PATIENT INFORMATION
***** PLEASE COMPLETE ALL INFORMATION REQUESTED FOR OUR RECORDS *****

Date: _____

Last Name: _____ **MI**: _____ **First Name**: _____

DOB : _____ **SEX** : ____ **SS #** : _____

Address: _____

City: _____ **State** _____ **Zip Code:** _____

Phone (Home): _____ **Phone (Cell):** _____

Phone (Work): _____ **Email**: _____

Emergency Contact: _____ **Telephone #:** _____

Ref. Doctor: _____ **Telephone #:** _____

Primary Doctor: _____ **Telephone #:** _____

Pharmacy Info (name, address, phone/fax #) _____

☐ **Is this a Work Related Injury:** ☐ **Is this an Auto Injury:** Yes ☐ No ☐ **Are You a Resident of a Nursing Home or Rehab Center** :

Additional Information (as requested by Insurance Carrier):

Marital Status: ☐ Single ☐ Married ☐ Other **Student Status**: ☐ Full time ☐ Part time

1) **Ethnicity**: ☐ Hispanic or Latino ☐ Not-Hispanic/Latino ☐ Unknown

2) **Race:** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ White

3) **Primary Language**: ☐ Chinese ☐ English ☐ French ☐ German ☐ Italian ☐ Japanese ☐ Portuguese ☐ Russian ☐ Spanish

4) **Preferred Method of Communication:** **Phone**: ☐ Home ☐ Cell ☐ Work **Email**: ☐ (provide e-mail address above)

Primary Insurance Carrier: _____

Policy Number: _____

Group Number: _____

Relationship: _____

Last Name: _____

First Name: _____

SS #: _____ **DOB:** _____

Secondary Insurance Carrier: _____

Secondary Policy Number: _____

Secondary Group Number: _____

Relationship: _____

Last Name: _____

First Name: _____

SS #: _____ **DOB:** _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any information pertinent to my case to myself, family members, physicians, hospitals, insurance company, adjuster and/or attorney involved in my case. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance company, regardless of my insurance status. A photocopy of this release shall be considered as effective and valid as the original.

_____ _____
Patient (or authorized signature) Date Signed

Long Island Neurology Consultants--New Patient Medical History Form

Last Name: _____ First: _____ M.I. _____ Date: _____

Phone #: _____ DOB: _____ Age: _____ Sex:_____

PLEASE GIVE ALL RECORDS, STUDIES AND LABS TO CHECK-IN STAFF WHEN YOU ARRIVE

For Insurance Purposes: Please Check if the patient resides in a nursing home or is presently in a rehabilitation center □

WHICH HAND DO YOU WRITE WITH? Right Left

PLEASE TELL US YOUR REASON FOR TODAY'S VISIT. PLEASE INCLUDE A DESCRIPTION OF YOUR SYMPTOMS, WHEN THEY BEGAN, AND IF YOU HAVE HAD THEM PREVIOUSLY.

_____

_____

_____

_____

_____

_____

_____

PAST MEDICAL AND SURGICAL HISTORY: (Check all that apply)—include medical diagnoses, operations, hospitalizations

□ Stroke _____ □ Neck/Back Surgery _____
□ Seizures _____ □ Other Neurologic Conditions _____
□ Brain Surgery _____ _____

□ Diabetes	□ Heart Disease	□ Peptic Ulcer	□ **Any metal in your body?**
□ High Blood Pressure	□ Pacemaker/Defibrillator	□ Cancer/Tumor	_____
□ High Cholesterol	□ Atrial Fibrillation	□ Depression/Anxiety	_____

Other:_____
_____
_____

MEDICATIONS: (please list all prescription and over-the-counter medication, including Aspirin)

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

ALLERGIES TO MEDICATIONS?

_____

_____

Can you tolerate Aspirin? □ **Yes** □ **No**

FAMILY MEDICAL HISTORY: list any illnesses (especially neurological problems) that your blood relatives have had.

_____

_____

_____

PLEASE COMPLETE OTHER SIDE

*****PLEASE COMPLETE OTHER SIDE*****

Long Island Neurology Consultants

Name: _____ Date: _____

SOCIAL HISTORY

Occupation: _____ Are you Disabled? _____

Tobacco: _____ Other recreational drugs: _____

Alcohol: _____

Marital Status: _____Who do you live with? _____
How many children do you have? _____Ages: _____

REVIEW OF SYSTEMS:

Please list any symptoms or problems and explain in the space provided.

If applicable:

Last Menstrual Period _____ **Height _____**

Please indicate if you might be pregnant □ Yes □ No **Weight _____**

1. General □ **None**	**7. Urinary** □ **None**
2. Head/Ear/Nose/Throat □ **None**	**8. Integumentary (Skin/Breast)** □ **None**
3. Eyes □ **None**	**9. Endocrine** □ **None**
4. Cardiac □ **None**	**10. Allergy/Immunologic** □ **None**
5. Respiratory □ **None**	**11. Neurological/Musculoskeletal** □ **None**
6. GI □ **None**	**12. Psychological/Psychiatric/Recent Stress** □ **None** **13. Symptoms or Disease not listed?**

SIGNATURE _____ DATE SIGNED: _____

******PLEASE COMPLETE OTHER SIDE*******

Long Island Neurology Consultants

360 Merrick Road 1st Floor, Lynbrook NY 11563-2526
(516) 887-3516 • Fax (516) 887-0331

Lewis A. Levy, M.D.
Mark A. Nelson, D.O.
Eric J. Hanauer, M.D.
Stephen J. Roth, M.D.
Kristin M. Waldron, M.D.
Diplomates in Neurology

FINANCIAL POLICY

Long Island Neurology consultants, its physicians and the staff are truly committed to provide you with the utmost professional service and remarkable quality experience. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

ALL PATIENTS MUST COMPLETE PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR.

WE WILL REQUIRE YOUR INSURANCE CARDS AND PHOTO ID TO BE PHOTOCOPIED FOR YOUR FILE.

DEDUCTIBLES, CO-PAYMENTS AND CO-ISNURANCE: By law, we **MUST** collect your carrier designated deductible, co-payment and co-insurance at the time of service. The patient should be aware of their insurance financial responsibility, if you have any questions, please contact your insurance carrier. Please be prepared to pay the balance on your account on each visit.

NON CO-PAYMENT PLANS: If your plan does not require co-pay and we participate, we will accept the designated fee. You are responsible for any deductible, co-insurance, and patient responsibility your plan indicates on their explanation of benefits.

REFERRRALS: If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment either in electronic or paper form. Referrals must be available at the time of the visit. If you do not have a referral or referral number, **YOU WILL BE REQUIRED TO RESCHEDULE THE APPOINTMENT**, unless it is a medical emergency. Many plans do not allow referrals to be backdated, so be sure that you check with your insurance provider on the date that you are to be seen.

OUT OF NETWORK PLANS: In some instances, we are out of network with a plan. Since we greatly appreciate your business we will honor your benefits on an "out-of-network" basis. We will do our best to contact your insurance company, before your care, to verify your benefits and notify you of your patient's responsibility. Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier, who will reimburse you directly.

MEDICAID: We do not accept Medicaid in the office as primary or secondary insurance. Please note patients with Medicaid secondary will be responsible for any co-insurance which remains unpaid by their primary carrier.

SELF-PAY PATIENT: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. We accept cash, checks and most major credit cards.

MEDICARE: We will submit to Medicare for the Medicare-allowed amount. You will be responsible for the yearly deductible and 20% co-insurance, which can be billed to a secondary carrier, provided you have one.

If you have any questions regarding this matter please do not hesitate to call our billing department at 516-887-3516 x116.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

PATIENTS SIGNATURE ***DATE***

LONG ISLAND NEUROLOGY CONSULTANTS

OFFICE POLICIES

YOUR UNDERSTANDING OF OUR POLICIES IS AN ESSENTIAL ELEMENT OF YOUR CARE AND TREATMENT. IF YOU HAVE ANY QUESTIONS, PLEASE DISCUSS THEM WITH OUR FRONT OFFICE STAFF.

Our telephone lines are open from 8:00 AM to 4:00 PM Monday through Friday. Doctor's visits are by appointment only.

If you have an urgent health concern outside of business hours, please call our office and our service will assist you to page the physician on call. Please remember this is for emergency issues which cannot wait until the office re-opens. Please remove the caller ID block to allow us to reach you. If you are experiencing a medical emergency, call 911 or go directly to your nearest emergency department. Our office is affiliated with Mount Sinai South Nassau Hospital if you require in–patient care.

It is our policy to confirm all appointments three days ahead of time. We have an automated system in place which makes the initial confirmation call. You will also be notified by text message and by e-mail. It is necessary for you to use this system to confirm or cancel your appointment. This will avoid further calls to your home. If we do not hear back from you after the 3rd call, your appointment may be cancelled to accommodate emergencies. If you need to speak with a person regarding your appointment, our office telephone number is 516-887-3516. Press option #2 or leave us a message on extension 202 and we will return your call. Upon cancelling or rescheduling an appointment, our office requires the courtesy of a forty-eight (48) hour notice; otherwise, you may be charged a $50.00 cancellation fee. A $50.00 fee will be charged to those patients with repeated no shows. **APPOINTMENT TIMES ARE EXTREMELY VALUABLE TO OUR PATIENTS.**

We require a copy of your insurance card and your license or photo identification at the time of service to protect you from insurance fraud.

You must inform the office of all insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor directly. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to contact you for assistance.

Co-pays are due at the time of your appointment as well as any balance for deductible and co-insurance. Unless other arrangements have been made in advance by you or your health insurance carrier, payments for any deductibles or co-insurance are due at the time of service. For your convenience, we accept cash, checks, and most major credit cards. If a co-pay is not paid at the time of your visit, a $25.00 surcharge will be applied. There is a service fee of $30.00 for all returned checks. There will be no exceptions to this policy.

Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees, and court fees shall be your responsibility in addition to the balance due to this office.

In keeping with meaningful use requirements regarding EHR/EMR, electronic access to your chart can be obtained via the internet. In addition, electronic copies of patient health information, patient summary records, and clinical summaries can be provided electronically. Moreover, patient specific clinical reminders may also be sent electronically based on certain clinical criteria. Please inform our office if you wish to obtain access to our patient portal.

In an effort to encourage overall health, our electronic medical record recognizes concerns about weight and elevated blood pressure. Your Body Mass Index (BMI) calculates your weight based on your height. Normal BMI parameters are: for ages 18-64, BMI ≥ 18.5 and < 25 and for ages 65 and older, ≥ 23 and <30. If your BMI is outside of this range, our system will place a

comment on your office visit note to your primary care provider. We encourage our patients to use several on-line resources such as those from the American Heart Association (AHA) for education about weight monitoring, diet, and activity/exercise. Elevated blood pressure is an important modifiable risk factor for your vascular health. Guidelines from the American Heart Association/American Stroke Association define elevated blood pressure (hypertension) for anyone with readings ≥ 130/80. If your blood pressure is elevated, our system will place a comment on your office visit note and we encourage you to follow up with your primary care provider for this important concern. You may also consider several on-line resources from the American Heart Association/American Stroke Association to learn more about this topic.

As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office. To verify whether your insurance requires a referral, you can contact your primary care physician or your insurance company. Your referral needs to be in place at the time of your scheduled appointment. If you are unable to obtain a referral in a timely manner, your appointment will be rescheduled to a future date. Please contact your primary care physician at least 48 hours in advance to request a referral for your visit. Health plans are not the same and do not cover the same services. In the event your health plan determines a service is "not covered" or we are not able to obtain an authorization, you will be responsible for the complete charge. Patients are encouraged to contact their insurance plan(s) for clarification of benefits prior to services rendered.

As of March 27, 2016 NY State law requires all prescriptions, including controlled substances, to be transmitted electronically. If you need a refill on your medication, please contact your pharmacy. Your pharmacy will make the request to our office via internet. Please allow 24 to 48 hours before you check with your pharmacy if the prescription has been filled. You may also use our **patient portal** at www.lineurology.com, under patient information click on patient portal or myehr123.com/lineuroportal to request a prescription refill. Please include the following information in your message request: Patient name, name of the medication, dosage, and pharmacy's name and number. If you have further questions, please contact our prescription liaison at 516-887-3516 select Option #5 or ext. 118. You must also be able to provide an unblocked telephone number where we can reach you in case of any questions or problems. Allow 24 hours for phoned in refill requests to be processed.

We will make every attempt to notify you of all test results when they become available. HIPAA compliance allows us to leave this information on your voicemail (unless you specify otherwise).

Medical forms that need to be completed by the Physician will require two weeks notice for processing. All forms need to be dropped off at our main office located at 360 Merrick Road 1st floor, Lynbrook NY 11563. Be sure to complete and sign any patient sections. You will be contacted by our office when the form(s) is ready to be picked up. Likewise, if you need a letter on your behalf from the Physician, it will require the same time to process. Please call the office and advise the staff of the specific details you need included in the letter. Forms and letters cannot be processed at the time of your appointment. In many cases, there may be an additional charge to complete forms.

I have read and understand the office policy of Long Island Neurology Consultants. It is my responsibility to abide by the rules and regulations and agree to the above policies.

Signature of Patient/Responsible Party: _____ Date: _____

Printed Name of Patient/Responsible Party: _____ Date: _____

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Patient ACCT#_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of Long Island Neurology Consultants Notice of Privacy Practices.

_____ _____ _____

Print Patient Name **Patient Signature/Legal Representative** **Date**

PLEASE LIST PERSON(S) **WE CAN DISCLOSE** YOUR PERSONAL HEALTH INFORMATION TO:

_____
_____
_____
_____

PLEASE LIST PERSON(S) **WHOM YOU DO NOT** WISH US TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION TO:

_____
_____
_____
_____

CAN WE LEAVE TEST RESULTS

ON YOUR ANSWERING DEVICE: YES_____NO_____

FOR LONG ISLAND NEUROLOGY CONSULTANTS ONLY

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Long Island Neurology Notice of Privacy Practices but was unable to for the following reason:

- **Patient declined to sign**
- **Patient unable to sign**
- **Other _____**

_____ _____
Employee Name Date

Long Island Neurology Consultants
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1st Floor
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NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE SIGNATURE DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.