-Complete Neurological Care P.C

Tel: (800) 200 - 8196

DATE:	STATUS : (Please circle one) Single/Married/Widowed/Separated/Divorced	
LAST NAME:	FIRST NAME:	
ADDRESS:		APT:
CITY:	STATE:	ZIP CODE:
SSN:	DOB:	
HOME#:	CELL:	
WORK #:	GENDER:(Please circle one) FEMALE MALE	
EMAIL:	OCCUPATION:	
EMERGENCY CONTACT: (PHONE, NAME, RELATION):		
HOW DID YOU HEAR ABOUT US? ZOCDOC/ INSURANCE/ PCP/ FRIENDS/ FAMILY/ INTERNET/ GOOGLE/ OUR WEBSITE/ YELP/ SOCIAL MEDIA (INSTAGRAM, FACEBOOK, REFERWELL) **PLEASE CIRCLE**		
PRIMARY INSURANCE:	INSURANCE ID:	
PHARMACY NAME:	PHONE:	
ADDRESS:		
REASON FOR VISIT:		
PRIMARY DOCTOR'S FIRST AND LAST NAME:		
ADDRESS:		
CITY:	State:	Zip:
Phone:	Fax:	

Authorization for Release of Medical Information: I hereby authorize -Complete Neurological Care P.C to release any medical or incidental information that may be necessary for medical care or to process medical insurance claims and authorization. I also hereby consent the disclosure of my health information to provide diagnosis and treatment clinicals to my primary care physician for coordination of care.

Payment Policy: I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not cover by insurance including, without limitation, deductible, co-payments, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. -Complete Neurological Care P.C, files claims for Medicare assignment and only the managed care plans, which we are contracted. Claims will not be filed with other insurance carriers. If you plan to pay by check and it's dishonored a processing fee of $35 will be assessed.

_____ _____

Signature **Date**

Please sign on the following lines provided in regards to agreement within -Complete Neurological Care P.C for today's date of _____ .

I, _____, am certified that this is not related to a motor vehicle accident or a work related accident.

I, _____, hereby authorize -Complete Neurological Care P.C, and/or its representatives, to provide medical services, such as; to conduct routine examinations, to perform diagnostic testing, to administer injections, and provide treatments. Which may also include all pharmaceutical products (medication) to myself or minor child (print name if applicable) _____ as maybe deemed necessary now and on subsequent visit.

ELECTRONIC COMMUNICATION CONSENT

The following general considerations summarize the information you need to determine whether you wish to receive the information you requested via electronic communication/ transmitted from all of -Complete Neurological Care P.C

- Email communication will be considered and treated with the same degree of privacy and confidentiality as written medical records.
- The email(s) we send you follow all HIPAA rules and requirements, transmitting from our office in a secure manner. However, those receiving email through unsecured email services, as well as other similar email services, are subject to possible email interception by unauthorized individuals.
- Text messages (SMS) are only sent to remind patients of appointments.
- Email messages should not be used for emergencies or time sensitive situations. In the event of a medical emergency, you should immediately call 911. For emergent of time sensitive situations, you should contact the direct office in which you see your physician.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.

I have read and understood the above description of the risks and responsibilities associated with electronic communication with my physician.

I acknowledge that commonly used email services are not secure and fall outside the security requirements set forth by the Health Insurance Portability and Accountability Act for the transmission of protected health information (HIPAA).

I hereby consent to use electronic communication as an adjunct to in-person in office visits with my physician/staff, and I hereby consent to electronic communication via non-secure email services.

I understand that I may revoke my consent to communicate electronically at any time by notifying -Complete Neurological Care P.C in writing at the address of the facility I attend, but if I do, the revocation will not have an effect on actions my provider/staff has already taken in reliance on my consent.

I agree and release my provider and practice from any and all liability that may occur due to electronic communication over a non-secure network.

I further agree to be held accountable and to comply with the patient responsibilities as outlined in this consent.

By signing the following, I acknowledge and have read/ understood this notice.

_____ _____

Signature **Date**

OCA Official Form No.960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New YorkState Department of Health]

Patient Name :	Date of Birth:	SSN:
Patient Address:		

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

In accordance with New York State Law and the Privacy Rule of the HealthInsurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes,and **CONFIDENTIAL HIVRELATEDINFORMATION** only if I place my initials on the appropriate line in Item9(a). In the event the health information described below includes any of thesetypes of information, and I initial the line on thebox in Item 9(a), I specifically authorize release of such information to the person(s)indicated in Item 8.

2. If I amauthorizing the release of HIV-related, alcohol or drug treatment, or mentalhealth treatment information, the recipient is prohibited from redisclosingsuch information without my authorization unless permitted to do so underfederal or state law. Iunderstand that I have the right to request a list of people who may receive oruse my HIV-related information without authorization. If Iexperience discrimination because of the release or disclosure of HIV-relatedinformation, I may contact the New York State Division of Human Rights at (212) 480-2493 or the NewYork City Commission of Human Rights at (212) 306-7450. These agencies areresponsible for protecting my rights.

3. I have theright to revoke this authorization at any timeby writing to the health care provider listed below. I understand that I mayrevoke this authorization except to the extent that action has already beentaken based on this authorization.

4. Iunderstand that signing this authorization is voluntary. My treatment,payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon myauthorization of this disclosure.

5. Informationdisclosed under this authorization might be redisclosed by the recipient(except as noted above in Item 2),and this redisclosure may no longer be protected by federal or state law.

6. **THISAUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION ORMEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCYSPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ❑ Medical Record from (insert date)_____to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health careproviders.
- ❑ Other:_____

Include: (Indicate by Initialing)

_____**Alcohol/Drug Treatment**

Health Information _____**Mental**

Authorization to Discuss Health Information _____**HIV-Related Information**

(b) ❑ By initialing here_____I authorize_____

Initials **Name of individual health care provider**

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items onthis form have been completed and my questions about this form have beenanswered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient orrepresentative authorized by law.