New Patient Enrollment Packet

Welcome to Gardens Neurology and IM. Please complete this packet before your first visit.

Physician: Nathaniel D. Kwok, M.D.
3401 PGA Boulevard, Suite 440 · Palm Beach Gardens, FL 33410
Office (561) 406-4469 Fax (561) 437-8255 kwokmdjupiter@gmail.com www.gardensneurology.com

HOW TO COMPLETE THIS PACKET

1. Complete every page that applies to you. Print clearly in ink, or type if you received a fillable copy.
2. Bring this packet, a photo ID, your red-white-and-blue Medicare card and/or Medicare Advantage card, any Medigap or other insurance cards, and a current medication list or pill bottles.
3. If another office holds your records, complete the Medical Records Release on page 12 and we will request them.
4. A parent, guardian, or legal personal representative must sign for a patient who cannot legally consent.
5. This packet collects information needed for registration, clinical care, privacy permissions, and billing, including Medicare and Medicare Advantage information used to file claims correctly.

WHAT IS IN THIS PACKET

HOW TO REACH US

Located with Gardens Neurology at 3401 PGA Boulevard, Suite 440. Do not use email or text for emergencies. Call 911 for life-threatening symptoms.

Office (561) 406-4469	**Fax** (561) 437-8255
Email kwokmdjupiter@gmail.com	**Web** www.gardensneurology.com
Privacy contact kwokmdjupiter@gmail.com	**Physician** Nathaniel D. Kwok, M.D.

IMPORTANT LIMITS

- Do not use email or unencrypted text for emergencies. Call 911 or go to the nearest emergency department for chest pain, stroke symptoms, severe bleeding, suicidal thoughts, or any life-threatening problem.
- Standard consumer email and SMS are not fully secure. Page 10 explains the risk and records your preference.
- Sensitive categories (mental health, substance use, HIV, genetic information) are released only when you authorize them on the records form.
- Keep the full Notice of Privacy Practices, Advance Beneficiary Notices (when a service may not be covered), and Good Faith Estimates for self-pay services as separate documents.

1. PATIENT IDENTITY

Legal Last Name | Legal First Name | Middle Name / Initial

Preferred Name (if different) | Date of Birth (MM/DD/YYYY) | Legal Sex (as on ID / insurance)

Gender identity (optional) ☐ Woman ☐ Man ☐ Non-binary ☐ Prefer to self-describe: _____

Pronouns (optional) | Marital Status | Preferred Language | Need interpreter? Y / N

Occupation | Employer

2. CONTACT INFORMATION

Mobile Phone | Home Phone | Preferred number: Mobile / Home

Email Address | Okay to leave voicemail? Y / N

Local / Florida Address (street, city, state, ZIP)

Out-of-state or seasonal address (if applicable)

Seasonal residents: tell us which months you are typically in each location so we can plan follow-up, labs, and medication refills.

3. EMERGENCY CONTACT

Name | Relationship | Phone

Alternate emergency contact (optional) | Relationship | Phone

4. ADVANCE CARE & PREFERRED HOSPITAL

Do you have an advance directive / living will? ☐ Yes ☐ No

Have you named a healthcare surrogate? ☐ Yes ☐ No

Do you have a durable power of attorney for healthcare? ☐ Yes ☐ No

If yes, surrogate / POA name and phone | Copy on file? Y / N

Preferred hospital | Preferred lab / imaging facility

5. PHARMACY

Preferred Pharmacy Name | Pharmacy Phone

Pharmacy Address / Cross streets

Mail-order or specialty pharmacy? Write it here as well. We will use this pharmacy for e-prescribing unless you tell us otherwise.

6. PRIOR PRIMARY CARE AND CURRENT SPECIALISTS

Prior / current PCP name

PCP phone / fax

List every physician or advanced practice clinician who currently treats you. This lets us coordinate care and request records.

Clinician name	Specialty	Phone / city

7. COVERAGE TYPE (complete the full insurance page next)

Check every type of coverage you have. Bring the physical cards to your first visit. Details and Medicare Secondary Payer questions are on the next page.

- ☐ Original Medicare (Part A / Part B)
- ☐ Medicare Advantage (Part C)
- ☐ Medicare Part D (drug plan)
- ☐ Medigap / Medicare supplement
- ☐ Commercial / employer plan
- ☐ Medicaid
- ☐ Tricare / VA
- ☐ Workers' compensation / liability
- ☐ Self-pay / no insurance

8. RACE AND ETHNICITY (federal quality reporting — you may decline)

This information is encouraged by federal health programs so practices can monitor and improve care for all patients. It is not used to deny care.

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline to respond

Race (check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other (specify below)
- ☐ Decline to respond

If Other, please specify

9. REASON FOR TODAY'S VISIT

What would you like us to focus on first?

How did you hear about this practice?

10. ORIGINAL MEDICARE

Copy the Medicare Beneficiary Identifier (MBI) exactly from the red-white-and-blue card. Do not use a Social Security number.

Medicare Beneficiary Identifier (MBI) | Effective date Part A | Effective date Part B

☐ I have Original Medicare Part A (hospital) ☐ I have Original Medicare Part B (medical)

11. MEDICARE ADVANTAGE (Part C — HMO, PPO, or similar)

If you are enrolled in a Medicare Advantage plan, that plan — not Original Medicare — is billed for covered services. Medigap does not work with an active Medicare Advantage plan.

Plan name (example: Humana, UHC, Aetna, Florida Blue) | Plan type: HMO / PPO / Other

Member ID | Group / PBP # | Plan phone on card

Primary care physician listed on the plan (if the plan requires one) | Referral required? Y / N

12. MEDIGAP / MEDICARE SUPPLEMENT OR OTHER SECONDARY

Medigap (Plans G, N, etc.) only pairs with Original Medicare. If you have Medicare Advantage, list other coverage here only if it is not a Medigap policy.

Carrier / plan name | Policy / ID # | Plan letter (G, N...)

Subscriber name (if not patient) | Customer service phone

Other coverage (employer plan, Medicaid, Tricare, Part D)
Carrier / plan name | Member ID | Group #

☐ I am the financially responsible party ☐ Another person is financially responsible:

Responsible party name / phone (if not patient)

13. MEDICARE SECONDARY PAYER SCREENING

Federal MSP rules require a good-faith effort to learn whether another payer must be billed before Medicare. Answer for today's visit. Staff may ask follow-up questions if you check Yes.

Are you currently working (full- or part-time)?	☐ Yes	☐ No
Is your spouse or a family member working and covering you on an employer group plan?	☐ Yes	☐ No
Do you have an employer group health plan of 20+ employees (working-aged) or 100+ (disability)?	☐ Yes	☐ No
Is this visit related to a work injury or workers' compensation claim?	☐ Yes	☐ No
Is this visit related to an auto, no-fault, or liability accident?	☐ Yes	☐ No
Are you within a 30-month ESRD coordination period with a group health plan?	☐ Yes	☐ No
Are you receiving Black Lung benefits for the condition being treated?	☐ Yes	☐ No
Has the VA authorized and agreed to pay for this care? If any Yes: insurer / employer / claim # / date of injury	☐ Yes	☐ No

Medicare entitlement is based on: Age Disability ESRD (circle one or more). This office screen is not a substitute for the full hospital MSPQ used at inpatient admission.

14. PAST MEDICAL HISTORY — have you EVER had any of the following?

Check Yes or No for each item. Use the next page to add details, years of diagnosis, and any condition not listed.

Asthma / breathing problems	☐ Yes	☐ No	Cancer (any type)	☐ Yes	☐ No
COPD / emphysema / bronchitis	☐ Yes	☐ No	Arthritis / joint replacement	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No	Osteoporosis / frequent fractures	☐ Yes	☐ No
Heart disease, MI, or heart failure	☐ Yes	☐ No	Chronic pain	☐ Yes	☐ No
Atrial fibrillation / arrhythmia	☐ Yes	☐ No	Neurologic disorder / neuropathy	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Seizure or epilepsy	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Migraines / chronic headaches	☐ Yes	☐ No
Stroke, TIA, or mini-stroke	☐ Yes	☐ No	Depression, anxiety, other MH	☐ Yes	☐ No
Blood clot (DVT) or PE	☐ Yes	☐ No	Memory loss / cognitive concern	☐ Yes	☐ No
Bleeding or clotting disorder	☐ Yes	☐ No	Alcohol or substance use disorder	☐ Yes	☐ No
Anemia or other blood disorder	☐ Yes	☐ No	HIV or immunocompromise	☐ Yes	☐ No
Diabetes or prediabetes	☐ Yes	☐ No	Eye disease (glaucoma, cataract)	☐ Yes	☐ No
Thyroid disorder	☐ Yes	☐ No	Hearing loss	☐ Yes	☐ No
Kidney disease or stones	☐ Yes	☐ No	Gynecologic or prostate problems	☐ Yes	☐ No
Liver disease or hepatitis	☐ Yes	☐ No	STI (past or current)	☐ Yes	☐ No
GERD, IBD, ulcer, or bowel disease	☐ Yes	☐ No	Long COVID / lasting symptoms	☐ Yes	☐ No

11. ADDITIONAL CONDITIONS AND DETAILS

List other illnesses and give brief details for any “Yes” answers above (year diagnosed, treating clinician, current status).

12. SURGERIES, PROCEDURES, AND HOSPITALIZATIONS

Procedure / reason for hospitalization	Approximate date	Hospital / city

13. FAMILY HISTORY (parents, siblings, children — major conditions)

Relative	Major conditions (heart disease, cancer type, diabetes, etc.)	Living?	Age if deceased
Mother		☐ Y ☐ N	
Father		☐ Y ☐ N	
Sibling(s)		☐ Y ☐ N	
Children		☐ Y ☐ N	
Other		☐ Y ☐ N	

14. SOCIAL HISTORY

Do you currently smoke cigarettes or cigars? ☐ Yes ☐ No

If no, did you smoke in the past? ☐ Yes ☐ No

Years smoked _____ Packs / day _____ Year quit (if former) _____ Interested in quitting? Y / N _____

Vaping, dip, or other nicotine products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Drinks per week (if yes) _____ What you typically drink _____

Recreational drugs or cannabis? ☐ Yes ☐ No

What / how often (if yes) _____

Who lives with you? Home situation? _____

Exercise (type and days per week) _____ Typical sleep hours / night _____

15. ALLERGIES AND ADVERSE REACTIONS

Any allergies to medications, foods, latex, contrast, or stings? ☐ Yes ☐ No

Always list the reaction (rash, hives, swelling, breathing difficulty, anaphylaxis, stomach upset). "Allergy" without a reaction is not useful clinically.

Allergen	Reaction	Allergen / reaction

16. CURRENT MEDICATIONS, SUPPLEMENTS, AND HERBS

Include prescriptions, over-the-counter products, vitamins, and herbs. Bring bottles to your first visit if the list is long.

#	Medication / supplement	Strength	How you take it (dose, times per day, indication)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

☐ I take no medications or supplements

17. PREVENTIVE CARE (approximate year of last service — write N/A if unknown)

Colon cancer screening (colonoscopy / FIT / Cologuard)	Mammogram
Pap / HPV / cervical screening	Bone density (DEXA)
Prostate screening / PSA (if relevant)	Lung cancer CT (if smoker history)
Eye exam	Dental exam
Skin check	Cardiac screening / calcium score / stress test
Last tetanus / Tdap	Pneumococcal vaccine
Shingles vaccine	COVID / influenza (most recent year)
Hepatitis B / other adult vaccines	Age-appropriate cancer genetic testing

18. GOALS, TECHNOLOGY, AND WHAT MATTERS TO YOU

Top health goals for the next 12 months

Wearables / apps / home devices you use (watch, CGM, BP cuff, scale)

Anything else you want your physician to know before the first visit

19. CONSENT TO EXAMINATION AND TREATMENT

I consent to evaluation, examination, testing, and treatment by Nathaniel D. Kwok, M.D. and the clinicians, nurses, and staff of Gardens Neurology and IM / Nathaniel D. Kwok, M.D.. This includes in-office care, telehealth when offered, and services the clinician judges reasonably necessary for my condition.

I understand that medicine is not an exact science, that no particular result is guaranteed, and that I may refuse any recommended test or treatment. I am responsible for telling the practice about my history, medications, allergies, and changes in my condition.

Life-threatening symptoms require 911 or an emergency department. After-hours messages, email, and text are not for emergencies and may not be read immediately.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

20. FINANCIAL RESPONSIBILITY

I request that payment of authorized Medicare, Medicare Advantage, Medigap, and other insurance benefits be made on my behalf to Nathaniel D. Kwok, M.D. for services furnished to me. I authorize the release of medical and other information needed to determine these benefits and to process claims.

I understand this practice participates in Medicare and accepts assignment for covered Medicare Part B services unless I am told otherwise before the service. I remain responsible for deductibles, coinsurance, copayments, and services that Medicare or my Medicare Advantage plan does not cover.

If a service may not be covered, the practice may give me an Advance Beneficiary Notice (ABN) before it is provided. Signing an ABN means I may have to pay if Medicare denies the claim. Laboratory, imaging, specialist, hospital, and pharmacy charges billed by other organizations are separate from this practice's fees.

Self-pay balances and amounts my plan does not pay are my responsibility. I may request a Good Faith Estimate for self-pay services as required by the No Surprises Act. Unpaid balances may be referred for collection after reasonable notice.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

21. PRACTICE POLICIES (initial each line)

initial I will arrive on time or notify the office as soon as I know I must cancel. Late-cancel / no-show fees, if any, are stated in the practice fee schedule.

initial Controlled-substance prescriptions, if ever appropriate, require an office relationship, monitoring, and compliance with state and federal law. Lost prescriptions are not automatically replaced.

initial Refill requests should go through the pharmacy or patient portal with at least 3 business days' notice. I will not wait until the last dose to request a refill.

initial Portal and email messages are for non-urgent questions. Staff or the physician will respond during business hours as capacity allows; this is not a substitute for a visit when an examination is needed.

initial I will treat clinicians and staff with respect. Abusive conduct may result in discharge from the practice after appropriate notice.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

22. NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGMENT

Federal law (HIPAA) gives you rights over your protected health information (PHI). We may use and disclose PHI to treat you, to obtain payment, and to run the practice (quality review, credentialing, appointment reminders, care coordination with specialists, pharmacies, and labs), as described in our Notice of Privacy Practices.

I have been offered a copy of the Notice of Privacy Practices for Nathaniel D. Kwok, M.D.. I understand I may request another copy at any time from the Privacy Officer at 3401 PGA Boulevard, Suite 440, Palm Beach Gardens, FL 33410, or kwokmdjupiter@gmail.com.

The practice may revise the Notice. The current version will be available in the office and, when posted, on the practice website.

I may request restrictions on certain uses or disclosures. The practice is not required to agree except where federal law requires agreement (for example, a restriction on disclosure to a health plan of an item I paid for in full out of pocket, when applicable).

I may revoke this acknowledgment in writing, except to the extent the practice has already relied on it.

Patient legal name _____ Date of birth _____

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

23. PEOPLE AUTHORIZED TO DISCUSS AND PARTICIPATE IN MY CARE

HIPAA allows us to share information with people involved in your care when it is reasonable to do so, but listing names here makes that permission clear for our staff. If a name is not listed, we will not discuss your care with that person except as the law allows (emergencies, required reports). This section does not replace a healthcare surrogate designation.

Full name	Relationship	Phone	Verbal	Written
			☐	☐
			☐	☐
			☐	☐
			☐	☐

☐ I do not authorize anyone other than myself (and required legal representatives) to discuss my care.

I understand this list remains in effect until I change it in writing or I die. I may add or remove names at any time by a signed written request.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

24. AUTHORIZATION TO COMMUNICATE BY ELECTRONIC MEANS

I authorize Nathaniel D. Kwok, M.D. and its clinicians and staff to contact me (or the personal representative I designate) using the methods I select below for appointments, test results when appropriate, refill status, care recommendations, practice updates, and similar operational or clinical messages.

Method (check all you allow)	Number / address to use
☐ Voice call and voicemail	
☐ Text / SMS (appointment and routine messages)	
☐ Unencrypted email	
☐ Secure patient portal / secure messaging only	
☐ Video visit / telehealth platform	

If messages may go to a personal representative instead of me, print that person's name and relationship

HOW LONG THIS PERMISSION LASTS

☐ Until I revoke it in writing ☐ Until this date: _____ ☐ Other: _____

RISKS YOU SHOULD KNOW

- Ordinary email and SMS are not encrypted end-to-end. Messages can be intercepted, forwarded, read on a shared device, or retained by your carrier or email provider.
- Do not send photographs of sensitive body areas, detailed mental-health narratives, or full Social Security numbers by unencrypted email or text.
- We will use reasonable safeguards (limited detail in texts, verification of numbers, option to use the portal instead). We cannot control the security of your own phone, computer, or inbox.
- I release Nathaniel D. Kwok, M.D., its clinicians, and staff from liability that arises solely from the inherent insecurity of the electronic channels I have chosen, except to the extent caused by the practice's negligence or violation of law.

BILLING AND COLLECTION CONTACTS

I understand that in the ordinary course of billing and collection, Nathaniel D. Kwok, M.D. may contact me about balances, estimates, and payment using any phone number or email I have provided, including cellular numbers. Contacts may include live calls, emails, texts, or recorded/artificial voice messages as permitted by applicable law. I may revoke this billing-contact permission by writing to the office; revocation does not cancel amounts I owe.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

A copy of this signed authorization will be given to you on request.

25. AUTHORIZATION TO DISCLOSE PHI TO FAMILY AND FRIENDS

Your privacy matters. Signing this form lets Nathaniel D. Kwok, M.D. disclose the information you describe to the people you name, in the ways you check. This is in addition to the "involved in care" list earlier in this packet and is useful when someone will pick up records, hear results, or help manage appointments.

Person 1

Full name _____ Phone _____

Relationship ☐ Spouse / partner ☐ Parent ☐ Child ☐ Sibling ☐ Other: _____

May receive information ☐ Verbally (phone or in person) ☐ In writing / printed records / appointment materials

Person 2

Full name _____ Phone _____

Relationship ☐ Spouse / partner ☐ Parent ☐ Child ☐ Sibling ☐ Other: _____

May receive information ☐ Verbally (phone or in person) ☐ In writing / printed records / appointment materials

Person 3

Full name _____ Phone _____

Relationship ☐ Spouse / partner ☐ Parent ☐ Child ☐ Sibling ☐ Other: _____

May receive information ☐ Verbally (phone or in person) ☐ In writing / printed records / appointment materials

SCOPE, EXPIRATION, AND YOUR RIGHTS

- The information that may be shared can include past, present, or future health information, including billing, treatment, and — unless I strike through this sentence — records related to mental health, substance use treatment, HIV/AIDS, and genetic information.
- Purpose: so the people named above can help with my care, appointments, and personal health management, or at my request.
- This authorization expires when I revoke it in writing, upon my death, or on this date if I fill one in: _____.
- I may revoke this authorization in writing to the Privacy Officer at Nathaniel D. Kwok, M.D., 3401 PGA Boulevard, Suite 440, Palm Beach Gardens, FL 33410. Revocation does not undo disclosures already made in reliance on this form.
- The practice will not condition my treatment on whether I sign this optional authorization.
- Information released to the people named above may be redisclosed by them and may no longer be protected by HIPAA.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____

26. AUTHORIZATION TO OBTAIN OR RELEASE HEALTH INFORMATION

This form meets the core elements and required statements of 45 CFR § 164.508. Complete a separate form for each outside facility when possible.

Patient legal name _____ Date of birth _____

Direction (check one)

☐ A. RELEASE FROM an outside provider / facility → TO Nathaniel D. Kwok, M.D. (we are requesting your old records)

☐ B. RELEASE FROM Nathaniel D. Kwok, M.D. → TO the recipient named below (we are sending your records out)

Outside provider, facility, or person

Name of practice / hospital / clinician _____ Phone _____

Address _____ Fax _____

City, state, ZIP _____ Email (if used for records) _____

Information to be released (check all that apply)

☐ Entire record for the dates below
☐ Office / progress notes
☐ History & physical
☐ Consult reports
☐ Laboratory results
☐ Imaging / radiology reports
☐ Pathology reports
☐ Operative reports
☐ ECG / EMG / EEG
☐ Immunization record
☐ Medication list
☐ Discharge summary

☐ Other (describe): _____

Date range: from _____ to _____ ☐ All dates on file

Sensitive information — also release the following if present in the record:

☐ Mental / behavioral health
☐ Substance use disorder (42 CFR Part 2 if applicable)
☐ HIV / AIDS related
☐ Genetic testing
☐ Reproductive / sexual health

Purpose of this disclosure

☐ Continuing / coordinating my medical care ☐ At my request ☐ Other: _____

This authorization expires

☐ One year from the date signed ☐ When the records have been sent / received ☐ On date: _____

I may revoke this authorization in writing sent to the Privacy Officer at Nathaniel D. Kwok, M.D., 3401 PGA Boulevard, Suite 440, Palm Beach Gardens, FL 33410. Revocation is not effective for disclosures already made in reliance on this form.

The practice will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization (except where legally permitted, such as research-related treatment or services provided solely to create information for a third party).

Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by HIPAA.

I understand I am entitled to a copy of this signed authorization.

Signature of Patient / Authorized Personal Representative _____ Date _____

Print Name _____ Relationship to Patient (if not self) _____