NO-FAULT PATIENT INFORMATION
PLEASE COMPLETE ALL INFORMATION

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 #) _____

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)

Was an "Application for Benefits" form completed with your insurance carrier? ☐ **Yes** ☐ **No**

INSURANCE INFORMATION

(If the above has not been done, your medical expenses will not be recognized for payment. Satisfaction of your account would then become your direct responsibility.)

Policyholder Name: _____

Policyholder Address: _____

Policy Number: _____ **Insurance Claim File #**: _____

Date of Accident/Injury: _____ **State How Accident/Injury Occurred**: _____

_____

_____

Insurance Carrier Name: _____

Address: _____

Are You Working? ☐ **Yes** ☐ **No** **Date Last Worked** _____ **Date Returned** _____

Claim Representative: _____ **Insurance Phone #** _____

Attorney: _____ **Phone #** _____

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*******

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ , ("Assignor") hereby assign to _____ , ("Assignee")
(Print patient's name) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____ , not withstanding any other agreement
(Print accident date)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)	**(Signature of Patient)**
	(Date of signature)
(Address of Patient)	
(Print name of Provider)	**(Signature of Provider)**
	(Date of signature)
(Address of Provider)	

NYS FORM NF-AOB (Rev 1/2004)

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS

NAME AND ADDRESS OF INSURER *	NAME, ADDRESS, AND PHONE NUMBER OF INSURER'S CLAIMS REPRESENTATIVE*

DATE	POLICYHOLDER	POLICY NUMBER	DATE OF ACCIDENT	CLAIM NUMBER

TO ENABLE US TO DETERMINE IF YOUR ARE ENTITLED TO BENEFITS UNDER THE NEW YORK NO-FAULT LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY.

IMPORTANT: 1. TO BE ELIGIBLE FOR BENEFITS YOU MUST COMPLETE AND SIGN THIS APPLICATION.
2. YOU MUST SIGN ANY ATTACHED AUTHORIZATION(S).
3. RETURN PROMPTLY WITH COPIES OF ANY BILLS YOU HAVE RECEIVED TO DATE.

NAME AND ADDRESS OF APPLICANT*

1. YOUR NAME	2. PHONE NOS. HOME	BUSINESS

3. YOUR ADDRESS (NO., STREET, CITY OR TOWN AND ZIP CODE)	4. DATE OF BIRTH	5. SOCIAL SECURITY NO.

6. DATE AND TIME OF ACCIDENT A.M. P.M.	7. PLACE OF ACCIDENT (STREET), CITY OR TOWN AND STATE

8. BRIEF DESCRIPTION OF ACCIDENT

9. DESCRIBE YOUR INJURY

10. IDENTITY OF VEHICLE YOU OCCUPIED OR OPERATED AT THE TIME OF THE ACCIDENT:

OWNER'S NAME MAKE YEAR

THIS VEHICLE WAS: ☐ A BUS OR SCHOOL BUS, ☐ OR A MOTORCYCLE ☐ A TRUCK, ☐ AN AUTOMOBILE,

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	☐	☐
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	☐	☐
WERE YOU A PEDESTRIAN?	☐	☐
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	☐	☐
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE TWO

12. WERE YOU TREATED BY A DOCTOR(S) OR OTHER PERSON(S) FURNISHING HEALTH SERVICES?

YES ☐ NO ☐

IF YES, NAME AND ADDRESS OF SUCH DOCTOR(S) OR PERSON(S):

13. IF YOUR WERE TREATED AT A HOSPITAL(S), WERE YOU AN

OUT-PATIENT? ☐ IN-PATIENT? ☐

DATE OF ADMISSION: _____

HOSPITAL'S NAME AND ADDRESS: _____

14. AMOUNT OF HEALTH BILLS TO DATE:	15. WILL YOU HAVE MORE HEALTH TREATMENT(S)?	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT?
$ _____	YES ☐ NO ☐	YES ☐ NO ☐

17. DID YOU LOSE TIME FROM WORK?	DATE ABSENCE FROM WORK BEGAN:	HAVE YOU RETURNED TO WORK?
YES ☐ NO ☐		YES ☐ NO ☐

IF YES, DATE RETURNED TO WORK: _____ AMOUNT OF TIME LOST FROM WORK: _____

18. WHAT ARE YOUR GROSS AVERAGE WEEKLY EARNINGS?	NUMBER OF DAYS YOU WORK PER WEEK:	NUMBER OF HOURS YOU WORK PER DAY:

19. WERE YOU RECEIVING UNEMPLOYMENT BENEFITS AT THE TIME OF THE ACCIDENT?

YES ☐ NO ☐

20. LIST NAMES AND ADDRESS OF YOUR EMPLOYER AND OTHER EMPLOYERS FOR ONE YEAR PRIOR TO ACCIDENT DATE AND GIVE OCCUPATION AND DATES OF EMPLOYMENT:

EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO
EMPLOYER AND ADDRESS	OCCUPATION	FROM	TO

21. AS A RESULT OF YOUR INJURY HAVE YOU HAD ANY OTHER EXPENSES?

YES ☐ NO ☐

IF YES, ATTACH EXPLANATION AND AMOUNTS OF SUCH EXPENSES.

22. DUE TO THIS ACCIDENT HAVE YOU RECEIVED OR ARE YOU ELIGIBLE FOR PAYMENTS UNDER ANY OF THE FOLLOWING:

	YES	NO
NEW YORK STATE DISABILITY?	☐	☐
WORKERS' COMPENSATION?	☐	☐

CONTINUATION ON NEXT PAGE

APPLICATION FOR MOTOR VEHICLE NO-FAULT BENEFITS - - PAGE THREE

THE APPLICANT AUTHORIZES THE INSURER TO SUBMIT ANY AND ALL OF THESE FORMS TO ANOTHER PARTY OR INSURER IF SUCH IS NECESSARY TO PERFECT ITS RIGHTS OF RECOVERY PROVIDED FOR UNDER THE NO-FAULT LAW.

THIS FORM IS SUBSCRIBED AND AFFIRMED BY THE APPLICANT AS TRUE UNDER THE PENALTIES OF PERJURY

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF WORK AND OTHER LOSS INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY WAGES, SALARY OR OTHER LOSS WHILE EMPLOYED BY YOU. YOUR ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____ SOCIAL SECURITY NO. _____

SIGNATURE _____ DATE _____

DO NOT DETACH

AUTHORIZATION FOR RELEASE OF HEALTH SERVICE OR TREATMENT INFORMATION

THIS AUTHORIZATION OR PHOTOCOPY THEREOF, WILL AUTHORIZE YOU TO FURNISH ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION OR TREATMENT, INCLUDING THE HISTORY OBTAINED, X-RAYS AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS. YOU ARE AUTHORIZED TO PROVIDE THIS INFORMATION IN ACCORDANCE WITH THE NEW YORK COMPREHENSIVE MOTOR VEHICLE INSURANCE REPARATIONS ACT (NO-FAULT LAW).

NAME (PRINT OR TYPE) _____

SIGNATURE _____ DATE _____

(IF THE APPLICANT IS A MINOR, PARENT OR GUARDIAN SHALL SIGN AND INDICATE CAPACITY AND RELATIONSHIP).

*LANGUAGE TO BE FILLED IN BY INSURER OR SELF-INSURER.

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#_____

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: _____

Long Island Neurology Consultants

Health Insurance Portability Accountability Act
777 Sunrise Highway
Suite 200
Lynbrook, NY 11563
T (516) 887-3516 F (516) 887-0331

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City: _____ State:_____ Zip: _____

I authorize the release of the following protected health information:

Office Notes ☐ Diagnostic Reports ☐ Laboratory Reports ☐ Other_____ Dates:_____

Attention:

_____

_____

_____

Send my medical information to:

Name: Long Island Neurology Consultants Fax # 516-887-0331

Address: 777 Sunrise Highway, Suite 200

City, State, Zip: Lynbrook, NY 11563

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicted above.
- I may refuse to sign this authorization , which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may re-disclosed by the recipient and no longer be protected by federal or state law. LINC shall not be held liable for any consequences resulting from re-disclosure.
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information form will be requested.
- Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- LINC may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This authorization expires on ___/____/____ (if date not completed/one year after signed).

_____ _____

Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

Print Name Relationship to patient

Retain this form in the patient's medical record and provide a copy to the patient.

An additional authorization (NYS DOH-2557) is required for disclosures when your medical records contain information relating to Acquired Immunodeficiency Syndrome(AIDS), or Human Immunodeficiency Virus (HIV) including but not limited to test results and the fact that the test was taken.

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

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

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.

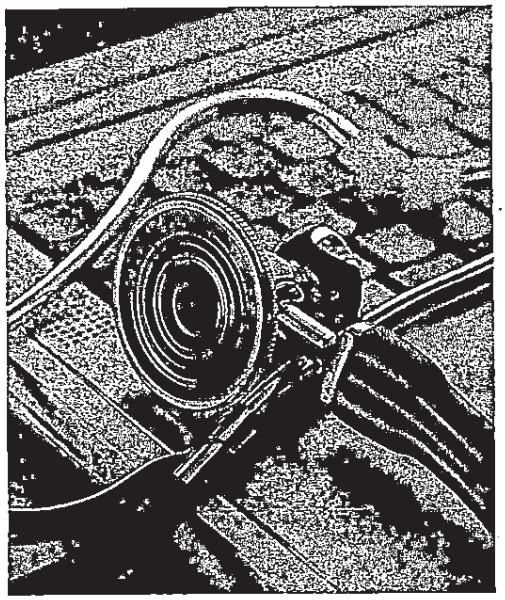
SELF-PAY PATIENT: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. We accept cash, checks and most major credit cards.

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***



Healthix can provide real-time clinical data to your physicians and providers so they can have access to your information when and where it's needed..

A list of the organizations that participate in Healthix can be found by visiting our website Healthix.org/directory

Healthix

LONG ISLAND NEUROLOGY CONSULTANTS

Notice to Patients About Long Island Neurology Consultants Participation in Health Information Exchange Operated by Healthix

Long Island Neurology Consultants participates in the health information exchange operated by Healthix. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law.

This Notice is to inform our patients that as part of participation in Healthix **Long Island Neurology Consultants** electronically sends/uploads our patients' Protected Health Information to Healthix.

Additionally, certain staff at **Long Island Neurology Consultants** are authorized to access patient information through Healthix subject to applicable consent rules. Consent to access Healthix is normally granted on an organization-by-organization basis. However, patients have the option of denying access to all organizations in Healthix. If you are interested in denying consent for all Healthix organizations to access your Protected Health Information, you may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

Information in Healthix about patients comes from places that have provided medical care or through health insurance (claims) information. These data sources may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program and other organizations that exchange health information electronically. An updated list of these data sources is available from Healthix. Patients can obtain an updated list at any time by visiting www.healthix.org or by calling 1-877-695-4749.

If you have questions, you may contact:

40 Worth Street, New York, NY 10013 / info@healthix.org / 877·695·4749 / healthix.org

Healthix

Details about the Information accessed through Healthix and the consent process:

1. **How Your Information May be Used.** Your electronic health information will be used **only** for the following healthcare services:
   - **Treatment Services.** Provide you with medical treatment and related services.
   - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
   - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
   - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included.** If you give consent, the Provider Organization(s) listed may access ALL of your electronic health information available through Healthix. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:
   - Alcohol or drug use problems & diagnoses
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Mental health conditions
   - Sexually transmitted diseases
   - Medication and Dosages
   - Diagnostic Information
   - Allergies
   - Substance use history summaries
   - Clinical notes
   - Discharge summary
   - Employment Information
   - Living Situation
   - Social Supports
   - Claims Encounter Data
   - Lab Test

3. **Where Health Information About You Comes From.** Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from Healthix. You can obtain an updated list at any time by Healthix's website at www.healthix.org or by calling 877-695-4749.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access.** Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Healthix for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call **Long Island Neurology Consultants**; or visit Healthix's website: www.healthix.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period.** This Consent Form will remain in effect until the day you change your consent choice, death or until such time as Healthix ceases operation. If Healthix merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice.** You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through Healthix while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form.** You are entitled to get a copy of this Consent Form.

Healthix

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow **Long Island Neurology Consultants** to obtain access to my medical records through the health information exchange organization called Healthix. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Healthix's website at www.healthix.org.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for **Long Island Neurology Consultants** to access ALL of my electronic health information through Healthix to provide healthcare.

☐ **2. I DENY CONSENT** for **Long Island Neurology Consultants** to access my electronic health information through Healthix for any purpose.

If I want to deny consent for all Provider Organizations and Health Plans participating in Healthix to access my electronic health information through Healthix, I may do so by visiting Healthix's website at www.healthix.org or calling Healthix at 877-695-4749.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date:
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)