NEUROLOGY FOLLOW UP VISIT

Patient Name: _____ Tel. # (_____) _____ Date: _____

Date of Last Office Visit: _____ Height: _____ Weight: _____

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

1. Have you had a No Fault or Workers Compensation injury since your last visit? ☐

2. **For Insurance Purposes: Please check the box if patient resides in a nursing home or is presently in a rehabilitation center** ☐

3. **Has there been any worsening or improvement in your condition since your last visit? If so, in what way?**

_____

_____

_____

4. **Do you have any new problems?**

_____

_____

5. **What medications are you now taking? Name of medication and dosage (if known)**

1. _____ 4. _____ 7. _____

2. _____ 5. _____ 8. _____

3. _____ 6. _____ 9. _____

6. **Does any medication that I gave you induce unwanted side effects?**
Name of medication and side effect:

_____

_____

7. **What tests have you had since your last visit?**

_____

8. **Does any non-medicinal treatment provide benefit? (Examples would include: Physical Therapy, Biofeedback Therapy, Chiropractic, Acupuncture, etc.)**
Name of treatment: **Benefit:**

_____

9. **Referring and other doctors attending your care:**

_____

10. **Are you disabled?** No _____ Partial _____ Total _____

11. **If you cannot work, please tell us why**:

_____

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 777 Sunrise Highway, Suite 200, 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: _____

Long Island Neurology Consultants

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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***

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Patient ACCT#_____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The Notice contains a section describing your rights under the law. You have the right to review our Notice before you sign this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

Our practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) law. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, or healthcare operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation will not be retroactive.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell phone? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____Date: _____

Parent or Guardian: _____ Date: _____