True North Neurology

1010 Route 112, 3rd Fl., Suite 300 Port Jeff. Sta NY 11776
5 Medical Drive, Port Jeff, Stat., NY 11776
6080 Jericho Tpke. Suite 100, Commack NY 11725
1500 William Floyd Pkwy, Suite 303, Shirley, NY 11967

PATIENT INFORMATION Date _____

Name _____ DOB_____ SEX F / M

Address _____Apt_____

City_____ State _____ Zip_____

Primary Phone _____ Other _____ Marital Status: C S M D WO

E-mail: _____ SS#_____

INSURANCE INFORMATION:

Primary _____ Policy Holder _____ DOB _____

Relation to Patient _____ ID # _____ Group # _____

Secondary _____ Policy Holder _____DOB_____

Relation to Patient _____ ID# _____Group#_____

Preferred Language _____ Ethnicity & Race _____

Employer _____ Occupation_____

Address _____ City _____ State_____ Zip_____

Emergency Contact _____

Relation_____ Phone_____

Referring Physician _____ Phone_____

Primary Doctor _____ Phone _____

How did you hear about our office _____?

Reason for this Visit: _____

_____

_____

Medications _____

_____

HEALTH QUESTIONNAIRE

Please list all CURRENT medical problems and doctors you are seeing:

Weight: _____ Height: _____ Level of education: _____

Do you have any Allergies: Y N Allergies to: _____?

What type of reaction do you get _____?

Please list all PAST medical problems, operations, hospital admissions: _____

_____

_____

Amounts per day: Alcohol _____ Coffee _____ Tea _____ Tonic/soda _____ Water_____

If you smoke, how much? _____ Recreational drugs: _____ yes _____ no
What time do you go to sleep and wake up? Weekdays _____ Weekends _____
Physical exercise/frequency/duration: _____
Present work status: _____ Do you like your job? _____ yes _____ no _____ not sure
With whom are you living (list relationships and ages): _____
If you have children, please list their ages: _____
Please list hobbies/recreational activities: _____
Do you have pets? _____
Any serious problems at home? _____yes _____ no Describe (if yes): _____
Is there any family history of?

_____ Sleep disorders _____Headaches _____ Mental illness _____ Strokes _____ Cancer
_____ Seizures _____ Alcoholism _____ Obesity _____ Heart disease _____ Diabetes
_____ Goiter/Thyroid _____ Excessive bleeding _____ Tuberculosis _____ Arthritis
_____ High blood pressure _____ other (Explain) _____

Have you had any of the following problems in the past 6 months (circle all that apply)?

Sleep disorders	new illness diagnosed	emotional trauma	change in job/school
change in smoking/drinking	weight loss or gain	allergic reaction /skin rash	sweating
hospitalization/surgery	stomach pain	nausea/vomiting	fever/chills
change in diet	bleeding/bruising	constipation	heartburn
high blood pressure	palpitations	breathing difficulty	chest pain
joint pain/swelling/redness	muscle aches	leg restlessness	chronic cough
excessive urination/thirst	bladder problems	diarrhea	weakness
cold hands and feet	leg/foot cramps	poor coordination/balance	numbness
breast lumps/discharge	symptoms of menopause	irregular periods	PMS
bad dreams /snoring	depression	headaches	insomnia
daytime sleepiness	dental problems	back pain neck pain	dizziness
teeth grinding/clenching	hoarseness	sinus problems wheezing	ringing in ears
feeling spacey/brain fog	decline in memory	anxiety/panic attacks	irritability
sexual dysfunction	change in skin/hair	suicidal thoughts	change in vision
seizures/shaking	loss of consciousness	change in marital status	Other:

Pharmacy Name & Location_____

CONTROLLED SUBSTANCES AGREEMENT

The purpose of this agreement is to create an understanding regarding controlled substances – a type of medication regulated by the state and federal governments.
Controlled substances include opioids (narcotics, analgesics), benzodiazepine tranquilizers, barbiturate sedatives, amphetamines, muscle relaxants and other pain medications.
While many of these medications are effective treatments for chronic pain and other neurological disorders, they have a strong potential for abuse and addiction.
Our goal at True North Neurology is to treat you **safely** and **effectively** while also preventing abuse and/or addictions. Due to a risk of serious adverse effects, our goal is to have you take the lowest possible dose of the medication that is effective and only when **absolutely necessary**.
Since these medications have the potential for abuse and/or diversion (i.e., sharing, trading, selling to anyone other than who the prescription is prescribed for), strict accountability is necessary for both medical and legal reasons. Therefore, the following policies are agreed to by you, the patient, to help us monitor these medications, keep you safe, and provide you with effective and excellent care.

Please Initial Each Line.

1. All prescriptions for any controlled substances from any of our physicians will be E-scribed directly to your pharmacy on file. _____
2. You may only have one (1) pharmacy on file – all controlled substance MUST be obtained from the SAME pharmacy. Multiple sources can lead to the possibility of medication interactions and poor coordination of treatment. _____
3. If you need to change pharmacies, our office must be informed in writing. _____
4. You must inform our office of any new medical conditions, new medications and adverse effects of any medication that you experience. _____
5. The provider you see at TNN is the provider who will be E-scribing your medication. _____
6. You must give the prescribing physician permission to discuss all diagnostic and treatment details with the dispensing pharmacists and other professionals who provide your health care for the purpose of maintaining accountability and coordinating your care. _____
7. You may not share, sell or otherwise permit others to have access to these medications. _____
8. You must take all medications exactly as prescribed unless you develop side effects in which you must consult with your doctor or local emergency services immediately. _____
9. You must not stop these medications abruptly or without consulting with the prescribing physician as an abstinence/withdrawal syndrome may develop. _____

10. 10.You agree that your urine may be tested for controlled substances before initiation of therapy and that random urine follow-up testing will be done. You agree that the presence of unauthorized substances, illicit substances or the absence of prescribed medications is cause for possible tapering and discontinuation of the controlled substances immediately or in the future and may prompt referral for assessment of addictive disorder(s). _____

11. You must bring the original prescription bottles of medication to each office visit. _____

12. You must keep all controlled substances in a secure area and out of reach of the reach of a child. _____

13. The use of these medications may induce drowsiness or change your mental abilities, making it unsafe to drive or operate heavy machinery. The effects of these medications are particularly problematic during any dose changes. If you are the slightest bit impaired, you must refrain from these activities. _____

14. You must discuss the long-term use of controlled substances with your primary care provider. Prolonged opioid use may be associated with serious health risks. _____

15. These medications will NOT be replaced if they are lost, destroyed, stolen, etc. If your medications have been stolen and you complete a police report regarding the theft and present that report to the prescribing physician, an exception may be made at the discretion of your treating physician. _____

16. Early refills will NOT be given under any circumstances. _____
17. If the responsible legal authorities have questions concerning your treatment, all confidentiality is waived, and these authorities will be given full access to our records of controlled substances administration. _____

18. Failure to adhere to any of these policies may result in tapering and cessation of therapy of controlled substances and/or referral for further specialty assessment. _____

19. Controlled substances written by TNN providers may not be obtained from other providers. Obtaining any medication from non-providers of TNN will result in immediate suspension of all controlled substance prescriptions. _____

I have read, understood and initialed the rules and regulations above and am in agreement with all rules and regulations of True North Neurology

Patient Name: _____ **Date:** _____

Patient Signature: _____ **Date**: _____

Physician Signature: _____ **Date:** _____

Information Release

I request that payment of authorized insurance benefits be made on my behalf to **True North Neurology**, for any services furnished me by physicians. I authorized any holder of medical information about me to release to the Health Financial administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Name: _____

Patient's Signature: _____ **Date:** _____

Patient Financial Agreement /Guarantee of Payment

Dear Patient

As a service to our patients, our office accepts assignment of most major medical plans. However, in the current managed care environment, reimbursement for certain services has been increasingly difficult to obtain. In addition, most in-office procedures now require pre-certification or referral. In an effort to continue to give our patients excellent, yet affordable care, we ask that you take time to read and sign the following agreement. This will enable us to continue to submit insurance claims on behalf of our patients.

- I understand that I must have a current **Insurance Referral** on file for every office visit and that it is my responsibility to obtain referrals from my PCP, according to the guidelines of my plan. If a referral is not obtained, I understand I will be responsible for the office visit.
- I understand that **Co-Payments** must be paid at the time of service.
- I understand that **I will be Responsible** for all deductibles, co-insurances and unpaid "allowable amounts."
- I understand that the doctor has agreed to accept assignment from my insurance carrier for services rendered in the office if participating.
- I understand that it is **my** responsibility to update **my** insurance information on file and give a copy of my insurance card.
- I understand that certain services performed by the doctor may not covered under my insurance as outlined in policy. **If the insurance denies payment, I will personally and fully be responsible for a payment.**
- I understand True North Neurology invokes a strict fifteen (15) minute late policy and my appointment will be forfeited if not followed.

***24 Hour Cancellation Policy**

I understand I must give the office **24 hours' advance notice** in order to cancel my appointment. If appointment is not cancelled with 24-hour notice, I will incur a **$50 fee** for all missed physician appointments, $**100 fee** for any daytime procedure appointments and **$200 fee** for any 4PM and later procedure.

Patient Name: _____

Patient's Signature: _____ **Date:** _____

TRUE NORTH NEUROLOGY
Tel: 631-364-9119 FAX: 833-799-0474

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____

Phone:

Requested Information:

- ☐ **All medical Records**
- ☐ **Radiology (X-Ray, MRI, etc.)**
- ☐ **Laboratory Testing**
- ☐ **Consults**
- ☐ **Dates of Treatment: From _____ To _____**
- ☐ **Diagnostic Studies**
- ☐ **Progress Notes**
- ☐ **Other_____**

I understand that my medical record may include a wide variety of inpatient and outpatient information on diagnosis, treatment and procedures including psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS) and (HIV) status.

For the purpose of: CONTINUITY OF CARE

RELEASE FROM: _____

TEL: _____ FAX: _____

ADDRESS: _____

_____

RELEASE TO: TRUE NORTH NEUROLOGY

TEL: 631-364-9119 FAX: 855-644-2983

I understand that I have a right to revoke this authorization at any time. I understand that if revoke this authorization, I must do so in writing and present my written revocation to a staff member of True North Neurology I understand that the revocation will not apply to information that has already been released by the authorization. This authorization will be expired 12 months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I may contact the office manager at the practice. New York State Law Section 17 and 18 of the Public Health Law, Chapter 165, section 48 & 49, states $0.75 per page plus postage for your medical record is legal charge that is permitted.

_____ _____

Signature of Patient or Guardian **Date**

_____ _____

Print Name of Patient or Guardian **If not signed by patient, please indicate**

NOTICE OF PATIENT CONFIDENTIALITY

Policy: True North Neurology, here, in after referred to as True North Neurology is firmly committed to preserving the confidentiality of all patient encounter within the limitations of the law of the State of New York.

Practices: Patients who come to True North Neurology may anticipate that healthcare providers and other office employees will treat patient information as confidential and will act in such a manner to protect the privacy and confidentiality of both clinical and personal information.

Patients must understand, however, that there are circumstances in which certain aspects of their healthcare services can and will be available to outside parties. These parties may include but may not be limited to health insurance companies and other payment guarantors such as parents, legal guardians, third party payers and employers. This loss of complete confidentiality occurs because of the need to report healthcare services to insurance companies and/or situations as listed below in confidentiality limitations.

Information that may be made available can include diagnostic testing information, therapeutic procedures and prescription drug information.

Any concerns about confidentiality should be addressed to the provider or nurse at the time of services.

Limitations of Confidentiality:

Confidentiality is limited in the following situations:

1. A court order or subpoenas for medical records is issued.
2. A patient is determined to be at risk of harm to self or others.
3. The patient makes or authorizes a claim under a health insurance or other health benefit plan or otherwise designates someone else as responsible for payment.
4. The law requires reporting of information (e.g., communicable diseases, injury by violent means, workers compensation injury)
5. The patient is a minor.

In any of these situations, information in medical records may be released, without the consent of the patient to necessary parties, which may include but not limited to, a court of law, parents, health insurance companies and other payment guarantor such as parents, legal guardians, third party payers, law enforcement or employers.

Persons under the age 18 (minors) generally must have consent of an adult parent to obtain medical treatment. Parents of minors who obtain medical treatment will likewise normally be entitled to information about the treatment. Exceptions are recognized for the provision of contraceptives, drug abuse treatment, prenatal care and emergency care.

Your signature below indicates that you have read and understand True North Neurology's confidentiality policy.

SIGNATURE: _____ **DATE:** _____

TRUE NORTH NEUROLOGY

Tel: 631-364-9119 FAX 877-343-5694

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **DOB:** _____

True North Neurology is authorized to release protected health information about the above-named patient below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please list anyone we can discuss your medical information with.

NAME	RELATIONSHIP TO PATIENT	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ **NONE**

Patient Information

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
This authorization shall be in effect until revoked by patient.

_____ _____

Patient Signature: **Date:**

True North Neurology
Patient Care Team Information

Please list below all providers that are presently active in your Medical Care.

Providers Name____ Specialty _______________________________________
Address ____ Town _________________________________ State_______
Phone ____ Fax _____________________________________ Zip ________________

Providers Name____ Specialty _______________________________________
Address ____ Town _________________________________ State_______
Phone ____ Fax _____________________________________ Zip ________________

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Address ____ Town _________________________________ State_______
Phone ____ Fax _____________________________________ Zip ________________

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Address ____ Town _________________________________ State_______
Phone ____ Fax _____________________________________ Zip ________________

Providers Name____ Specialty _______________________________________
Address ____ Town _________________________________ State_______
Phone ____ Fax _____________________________________ Zip ________________

Providers Name____ Specialty _______________________________________
Address ____ Town _________________________________ State_______
Phone ____ Fax _____________________________________ Zip ________________

New Patient Adult Sleep Medicine Questionnaire
Sleep Clinic

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

Use the scale below to choose the most appropriate number for each situation.

0= Would never doze 1= Slight chance 2= Moderate chance 3= High Chance

Situation	Chance of Dozing 0	1	2	3
Sitting and Reading				
Watching TV				
Sitting Inactive in a public place (e.g., movie theater or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after lunch without alcohol				
In a car while stopping for a few minutes in traffic				

Symptom Checklist

Fatigue/ Sleepiness	YES	NO
I struggle to stay awake / feel tired during the day.		
I have fallen asleep while driving.		
I have difficulty with memory or concentration.		
Obstructive Sleep Apnea (OSA)		
I snore or have been told I snore.		
I have experiences choking, shortness of breath, or gasping during sleep.		
I avoid sleeping on my back.		
I struggle with nasal congestion.		
I experience leg swelling.		
I wake at night to urinate.		
Someone in my family has sleep apnea.		