

Neuro Trauma Centers

Central Office: 3044 University Pkwy,
Sarasota, FL 34243, United States
Contact: Morgan Pile
intake@neurotc.com



Name: _____ Date of Birth: _____ Age: _____
Cell Phone: _____ Email: _____ SSN: _____ Sex: MF
Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact Name: _____ Phone: _____ Relationship: _____

Provide a Brief Description of How the Injury Occurred: _____ Date of Injury: _____

Describe any information that you would like our physicians to know about your medical history: _____

Past Medical History: _____

Family History: _____

Surgical History: _____

Please check all of the symptoms that you have experienced since the injury occurred:

- Headache
- Anxiety
- Depression
- Sensitivity to light
- Sensitivity to sound
- Dizziness
- Vertigo
- Disorientation
- Confusion
- Loss of balance
- Lack of coordination
- Brain fog
- Blurred vision
- Double vision
- Ringing in the ears
- Memory issues
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulty waking from sleep
- Drowsiness
- Fatigue
- Difficulty concentrating or keeping attention
- Unusual or irritable behavior
- Easily distracted
- Difficulty finding the right words when speaking

Brain Injury Screening Tool (BIST)

- 0 = Not experienced at all
- 1 = No more of a problem
- 2 = A mild problem
- 3 = A moderate problem
- 4 = A severe problem

Please circle or check one number per line. Compared with before the accident, do you now (i.e., over the last 24 hours) suffer from:

- I have trouble concentrating..... 0 1 2 3 4
- I get confused easily..... 0 1 2 3 4
- I feel tired during the day..... 0 1 2 3 4
- It takes me longer to think..... 0 1 2 3 4
- I forget things..... 0 1 2 3 4
- I don't like bright lights..... 0 1 2 3 4
- I don't like loud noises..... 0 1 2 3 4
- I am easily annoyed..... 0 1 2 3 4
- I sleep a lot more or I can't fall asleep 0 1 2 3 4
- If I close my eyes, I feel like I am at sea..... 0 1 2 3 4
- I have trouble with my eyesight (vision) 0 1 2 3 4
- Headaches (my head hurts) 0 1 2 3 4
- Taking Longer to Think 0 1 2 3 4
- I feel restless... 0 1 2 3 4
- My neck hurts..... 0 1 2 3 4
- I feel like I will be sick..... 0 1 2 3 4

I acknowledge that all of the information provided on these intake forms are true and correct to the best of my knowledge. I understand that any false or misleading information may negatively impact my health care, and I take full responsibility for the accuracy of the information provided. I further acknowledge that I may have had assistance in completing these forms, but I have reviewed all of the information and agree that it is accurate and true.

Patient Signature (or parent/guardian)

Date



AUTHORIZATIONS AND RELEASES

Initials

Notice of Privacy Practices. A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) how medical information about you may be used or disclosed; 2) your accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information. The undersigned certifies that he/she has read the foregoing, received a copy of the NPP, and is the patient or patient's personal representative.

Initials

Consent for Treatment. I consent to necessary medical examination, testing, and/or treatment as determined by my physician, which may be performed by the Neuro Trauma Centers, as deemed necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained from said treatment. Furthermore, I understand that I am seeking treatment only for injuries and/or symptoms related to the accident/incident in question.

Initials

Consent for Release of Medical Records. I authorize the release of any medical information necessary to process my insurance claim(s) and also certify all insurance information given by me to this clinic is correct and complete. I am authorizing the release of my medical information to Neuro Trauma Centers's capital partners and or to my Attorney.

Initials

Consent for Payment. I, the undersigned patient, am directing my Attorney, to pay any outstanding bills out of my settlement and, in effect, protecting any such balance owed to the Neuro Trauma Centers. I hereby make and declare the instructions herein contained to be irrevocable. I understand that I am directly responsible for all medical bills and this agreement is made solely for the doctor's additional protection and consideration of his/her awaiting payment. I further understand that such payment is not contingent on any outcome of settlement, judgment, or verdict by which I may eventually recover, allowing for my outstanding medical bills to be paid. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not away payment, but will require me to make payment as services are rendered. Neuro Trauma Centers expects to be paid by the first available means whether by med pay, PIP, or settlement of your case. Should an overpayment be made, and you have a credit balance on your account, a refund will be issued to either you or the appropriate party.

Initials

Consent for Communication and PHI Disclosure. We may need to contact you regarding your medical care, appointments, or any other reason. I authorize Neuro Trauma Centers to contact me via the phone number provided, by text message, or by email. I will notify the Neuro Trauma Centers if I prefer not to be contacted by any of those methods. I also give consent for any audiovisual telehealth appointments.

Patient Name (printed)

Date of Birth

Patient Signature (or parent/guardian)

Date



ASSIGNMENT AND LIEN FOR MEDICAL SERVICES

Attorney Name: _____ Patient Name: _____
Attorney Address: _____ Patient Address: _____
Attorney Phone: _____ Patient Phone: _____
Date of Injury: _____ Date of Birth: _____ SSN: _____

AUTHORIZATION FOR PAYMENT FOR SERVICES PROVIDE

Neuro Trauma Centers ("NTC") is a clinically integrated network of physicians who treat patients that have suffered a brain injury. You have been referred to NTC through either a personal injury attorney or another healthcare provider. Because the cost for NTC services should be covered under your or the other party's insurance plan, you may incur no personal financial obligation for payment for therapy services specific to your personal injury. However, I understand that absent payment under any judgment or settlement, I am personally financially responsible to NTC.

In consideration for services rendered and to be rendered to me by NTC and its affiliated medical care providers, I hereby irrevocably assign, convey, and transfer to NTC, a vested interest in (and the right of action against anyone responsible for medical expenses) the proceeds of any judgment, settlement or verdict in the lawsuit or claim which I am prosecuting to recover damages for my injuries. This assignment of interest is for current medical care, as well as any future medical care.

I further authorize, empower and instruct my attorney to deduct immediately from the proceeds of any settlement and/or judgment, any and all amounts due and owing to NTC without further authorization from me, and to forward these payments directly to NTC without delay upon resolution of my claim/lawsuit. I acknowledge that if I change the attorney handling my case, it is my responsibility to notify my new attorney of this assignment and medical lien in favor of NTC.

I understand that under the Health Information Portability and Privacy Act of 1996 ("HIPAA"), my personal medical information may be shared in order to manage and expedite my medical care. I authorize NTC and its affiliated medical providers to secure, release and disclose such medical information as permitted under law.

My signature is an acknowledgement that I authorize this Assignment and Lien for Medical Services ("Lien") and have received a copy of this authorization/assignment.

Patient Signature (or parent/guardian)

Date

ATTORNEY ACKNOWLEDGMENT OF MEDICAL LIEN

The undersigned Attorney for the patient identified above hereby agrees to observe all terms stated in this Lien and agrees to withhold from any settlement, judgment or verdict sums adequate to protect NTC for its outstanding medical bills. Attorney agrees to hold such sums in the Attorney's Client Trust Account. Attorney further agrees to honor this Lien and to pay, in full, NTC's costs for providing medical treatment. If a patient secures new counsel, the Attorney will inform the new counsel of this Lien and inform NTC of this change in counsel. Failure of Attorney to sign and return this document to NTC does not release Attorney's responsibility to honor this lien. Attorney also agrees to request bills and records directly from NTC at cm@NTCnstitute.net and not direct such request to the treating clinic.

Attorney Signature

Date

Neuro Trauma Centers

Central Office: 1221 W. 103rd St., Suite #225
Kansas City, MO 64068
Contact: Morgan Pile
intake@neurotc.com



Medical Records Release Request

Name: _____
Address: _____

Date of Birth: _____
Phone: _____

I hereby authorize and request that you release all of my medical records or other health care information including intake forms, chart notes, and reports concerning my health and treatment from _____ (date of the injury) to _____ to the Neuro Trauma Centers.

Medical Records Custodian: Morgan Pile

Please email my records to intake@neurotc.com

Patient Signature (or parent/guardian)

Date