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 _____**

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*****

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 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 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 ≥ 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 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 ≥ 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, 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).

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 1st Floor, Lynbrook NY 11563-2526
(516) 887-3516 • Fax (516) 887-0331

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Diplomates in Neurology

FINANCIAL POLICY

Long Island Neurology consultants, its physicians, and the staff are truly committed to providing you with the utmost professional service and a 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 BEFORE 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 before 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 before 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 that patients with Medicaid secondary will be responsible for any coinsurance that remains unpaid by their primary carrier.

SELF-PAY PATIENT: Payment is expected at the time of service unless other financial arrangements have been made before 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% coinsurance, which can be billed to a secondary carrier, provided you have one.

You expressly consent and agree that, to discuss or provide services for your account(s) (the "Accounts") or to collect amounts you may owe, Long Island Neurology Consultants and its officers, agents, affiliates, employees, first and third party debt collection agencies, and any affiliated or business associated service providers or vendors of any of these parties, associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You confirm that any telephone number provided is associated with you and not a third-party. You expressly consent and agree that We may also utilize your information to contact you by letters or notices via mail, by sending emails, using any e-mail address you provide to us, by sending text messages or by prerecorded or artificial voice or voice messages, via predictive or automatic dialing methods, systems, or devices, and pre-recorded or artificial voice announcements or prompts at any telephone number associated with the Accounts, including landlines, wireless or mobile telephone numbers, regardless of whether you incur charges as a result. If you have any questions regarding this matter, please do not hesitate to call our billing department at 516-887-3516 x116.

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:

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
360 Merrick Road
1st Floor
Lynbrook, NY 11563-2526
516-887-3516 Fax 516-887-0331

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:

7. Purpose for Release of Information:

8. Unless previously revoked by me, the specific information below may be disclosed from: _____ (INSERT START DATE) until _____ (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except:

_____

For the following to be included, indicate the specific information to be disclosed and initial below.

	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:	10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

_____ _____
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

_____ _____ _____
STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Long Island Neurology Consultants

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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: _____