient hereby requests that payment of authorized Medicare benefits to or on behalf of the patient for services furnished by Palma Sola Neurology Associates, LLC shall be made to Palma Sola Neurology Associates, LLC and the patient specifically assigns such benefits to Palma Sola Neurology Associates, LLC. The undersigned certifies that all information given by the patient in connection with applying for benefits under Title XVII of the Social Security Act is true correct and complete in all aspects and permits a copy of this authorization to be used in the place of the original.
    b. **Other third-party payors:** The patient hereby assigns Palma Sola Neurology Associates, LLC benefits under any insurance policy, health plan, worker's compensation, and or third-party payor liable to the patient in consideration for services rendered by Palma Sola Neurology Associates, LLC. If my insurance company, fail to make payments for me for charges and services rendered by Palma Sola Neurology Associates, LLC I hereby assign and transfer to Palma Sola Neurology Associates, LLC any and all causes of action that I might have or that exist in my favor, against such company and authorize Palma Sola Neurology Associates, LLC to prosecute said cause of action in their name as assignee. I further authorize Palma Sola Neurology Associates, LLC to compromise, settle, or otherwise resolve said claim or cause of action as they see fit. To avoid exhaustion of No-Fault benefits while Palma Sola Neurology Associates, LLC pursues its right under this assignment, I authorize and direct my insurance company to set aside and place in escrow any disputed amounts or reductions until the resolution of the dispute.

Patient or Parent/Legal guardian signature: _____
(Signature of parent/legal guardian is REQUIRED if patient is under 18 years of age)

Patient or Parent/Legal guardian name (Please print): _____

Relationship to patient: _____ Date: _____

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No-Show/Cancellation Policy

Thank you for trusting us with your medical treatment. We strive to provide exceptional neurological care to all our patients. To serve you better and to be fair to other patients who are waiting to seek medical treatment at our office, we have implemented a No-Show/Cancellation Policy effective May 1st, 2023. **Please note, you will be charged $25 for each no-show appointment if you do not:**

- Cancel or reschedule your appointment with at least **24 hours' notice.** If you notify us less than 24 hrs., then it will be documented as a No-Show in our system, and you will be billed a $25 fee. All no-show fees are the responsibility of the patient and must be paid before the patient's next appointment. After the first no-show appointment, you will be notified by phone or email warning you that you have broken our no-show policy.
- If you miss two no-show appointments within a year, you will receive a warning letter from our office.
- If you miss three no-show appointments within a year, it may result in you being discharged from our office upon approval by management.

I have read and understand Palma Sola Neurology Associates' No-Show/Cancellation Policy and I understand it is my responsibility to plan appointments accordingly and notify the office in a timely manner.

_____ _____
Patient name Date of birth

_____ _____
Patient signature Date

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General Consent for Care and Treatment

To the patient:

You have the right, as a patient, to be informed about your condition, recommended surgical, and or diagnostic procedure to be used so that you may make the decision whether to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.
You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and potential benefit of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, mid-level provider (Nurse practitioner, Physician Assistant, or Clinical nurse specialist), other healthcare provider, and or the designee as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing invasive, non-invasive, or interventional procedure are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed name of patient or legal representative Relationship to patient

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MEDICATIONS

Patient name _____ Date of Birth _____

For medication refills which one would you prefer? **30 day(s)** or **90 day(s)**

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING OVER-THE-COUNTER SUPPLEMENTS

Name of Drug	Dosage	Frequency (How many times a day)

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Patient consent & Contact information

Patient name _____ Date of Birth _____

I understand that as a part of my healthcare Palma Sola Neurology Associates originates and maintains health records describing my health history, symptoms, examination, test results, diagnoses, treatment, and any plans for future care or treatment. I have been given a copy of the Notice of Privacy Practices.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.
- I understand that I have the right.
- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. Also, that the organization is not required to agree to the restrictions required.
- To revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon.

Does Palma Sola Neurology Associates have permission to:
Send test results to your home.☐
Leave appointment information on your answering machine/voicemail.☐
Leave billing information on your answering machine/voicemail.☐
Leave medical information on your answering machine/voicemail.☐

You may be contacted for research however your personal information will not be released consistent with HIPAA federal stature.
I understand that I can change any of the foregoing agreements at any time by giving written notice to Palma Sola Neurology Associates.

_____ _____
Signature Date

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Advanced Health Care Directive

Patient Information:

Full Name: _____

Date of Birth: _____

Medicare Number: _____

Address: _____

Phone Number: _____

Designated Health Care Proxy:

I, the undersigned, appoint the following individual as my Health Care Proxy to make medical decisions on my behalf if I am unable to communicate or make decisions for myself:

Name of Proxy: _____

Relationship to Patient: _____

Phone Number: _____

Alternate Proxy (Optional):

Name: _____

Phone Number: _____

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Instructions for Future Medical Care:

In the event I am unable to make my own medical decisions, I request the following preferences:

1. **If I have a terminal condition:**

   ☐ Do not attempt life-sustaining treatment.

   ☐ Only provide comfort care.

   ☐ Attempt all life-sustaining measures.

2. **If I am in a persistent vegetative state or irreversible coma:**

   ☐ Do not continue life support.

   ☐ Provide only comfort care.

   ☐ Continue life support and explore all treatments.

3. **Organ and Tissue Donation (Optional):**

   ☐ Yes, I wish to donate my organs and tissues.

   ☐ No, I do not wish to donate.

Authorization for Release of Medical Information

I authorize the disclosure of my health care information to my Health Care Proxy and those involved in my care.

☐ Yes, I consent.

☐ No, I do not consent.

I affirm that I am of sound mind and fully understand the contents of this directive. I am signing this document voluntarily and without coercion.

_____ _____

Signature Date

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Review of Systems

Patient name_____ DOB_____ Date_____

DO YOU CURRENTLY HAVE?

General	Y	N	**Stomach**	Y	N	**Neurological**	Y	N
Headache(s)			Trouble swallowing			Stroke		
Lethargy/Weakness			Heartburn/indigestion			Seizure(s)		
Chills/Night Sweat(s)			Change in bowel habit(s)			Head Injury		
Fever			Loose stool/diarrhea			Memory loss		
Fainting spells/unconscious			Black/bloody stool(s)			Confusion		
Weight loss			Frequent stomach pain			Trouble speaking		
Dizziness			Vomiting blood			Tremors/shaking		
Eyes			Constipation			Unsteady gait		
Wears glasses			Irritable bowel			Trouble walking		
Eyesight worsening			Ulcer(s)			Arm/leg weakness		
Double Vision			Stomach/bowel cancer			Arm/leg tingling		
Eye pain			**Kidney/Prostate**			Arm/leg numbness		
Ear, Nose, & Throat			Frequent voiding			**Psychiatric**		
Deafness			Burning on urination			Nervous breakdown		
Noise in ear(s)			Pus/blood in urine			Panic attack(s)		
Congestion/Sneezing			Trouble starting urination			Cry often/depressed		
Sinus trouble/hay fever			Dribble with cough/sneeze			Worry a lot		
Nosebleed(s)			Loss of urine control			Considered suicide		
Sore throat or tongue			Prostate disease/cancer			Loss of interest in eating		
Hoarse voice			Sexual difficulty			Anxiety/tension		
Dental problem			**Skin**			Loss of energy/fatigue		
Heart			Rash			**Endocrine**		
Chest pain with exertion			Sore(s)			Unwanted weight change		
Heart attack			Dry/oily skin			Change in skin		
Heart murmur			Hair growth/loss			Excessive thirst		
Heart racing/palpitations			**Muscle/Bone**			Excessive tiredness		
Irregular heartbeat			Back pain			**Breast/Menstrual**		
Mitral valve prolapsed			Neck pain			Endometriosis		
High blood pressure			Back surgery			Are you pregnant?		
Swollen feet/ankle(s)			Arthritis			Irregular period(s)		
Heart Valve replacement			Fibromyalgia			Breast discharge		
Atrial fibrillation			Aching muscle(s)/joint(s)			Lumps in breast		
Lung			Shoe lift or brace			**Sleep**		
Lung cancer			Bone/joint injury			Dreams/sleepwalk		
Shortness of breath			Osteoporosis			Leg twitching		
Chest pain			**Hematologic**			Insomnia		
Coughing up phlegm			Blood disease			Daytime drowsiness		
Cough up blood			Enlarged glands			Snore		
Wheezing/cough			Bleed/bruise easily			Breath holding/gasping		
Pneumonia			Anemia/low blood			Restless sleep		

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The Epworth Sleepiness Scale

Patient name _____ Date_____

Patient Date of Birth:

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0= No chance of dozing
1= Slight chance of dozing
2= Moderate chance of dozing
3= High chance of dozing

Situation	Chance of Dozing
Sitting and Reading	
Watching TV	
Sitting inactive in a public place	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car while stopped for a few minutes in traffic	

To check your score, total the points Total: _____

The Epworth Sleepiness scale key

1-6	Congratulations, you may be getting enough sleep
7-8	Your score is average
9	Seek the advice of a sleep specialist