New York Neurology Associates, P.C. Office Policy

As of February 20, 2017 New York Neurology Associates, P.C. has updated the office policies to reflect our growing demand and to protect and improve patient care.

Cancellations and Reschedules
We understand that there are times when schedules can change due to emergencies or other engagements. Appointments must be cancelled or rescheduled 24 hours in advance. More than three *last minute cancelations* and or *last minute reschedules* within a year may result in a formal discharge from the practice.

No-Shows
More than two *no-shows* within a year may result in a formal discharge from the practice.

Late Arrivals
Our doctors make every effort to see the patients on time but medical emergencies or other circumstances may cause wait times for the patients. Arriving more than 15 minutes past the start of an appointment results in the doctor's discretion to see the patient for the remaining appointment time. In the event the doctor is unable to accommodate the patient due to the patient's tardiness, the appointment will be marked as a *last minute cancellation* and rescheduled.

Confirming Appointments
If the office does not receive a confirmation by 5pm the day before the appointment, it will be cancelled and made available to patients on a waitlist. Arriving to an unconfirmed appointment results in the doctor's discretion, based on availability, to see the patient. If the doctor is unable to accommodate the patient, the appointment is marked as a *last minute cancelation* and rescheduled.

Payments
Copays, coinsurances, and deductibles that apply to the office visit or testing are provided directly from the insurance company. Payments are to be made before being seen by the doctor. Although cash is preferable, we do accept all major credit cards, except AMEX. Any credit transactions under $50 has a $3 service fee.

Medical Records
Your medical records are confidential; to obtain your medical records and/or have it transferred to another physician, please ask the receptionist for the medical release authorization for you to complete and return. **Records will not be released without authorization form.** Records that exceed 10 pages are charged at 75¢ per page.

By signing this form I understand and agree to the policies stated above.

(Patient):

_____

Print Name Signature Date

Relationship if signed by person other than patient:

_____

Print Name Signature Date

DATE: _____

PATIENT INFORMATION

NAME: _____
First Middle Last

ADDRESS: _____
Street Apt. Number

_____
City State Zip Code

TELEPHONE: (___)_____(___)_____(___)_____
Home Business Cell phone

DATE OF BIRTH: _____AGE: _____Email Address: _____

SOCIAL SECURITY NO: _____ SEX: ( ) Male ( ) Female

STATUS: ( ) Child ( ) Married ( ) Single ( ) Divorce ( ) Widow (er)

Spouse's Name: _____

PATIENT' S EMPLOYER: _____
Address: _____
REFERRED BY: _____
Name Telephone Number

_____
Address

IN CASE OF EMERGENCY, NOTIFY: _____
Name

Address: _____

_____
Telephone No. Relationship

INSURANCE INFORMATION (Please check if primary or supplemental ins.)

	Identification Number	Primary Ins.	Supplemental Ins.
Medicare	_____	_____	_____
BC / BS	_____	_____	_____
GHI	_____	_____	_____
Major Medical	_____	_____	_____
Other	_____	_____	_____
Name of Policyholder:	_____	_____	_____

Date of Birth of Policyholder: _____
Was condition related to patient's employment?: _____
An accident: _____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE

I authorized the release of any medical or other information necessary to process this claim

SIGNED: ✔_____
DATE: _____

NEW YORK NEUROLOGY ASSOCIATES, P.C.

Name: _____

Please State the main complaint/reason of this visit: _____
_____

Please state any other complaints that you may have whether or not they are related to this visit: _____
_____
_____

Please state whether any of these above complaints related to automobile/work, or injuries of any accidents whatsoever: _____
_____

Please state if any of the above reasons of today's visit is of any way associated with any ongoing or planned litigation: _____.

If so, please explain: _____

Please list **ALL** medications currently taking: _____
_____
_____

Please list **ALL** previous medical problems aside from the one you are here for today: _____
_____
_____

Please list **ALL** prior surgeries in the past: _____
_____
_____

Please list **ALL** family history of any medical problems that you are aware of: _____
_____
_____

Drug Allergies: _____
Any Allergies: _____
Do you smoke?: _____ Illicit drug use?: _____
Alcohol use: _____ Height: _____ Weight: _____
Occupation: _____ Marital status: _____
Any children?: _____

Signature: ✔_____ Date: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

✔ - required fields

CARRIER

PICA ☐☐☐ PICA ☐☐☐

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ✔

3. PATIENT'S BIRTH DATE MM DD YY ✔ SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street) ✔

6. PATIENT RELATIONSHIP TO INSURED ✔ Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY ✔ STATE

8. PATIENT STATUS ✔ Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE ✔ TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO: ✔

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ✔ DATE ✔

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ✔

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ____ . ____ 3. ____ . ____

2. ____ . ____ 4. ____ . ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

NEW YORK NEUROLOGY ASSOCIATES, P.C.
Gary Starkman, M.D.

1035 Park Avenue, New York, NY 10028
(212) 987-1000

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

INTRODUCTION

New York Neurology Associates, P.C., et al understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "protected health information". "Protected health information" includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures we will make of your protected health information. We must comply with the provisions of this notice as currently in effect, although we reserve the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a written copy of our most current privacy notice from the Practice's Privacy officer.

PERMITTED USES AND DISCLOSURES

We can use or disclose your protected health information for purposes of *treatment, payment and health care operations*. For each of these categories of uses and disclosures, we have provided a description and example below. However, not every particular use or disclosure in every category will be listed.

- *Treatment* means the provision, coordination or management of your health care, including consultations between health care from one health care provider to another. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to contact a physical therapist to create the exercise regimen appropriate to your care.

- *Payment* means the activates we undertake to obtain reimbursement for the health care provided to you, including billing, collections, claims management, determinations of eligibility and coverage utilization review activities. For example, prior to providing health care services, we may need to provide information to your Third Party Payor about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the Third Party Payor for the services rendered to you, we can provide the Third Party Payor with the information regarding your care necessary to obtain payment. Federal or State law may require us to obtain a written release when necessary under applicable law.

- *Health care operations* means the support functions of our practice related to treatment and payment, such as quality insurance activities, care management, receiving and responding to patient comments and complaints, physicians reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring of you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. In addition, we may remove information that identifies you from your patient information so that others can use the de-identified information so that others can is the de-identified information to study health care and health care delivery without learning who you are.

OTHER USES AND DISCLOSURESOF PROTECTED HEALTH INFORMATION

In addition to using and disclosing your information for treatment, payment and health care operations, we may use your protected health information in the following ways:

- We may contact you to provide appointment reminders for treatment or medical care.

I, _____, acknowledge that I have been provided with a copy of New York Neurology Associates, P.C. et al's privacy notice.

Date: _____

Signature ✔_____

ACCIDENT VERIFICATION FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

INSURANCE ID# _____

Please complete this form as per requirements from your healthcare provider.

1. Are you being seen for a work related accident?

   ☐ YES ☐ NO

2. Are you being seen for a motor vehicle related accident?

   ☐ YES ☐ NO

3. If yes, what was the date of your accident? _____

_____ ✔ _____

PATIENT SIGNATURE

DATE: _____