North Suffolk Neurology, P.C.
www.northsuffolkneurology.com

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 Insurance _____ Policy Holder _____ DOB _____

Relation to Patient _____ ID # _____ Group # _____

Secondary Insurance _____ Policy Holder _____DOB_____

Relation to Patient _____ ID# _____Group#_____

Preferred Language _____ Ethnicity & Race _____

Employer _____ Occupation_____

Address _____

_____ State_____ Zip_____

Emergency Contact _____ Relation_____ Phone_____

Referring Physician _____ Phone_____

Primary Doctor _____ Phone _____

How did you hear about our office _____

Reason for this Visit _____

_____

Medications: _____

_____

Do you have any Allergies: Y N Allergies to _____

What type of reaction do you get _____

Pharmacy Name & Location_____

HEALTH QUESTIONNAIRE

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

_____

_____

_____

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

_____

_____

Height: _____ Weight: _____

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: _____

Level of education: _____ Do you have pets? _____

Any serious problems at home? _____yes _____ no Describe (if yes): _____

Is there any family history of:

_____headaches	_____ arthritis	_____ mental illness	_____ strokes
_____ seizures	_____ alcoholism	_____ obesity	_____ heart disease
_____ goiter/thyroid	_____ diabetes	_____ excessive bleeding	_____ cancer
_____ high blood pressure	_____ tuberculosis	_____ sleep disorders	_____ other

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

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

Other:

CONTROLLED SUBSTANCES AGREEMENT

Please Initial On Each Line.

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 North Suffolk 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.

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 NSN 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. 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 NSN providers may not be obtained from other providers. Obtaining any medication from non-providers of NSN 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 North Suffolk Neurology, PC.

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 North Suffolk Neurology, PC 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 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.

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 or I do not call to cancel an appointment (NO SHOW) I will be charged $50 for all missed physician appointments and $100 for procedure appointments.

Patient Name: _____

Patient's Signature: _____

Date: _____

NORTH SUFFOLK NEUROLOGY, PC
5 Medical Drive, Port Jefferson Station, NY 11776
Tel: 631-364-9119 FAX: 631-364-9118; FAX: 631-675-0391

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: CONTINUTY OF CARE _____

RELEASE FROM: _____

TEL: _____ FAX: _____

ADDRESS: _____

_____

RELEASE TO: NORTH SUFFOLK NEUROLOGY

TEL: 631-364-9119 FAX: 631-675-0391

5 MEDICAL DRIVE

PORT JEFFERSON STATION, NY 11776

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 North Suffolk Neurology, PC. 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**

NORTH SUFFOLK NEUROLOGY, PC
Credit Card Payment Authorization

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In the order to accomplish this in a cost-effective manner for all our patients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. I am ultimately responsible for payment of charges for services I receive from this practice including those covered by my insurance. As a convenience, this practice will submit claims for reimbursement with my insurance provider; however, all payment responsibility is ultimately mine.
2. Some immediate payment may be expected at the time of service. This may include a co-pay and additional payment if this practice determines that the cost of my visit today will not be reimbursed by my insurance provider. This often happens if my deductible is not yet satisfied.
3. This practice may deny service or charge a service fee for failure to pay at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information.
6. I understand that my signature and payment information will be maintained on file for future use by the practice. The applicable payment card or bank account number will be truncated and "tokenized" by the payment agent in order to help maintain the security of my payment information.
7. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
8. I authorize the above practice and/or its designated payment agent to apply charges to my payment card and/or bank account for all amounts owed to the practice for medical visits, procedures or supplies, including (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
9. In the case of a patient balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
10. I will not be provided with advance notice of payments authorized hereunder for transactions up to amount specified by me. I will be provided with a courtesy notification prior to processing any payment in excess of such amount. Transaction receipts will be maintained in the patient file or will be emailed to me if I provide and maintain a valid email address.
11. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

North Suffolk Neurology, agrees that the maximum amount charged to the below payment method, will not exceed $150.00

NAME (as it appears on card):			**CC NUMBER:**
BILLING ADDRESS:			**EXP DATE:**
CITY:			**CVVS:**
EMAIL ADDRESS:			**VISA AMEX MC OTHER**
SIGNATURE:			**DATE:**

ALL INFORMATION IS STRICTLY KEPT CONFIDENTIAL AND USED ONLY FOR THE PURPOSES ABOVE

NOTICE OF PATIENT CONFIDENTIALITY

Policy: North Suffolk Neurology PC. Hereinafter referred to as North Suffolk 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 North Suffolk 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 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 North Suffolk Neurology's confidentiality policy.

SIGNATURE: _____ **DATE:** _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **DOB:** _____

North Suffolk 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**
_____	_____
_____	_____
_____	_____

☐ **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:**