

DocJ's Advanced Neurology & Epilepsy Freedom Center

A Johns Hopkins & Cleveland Clinic Alumnus Group



6000 MetroWest Blvd., Suite 104-105,
Orlando FL 32835

805 CR 466, Suite 101, Lady Lake, FL 32159

United States of America 

Phone: (+1) 407-365-3033 • Fax: (+1) 407-365-3034

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New Patient Forms

Patient name: _____ DOB: _____ Age: _____

Address: _____ SS#: _____



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Phone number: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Relationship to patient: _____

Insurance: _____ ID: _____ (attach copy)

Referring Physician Name: _____ Phone: _____

Chief Complaint: _____

Symptoms: _____

Preferred Pharmacy Name: _____

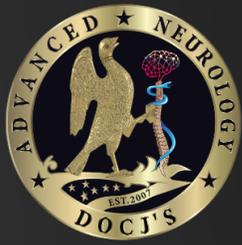
Address of Pharmacy: _____

Pharmacy Phone: _____

Recent Hospital Visit: Y/N? _____ Hospital if Y: _____ Approx. Date: _____

List All Medications Patient is currently taking: _____

Additional comments: _____



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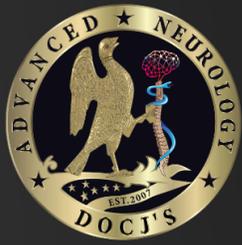
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Video/Audio Recording Consent

I hereby authorize Falcon Medical Group, Inc/ DocJ's Advanced Neurology, hereby by Company, its employees or agents, to digitally video and/or audio record me while under the care. I further authorize the use of any such photographs, video, and audio recordings to be used by other physicians involved in my medical care. I understand that such photograph(s), audio recordings(s) and/or video recordings may be used for clinical, education, research and/or medico-legal purposes. The Company and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings. Any recordings obtained during the course of the clinical care or study will be considered a protected portion of your medical record.

Patient Signature: _____ Date: _____
(Patient or Legal Guardian, if applicable)

Witness: _____ Date: _____



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Informed Consent/ Insurance Verification & Billing

I hereby authorize the Company and/or Falcon Medical Group, Inc., acting as Service agent for the **Medical Director, President & CEO Dr. Jaivir S. Rathore**, to contact my insurance carrier (shown below) in order to determine eligibility for medical services. I understand that my insurance will be billed for services rendered by both Dr. Rathore and/or other medical staff providing treatments with or without his supervision. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered by either the physician and/or facility, I will, within five days of receipt of this check, make payment in the amount of said check to the facility. The following also applies to the use of my insurance to cover the cost of services rendered. The amount due not covered by insurance will be patient responsibility.

Authorization to Release Medical Information for Billing/Payment

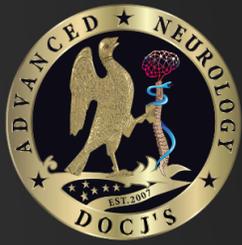
I hereby authorize the release of any information needed, including Medical Records regarding services provided by the Physician/Facility to process insurance claims and obtain payment from the insurance carrier.

Assignment of Insurance Benefits

I hereby irrevocably authorize assignment of payment of my benefits for the services rendered by the physician and the facility made directly to the facility.

Patient Name: _____ Relationship to the patient: _____

Signature: _____ Date: _____
(Patient or Legal Guardian, if applicable)



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Office Policy, Procedures, and Patient Responsibilities

- 1. Payment Responsibility:** All copays, co-insurance, and deductibles must be collected prior to services being rendered. Any cost provided is a coverage contract between patient and insurance carrier. It is the patient's responsibility to be familiar with their insurance benefits and policy.
- 2. Appointment Cancellation:** Doctor Appointments must be canceled with at least 24 hours' notice. A \$75.00 late cancellation or no-show fee will apply if notice is not given. Procedure appointments, including routine and/or continuous Video EEGs, require 7 days' notice. Failure to provide this notice will result in a \$350.00 fee, due at the time of rescheduling of next appointment, in addition to the applicable copay.
- 3. Form Fees:** All forms (excluding excuse notes), such as FMLA, Disability, or any detailed fillable forms, will incur a charge starting at \$35.00, up to 5 pages, \$10.00 per page for additional pages. The fee is due at drop-off, and the completed forms will be returned within 7-14 business days. You will be notified when your form is ready.
- 4. Updating Personal Information:** Patients are responsible for updating their demographic information, including address, phone number, driver's license or other valid ID, and insurance cards.
- 5. Access to Medical Records:** Patients have the right to access their medical records. Patient may access it for free through the portal. If medical records are requested from a medical facility or office, there is no charge. If patients request medical records for their own records or for any other reason, there is a \$2.00 charge per page for email, print-out, fax, etc.
- 6. Insurance Authorization/Referrals:** Some insurance carriers require prior authorizations or referrals before services can be rendered. There may take 1-2 weeks to process. If no contact has occurred, it is the patient's responsibility to follow up with the insurance company or Primary Care Physician.
- 7. Billing and Payment:** If you receive a bill due to a denial of insurance coverage, payment in full is required within 30 days from the date of the bill. On day 31, the balance will be sent to collections, and the account will be reported to credit bureaus. If you are experiencing financial hardship, don't hesitate to get in touch with the office to discuss a reasonable payment arrangement. Patients are responsible for the full balance if insurance does not provide coverage.

Signature: _____ Date: _____

(Patient or Legal Guardian, if applicable)



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3-Month Follow-Up Policy for DocJ's Advanced Neurology Patients

I, **(Print Legal Name)** _____, understand that I am required to see a provider at least once every three (3) months to maintain continuous care with DocJ's Advanced Neurology, unless a provider approves an exception.

Why Regular Visits Are Important:

1. **Ongoing Care:** Regular visits ensure continuous, comprehensive management of your medical condition(s).
2. **Medication Monitoring:** Providers can assess your medications' effectiveness and any side effects.
3. **Timely Refills & Adjustments:** Visits allow for prescription refill(s) and necessary adjustments to be completed within 2 to 4 weeks.
4. **Prior Authorizations:** Updated clinical information is necessary to complete any required prior authorization(s) for medication(s).

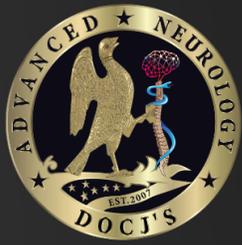
Consequence of Non-Compliance:

- Failure to attend scheduled appointments or non-compliance with medical advice may result in
 - Delays in care and medication refills
 - The office is unable to process prior authorizations for medications
 - Possible discharge from the practice for repeated non-compliance

Patient Responsibility Reminder:

By becoming a patient at DocJ's Advanced Neurology, you are committing to take an active role in your care. While we are here to support you, timely follow-ups are essential to achieving the best health outcomes.

Signature: _____ Date: _____
(Patient or Legal Guardian, if applicable)



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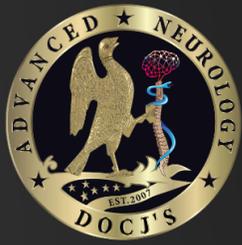
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Prescription Refill Policy

1. Requesting Refills:
 - For prescription refills, patients should have their pharmacy fax a refill request to our office.
 - Scheduled II medications (Those requiring a DEA-compliant prescription) cannot be refilled via fax and require a new prescription to be issued in person.
2. Timely Requests:
 - It is the patient's responsibility to notify the office at least 2 to 4 weeks before running out of medication.
 - Last-minute refill requests may not be filled and will be subject to review. Patients may be advised to visit the Emergency Room for medication refills in such cases.
3. Changes to Medication or Dosage:
 - Any changes to medication(s) or dosage(s) require a scheduled office visit with Dr. Rathore or another provider at DocJ's Advanced Neurology.
4. Scheduled Medications with No Refills:
 - For medications with 0 refills remaining, the patient must make an appointment with Dr. Rathore or another provider at DocJ's Advanced Neurology.
 - If patient runs out of medication before their appointment, they may have to request an earlier clinic visit or get a refill from an Emergency Room to fill their medication/s.
5. New Patients:
 - Prescription refills from other providers can only be prescribed after new patients have seen Dr. Jaivir Rathore at DocJ's Advanced Neurology.

Signature: _____ Date: _____
(Patient or Legal Guardian, if applicable)



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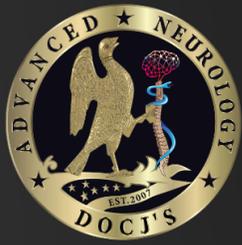
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Summary of the Florida Patient's Bill of Rights and Responsibilities

Florida law requires that your health care provider/ facility recognize your rights and that you respect the health care provider's/facility's right to expect certain behaviors on the part of patients. You may request a copy of the full text of this law from your health care provider/facility. A summary is as follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to requests and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment, whether the health care provider or health care facility accepts Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, sexual orientation, gender identity, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.

For more detail, please visit: <https://www.flsenate.gov/laws/statutes/2011/381.026>



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Medical Records Release Form

By signing this form, I (Patient Name Printed), _____ DOB: _____

authorize _____ to release the following confidential health information for continuation of care: (Facility/Doctors office)

Attn: _____

To: DocJ's Advanced Neurology

Fax #: 407-365-3034

Ph#: _____

Fax#: _____

Date of Service: _____

Circle below: Complete Medical Records

H&P (within the last year)

Pathology/Lab Reports

Radiology/Imaging Reports

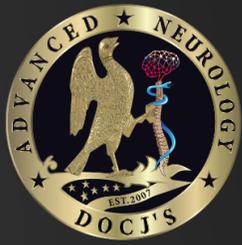
Operative Reports

Other (Specify): _____

Please fax all records attention DocJ's Advanced Neurology, Jaivir S. Rathore, MD, FAES, FAAN, to fax number (407-365-3034).

Expiration date: ___ / ___ / ___ (If left blank, authorization will expire 1 year from the date on signature line)

- I understand that declining to sign this form does not mean denial of care from the facility of provider; it may limit the coverage from insurance company for repeated testing or other rendered services out of the insurance policies governed time frame.
- I have fully read, understood, and given a copy of the Patient Privacy Policy. This notice is in compliance with HIPAA and governed within such.
- I understand the patient has a right to revoke authorization for disclosure of protected health information. Submission of revocation must occur in the form of a written request to the practice's compliance officer.
- I understand that Florida Statute 456.057 (12), makes it clear that any third party to whom records are disclosed is prohibited from further disclosing any information in the medical record without expressed written consent of the patient or legal representative.



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Print Name: _____ Signature: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information: (Required by the Health Insurance Portability and Accountability Act ----- 45 CFR Parts 160 and 164)

I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power of attorney for health care named _____.

Authorization for release of PHI covering the period of health care (check one)

- a. From (date) _____ to (date) _____ OR b. all past, present and future periods.

I hereby authorize the release of PHI as follows: (check one):

- a. My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse). OR b. my complete health record with the exception of the following information (check as appropriate):

Mental health records
 Communicable diseases (including HIV and AIDS)
 Alcohol/ drug abuse treatment
 Other (please specify): _____

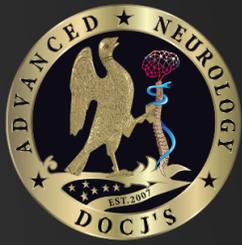
In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.



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This authorization shall be in force and effect until 12 months after my death or _____, (date or event) at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature
(Patient or Legal Guardian, if applicable)

Date

Witness (Staff)

Date