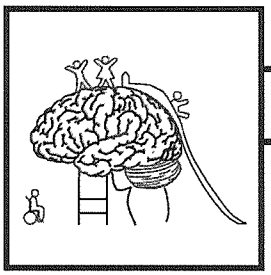


JOSE R. FORADADA, III, MD, PA

CHILDREN'S NEUROLOGICAL SPECIALTIES

DATE: _____

Patient Name: _____DOB: ___/___/____ AGE:____SEX: M__F__

Address: _____APT/Unit #: ____

City: _____State:_____Zip:_____SS#:_____

Home: (___)_____Cell: (___)_____ Work: (___)_____

Patient's School Name/Employer: _____

Other family members treated here: _____

Primary Care Physician:_____Phone: (___)_____

Pharmacy: _____PHARMACY (not store) Phone: (___)_____

Whom may we thank for referring you? _____

Parent(s)/Legal Guardian Information

Mother/Guardian Name: _____DOB:_____Age:_____

Address: _____APT/Unit #: ____

City: _____State:_____Zip:_____Email:_____

Home: (___)_____Cell: (___)_____ Work: (___)_____

Occupation: _____Employer:_____SS#:_____

Father/Guardian Name: _____DOB:_____Age:_____

Address: _____APT/Unit #: ____

City: _____State:_____Zip:_____Email:_____

Home: (___)_____Cell: (___)_____ Work: (___)_____

Occupation: _____Employer:_____SS#:_____

Step Parent:_____DOB:_____Age:_____

Address: _____APT/Unit #: ____

City: _____State:_____Zip:_____Email:_____

Home: (___)_____Cell: (___)_____ Work: (___)_____

Occupation: _____Employer:_____SS#:_____

Emergency Contacts

1.)Name: _____Relationship: _____Phone: (___)_____

2.)Name: _____Relationship: _____Phone: (___)_____

Insurance Information

Primary Insurance: _____Policy: _____Group Number: _____

Policyholder's Name: _____DOB: _____

Relationship to patient: _____Policyholder's SS #: _____

Does the patient have a secondary insurance?_____

Name of Secondary Insurance: _____Policy: _____GroupNumber: _____

Policyholder's Name: _____DOB: _____

Relationship to patient: _____Policyholder's SS #: _____

Medical History

Birth Weight: _____ Pre-term or Full-term? _____

Complications during pregnancy and/or delivery?

_____

_____

Allergies: _____

Current Medications: _____

_____

Hospitalizations

Date: _____Reason: _____

Date: _____Reason: _____

Are Immunizations up to date? _____ If not, please explain _____

Are there any concerns with the patient's development? _____

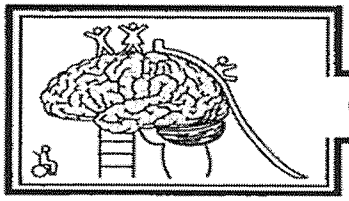
If yes, please explain: _____

_____

Reason for today's visit: _____

_____

_____



JOSE R. FORADADA, III, MD, PA

CHILDREN'S NEUROLOGICAL SPECIALTIES

OFFICE AND FINANCIAL POLICY

1. We are committed to providing you the best possible care and are pleased to discuss professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your responsibility. All patients must complete our "patient information form" before seeing the doctor.

2. Minors must be accompanied by a parent or guardian. Any treatment will be denied to unaccompanied minors.

3. MEDICAL INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We file Insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCES, COVERED CHARGES, SECONDARY INSURANCES, "USUAL & CUSTOMARY" CHARGES, ETC.
   Full payment is due at the time of service, unless prior arrangements have been made with this office. You are responsible for any deductible, cost share or non-covered services.
   We DO NOT file secondary insurances.

4. If you have medical insurance we will help you receive maximum benefits. If you were involved in a motor vehicle accident, we will not accept medical insurance for your visit. However, we will complete claim forms so that you may be reimbursed by your insurance company to the extent of your coverage. If there is an attorney involved, he/she needs to make prior arrangements with this office.

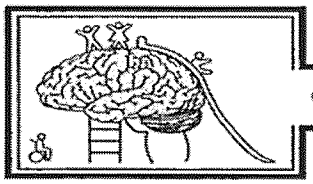
5. There is a $50.00 "no-show" fee for failure to cancel or reschedule any of our office visits within a 24 hour period of your appointment date. Please be aware that this fee WILL NOT be covered by your insurance company and it is the patient's (parent/guardian) responsibility. Also, please be advised that prior to making another appointment, this fee must be paid in full. Otherwise, this will lead to dismissal from our practice. There will be no exceptions!

6. Arriving late for a scheduled appointment is considered a "no-show" in this practice.

7. If your insurance company requires you to obtain a referral or authorization to be seen by a specialist, it is your responsibility to contact your primary care physician or insurance company to obtain the referral/authorization before you are seen in this office. If you do not have a referral/authorization for your visit/procedure, you will be required to pay for your visit before being seen or your appointment will have to be rescheduled.

*** These policies are subject to change without notice. ***

Responsible party signature: _____ Date:_____



JOSE R. FORADADA, III, MD, PA
CHILDREN'S NEUROLOGICAL SPECIALTIES

Permission to Treat

I (We)_____ authorize Jose R. Foradada III, MD, P.A.
print name(s) of legal guardian(s)
and its personnel to deliver medical services to my child_____, listed below.
Print Patient's name

(please print)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

It will be required for the legal guardian to provide a print out of their driver's license if they will not be attending the visit.
If you're not the biological mother / father of the above named patient you will be required to provide court documentation.

4710 N. Habana Ave., Suite 307 • Tampa, Florida 33614
(813) 874-2000 • Fax: (813) 875-9303

JOSE R. FORADADA, III, M.D., P.A
4710 N. Habana Avenue, Suite 307
Tampa, Florida 33614
(813)874-2000
(813)875-9303

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Medical Record Number: _____

Social Security Number: _____ Date of Birth: _____

I authorize the medical practice of Jose R. Foradada, III, M.D., P.A. to make the disclosure

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

____ Physician Progress Notes_____(dates)
____ History and Physical_____(dates)
____ Laboratory Results_____ (dates)
____ Radiology Results_____ (dates)
____ Pathology Report_____ (dates)
____ Electroencephalogram Reports_____(dates)
____ Entire Record_____ (dates)
____ Other_____(dates)

1. I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol and drug abuse.

2. This information may be disclosed to and used by the individual or organization:

   Name of Person/Organization_____

   Address_____City_____State_____Zip_____

3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Office Manager. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or: _____ condition. If I fail to specify an authorization date, even, or condition, this authorization will expire in 360 days.

4. I understand that authorizing the disclosure to this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or request a copy of the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Date

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential information may bedisclosed to other healthcare providers for healthcare emergency or for the purpose of providing you with continuum of quality healthcare.

- Your confidential healthcare information may be disclosed, to include treatment, hospitalization, psychological or psychiatric treatment, drug abuse, alcoholism, sickle cell anemia, acquired immunodeficiency syndrome (AIDS), or test for/or infection with human immunodeficiency virus (HIV) , or any other information that could be compromising to myself that may be needed to process the medical claim to your insurance provider for the purpose of receiving payment for providing you with healthcare services.

- Your confidential healthcare information may be disclosed to public cfficials or law enforcement agencies in an investigation in which you are a victim of abuse, crime, or domestic violence.

- Your confidential healthcare information may be disclosed to public health organizations or federal organizations in the matter of communicable disease, defective devices, or a food or medication reaction.

- Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to revoke your permission to disclose confidential healthcare information at any time.

- You may be contacted by our office personnel to remind you of appointments, healthcare treatment options or other healthcare services that may be of interest to you. Messages related to follow-up appointments may be left on an answering service machine, or with the individual answering the telephone.

- You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends, or others involved in your healthcare or payment for healthcare services. However, the physician's office may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of a medical emergency.

- You have the right to receive confidential communication about your healthcare status.

- You have the right to review and request a copy of any and/or all portions of your healthcare information.

- You have the right to request changes to be made to your healthcare.

- You have the right to know who has obtained your confidential healthcare information.

- You have the right to have a copy of this Privacy Notice upon request.

- The physician's office is required by law to protect the privacy of its patients and will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.

- You have the right to complain to the Privacy Officer of this office and Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to: ATTN: Privacy Officer, Jose R. Foradada III, M.D.,P.A., 4710 N Habana Avenue Suite 307, Tampa, FL 33614.

- All complaints will be investigated. No personal issue will be raised for filing a complaint with the physician's office.

- Further information about this privacy notice, please contact the Privacy Officer at (813)874-2000

English

I, _____(print name) have received all the information on "The Privacy Notice Act" from Dr. Foradada's office.

Sign: _____

Date: _____

Español

Yo, _____(imprimir nombre) he recibidotoda la informacionsobre el "Aviso Del Acto de Privacidad" de la oficina del Dr. Foradada.

Firma: _____

Fecha: _____