THE COMPASS CLINIC

Specializing in Memory and Movement

You have been referred to The Compass Clinic, specializing in memory loss and movement disorders. Our team of providers include, Dr. Ira Goodman, Dr. Sheila Baez-Torres, Anamaria Shanley NP, and Georgette Khoury NP. Our goal is to provide you with the best individualized care, incorporating the latest scientific evidence-based therapies. The Compass Clinic works closely with Bioclinica Research, offering possible additional treatment options.

Your initial office visit will include an approximate one-hour consultation reviewing your history and medical records and an examination. It is important that your records are available at your initial office visit, including recent blood work and any brain imaging. As part of your referral your primary care provider/referring provider should already forwarded your medical records.

Further neurological testing may be recommended and it is important you return to the office to go over the results. As results are received by the office, you are asked to call to receive preliminary results and to ensure results are received. After your first follow up appointment, a specific treatment plan will be discussed that may require periodic appointments in the future. It is important that you continue to follow up with your primary care provider and other specialist as appropriate.

Your appointment has been scheduled for:

DATE: ________________________________ **TIME:** ___________________

****Please check in 20 minutes early****

In order to better serve you, we ask that you complete the enclosed forms in their entirety and bring them with you to your visit. We also ask that you bring the following information:

1. Your insurance cards and photo ID.
2. If you have an HMO, you must have a referral from your Primary Care Physician.
3. Please be prepared for any co-insurance or co-payment that may be due at time of service.

PLEASE NOTE: FAILURE TO PROVIDE ANY OF THE ABOVE INFORMATION WILL RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.

Do not hesitate to contact our office with any questions or concerns at 407-210-1320.

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Patient Information

Patient Name ____
Last First M.I

Address____
Street City State Zip

Birthdate ____________________ **SSN** ____________________________ **Sex** ☐ Female ☐ Male

Phone Numbers: **Home** _____________________________ **Cell** _____________________________

Email Address: ____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐Separated ☐ Divorced ☐ Partner

Occupation ________________________________ **Employer/School** ______________________________

Employer/School Phone____

Employer/ School Address ____
Street City State Zip

Spouse Name ___________________________________ **Employer** ________________________________

Birthday _______________________________________ **SSN** _____________________________________

IN CASE OF EMERGENCY, CONTACT:

Name __________________________________ **Relationship** _____________________________________

Phone Number ___________________________ **Alternate Number** ________________________________

Insurance

Responsible Party ____________________________ **Relationship** __________________________________

Insurance Co ___________________________ **Policy ID** ____

Subscriber Name ___________________________ **Birthday** ________________ **SSN** __________________

Relationship _________________________ **Additional Ins Coverage**? ☐ Yes ☐ No

Insurance Co ___________________________ **Policy ID** ____

Insurance Assignment and Release

I certify that I have insurance coverage with _____________________________ and assign directly to **The Compass Clinic** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named practice may use my health care information and may disclose such information to the above- named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **The Compass Clinic** for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Center for Medicare And Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

______________________________ ______________________________ ______________
Signature of Patient or Beneficiary Print Name Relationship Date

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Patient Name: ______________________________________ Date of Birth: ___________

Medication List: ***Please list all prescribed and over-the-counter medications.***

Medication	Dose Given	Frequency (ie. 2x daily)	AM	PM	Approx. Start Date

Please list any drug, medication or other allergies:

1. ____
2. ____
3. ____

Pharmacy: ___________________________ **Phone #:** _______________________

100 W Gore Street, Suite 406 · Orlando, FL 32806
t. 407-210-1320 · f. 321-202-2582 · Compass-Clinic.com

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Patient Name: ______________________________________ Date of Birth: ________________

List of current physicians:

Specialty	Physician	Phone	Fax	Still your doctor? Yes	No

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Authorization for Use or Disclosure – The Compass Clinic- Dr. Ira J. Goodman M.D.

Attention Health Care Provider:

Please provide the medical records requested by The Compass Clinic as authorized by the patient listed below.

Patient Name: ____

SS#: ___________________________________ DOB:_______/_________/_____________________________

Street or PO Box: ____

City, State, Zip: ____

Phone Number (Day):_______________________Phone Number (Evening):____________________________

I, ____________________________, hereby authorize _______________________________ to Use and/or disclose my PHI as follows:

Disclose to: ☐ Via Fax ☐ Via Mail

The Compass Clinic
100 W. Gore Street, Suite 406
Orlando, Florida 32807
Phone: 407-210-1320 Fax: 321-202-2582

Disclosure Purpose: For treatment at the request of the patient.

Disclosure Description: ☐ Billing ☐ Lab Reports ☐ X-rays ☐ History

☐ Shot Records Only ☐ Radiology Reports ☐ Pathology Reports ☐ Entire Record

☐ Other (Describe):____

______________________________ for records dated from: __________________ to: _________________

I understand that:

- Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- The statements included in this Authorization are binding on the Provider.
- The use or disclosure requested under this Authorization ____will ____ will not result in direct or indirect remuneration to the Provider from a third party.

I understand that I have the right to:

- Revoke this Authorization, in writing, at any time by sending such written notification to the Provider. I also understand that such a revocation will not have any effect on any information already used or disclosed by the Provider before the Provider received my written notice of revocation.
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law to the extent the state law provides greater access rights.
- My revocation of this Authorization will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

This authorization will expire in one hundred eighty days (180): _____________ (Date)

____ Name of Patient or Personal Representative*

____ Signature of Patient or Personal Representative*

____ Relationship of Patient or Personal Representative*

____ Date

Personal Representative may be required to provide verification or representative status. *

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Sheila Baez-Torres, MD, MBA - *Board Certified Neurologist*
Anamaria Shanley, MSN, ARNP-BC
Georgette Khoury, ARNP

Office Visit Agreement

Your first and second visits in our office will be with either Dr. Goodman or one of our nurse practitioners, with Dr. Goodman coming in during the visit to complete the evaluation. All subsequent visits **will be** with the nurse practitioners. Depending on the severity, Dr. Goodman may or may not be involved in those visits. Dr. Goodman is working diligently in research to find a cure for Alzheimer's and dementia.

Form Completion Policy

Effective July 16th, 2014 The Compass Clinic will begin charging for form completions. Each form will be completed at a charge of $25.00 **per** form. This charge will be payable by the patient requesting completion and will not be billed to insurance companies, attorneys, etc. Requests will be completed in seven to ten business days and payment is due prior to or upon completion of the form.

Medication Refill Policy

There is a forty eight to seventy two hours (2-3 business days) wait for medication refills. If you call in your refill on a Friday afternoon then your request will begin on the next business day. Do not wait until you are out of the medication before your request is called in. Your doctor may not be in the office or available to approve your refill on an emergency basis.

Medical Records Release Policy

You will need to sign a release form to allow our office to release any records to the doctor(s) of your choice. Please allow one to two weeks for requests to be processed. If you, as the patient, are requesting a copy of your records, the fee is $1.00 per page. Please allow up to one week for your request to be processed.

Billing of Co-pays/ Balances

Co-pays are due at the time of your visit and must be collected per our contracts with your insurance company. We reserve the right to reschedule your appointment if you are unable to pay at the time of visit. If we do agree to see you at the time of the visit without payment of your required co-pay and/or payment on your balance you will be charged a $5.00 statement fee for **each** statement that is mailed to you for collection of these fees.

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Collection Fee

A fee totaling 30% of the balance due will be added to your account if we have to send your account to an outside collection agency.

No Show/ Cancellation Policy

If it is necessary to cancel/reschedule your appointment, please do so prior to 24 hours of your appointment to avoid a $50.00 charge and to allow someone else to use that appointment time. The fee of $50.00 is to be paid by the patient and is not billable to any insurance, attorney, etc.

Late Appointment Arrivals

Please arrive 20 minutes prior to your new patient appointment. **If you arrive more than 15 minutes late for your appointment, you will be rescheduled**.

Thank you for your cooperation in helping us to provide the best care possible to you.

______________________________ Patient Name (Print Name)

______________________________ Patient Signature

____________________ Date

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Notice of Privacy Practices for Protected Health Information

This notice of privacy Practices describes the practices for safeguarding your personal health information. The terms of this Notice applies to patients and dependents for medical treatment.

We are required by law to maintain the privacy of our patient's personal health information and to provide the notice of our legal duties and privacy practices with respect to personal health information (PHI). We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary as rules of law dictate and to make the new Notice effective for all personal health information (PHI) maintained. Copies of the revised Notices will be mailed to our patients. You have the right to request a copy of the Notice.

Uses and Disclosure of Your Personal Health Information (PHI)

Authorization: Except as explained below, we will not use or disclose your personal health information (PHI) for any purpose unless you have signed a form (Authorization Form) allowing a use of disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to our office of record.

Disclosures for Treatment: We may disclose your personal health information (PHI) as necessary for your treatment. For example, a doctor or healthcare facility involved in your care from a referral may need your personal health information (PHI) in our possession to provide care for you. If you pay out of pocket in full for your treatment, you may direct us not to disclose any information to your health care plan.

Uses and Disclosures for Payment: We will use and disclose your personal health information (PHI) as necessary for payment purposes. For example, we may use your personal health information (PHI) to process insurance claims, including Medicare and commercial carriers.

Uses and Disclosures for Healthcare Operations: We will use and disclose your personal health information (PHI) as necessary for healthcare operations. For example, we may use or disclose your personal health information (PHI) to healthcare facilities or for diagnostic testing, such as; MRI's, CT scans, radiology or laboratory testing.

Practice Uses and Disclosures: We may contact you with reminders of an upcoming appointment, information about other treatment options, or health related products, programs, or services that may be available to you.

Outside Business Consultants: Some aspects of our services are sometimes performed by persons outside of our organization and are here under contract or agreements. It may be necessary for us to disclose your personal health information (PHI) to these outside contractors or organizations that perform services for us. We require them to safeguard the privacy of your personal health information (PHI) and we require them to be HIPAA complaint.

Family, Friends and Personal Representatives: With your approval, we may disclose to family members, close personal friends or other persons that you may identify, your personal health information (PHI) relevant to their involvement with your care. If you are unavailable, incapacitated or involved in an emergency, and we determine that a limited disclosure is necessary to provide your treatment/care, we may disclose your personal health information (PHI) without your approval.

Other Uses and Disclosures: We are permitted or required under HIPAA or State law to use or disclose your personal health information (PHI) without your authorization, in the following situations:

- For any purposes required by Law;
- For public health requests such as: Death, Injury or suspected child abuse or neglect;
- To a government authority if we believe an individual is a victim of abuse, domestic violence, neglect or for health oversight actions (such as inspections, licensures actions, civil or administrative or criminal proceedings;
- For administrative or judicial proceedings such as: Subpoena, court orders, or a discovery request;
- For law enforcement purposes such as: Reporting injuries, wounds, or for locating or identifying suspects, missing persons or witnesses;
- To medical examiners, coroners, and funeral directors;
- For procuring, banking or transplants of organs, eye or tissue donations;
- For certain research projects;
- To avoid a serious threat to health or safety under certain instances;
- For intelligence or national security issues, members of the armed forces for military activities, or information about an inmate or an individual being held at a correctional institution or a law enforcement agency having custody;
- To be compliant with workers compensation programs or requests.

We will follow all state and federal laws or regulations that provide additional privacy protections. We will only release or disclose AIDS/HIV related information, any information relating to your mental status, genetic testing information or any substance abuse issues as permitted by state and federal law or regulations.

Your Rights:

Restrictions on Use and Disclosure of Your Personal Health Information (PHI): You have the right to request restrictions on how we use or disclose your personal health information (PHI) for treatment, healthcare operations or payment (Commercial Insurance Carriers and Medicare/Medicaid). You have the right to restrict disclosures to family members or others who are not involved in your care or who are not financially responsible for your care. To request restrictions on certain individuals, send a written request to our office to “Attention: Privacy Officer”.

We are not required to always agree with your request for a restriction but, if we do grant your request, you will receive a written acceptance of your request.

Receipt of Confidential Communications of Your Personal Health Information (PHI): You have the right to request communications relating to your personal health information (PHI) by alternative means such as: Fax (with a secure cover sheet), or at an alternative location. **You may receive electronic copies of your personal health information, if our office utilizes electronic medical records.** We will accommodate any reasonable requests. To request a confidential communication, please send a written request to our office, “Attention: Privacy Officer”.

Access to Your Personal Health Information (PHI): You have the right to inspect and/or obtain copies of your personal health information (PHI) that we maintain in your designated personal records, with one or two exceptions. To request access to your information, you must send written request to our office, “Attention: Privacy Officer”. A medical records release form can be obtained at our office.

Amendment of Your Personal Health Information (PHI): You have the right to request an amendment to your personal health information (PHI) to correct any errors or omissions. To request an amendment to your personal health information (PHI), you must send a written request to our office, “Attention: Privacy Officer”. We are not required to grant the request in certain instances.

Accounting of Disclosures of Your Personal Health Information (PHI): You have the right to receive an accounting of certain disclosures made by us of your personal health information. To request an accounting, you must send a written request to our office, “Attention: Privacy Officer”.

Dissemination of Health Information: You may restrict disclosures to a health plan concerning treatment for which the individual has paid out of pocket in full.

Marketing and Fundraising: We will not sell your personal health information (PHI) for use in any marketing or fundraising program without written consent.

Individual Authorization: We have modified the individual authorization and other requirements to facilitate research and disclosure of child immunization proof to schools and have enabled access to decedent information by family members or designated legal guardians.

Breach Notification: Should a breach occur in our system and your health information is compromised, we will notify you as soon as we become aware of the breach.

Complaints: If you believe your privacy rights have been violated, you can send a written complaint to our office, "Attention: Privacy Officer".

If you have any questions or need assistance regarding this Privacy Notice or your privacy rights, please contact our office.

Consent:

I, ____, acknowledge that I have read and agree to the Privacy Practices for Protected Health Information effective today. I consent to the use and disclosure of my PHI for treatment, payment and healthcare operations as described above. I know that if I don't consent, The Compass Clinic cannot provide services to me.

____ ___________________________

Signature *Date*

I grant the following people access to my medical records and grant them permissions to discuss my medical state and plan of care with The Compass Clinic and its employees on my behalf.

____ ___________________________

Name *Relationship*

____

Phone Number

____ ___________________________

Name *Relationship*

____

Phone Number

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General Directions

I-4 WEST to the Office (Coming from North of Orlando)

- Take the ANDERSON STREET exit.
- At the end of the exit ramp, turn right onto ANDERSON STREET.
- Turn left onto DIVISION STREET (first light after getting off Anderson).
- Turn left on GORE STREET and proceed down Gore Street over train tracks.
- Turn right on LUCERNE TERRACE.
- 100 W GORE STREET is on your left. Complimentary valet parking is available while our garage is under construction.
- We are in Suite 406 on the 4th floor.

I-4 EAST to the Office (Coming from South of Orlando)

- Take the KALEY STREET exit and turn right at the bottom of the ramp on KALEY STREET.
- Turn left onto DIVISION STREET (first light after exiting the ramp).
- Take DIVISION STREET down to GORE STREET and turn right.
- Go over train tracks and take your next right onto LUCERNE TERRACE.
- 100 W Gore Street is on your left. Complimentary valet parking is available while our garage is under construction.
- We are in Suite 406 on the 4th floor.

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