



Dr. Erin Doty, M.D.  
 Dr. Steven Toenjes, M.D.  
 Meredith Hawthorne, PA-C  
 Amy Toenjes, ARNP  
[www.fcneuro.com](http://www.fcneuro.com)

### First Coast Neurosciences Patient Demographics Form

First Name		M.I.	Last Name		Date of Birth	
Address:			City		State	Zip
Cell	Home		Email			
Marital Status		Employment Status		Employer		Position
Sin	Mar	Par	Div	Wid	Stu	FT PT Dis Ret
Emergency Contact Name			Phone			Relationship to Patient
Caregiver Name (If Applicable)			Phone			Relationship to Patient
Preferred Language				Race		

Primary Insurance		Member ID	Group Number
Policy Holder Name		Policy Holder Date of Birth	Relationship to Patient
Secondary Insurance		Member ID	Group Number
Policy Holder		Policy Holder Date of Birth	Relationship to Patient

Referred By	Primary Care Physician
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I affirm that the above information is correct to the best of my knowledge

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## New Patient Questionnaire

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Current Medical Problems:** (Please mark all that apply)

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Seasonal Allergies
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	GERD
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	COPD	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	Aneurysm	<input type="checkbox"/>	Depression/Anxiety
<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	Headache/Migraine	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Heart Disease/Heart Attack	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Atrial Fibrillation	<input type="checkbox"/>	Brain Tumor
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

**Family Medical Problems:** (Parent, Sibling, Child- Please mark all that apply)

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Seizure
<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	Asthma/COPD	<input type="checkbox"/>	Headache/Migraine
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart Disease/Heart Attack	<input type="checkbox"/>	Brain Tumor
<input type="checkbox"/>	Hypothyroidism	<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	Aneurysm
<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart Rhythm Abnormality
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

**Social History:**

Do you drink alcohol?		Yes	No	Average Consumption:						
Do you smoke cigarettes?		Yes	No	Daily use in packs per day:						
Are you a former smoker?		Yes	No	Estimated quit date:						
Do you use illegal or recreational drugs?		Yes	No	Specify:						
Marital Status	Sin.	Mar./Part.	Div.	Wido.	Employment Status	Stu.	PT	FT	Ret.	Dis.

**Past Surgeries:**

**In the last four weeks, have you experienced any of the following symptoms:** (Please mark all that apply)

<input type="checkbox"/>	Change in Weight	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Fever/Chills	<input type="checkbox"/>	Abnormal Heart Beat	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Change in Vision	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Diarrhea/ Constipation	<input type="checkbox"/>	Difficulty Falling Asleep
<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Difficulty Staying Asleep

### New Patient Medications & Allergies

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please clearly print all medications you are currently taking (prescribed and over-the-counter):

Medication Name	Strength	Dosage (non-medical terms)
<i>Example: Bayer Aspirin</i>	<i>81mg</i>	<i>Once a day</i>
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		
11)		
12)		
13)		
14)		
15)		

#### Allergies to medications:

Medications	Reaction
1)	
2)	
3)	
4)	
5)	



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### Private Health Information Release

By completing this form and signing below, I am giving permission for all staff members of First Coast Neurosciences to speak with anyone listed on this form regarding my medical care and condition; including but not limited to appointments, test results, referrals, and billing.

Name	Contact Number	Relationship

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

## Controlled Substance Agreement

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

We are committed to doing what we can to treat chronic pain conditions. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use I understand that my medical condition may necessitate the need for prescription medications that are controlled substances (ex: pain medication). If I am prescribed any controlled substances, I accept the following:

1. I am reading and making this agreement while in full possession of my faculties and not under the influence of any substances that might impair my judgment.
2. I have been informed of the risks and benefits of the use of controlled substances, including the risk of tolerance and drug dependency.
3. I agree not to share, sell or otherwise permit others, including my family and friends, to have access to these medications.
4. I understand that all controlled substances must come from the physician whose signature appears below or, during his or her absence, by the covering physician, unless specific authorization is obtained for an exception. I will not obtain controlled substances from any other physician. Early refills will not be given. Renewals are based on kept appointments.
5. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.

The pharmacy I have selected is: **Pharmacy Name** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Address:** \_\_\_\_\_

6. I give my prescribing physician permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purpose of maintaining accountability.
7. I, and I alone, am responsible for the protection of my medications and to keep them in my possession at all times. If I lose them, for whatever reason, I will NOT ask for an early refill or for prescriptions to be called in. The Clinic will require a police report if drugs are lost or stolen before the physician prescribes more drugs.
8. I will not participate in the diversion of my medications for illegal use; nor will I give or sell to anyone.
9. I will not seek the same or similar medications from any other source, whether professional or otherwise and if I am prescribed them by another practitioner, I will notify the physician here.
10. I will disclose to the Clinic drugs I take at any time, prescribed by any physician.
11. I understand that it may be dangerous for me to operate an automobile or other machinery while using these medications and I may be impaired during all activities, including work.
12. I further accept full responsibility for any sickness, injury or untoward event which may happen to anyone else as a result of my taking any of the medications prescribed at the Clinic.
13. I understand that the prescription of controlled substances is under the supervision of many governmental agencies and adherence to regulations is my responsibility. If the responsible legal authorities have questions concerning my treatment, as might occur, all confidentiality is waived, and these authorities may be given full access to the Clinic's records of controlled substances administration.
14. I understand that I will undergo medical tests and examinations before and during my treatment at the Clinic. Those tests include random unannounced checks for drugs and I hereby give my permission to perform the tests or my refusal may lead to termination of treatment with controlled substances. Presence of unauthorized substances may result in my discharge from the Clinic.
15. In the even that I am arrested or incarcerated related to legal or illegal, refills on controlled substances will not be given.
16. I may be discharged, in accordance with practice standards, from treatment at any time, for violation of this Agreement. Discharge may be immediate for alleged criminal behavior.
17. FEMALES- I also understand that if I become pregnant, or if I am suspicious that I am pregnant, I will notify the staff of the office. I further accept that any medication may cause harm to my unborn child and hold the Clinic and all staff members harmless for injuries to the unborn child.
18. I give my consent to First Coast Neurosciences and all its agents to make report to or otherwise cooperate with any law enforcement officials or regulatory agencies in any investigation which may arise because of or related to my receiving prescriptions as a patient of First Coast Neurosciences or if its agents suspect illegal activity. I waive all rights of privacy and privilege in this regard and these authorities may be given full access to my records by FCN without order of clerk or court.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

I elect not to sign, as I have a controlled substances agreement with another provider.

## **NURSE PRACTITIONER/PHYSICIAN ASSISTANT**

First Coast Neurosciences provides patient friendly services and the highest quality healthcare by employing a team of healthcare providers to attend to your needs. Our practice uses a team of healthcare providers which are headed by physicians, the 'team captains', and include Nurse Practitioners, Physician Assistants and Medical Assistants. Initial visits and workups are typically done by a physician who develops the healthcare plan while follow up care and management is handled by the Physician Assistants and Nurse Practitioner(s). Having a team supporting your healthcare provides you the best and most efficient healthcare service possible and our patients consistently express to us how pleased they are with their team members. Below is a brief description of some of the healthcare members that may be on your team.

*A Physician Assistant (PA)* is a healthcare professional licensed to practice medicine with supervision by a licensed physician. A Physician Assistant is concerned with preventing, maintaining, and treating human illness and injury by providing a broad range of healthcare services that are traditionally performed by a physician.

*A Nurse Practitioner (NP)* is a registered nurse who has an advanced education and clinical training in a healthcare specialty. A Nurse Practitioner has advanced education and clinical training in the treatment of neurological diseases, as well as medical diagnosis and treatment of adults and children.

Nurse Practitioners and Physician Assistants exercise autonomy in medical decision making as determined by their supervising physician. Physician Assistants are educated in the medical model designed to complement physician training. Both will conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive healthcare, assist in medical decision making, and write prescriptions.

**I have read and understand the team approach to healthcare services provided by First Coast Neurosciences and agree that the Nurse Practitioners (NP) and Physician Assistants (PA) are an extension of my physician's comprehensive care plan and that I will have appointments with the designated Nurse Practitioners and/or Physician Assistants as determined by the practice.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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### **Assignment of Insurance Benefits**

I hereby assign to Erin Doty, M.D., PA d/b/a First Coast Neurosciences all rights and benefits that I have under any Group Health, HMO plan, Individual Health, Automobile, Disability or any other Health or Medical Plan or policy or reimbursement plan that may pay benefits for service and treatment that I have received or will receive. I hereby authorize Erin Doty, M.D., PA d/b/a First Coast Neurosciences to release information necessary to process claims with my insurance company. I further authorize payment of insurance benefits directly to Erin Doty, M.D., PA d/b/a First Coast Neurosciences.

*I understand I am financially responsible for all charges, whether or not claims are paid by the insurance company.*

### **Authorization for Medical Treatment**

I consent to receive services at the office of Erin Doty, M.D., PA d/b/a First Coast Neurosciences, which may include assessment, routine diagnostic procedures, medications and such medical treatment as the attending Physician/Nurse Practitioner/Physician Assistant considers being necessary for my care. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of examination or treatment at this medical office.

### **Acknowledgment of Privacy Policy**

We are required by law to provide you with our Notice of Privacy Practices, please ask for a copy at the front desk or review it online at [www.fcneuro.com](http://www.fcneuro.com). Please sign this form to acknowledge that you have been provided an opportunity to review our notice HIPPA and Privacy Practices form via a copy or through our website.

*By signing below, I have read, understood, and agree to the above listed terms and policies.*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## OFFICE POLICIES

We welcome you to our practice and thank you for choosing First Coast Neurosciences for your neurological care. As a valued patient, it is important that you become familiar with our office policies and practices.

### Please read and initial each:

\_\_\_\_\_ **Copays/Deductibles/Co-insurance-** Please be prepared to pay your co-pay for each office visit. Your appointment may be rescheduled if you are unable to make a payment for our services. In the event that your exact copay amount is unknown due to the lack of consistent and reputable data in the insurance verification systems, at the time of the visit, \$75 for a follow up and \$165 for all other visits excluding Botox will be collected. Once you have received the explanation of benefits (EOB) from your insurer identifying the exact amount due from you, please call our billing company at 904-723-5665 to settle any amounts due. Any over-payments will be applied as a credit towards your next visit or be refunded after all insurance payments and EOB's have been received.

\_\_\_\_\_ **Grace Period High Deductible Plan** - If at the time of your appointment your monthly insurance premium is not up to date, and you are listed as being in your 'Grace Period' your appointment will be canceled until you have corrected the lapse in your insurance. You can call to reschedule once your insurance premium is paid in full and our staff verifies that insurance is active and not in a 'Grace Period'.

\_\_\_\_\_ **In-network & Authorization:** It is your responsibility to verify that our providers are in network providers for your insurance plan. It is also your responsibility to ensure you have a current insurance authorization for treatment from your Primary Care Physician if one is required by your insurance plan. If we do not receive payment for your visit due to a lack of insurance authorization, you will be asked to pay the entire amount allowed by your insurance plan. Your appointment will be rescheduled if you do not have a valid authorization for your visit.

\_\_\_\_\_ **Cancellation & No-Show Fees:** In order to accommodate all patients, we respectfully request a 48-hour notice for any cancellations of appointments. If we do not receive at least a 24-hour notice to cancel your appointment, you will be held responsible for a \$25 cancellation fee. If you do not show up for a scheduled appointment, you will be held responsible for a \$35-\$50 missed appointment fee. If multiple appointments are canceled or missed a reservation fee of \$25-\$50 will be collected before scheduling appointments. We request all patients arrive at their scheduled 'Check In Time.'





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## Office Policies Continued

### Please read and initial each:

\_\_\_\_\_ **Collections:** If your account is sent to collections, you will be required to pay the entire balance before you can be scheduled for additional appointments at our office.

\_\_\_\_\_ **Refills:** If you need a refill of your medication, please call your pharmacy directly and request the refill. The pharmacy will then notify us of the request and we will approve or deny the request. Please allow 24-48 hours to process refill requests. There are no refills after 4:30 pm or on weekends. Controlled substances that require a paper prescription need to be requested two business days in advance.

\_\_\_\_\_ **Late Arrival:** We respect patients time and do what we can to ensure our providers run on time; therefore, your appointment may need to be rescheduled if you arrive after your 'Check In Time.' We will try to accommodate late patients and work them into the schedule if possible.

\_\_\_\_\_ **Disability/FMLA Paperwork:** There is a fee for all disability/FMLA paperwork submitted for completion by the physician. This fee is due upon submission of the paperwork. We require 7-14 business days to complete all paperwork.

- 1 Page \$15.00
- 2-3 Pages \$25.00
- 4 or more \$40.00
- All FMLA paperwork \$40.00

\_\_\_\_\_ **Botox Therapy:** Balances must be paid in full in order to receive the next scheduled injection. Authorizations are not a promise of payment, and you are held responsible for any remaining amounts not covered by your insurance carrier.

If you have any questions regarding these policies and procedures, please ask one of our staff members and they will be happy to help you.

*By signing below, I have read, understood, and agree to the above listed terms and policies*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_