

**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 \_\_\_\_\_
- Seizures \_\_\_\_\_
- Brain Surgery \_\_\_\_\_
- Neck/Back Surgery \_\_\_\_\_
- Other Neurologic Conditions \_\_\_\_\_
- Diabetes
- High Blood Pressure
- High Cholesterol
- Heart Disease
- Pacemaker/Defibrillator
- Atrial Fibrillation
- Peptic Ulcer
- Cancer/Tumor \_\_\_\_\_
- Depression/Anxiety \_\_\_\_\_
- Any metal in your body?** \_\_\_\_\_

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 \_\_\_\_\_

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

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 a medical concern, please contact our office. If our phones are answered by our service and you believe you may be experiencing a medical emergency, please hang up and call 911 or go to the nearest emergency department immediately. Otherwise, our service line is intended only for urgent medical concerns that cannot safely wait until regular office hours. Please note that routine matters are not handled after hours, including medication refills, new prescription requests, prior authorizations, paperwork requests, and controlled substance requests. Messages regarding these issues will be addressed during normal business hours.

Again, this service is not an emergency response line. If you feel your condition requires immediate medical attention, or if you cannot safely wait several hours for a return call from the on-call provider, please seek care at an urgent care center, emergency department, or call 911.

Return calls may come from a private or blocked number. If your phone does not accept these calls, you may miss our callback. Please note that multiple calls or messages will not shorten response time. Non-urgent concerns may be deferred to regular office hours.

It is our policy to confirm all appointments three days ahead of time. We have an automated system in place that 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 3<sup>rd</sup> 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 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.**

Please arrive on time for all appointments and allow sufficient time to complete any required medical documentation before your scheduled visit. Patients arriving more than 10 minutes late may not be seen and may be required to reschedule at the provider's discretion. In such cases, the appointment will be considered a no-show and may be subject to a cancellation fee. Repeated missed appointments, no-shows, or late arrivals, including three or more occurrences, may result in dismissal from the practice. Patients may request to transfer care to another provider within the practice. Such requests must be reviewed and approved by both the current provider and the accepting provider before any change can be made.

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 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 patient portal. In addition, electronic copies of patient health information, patient summary records, and clinical summaries are 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  $\geq 18.5$  and  $< 25$ , and for ages 65 and older,  $\geq 23$  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 online 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 online 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 promptly, 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 send a request to our office via the 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](http://www.lineurology.com), under patient information, click on patient portal or [myehr123.com/lineuroportal](http://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).

Patients may request completion of medical forms or provider letters through our office. Please note that providers are not obligated to complete outside forms or write letters and may decline such requests at their sole discretion. Requests approved for completion may be subject to an administrative fee, which must be paid prior to completion of the forms or letters. Please allow up to 2 weeks for processing. All required documents and forms must be submitted to our staff before processing can begin. You will be notified once your documents are completed.

**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

360 Merrick Road 1<sup>st</sup> 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-INSURANCE:** 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.

**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.

**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***

**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: <u>OWNER'S NAME</u> <u>MAKE</u> <u>YEAR</u>
--

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

	YES	NO
11. WERE YOU THE DRIVER OF THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PASSENGER IN THE MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A PEDESTRIAN?	<input type="checkbox"/>	<input type="checkbox"/>
WERE YOU A MEMBER OF OUR POLICYHOLDER'S HOUSEHOLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU OR A RELATIVE WITH WHOM YOU RESIDE OWN A MOTOR VEHICLE?	<input type="checkbox"/>	<input type="checkbox"/>

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 YOU 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)? YES <input type="checkbox"/> NO <input type="checkbox"/>	16. AT THE TIME OF YOUR ACCIDENT WERE YOU IN THE COURSE OF YOUR EMPLOYMENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	---	---

17. DID YOU LOSE TIME FROM WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE ABSENCE FROM WORK BEGAN: _____	HAVE YOU RETURNED TO WORK? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	--

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

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:

NEW YORK STATE DISABILITY?	YES	NO	<input type="checkbox"/>
WORKERS' COMPENSATION?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

NYS FORM NF-2 (Rev 1/2004)

Page 3 of 3



# Long Island Neurology Consultants

360 Merrick Road 1<sup>st</sup> 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*

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 with test results 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: \_\_\_\_\_