CENTRAL FLORIDA NEUROSURGERY INSTITUTE
Hunaldo J. Villalobos, M.D., FAANS, FACS
Board certified by the American Board of Neurosurgical Surgery

PHONE: 407-288-8638 FAX# 407-288-8639

Dear Sir or Madam:

On behalf of Central Florida Neurosurgery Institute, We would like to welcome you to our patient network. We take pride in knowing that you have placed your trust in us to provide for your care while being treated at the Institute. By having the best medical team and a focus on patient care, we are ready to meet all of your Neurosurgical needs.

Our patient-focused environment fosters open communication, cooperation, innovation, respect and compassion. Our staff is prepared to provide information you may need to prepare for the care you will be receiving at the Institute. Please ask any staff member if there is anything we can do to make your visit with us the best that it can be. Again, welcome and please take a moment to review the attached information.

Thank you for choosing the Central Florida Neurosurgery Institute.

Yours In Health,

Management for
Central Florida Neurosurgery Institute

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WELCOME TO OUR PRACTICE

This letter confirms your appointment with Dr. Hunaldo J. Villalobos at _____am

on _____in the following of

- ☐ 801 North Orange Avenue, Suite 720, Orlando, FL 32801
- ☐ 720 West Oak Street, Suite 111, Kissimmee, FL 34741

Please arrive at least 15 minutes prior to your appointment time to complete the registration process. Enclosed please find our New Patient Registration Forms and Medical History Forms. We ask you to complete all of the forms prior to your appointment. You must mail the completed forms to our office before your appointment. There is a stamped envelope enclosed. If you have access to a fax you may fax it to the number above or email to cvalle@cfneuro.com. If we do not have your completed forms before the time of registration, your appointment may be delayed by up to 30-45 minutes, rescheduled or even canceled.

Please bring the following items with you to your appointment:

1. **Films or CD of MRI, CT Scans, and/or X-Rays.**
2. **Referral or Authorization for your appointment, if required.**
3. **Insurance Card and Photo Identification.**
4. **Medication List that you take on a daily with strength and regimen**
5. **If you speak a language other than English please bring an interpreter.**

If you do not have your radiology films or CD, your appointment will be rescheduled. Feel free to call our office at 407-288-8638 with any questions or concerns. ***Please note, if you had images done at Simon Med we will accept "FILMS ONLY"***

If you have any questions regarding your insurance coverage for this appointment, please contact your insurance carrier directly prior to your appointment. Please be aware payment is due at the time of service for any and all services provided. You are responsible for any co-pays, deductible, or co-insurance that may apply per your insurance coverage guidelines.

Thank you,

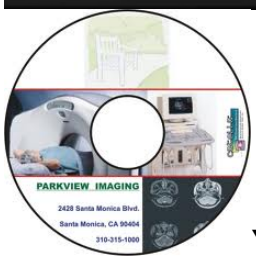
_____
Patient Care Team
Central Florida Neurosurgery Institute

IMPORTANT NOTICE: FILM/CD POLICY

Please be aware that all patients must bring their most recent diagnostic test(s) (MRI and/or CT scan) with them to their scheduled appointment.

Again, you are required to bring your most recent MRI and/or CT scan studies to your scheduled appointment.

Front Back



You may bring printed films or a CD (compact disc) with the digital images of your study. A report of the results is not sufficient for proper evaluation.

<u>If you do not have your radiology films or CD, your appointment will be rescheduled.</u> If you have any questions regarding this policy, feel free to call our office prior to your appointment date.

Thank you,

_____

Patient Care Team

Today's Date ____/____/____ Doctor Hunaldo J. Villalobos Primary Care Physician:_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss	☐ Sr. ☐ Jr.

Street Address	City	State	Zip Code

Home Phone #	Cell Phone #	E-mail Address
( ) -	( ) -	

Gender	Social Security Number	Marital Status	Date of Birth	Age
☐ M ☐ F		☐Single ☐Married ☐Widow ☐Divorced	/ /	

INSURANCE INFORMATION

Occupation/Job Title	Employer /Employer Phone Number

Employer Address

Primary Insurance	Address of primary insurance carrier			Phone number ( ) -	
Insured Name	Insured S. S. #	Insured ID #	Group #	Eff. Date	Office Use Only /CP $

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER _____.

Secondary insurance	Address of secondary insurance carrier			Phone number ( ) -	
Insured Name	Insured S. S. #	Insured ID	Policy Group #	Eff. Date	Office Use Only /CP $

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

Insurance Type ☐ PPO ☐ EPO ☐ HMO ☐ POS ☐ Self Pay ☐ Medicare ☐ Public Aid ☐ WC ☐ OTHER _____.

Referred to Institute by (Please use one) **Phone Number**

☐ Doctor _____ _____

☐ Hospital _____ _____

☐ Insurance Plan _____ _____

☐ Family _____ _____

☐ Friend _____ _____

☐ Advertisement ☐ Internet Source ☐ Magazine

☐ Other _____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (I RECEIVED A COPY OF FORM)
To: Central Florida Neurosurgery Institute

X _____ / /
Signature Date

HIPPA AUTHORIZATION
(I RECEIVED A COPY OF HIPPA NOTICE)
REQUIRED FOR CLAIMS PROCESSING

X _____ / /
Signature Date

Today's Date ____/____/____ Doctor Hunaldo J. Villalobos Primary Care Physician: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	Date of Birth
			/ /

DEMOGRAPHICS (FOR GOVERNMENTAL STATISTICAL ANALYSIS)

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian ☐ African American
☐ White ☐ Hispanic ☐ Other Pacific Islander ☐ Other Race ☐ I Decline to Report

Ethnicity ☐ Non-Hispanic ☐ Hispanic If Hispanic, country of Origin _____ ☐ Decline Report

Preferred Language ☐ English ☐ Spanish ☐ Other _____

PHARMACY / PRESCRIPTION INFORMATION

Preferred Pharmacy:

☐ Costco ☐ CVS ☐ Publix ☐ Target ☐ Wal-Mart ☐ Walgreens ☐ Other _____

Address or Cross-Streets: _____

City: _____

State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

☐ This is a mail order pharmacy

I authorize Central Florida Neurosurgery Institute and its affiliated providers to view my external prescription history via Rxhub and the Sure scripts service. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include several years of prescription history.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

To: Central Florida Neurosurgery Institute

_____ / /

Patient Signature Date

I ATTEST I HAVE RECEIVED A COPY OF THE FOLLOWING FORMS & POLICIES:

CENTRAL FLORIDA NEUROSURGERY INSTITUTES' NOTICE OF PRIVACY POLICY ACT, FORM COMPLETION POLICY, MEDICATION REFILL POLICY, NO SHOW POLICY, AND MEDICAL RECORDS RELEASE POLICY.

_____ / /

Patient Signature Date