NY Neurological Associates, P.C.

PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Patient's Name: (Last, First) | Legal Sex: | Date of Birth:

Street Address: | Apt #

City: | State: | Zip:

Cell Phone: (required) | Home phone:

E-Mail: (required) | Work phone:

Race/ethnicity (optional) ☐ White/Caucasian ☐ Black/African-American ☐ Asian ☐ Latino/Hispanic ☐ Mixed race/ethnicity ☐ Declined

EMERGENCY CONTACT

Name:	Phone:
Is this person your health care proxy? ☐ Yes ☐ No	Home Address:
Relationship:	

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co. Name:	Insurance Co. Name:
Insurance ID:	Insurance ID:
Name of Insured:	Name of Insured:
Insured DOB:	Insured DOB:

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR YOUR MEDICAL BILL)

Name:	Home Address:
Home Phone:	Alternate Phone:

CARE TEAM

REFERRING PROVIDER: Who referred you to see us?	**PRIMARY PROVIDER** (if not the same as your referring doctor)
Name:	Name:
Phone:	Phone:
Address:	Address:

PREFERRED PHARMACY INFORMATION (REQUIRED)

Name: | Address: | Phone:

PATIENT PORTAL

We encourage all of our patients to join our patient portal. Our portal includes secure e-mail communication with our office, self-scheduling of appointments, request of refills, and review of results. Do you consent to join our patient portal? ☐ Yes ☐ No

Do you have an open No Fault or Workers Compensation case? ☐ Yes ☐ No

Is your visit today the result of a car accident? ☐ Yes ☐ No

Is your visit today related to a work related injury? ☐ Yes ☐ No

If you answered yes to any of the above, payment is due in full at time of service.

_____ *Signed:*

_____ *Date:*

NY Neurological Associates, P.C.
www.nynapc.com

OFFICE POLICIES

INSURANCE INFORMATION:

If you are using health insurance for the office visit:

- It is your responsibility to verify with your insurance company that our physicians are“in-network” with your specific plan. We do our best to keep on top of this but because of the number of sub-plans, we are not always aware of our individual sub-plan participation.
- If a referral from your primary care doctor is required by your insurance plan, we must receive it 48 hours prior to your visit or your appointment will not be held.
- Please provide complete insurance information at the time of scheduling so we have ample time to verify your benefits.
- If you learn after the office visit that we are not in-network or that you needed a referral and it was not provided, you will be responsible for payment in full for the visit.

If we do not participate in your insurance plan:

- You will be responsible for payment in full at the time of the visit.
- Upon request, we will provide a receipt of medical services rendered so you can submit a claim to your insurance company.

DEPOSIT TO HOLD NEW PATIENT APPOINTMENT:

- We require a $50 deposit to secure your in-person first appointment.
- Once your insurance company has processed your claim and your responsibility has been determined, any difference will be refunded or collected from the card on file.
- Please allow up to 7 business days from the time of your e-emailed credit notification for your credit to post by your credit card company.
- NO-SHOW/LATE CANCELLATION FEE: If you fail to show for the appointment, or do not provide us more than 24 hours notification, this deposit will be converted to a non-refundable NO-SHOW fee.

CREDIT CARD ON FILE:

- We require a credit card on file to cover deductibles, co-insurances, co-pays, and in some cases denial of medical payment by your insurance company.

REGISTRATION FORMS:

- To avoid prolonged in-person contact due to COVID 19, please submit registration documents within 48 hours of scheduling your appointment. This allows us time to verify insurance and collect additional medical information prior to the visit.

FOLLOW-UP VISITS:

You will be required to have an appointment at appropriate intervals for review of results, review of your medical condition, and management of medication. These appointments may be tele-visits or in-person at the discretion of the physician.

ELECTRONIC COMMUNICATION:

- We encourage you to use our patient portal for brief communication with the office in between scheduled office visits.
- You will be asked to schedule an appointment if the inquiry can not efficiently be handled electronically.
- Your signature at the bottom of the page confirms your consent to electronic communication.

TELEVISITS:

- Televisits are conducted with audio and video over Zoom, Doximity, or Facetime.
  Your signature at the bottom of the page confirms yourconsent to telemedicine visits.

IN-PERSON COVID 19 PRECAUTIONS:

- Due to COVID 19, we are spacing out our in-person appointments to reduce the number of people in our office at one time.
- We unfortunately are unable to see you in-person if you are in quarantine or isolation due to COVID 19. Please inquire regarding possible telemedicine visits.
- To minimize the number of people entering our office, we prefer you come unaccompanied to your visit. If one additional person is essential for the visit, please discuss this at the time of scheduling.
- You must wear a mask to enter the building and you must keep it on at all times.
- We will check your temperature.
- Please use hand sanitizer UPON ENTRY. Hand sanitizer is readily available in our office.
- To maintain air flow, the exam room door may remain open when the doctor is with you.
- You will be provided with a code to enter the front door—please make sure you have this code on the day of the appointment to enter the building.

PRESCRIPTION REQUESTS:

- Please request refills during your appointment to last until your next scheduled visit.
- Prescriptions of controlled substances may require a physician visit.
- Routine refill requests will not be addressed after-hours, on weekends or holidays.
- If you need an emergency refill and it is a weekend or holiday, there will be a $50 emergency prescription fee to contact your pharmacy outside of normal business hours. We strongly encourage you to monitor your medication consumption and plan ahead.
- Please allow up to 48 hours to process routine refill requests submitted Monday through Friday.

LATE ARRIVALS:

Due to COVID 19, we are spacing out our in-person appointments to reduce the number or people in our office at one time. If you arrive more than 30 minutes late for check-in, we will do our best to accommodate you at the discretion of our physician. You may be subject to a no-show fee of $50 and your appointment may need to be rescheduled.

NO-SHOW/LATE CANCELLATIONS PROCEDURE FEE:

Failure to cancel more than 24 hours in advance for EEG, EMGs, and skin biopsies will result in a no show/late cancellation fee of $100.

FORM FEES:

All forms and letters are charged at an additional fee ranging from $25 to $50.

FEEDBACK:

We appreciate positive feedback of our staff and physicians in person, by mail, or online so please take a few moments to review us. If you have an experience that is troubling, please address it directly with our office staff rather than online. All complaints will be brought to our physicians' attention and will be addressed in a timely manner so we may rectify your complaint.

Name (of patient or guarantor)	*Signature (of patient or guarantor)*	*Today's date*

NY Neurological Associates, P.C.
www.nynapc.com

- HIPAA Privacy
- Release of Information
- Assignment of Benefits
- Financial Responsibility
- Medication History
- Health Information Exchange

Name of Patient: _____ Date of Birth: _____

HIPAA PRIVACY ACKNOWLEDGEMENT: I hereby acknowledge the receipt of NY Neurological Associates PC, HIPAA privacy notice.

RELEASE OF MEDICAL INFORMATION: I certify that all information that I have provided to NY Neurological Associates PC is true and correct. I hereby authorize NY Neurological Associates PC, to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

- Any person or entity responsible for payment for the medical services rendered to me including insurance carriers, governmental agencies, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care.
- Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.
- I acknowledge that the above authorization has no expiration date and is valid to authorize the release of medical records and billing information at any time a valid request is received. This includes information relative to alcohol abuse, drug abuse, psychological or psychiatric conditions and Acquired Immune Deficiency Syndrome (AIDS).

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize NY Neurological Associates PC to file claims on my behalf for covered services rendered. I hereby assign, transfer, and set over to NY Neurological Associates PC sufficient monies and or benefits to which I may be entitled to from governmental agencies including Medicare, insurance carries or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf. If coverage is denied, I give my express consent to appeal to the insurance on my behalf.

FINANCIAL RESPONSIBILITY:

Managed care/commercial insurance plan: I understand that I am financially responsible for deductibles, co-pays, co-insurance. I am responsible for obtaining a referral if required. If referral is not on file 48 hours prior the appointment, the appointment will not be held. This additional time is needed to verify eligibility in your insurance plan. I am financially responsible for noncovered services including administrative fees. Payment is required at the time services are rendered. Managed care/commercial insurance plan—non-participating provider: If you do not have out of network benefits, you will be responsible for 100% of the provider's full charge. If you do have out of network benefits, you will be responsible for paying your deductible if it is not yet met for the calendar year, co-insurance, and any other financial obligations as stated in your plan. I am financially responsible for non-covered services including administrative fees. Payment is required at the time services are rendered.

Medicare: I understand that I am responsible for paying my deductible, if not yet met for the calendar year, as well as any services not covered by Medicare. If you do not have a secondary coverage or Medigap, you will also be asked to pay the 20% Medicare coinsurance. I am financially responsible for non-covered services including administrative fees. Payment is required at the time services are rendered.

Uninsured: I understand that I am financially responsible for 100% of the provider's full charge. Payment is required at the time services are rendered. If you are unable to pay your bill in full, please inquire regarding a payment plan. By signing the financial responsibility statement, the patient and guarantor(s) acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health maintenance organization (or preferred provider organization) because of a failure to comply with such coverage requirements or for any other reason. A copy of this form shall have the same force and effect as the original.

CONSENT TO MEDICATION HISTORY: I authorize NY Neurological Associates PC to electronically access my medication history from my pharmacies for review and inclusion in my electronic medical record.

CONSENT TO HEALTH INFORMATION EXCHANGE: I authorize NY Neurological Associates PC to electronically access my medical records from other health care providers outside of NY Neurological Associates PC for the purpose of continuity of care.

I acknowledge that I have read and understand its contents fully. The undersigned is the patient, the patient's legal representative or is authorized by the patient to execute this form and accepts its terms.

_____ _____

Signature of patient or authorized representative *Date*

NY Neurological Associates, P.C.

NEW PATIENT MEDICAL HISTORY

PATIENT INFORMATION		
Name:	Date of birth:	Today's Date:
Primary Doctor:		
Other Neurologist(s), You have seen		

What is the reason for today's visit? Why did your doctor refer you for neurological evaluation?

Have you seen any other doctors for this condition? If yes, Who? When? What testing was done?

PAST MEDICAL AND SURGICAL HISTORY

Medical problems:	*Hospitalizations:*	*Surgeries:*

CURRENT MEDICATIONS

Please include names, doses, and approximately when it was started:

ALLERGIES TO MEDICATIONS

☐ NONE	*Name/Reaction/Date*

SOCIAL HISTORY

Tobacco use: ☐ Current smoker ☐ Former Smoker ☐ Never smoker **How many packs per day?** _____ **How many years?** _____

Alcohol use: ☐ Current ☐ Former ☐ Never **How many drinks per week?** _____

Are you ☐ **RIGHT or** ☐ **LEFT handed ?** **What languages do you speak at home?** _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

How much school did you complete? _____

Are you currently working? ☐ Yes ☐ No **What is/was your occupation?** _____

Advanced directives:

- Do you have a living will--a legal document specifying what actions should be taken in case you cannot make decisions? ☐ Yes ☐ No
- Do you have a health care proxy--a legal document listing someone to make your medical decisions in case you cannot? ☐ Yes ☐ No

If yes, who is your proxy? _____

FAMILY HISTORY

RELATION	Alive/ Deceased	AGE	Has a problem similar to mine	All known health problems
MOTHER				
FATHER				
BROTHERS				
SISTERS				
CHILDREN				
OTHERS				

SYMPTOM REVIEW

Constitutional
- ☐ Excess weight gain
- ☐ Excess weight loss
- ☐ Loss of appetite
- ☐ Fever
- ☐ Low activity level
- ☐ Fatigue
- ☐ None of the above

Eyes
- ☐ Eye pain
- ☐ Blurry vision
- ☐ Eye redness
- ☐ Eye itchiness
- ☐ Eye swelling
- ☐ Eye discharge
- ☐ None of the above

Ears, Nose, Mouth,Throat
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Sinus pressure
- ☐ Drooling
- ☐ Facial swelling
- ☐ Congestion
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Foul smelling breath
- ☐ Mouth lesions
- ☐ None of the above

Cardiovascular
- ☐ Chest pain
- ☐ Rapid heart rate
- ☐ None of the above

Respiratory
- ☐ Cough
- ☐ Bark like cough
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Pain with respiration
- ☐ Noisy breathing
- ☐ Rapid respiration
- ☐ Difficulty breathing
- ☐ None of the above

Genito-urinary
- ☐ Discharge
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Urinary frequency
- ☐ Urinary urgency
- ☐ None of the above

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Mucus in stools
- ☐ None of the above

Musculoskeletal
- ☐ Soft tissue swelling
- ☐ Joint swelling
- ☐ Myalgia
- ☐ Limited motion
- ☐ Previous injuries
- ☐ Trauma
- ☐ None of the above

Neurological
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Burning
- ☐ Shooting pain
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ None of the above

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Stress
- ☐ Loss of interest
- ☐ None of the above

Other things your doctor should know about you:

FOR PATIENT USE ONLY

Patient Name: _____

Patient Signature: _____ *Date:* _____

FOR DOCTOR USE ONLY

Seen by: ☐ Dr. Fatimi ☐ Dr. Snyder ☐ Dr. Zaharakis

Doctor Signature: _____ *Date:* _____