# Sylvia Zuniga-Barboni, M.D.

## Advanced Neurology of the Palm Beaches

**PATIENT INFORMATION**

DATE ______

LAST NAME ______ FIRST NAME ______ MIDDLE NAME ______

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W DATE OF BIRTH: ___/___/___ SOCIAL SECURITY #: ______

MAILING ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

ALTERNATE ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

HOME PHONE ______ E-MAIL ______ CELL PHONE ______

PLACE OF EMPLOYMENT ______ WORK PHONE ______

WORK ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

**REFERRING DOCTOR** ______ PHONE ______ UPIN # ______

ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

**PARENTAL INFORMATION**

**INFORMATION IS NEEDED ON THE PARENT WHO IS INSURED. IF THERE IS NO INSURANCE THEN INFORMATION IS NEEDED ON THE FINANCIALLY RESPONSIBLE PARENT.**

LAST NAME ______ FIRST NAME ______ MIDDLE NAME ______

SEX: ☐ M ☐ F MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W DATE OF BIRTH: ___/___/___ SOCIAL SECURITY #: ______

PLACE OF EMPLOYMENT ______ WORK PHONE ______

WORK ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

**SPOUSAL INFORMATION**

LAST NAME ______ FIRST NAME ______ MIDDLE NAME ______

DATE OF BIRTH: ___/___/___ SOCIAL SECURITY #: ______

PLACE OF EMPLOYMENT ______ WORK PHONE ______

WORK ADDRESS ______ CITY ______ STATE ______ ZIP CODE ______

PHARMACY NAME ______ PHONE NUMBER ______

PERSON WHO DOES NOT LIVE WITH YOU TO CONTACT IN AN EMERGENCY PHONE NUMBER

I hereby authorize payment directly to Dr. Sylvia Zuniga-Barboni of the medical and/or surgical benefits otherwise paid to me but not to exceed the charges made for such treatment. I understand that I am financially responsible for the charges not covered by my insurance.

Signature:______________________________________________

I hereby authorize Dr. Sulvia Zuniga-Barboni to release to my insurance company and/or Primary Care Physician any information acquired, including diagnosis and records in the course of my examination or treatment.

Signature:______________________________________________

I hereby authorize any doctor, hospital or medical facility to release records to Dr. Sylvia Zuniga-Barboni.

Signature:______________________________________________

Sylvia Zuniga-Barboni, M.D.
ADVANCED NEUROLOGY OF THE PALM BEACHES
Board Certified in Neurology
American Board of Electrodiagnostic Medicine

## HAVE YOU HAD A MEDICAL HISTORY OF ANY OF THE FOLLOWING? PLEASE SPECIFY YOUR CONDITION

| | | Specify Condition | Still Present |
|---|---|---|---|
| Anemia or other Blood Disease | □ yes □ no | ______________ | □yes □no |
| Blood Pressure | □ yes □ no | ______________ | □yes □no |
| Cancer | □ yes □ no | ______________ | □yes □no |
| Heart Problems | □ yes □ no | ______________ | □yes □no |
| Endocrine,( thyroid, diabetes) | □ yes □ no | ______________ | □yes □no |
| Gastrointestinal | □ yes □ no | ______________ | □yes □no |
| Genitourinary | □ yes □ no | ______________ | □yes □no |
| Head, Eyes, Ears, Nose, Throat | □ yes □ no | ______________ | □yes □no |
| Psychiatric | □ yes □ no | ______________ | □yes □no |
| Respiratory | □ yes □ no | ______________ | □yes □no |
| Skin | □ yes □ no | ______________ | □yes □no |
| Unexplained Weight Loss | □ yes □ no | ______________ | □yes □no |
| Neurologic: | | | |
| 1. Stroke | □ yes □ no | ______________ | □yes □no |
| 2. Seizures | □ yes □ no | ______________ | □yes □no |
| 3. Headache | □ yes □ no | ______________ | □yes □no |
| 4. Numbness/Tingling | □ yes □ no | ______________ | □yes □no |
| 5. Neck/Back Pain | □ yes □ no | ______________ | □yes □no |
| 6. Other Neurologic Illness | (specify) | ______________ | □yes □no |

| Surgeries or Hospitalizations | Date | Surgeries or Hospitalizations | Date |
|---|---|---|---|
| 1. ______________ | ________ | 5. ______________ | ________ |
| 2. ______________ | ________ | 6. ______________ | ________ |
| 3. ______________ | ________ | 7. ______________ | ________ |
| 4. ______________ | ________ | 8. ______________ | ________ |

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# PATIENT MEDICAL HISTORY

NAME ______________________ AGE _____ DOB __________ DATE ____________

HANDED: ☐ LEFT ☐ RIGHT GENDER: ☐ MALE ☐ FEMALE

REASON FOR VISIT: ______________________________________________

**MEDICATIONS AND DOSE:**

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**FAMILY HISTORY**
**RELATIVES ONLY, SPECIFY WHICH ONE**

| DISEASE | NO | YES WHICH RELATIVE |
|---|---|---|
| ALZHEIMER'S | | |
| MIGRAINE | | |
| CANCER | | |
| EPILEPSY | | |
| HEART DISEASE | | |
| HIGH BLOOD PRESSURE | | |
| DIABETES | | |
| STROKE | | |
| ANXIETY DEPRESSION | | |
| ADHD/ADD | | |
| OBESITY | | |
| OTHER | | |

**DRUG ALLERGIES:**
1. ______________________
2. ______________________
3. ______________________
4. ______________________

DO YOU SMOKE? ☐ YES ☐ NO
HOW MUCH? ______________________

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO
HOW MUCH? ______________________

PLEASE FILL OUT PAGE 2 → → → → →→ → →→ →

# AUTHORIZATION/ ACKNOWLEDGEMENT

**RECEPT OF NOTICE OF PRIVACY PRCTICES:**

I, (Print Patients Name) ______________________ have read a copy of Advanced Neurology's Notice of Privacy Practices.

_______________________________________________

Patient signature (or Guardian) Date

**CANCELLATION POLICY:**

If the patient can not adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel/ reschedule within 24 hours of the scheduled appointment. Advanced Neurology reserves the right to charge the patient a fee if the patient does not cancel the appointment within 24 hours. Additionally, Advanced Neurology reserves the right to reschedule appointments to which the patient is more than 15 minutes late.

_______________________________________________

Patient signature (or Guardian) Date

**CONTACT PERMISSION:**

In the event Advanced Neurology needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

CHECK ALL THAT APPLY:

- Alternative phone number to contact you ____________________
- Leave a message on a answering machine.
- Speak with spouse/ significant other/ Emergency contact/ Other family member.

  Name ____________________________________________

- Do **NOT** contact anyone else on my behalf or leave a message on machine.

_______________________________________________

Patient signature ( or Guardian) Date

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## INSURANCE WAIVER & HOSPITAL INFORMATION

Dear Patient:

Please be advised that all services provided to you in our office will be billed to your insurance company if we are contracted with your plan. It will be left up to you to pre-verify that we participate with your insurance company or their Networks. If we are not a participating provider with your insurance company, you will be responsible for the payment for the services provided to you.

Also, please be aware of what is covered and what is not covered under your specific insurance plan. **We may attempt to verify coverage, but it is NOT a guarantee of benefits**. If there is a service that is not covered by your insurance company, you will be the liable party.

Dr. Zuniga-Barboni is on staff at Palm Beach Gardens Medical Center, but she does not take ER calls, nor does she do hospital visits. Rather, she will conference with the on-call Neurologist, Also Dr. Zuniga-Barboni has access to all her patients' medical records 24/7 through the Provider's Portal at Gardens Medical Center to our office medical software.

I hereby acknowledge that I have read, accepted and understood the above insurance waiver for all the services provided to me.

______________________________ ______________________________

**Name of Patient** **Date**

______________________________

**Signature of Patient**

**3400 Burns Road, Suite 101 * Palm Beach Gardens FL 33410**
**Tel (561) 626-1159 * Fax (561) 275-7050**

# Advanced Neurology of the Palm Beaches

Sylvia Zuniga-Barboni MD-FAAN
Diplomate American Board of Neurology
Diplomate American Board of Electrodiagnostic Medicine
Medical License # ME92064

## Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email, or text. Advanced Neurology of the Palm Beaches, LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email. When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email, or text. Advanced Neurology of the Palm Beaches, LLC will not be responsible for any privacy or security breaches that may occur through voicemail, email, or text communications that you have consented to.

You may choose to limit the type of voicemail, email, or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

☐ I do not consent to any voicemail, email, or texting communication.

☐ I consent to receiving communication about the scheduling of appointments, Billing, Statements, or other communications that do not reveal my protected health information only by the following means (check all that you consent to):

- ☐ Email
- ☐ Text
- ☐ voicemail

☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):

- ☐ Email
- ☐ Text
- ☐ voicemail

E-mail address you are consenting to communicate through: ____________________

Phone number you are consenting to communicate through: ____________________

Patient Name: ____________________

Signature: ____________________ Date: ____________________

Authorized Representative/Guardian Name: ____________________

Signature: ____________________ Date: ____________________