Palm Beach Neurological Center

MICHAEL M. TUCHMAN, M.D, FAAN LISA-LEIGH CIARAVINO, APRN, FNP-BC
3355 Burns Road, Suite 201
Palm Beach Gardens, FL 33410
561-694-1010

Patient Name: _____ **Chart #:** _____

Here at Palm Beach Neurological Center it is our pleasure to conveniently send your prescriptions electronically to your preferred pharmacy. In order to do so we require the following information regarding your pharmacy:

PHARMACY INFORMATION

* Indicates required field

***PHARMACY NAME:** _____

***PHARMACY PHONE #:** _____

PHARMACY FAX #: _____

PHARMACY ADRESS: _____

_____

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Michael M. Tuchman, M.D., FAAN **Lisa-Leigh Ciaravino, APRN, FNP-BC**

QUALITY • CARE • EDUCATION • RESEARCH

3355 Burns Rd., Ste 201 • Palm Beach Gardens, FL 33410

(561) 694-1010 • Fax (561) 694-6921

Name_____ Pt#_____ Date_____

Patient's Family Medical History

Family Member	Alive?	Current Age/ Age of Death	Any Known health Problems/Cause of Death
Father			
Mother			
Brothers 1			
Brothers 2			
Brothers 3			
Sisters 1			
Sisters 2			
Sisters 3			
Children 1			
Children 2			

Review of Patient Symptoms

General

- ☐ Unexplained Change in Weight
- ☐ Fever or Chills
- ☐ Sweats
- ☐ Change in Voice

Sleep

- ☐ Insomnia
- ☐ Snoring
- ☐ Daytime Drowsiness

Head

- ☐ Head Pain
- ☐ Eye Pain
- ☐ Hearing Problems
- ☐ Vertigo (Dizziness)
- ☐ Tinnitus (Ringing in Ears)

WELCOME TO THE PALM BEACH NEUROLOGICAL CENTER

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LISA-LEIGH CIARAVINO, APRN, FNP-BC
3355 BURNS ROAD, SUITE 201
PALM BEACH GARDENS, FL. 33410

AUTHORIZATION FOR TREATMENT/FINANCIAL AGREEMENT

I, hereby authorize **Palm Beach Neurological Center** to furnish Medicare, my/the patient's insurance company, attorney or any representative thereof, with any and all information requested regarding my/the patient's past and present physical condition and treatment.

I authorize the provider in charge of my/the patient's care to administer such medical care deemed advisable in my/the patient's diagnosis and treatment.

I authorize my/the patient's insurance company, attorney or Medicare to pay directly to the Palm Beach Neurological Center any medical and/or surgical expenses payable under the terms of my/the patient's contract. I also agree that any balance not covered will be paid by me/the patient and photocopies of this form will be valid. I agree that should this account be referred to an agency or attorney for collection, I/the patient will be responsible for all collection costs, attorney's fees and court costs.

MISSED APPOINTMENTS ARE SUBJECT TO A $150.00 FEE. TWO (2) BUSINESS DAYS' NOTICE IS REQUIRED FOR CANCELLATIONS. THIS FEE IS NOT COVERED BY INSURANCE.

I UNDERSTAND AND ACCEPT THAT DR. TUCHMAN AND LISA-LEIGH CIARAVINO, APRN PROVIDE CONSULTATION AND CLINICAL CARE IN OFFICE DURING REGULAR OFFICE HOURS. THEY DO NOT PROVIDE HOSPITAL CARE AND ARE NOT AVAILABLE FOR EMERGENCIES ON NIGHTS, WEEKENDS OR HOLIDAYS.

IN THE EVENT OF ANY EMERGENCY, I AM TO CALL 911 FOR ASSISTANCE.

I AGREE TO THE POLICIES OF THE PALM BEACH NEUROLOGICAL CENTER AND WISH TO BE SEEN.

SIGNATURE OF PATIENT _____ DATE _____

POWER OF ATTORNEY/PLEASE SIGN AND PRINT NAME _____ DATE _____

WITNESS _____ DATE _____

PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED. THANK YOU