

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: _____

Secondary Insurance Carrier: _____

Policy Number: _____

Secondary Policy Number: _____

Group Number: _____

Secondary Group Number: _____

Relationship: _____

Relationship: _____

Last Name: _____

Last Name: _____

First Name: _____

First Name: _____

SS #: _____ DOB: _____

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)
Z:/data/originalforms/patientinfoforms2014-02/07

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 the box if the patient resides in a nursing home

WHICH HAND DO YOU WRITE WITH? Right Left

PLEASE TELL US THE REASON FOR YOUR VISIT TODAY. 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, and 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: _____ 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 <input type="checkbox"/> None	7. Urinary <input type="checkbox"/> None
2. Head/Ear/Nose/Throat <input type="checkbox"/> None	8. Integumentary (Skin/Breast) <input type="checkbox"/> None
3. Eyes <input type="checkbox"/> None	9. Endocrine <input type="checkbox"/> None
4. Cardiac <input type="checkbox"/> None	10. Allergy/Immunologic <input type="checkbox"/> None
5. Respiratory <input type="checkbox"/> None	11. Neurological/Musculoskeletal <input type="checkbox"/> None
6. GI <input type="checkbox"/> None	12. Psychological/Psychiatric/Recent Stress <input type="checkbox"/> None 13. Symptoms or Disease not listed?

SIGNATURE _____ DATE SIGNED: _____

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

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 South Nassau Communities 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. 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. 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 702 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 will be charged a \$50.00 cancellation fee. A \$50.00 fee will be charged to those patients with repeated no shows.

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. 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.

For services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

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 $\geq 130/80$. 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 <https://lincneuro.com> 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).

When you have a form that needs to be filled out by the doctor, we will require two weeks notice for processing. You must drop the form off at our office and be sure to complete all the sections that need to be filled out by you. You will be contacted when it is ready to be picked up. Likewise, if you need a letter on your behalf from the doctor, it will require the same time to process. Please call the office and advise the staff of the specific details that need to be included. Forms and letters cannot be processed at the time of your appointment. In many cases, there may be an additional charge to complete forms.

APPOINTMENT TIMES ARE EXTREMELY VALUABLE TO OUR PATIENTS

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: _____

Long Island Neurology Consultants

777 Sunrise Highway • Suite 200 • Lynbrook, New York 11563-2950

227 Franklin Avenue • Hewlett, New York 11557-1902

(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

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.

CO-PAYMENTS: By law, we **MUST** collect your carrier designated co-payment at the time of service. Please be prepared to pay the co-pay 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 and balance your plan indicates on their explanation of benefits.

REFERRALS: 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.

NON-PLAN PATIENTS: 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.

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.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

PATIENTS SIGNATURE

DATE

Long Island Neurology Consultants

777 Sunrise Highway • Suite 200 • Lynbrook, New York 11563-2950
227 Franklin Avenue • Hewlett, New York 11557-1902
(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

PORTAL ANNOUNCEMENT

We are pleased to announce a new aspect of our practice, our **Patient Portal**. This will allow you to request prescription refills at any time and will allow you to view documents related to your medical care.

Once you have logged onto the Portal for the first time, we would greatly appreciate it if you would send us a "Hello" message so that we will know that you have successfully accessed the portal.

The Portal is to be used only to:

1. View and download the following documents:

Electronic test results

Your Visit Summary

2. Request medication refills.

Note: these will not be attended to when the office is closed.

You must allow five business days for your request to be addressed.

ANY MESSAGES, INCLUDING QUESTIONS REGARDING YOUR MEDICAL CARE, SHOULD NOT BE SENT VIA THE PORTAL AND WILL NOT BE ANSWERED VIA THE PORTAL. PLEASE PHONE OUR OFFICE IF YOU HAVE SPECIFIC MEDICAL QUESTIONS OR CONCERNS.

The portal can be accessed at

<https://lincneuro.com/portal>

Please note that in order for our system to authenticate your information we must have your social security number and your email address in our records.

Our office will be able to help you with the use of the portal. Please call with questions at 516-887-3516 option 2 or leave a message on extension 108.

Sincerely,

Long Island Neurology Consultants

Long Island Neurology Consultants

777 Sunrise Highway • Suite 200 • Lynbrook, New York 11563-2950
227 Franklin Avenue • Hewlett, New York 11557-1902
(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

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