Dr. Steven Toenjes, M.D.
Amy Toenjes, ARNP
Meredith Hawthorne, PA-C
Amanda Hare, DNP

www.fcneuro.com

Automobile Claim Information Sheet

Patient Name:	DOB:
Date of Accident:	State Accident Occurred:
Phone:	• Driver • Passenger • Pedestrian
Auto Insurance Carrier:	Health Insurance: Member ID:
Claim Number:	Adjuster Name:
Claim Address:	Adjuster Phone:
Insured Name:	Insured DOB:
Attorney Name:	Attorney Phone: Contact Name:

By signing below, I am affirming that this information is correct as to the best of my knowledge

Patient Signature_____ Date: _____

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Notice of Intent to Initiate Treatment

Patient Name:
Date of Initiated Treatment:
Insurance Co:
Claim Number:
Date of Accident:

Pursuant to the Florida Statue 627.736(5)©1., this physician and/or medical facility has initiated treatment of the above-names patient for injuries sustained in a motor vehicle accident and for which medical expenses are being incurred under the Florida Motor Vehicle No-Fault Law. Pursuant to the same, all charges for medical treatment or services rendered to the patient will be furnished to the insurer within 75 days of the date of treatment or service.

Note: If at any time you reduce deny or otherwise refuse to timely pay our bills submitted, please reserve sufficient No-Fault and/or medical payment coverage (if applicable) to pay all disputed, reduced and/or denied payments. We intend to pursue any and all amounts due. This includes filing litigation, if necessary. If benefits are exhausted and you fail to reserve sufficient funds to pay all disputed, reduced and/or denied bills, we will seek an award of benefits in excess of the stated coverage limits.

Patient Signature: _____Date: _____

FCN First Coast Neurosciences

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Auto Pain and Disability Questionnaire

Please complete one form for each 'pain' you are experiencing (e.g. neck pain and back pain = 2 forms).
Please ask the Front Desk for additional forms if needed.

ame: _____Pain: _____ Date: _____

Please mark the number that best describes how you feel:

Does your pain interfere with your normal work inside and outside the home?												
Normal	0	1	2	3	4	5	6	7	8	9	10	Unable
Does your pain interfere with personal care (such as washing, dressing, etc.)?												
No help	0	1	2	3	4	5	6	7	8	9	10	Need help
Does your pain interfere with your traveling?												
Go anywhere	0	1	2	3	4	5	6	7	8	9	10	Appts. only
Does your pain affect your ability to sit or stand?												
No problems	0	1	2	3	4	5	6	7	8	9	10	Can't sit/stand
Does your pain affect your ability to lift overhead, grasp objects, or reach for things?												
No problems	0	1	2	3	4	5	6	7	8	9	10	Can't do at all
Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?												
No problems	0	1	2	3	4	5	6	7	8	9	10	Can't do at all
Does your pain affect your ability to walk or run?												
No problems	0	1	2	3	4	5	6	7	8	9	10	Can't do at all
Has your income declined since your pain began?												
No decline	0	1	2	3	4	5	6	7	8	9	10	Lost all income
Do you have to take pain medication every day to control your pain?												
None needed	0	1	2	3	4	5	6	7	8	9	10	Daily/hourly
Does your pain force you to see doctors more often than before your pain began?												
Never see	0	1	2	3	4	5	6	7	8	9	10	See weekly
Does your pain interfere with your ability to see people who are important to you as much as you would like?												
No problem	0	1	2	3	4	5	6	7	8	9	10	Never see
Does your pain interfere with recreational activities and hobbies that are important to you?												
No interfere	0	1	2	3	4	5	6	7	8	9	10	Total interfere
Do family/friends need to help you complete everyday tasks(e.g. work outside/inside the home)because of your pain?												
Never need	0	1	2	3	4	5	6	7	8	9	10	Need all time
Do you now feel more depressed, tense, or anxious than before your pain began?												
No dep/ten	0	1	2	3	4	5	6	7	8	9	10	Severe dep/ten
Are there emotional problems caused by your pain that interfere with your family, social, and/or work activities?												
No problems	0	1	2	3	4	5	6	7	8	9	10	Severe prob.

Total PDQ Score: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

_____	_____	_____
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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First Coast Neurosciences Patient Demographics Form

First Name	M.I.	Last Name	Date of Birth	
Address:		City	State	Zip
Cell	Home	Email		
Marital Status Sin Mar Par Div Wid	Employment Status Stu FT PT Dis Ret	Employer	Position	
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

I affirm that the above information is correct to the best of my knowledge

Patient Signature: _____ Date:_____

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New Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Current Medical Problems: (Please mark all that apply)

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

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

	High Blood Pressure		Arthritis		Seizure
	High Cholesterol		Asthma/COPD		Headache/Migraine
	Diabetes		Heart Disease/Heart Attack		Brain Tumor
	Hypothyroidism		Stroke/TIA		Aneurysm
	Sleep Apnea		Cancer		Heart Rhythm Abnormality
	Other:		Other:		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)

	Change in Weight		Difficulty Breathing		Joint Pain		Anxiety
	Fever/Chills		Abnormal Heart Beat		Nausea/Vomiting		Rash
	Change in Vision		Chest Pain		Diarrhea/ Constipation		Difficulty Falling Asleep
	Difficulty Swallowing		Abdominal Pain		Depression		Difficulty Staying Asleep

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New Patient Medications & Allergies

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

Medication Name	Strength	Dosage (non-medical terms)
Example: Bayer Aspirin	***81mg***	***Once a day***
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: _____

FCN First Coast Neurosciences

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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 selectedis: **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 maintainingaccountability.
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.

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NURSE PRACTITIONER/PHYSICAN 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. 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: _____

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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: _____