True North Neurology

1010 Route 112, Suite 300
Port Jefferson Station, NY
11776

5 Medical Drive
Port Jefferson Station, NY
11776

1500 William Floyd Pkwy
Suite 303
Shirley, NY 11967

6080 Jericho Tpke, Suite 100
Commack, NY 11725

PATIENT INFORMATION Date _____

Name _____ DOB_____ SEX F / M

Address _____Apt_____

City_____ State _____ Zip_____

Primary Phone _____ Other _____ Marital Status: 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: _____

_____

_____

Is this a work-related injury? _____

Medications (include frequency and strength) _____

_____

_____

_____

Allergies: _____

Pharmacy Name & Location_____

HEALTH QUESTIONNAIRE

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

Weight:_____ Height: _____ Level of education: _____

Please list all PAST medical problems, operations, hospitalizations: _____

_____

_____

_____

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

Do you smoke? Y/N (Circle Type) cigarettes / e-cigarettes / cigars / vape. If you smoke, how much? _____

Do you use any recreational drugs: Y / N. Specify type: _____

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?

Condition	Relationship	Condition	Relationship
☐ Headaches	_____	☐ Seizures	_____
☐ Arthritis	_____	☐ Alcoholism	_____
☐ Mental illness	_____	☐ Obesity	_____
☐ Strokes	_____	☐ Heart disease	_____
☐ Tuberculosis	_____	☐ Sleep disorders	_____
☐ Diabetes	_____	☐ Goiter/Thyroid Disease	_____
☐ Bleeding Disorder	_____	☐ High blood pressure	_____
☐ Cancer	Type: _____	Other:	_____

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

change in marital status, 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, sleep apnea, 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, Other:

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 primary care physician, according to the guidelines of my plan. If a referral is not obtained, I understand I will be responsible for payment for the office visit.
- I understand that any 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 be 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** to cancel my appointment. If the appointment is not cancelled with 24-hour notice, I will incur a **$50 fee** for all missed provider appointments, **$100** for procedure appointments scheduled before 4 pm, and **$200** for any procedure scheduled after 4 pm.

Patient Name: _____

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

TRUE NORTH NEUROLOGY

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: _____

ADDRESS: _____

_____

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 expire 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 (minor) generally must have the 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.

Patient Name: _____

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

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 patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

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 this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

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 practice 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 leave a detailed message 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:

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

This consent was signed by: _____
(PRINT NAME PLEASE)

Patient Name: _____

Patient's Signature (Guardian): _____ **Date:** _____

TRUE NORTH NEUROLOGY
Patient Care Team Information

Please list below all providers that are all presently participating in your care.

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____

Provider's Name: _____ Specialty: _____
Address: _____
Phone: _____ Fax: _____