The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Release of Medical Records

PATIENT: _____

DATE OF BIRTH:_____

ADDRESS: _____

City: _____ State: _____ Zip Code:_____

PHONE: _____

I hereby request that my medical records be released to:

Dr. Allen Lifton, M.D
200 Capri Isles Blvd
Suite 7D
Venice, FL 34292
Phone: (941) 485-2220
Fax: (941) 485-2150

Patient's Signature_____ Date_____

_____ Date_____
Authorized signature, if patient is unable to sign:

Relation to Patient_____

The Neurology Center – Allen M. Lifton, M.D.-200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Last Name:	First Name			M.I.	Date:
DOB	SS#	Gender Male/Female	Marital status (circle one)	Single / Married / Divorced Separated / Widow/ Widower	
EMAIL:					
Florida Address:					
CITY ZIP CODE			STATE		
Secondary Address:					
Home No:	Cell No:	Alternate No:			
Emergency Contact:		Phone No:		Relation:	
Primary Care Physician:		Referring Physician:			
NOTE: IS THIS A JOB OR ACCIDENT RELATED INJURY YES NO		**IF YES PLEASE PRESENT WORKER'S COMP OR AUTO INSURANCE INFORMATION.**			
Primary Insurance:		Coverage Date:		Co-Pay:	
Subscriber No:	Group #	Group Name:			
Subscriber Name: (if different than self)	Date of Birth	S.S. #			
Secondary Insurance:		Coverage Date:		Co-Pay	
Subscriber No:	Group #	Group Name:			
Subscriber Name: (if different than self)	Date of Birth	S.S. #			
Pharmacy:		Mail-in Pharmacy:			
City:	State:	Phone No:	Fax No:		

Note: We will bill your insurance as a courtesy to you. However, if payment is not received from your insurance company within 45days of billing, the full payment will be expected from you. Uncovered services and/or co-pays are due at the time of service.

Please read:
I authorize payment to be made directly to Dr. Allen Lifton for services rendered. I also agree to pay any amount not approved by my insurance company. I agree to pay any collection or attorney fees that may be incurred. I authorize the release the use of this information or copies thereof to be considered as effective and valid as the original.

_____ _____
Signature of Patient Date

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Patient's name:_____ Today's date: _____

Describe the reason for your appointment: _____

_____

_____

NOTE: Please list ALL medications, vitamins, herbal supplements and any over the counter medications that you are taking.

Name of Medication	Strength	Dosage	How long

List any allergies that you may have:_____

_____

PLEASE LIST MEDICAL HISTORY: (LIST MEDICAL PROBLEMS, SURGERIES, TRAUMAS)

The Neurology Center – Allen M. Lifton, M.D.-200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Patient's name: _____ Today's date: _____

NEUROLOGICAL REVIEW

__ Headache/Migraine
__ Confusion/Memory Loss
__ Depression
__ Hallucinations/Visual disturbances
__ Concentration difficulty
__ Excessive daytime sleeping
__ Headache/Tension
__ Falling down
__ Cerebrovascular disease
__ Cervical spine disease
__ Lumbar spine disease
__ Peripheral nerve disease
__ Decreased hearing (right/left)
__ TIA/CVA
__ Loss of smell
__ Personality Change
__ Blow to head
__ Facial numbness or tingling
__ Sensation of room spinning
__ Dizziness
__ Difficulty chewing
__ Visual changes (blurred, diplopia, amaurosis)
__ Head injury
__ Lethargy
__ Fainting
__ LOC/Concussion
__ Epilepsy/Seizures
__ CNS malignancy
__ Syncope
__ Loss of taste
__ Numbness
__ Coordination difficulty
__ Brief paralysis
__ Poor balance
__ Tingling
__ Tremors
__ Speech difficulty
__ Trouble with smell
__ Drooling
__ Dysphagia/Hoarseness
__ MS
__ Weakness
__ Stiffness

PREVIOUS TESTING

Have you had an MRI? _____ Why? _____ Where? _____ When? _____

Have you had a CT scan? _____ Why? _____ Where? _____ When? _____

Have you had an EEG? _____ Why? _____ Where? _____ When? _____

Have you had a Nerve Test? _____ Why? _____ Where? _____ When? _____

Have you had an EMG? _____ Why? _____ Where? _____ When? _____

Have you had an ECHO/Carotid? _____ Why? _____ Where? _____ When? _____

FAMILY HISORY

Do you know of any blood relative who has or had:

__ Asthma
__ Heart Problems
__ Diabetes
__ Kidney Disease
__ Headaches
__ Psychiatric Disease
__ Migraine
__ Lung Disease
__ Multiple Sclerosis
__ Brain Tumor
__ High Blood Pressure
__ Epilepsy/Seizures
__ Aneurysm
__ Stroke
__ Thyroid

SOCIAL HISTORY

Current job:_____ Previous job:_____

Do you smoke? _____ If yes how much? _____Per _____

Do you drink alcohol? _____ If yes how much per week? _____

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Do you drink coffee, tea or colas? _____ If yes how many cups per day? _____ per week_____

Patient's name: _____Today's date: _____

Patient's Review of Systems – Check off any problems of conditions that you are experiencing or have experienced

Constitutional:
____Fatigue ____Fever ____Loss of Appetite ____Maximum Lifetime Weight ____Night Sweats
____Weakness ____Weight Change ____Weight Loss – Past 12 months ____Weight Gain – Past 12 months

Allergy/Immune:
____Colds ____Ear fullness ____Itchy eyes ____Runny nose ____Scratchy throat ____Sinus congestion

Ophthalmology:
____Blurry vision ____Cataracts ____Diminished vision ____Discharge ____Double vision
____Eye irritation ____Seasonal symptoms

Endocrinology:
____Cold intolerance ____Diabetes ____Excessive sweating ____Excessive thirst ____Fatigue
____Heat intolerance ____Hot flashes ____Sexual dysfunction ____Frequent urination

Cardiology:
____Chest Pain ____Chest pain while Asleep ____Dizziness ____Irregular Heart Beat
____Leg Swelling ____Pain in legs while walking ____Palpitations ____Shortness of Breath
____Varicose Veins

Gastroenterology: ____Abdominal Pain ____Blood in Stool ____Change in bowel habits ____Constipation
____Diarrhea ____Difficulty swallowing ____Frequent Bloating ____Heartburn ____Indigestion
____Nausea ____Vomiting ____Vomiting Blood

Musculoskeletal: ____Back pain ____Joint Pain ____Joint Stiffness ____Joint Swelling ____Leg Cramps
____Shooting Arm Pain ____Shooting Leg Pain

Dermatology: ____Dry//sensitive skin ____Hives ____Lumps ____Rash

Neurology:
____Balance Difficulty ____Dizziness ____Fainting spells ____Falls ____Gait abnormality ____Headache
____Loss of sensation in specific body area ____Loss of strength in specific body area ____Numbness
____Memory Problems ____Pain ____Seizures ____Tingling ____Tremors ____Trouble with coordination

Psychology:
____Anxiety ____Depression ____Hallucinations ____Irritability ____Mental or Physical Abuse
____Nightmares ____Sleep Disturbance ____Stress/Tension

The Neurology Center – Allen M. Lifton, M.D.-200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Patient Consent to Release Mail and/or Telephone Messages

Last Name First Name M. I.

Do we have the permission to:

Send a yearly appointment reminder to your home? Y____ N____

Send test results to you home? Y____ N____

Leave the following information on your home answering machine/voice mail:

Appointment information Y____ N____
Billing information Y____ N____
Medical information Y____ N____

Leave the following information on you work answering machine/voice mail:

Appointment information Y____ N____
Billing information Y____ N____
Medical information Y____ N____

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share medical information with the person named below:

Name: _____

I give permission to share billing information with the person named below:

Name: _____

_____ _____
Signature of Patient Date

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (Print): _____

Signature: _____ Date: _____

Relationship to Patient: _____

Directions:

We are located in Gondola Park which is in a residential condo setting.

Driving south on 41
Take a LEFT (east) on Venice Ave.
Take a LEFT at the 3rd light (Capri Isles Blvd)
Go past the first block (Auburn Lakes) and take a RIGHT into next on driveway into Gondola Park
Take an immediate RIGHT (by the mailboxes)
Go about half way down, you will see The Neurology Center on your left, Unit 7D
Our unit faces Capri Isles Blvd and the golf course.

Driving north on 41
Take a RIGHT (east) on Venice Ave.
Take a LEFT at the 3rd light (Capri Isles Blvd)
Go past the first block (Auburn Lakes) and take the next RIGHT into Gondola Park
Take an immediate RIGHT (by the mailboxes)
Go about half way down, you will see The Neurology Center on your left, Unit 7D
Our unit faces Capri Isles Blvd and the golf course.

Coming from Jacaranda in Venice or River Road
Travel west on Venice Ave.
At the Jacaranda round-about, continue on Venice Ave.
After the Jacaranda round-about, Turn Right at the second light (Capri Isles Blvd)
Go slowly past the first block on the right (Auburn Lakes) and turn RIGHT onto driveway into Gondola Park
Take an immediate RIGHT (by the mailboxes)
Go about half way down, you will see The Neurology Center on your left, Unit 7D
Our unit faces Capri Isles Blvd and the golf course.

Please bring and note:

-Before your appointment date, have all medical records sent to our office via fax (941)485-2150
-Bring all medication in original bottles and/or updated list of medications.
-Bring Identification and insurance cards.
-Filled out forms to be delivered to our office 7 days prior to your appointment.
-All co-pays and amounts not covered by insurance are due at the time of service
-Please check with your insurance company for coverage prior to your appointment to insure there has not been a recent change.

Please check website neurologyconcerns.com for additional information.

The Neurology Center – Allen M. Lifton, M.D.
200 Capri Isles Blvd Suite 7D; Venice, FL 34292
Phone: (941) 485-2220 Fax: (941) 485-2150

Rights and Responsibilities

You have the right to:

Courtesy, kind, competent care.
Collborative care with your primary physician or any of your specialist.
Ask questions
An explanation of your treatment plan.
Learn about your disease and options.
Be seen within 30 minutes of your appointment time. (Every effort will be made to do so.)
Have your phone calls returned in a timely manner. (We will make every effort to return your call within 1 business day.)
Obtain a second opinion.
Seek treatment elsewhere.
Know my credentialing, scope of practice, training and education.
Reasonable fee for services.
Confidentiality and privacy of your diagnosis and care.

_____
Initial

You are responsible for:

Notifying us if you are unable to make an appointment 24 business hours before your appointment. There is a no-show fee of $95 for follow up appointments and $150 for new patients as those times have been reserved for you.
Giving us 2 business days for medication refill requests.
Giving us an updated and complete (Name of RX, Dosage, Instructions) medication list that includes over the counter and herbal supplements.
Seeking additional information on your diagnosis, medication and treatment options.
Respect the thoughts, feelings and behavior of others you encounter in the office, including maintaining their privacy and right to confidentiality.
Keeping your bill current and providing us with current insurance information
Providing us with a current and accurate address as a way to keep in touch with you beyond web encounters.

_____ _____
Print Name Date

_____
Patient Signature or legal representative

"Wherever the art of Medicine is loved, there is also a love of humanity" -Hippocrates-

Our care begins with you.

Part of that is having a thorough medical history. So that we can best care for you, please provide us with all the required paperwork. Allen Lifton, M.D. and Brian Vereb, A.R.N.P. **need your history and forms 7 days prior to your appointment.** We thank you in advance in making sure all of your paperwork has arrived so we are fully prepared for your visit. In the event you are unable to have all of the information to us 7 days before your visit, **we will need to reschedule your appointment** and we will do our best to find a time more convenient for you and our providers. For any cancellations, please contact our office 24 business hours prior to your appointment to avoid no-show fees.

Options for delivering your forms to us:

Mail or In-person Delivery

The Neurology Center

Allen M. Lifton, M.D.

200 Capri Isles Blvd

Suite 7d

Venice, FL 34292

Please allow enough time for mail delivery and call to confirm that they were received.

Fax:

941-485-2150

Please call our office at 941-485-2220 to confirm that we have received your forms.

_____ _____

Patient's Signature or legal representative **Print name**