Be Mobile Neurology

813-981-4403
Fax 813-852-6830
3903 Northdale Blvd Suite 100E
Tampa, FL 33624

New Patient Registration Form

Date ___/___/____ Name First_____Last_____

DOB_____ Age_____ Sex ☐male ☐female

Email_____

Phone #_____Secondary Phone #_____

Street Address_____

City_____ State_____ Zip Code_____

Emergency Contact_____ Phone #_____

Relationship to Patient_____

Financially Responsible Party_____

How I heard about Be Mobile Neurology:

☐Physician_____ ☐Website ☐Flyer

☐Friend_____ ☐Google/other Internet search ☐Press Release/News

Preferred Physician I am requesting Be Mobile Neurology send my medical records and communicate directly regarding my medical condition and plan of care to: Dr._____

Phone #_____Fax #_____Email_____

Preferred Pharmacy_____

Phone #_____Fax #_____

Address_____

Preferred Lab_____

Phone #_____Fax #_____

Address_____

Preferred Imaging Center_____

Phone #_____Fax #_____

Address_____

Appointment Confirmation:

I request my appointment confirmation be made by one of the following: ☐Text Alert to cell phone # _____ OR ☐Email_____ (initials)_____

Test Results Ordered by Be Mobile Neurology:

I understand test results that are not time sensitive will be emailed to me. If the test results are of a time sensitive matter, Be Mobile Neurology will call me with the results and I request the following(please select one phone number):

☐Leave a detailed voice message on my cell phone _____ (initials)_____

OR

☐Leave a detailed voice message on voice mail or machine_____ (initials)_____

☐I give my permission to leave a detailed message with individual answering the phone (initials)_____

Sharing of Medical Information:

I give Be Mobile Neurology and Dr. Boland permission to discuss my medical condition with the following individuals:

Name: _____Relationship_____ (initials)_____

Name: _____Relationship_____ (initials)_____

ePRESCRIBE: I request when appropriate my physician and Be Mobile Neurology send electronic prescriptions directly from the practice to a pharmacy of my choice. (initials)_____

Pictures/Videos: I ☐authorize ☐do NOT authorize my physician and Be Mobile Neurology to video or photograph me during the course of my treatment for medical reasons and/or as otherwise desired by my treating physician, and agree such recording may become a part of my medical record. (initials)_____

In addition I ☐authorize ☐do NOT authorize my physician and Be Mobile Neurology to use my video or photographs for education purposes including medical students, residents and other physicians. (initials)_____

Acknowledgment of Agreement to Remit Payment for Services Policy: I have reviewed the financial responsibility policy and agree to its terms. I understand full payment is due at the time of service. (initials)_____

Acknowledgement of Receipt of Privacy Practice Policy: I have been provided with the Privacy Practice Policy. (initials)_____

Patient Name_____

Patient Signature_____ Date _____

Patient Representative Name _____

Patient Representative Signature_____ Date_____