MASSAPEQUA NEUROLOGIC, P.C.

PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____ Sex: _____

Address: _____ City: _____ ZIP _____ SS#: _____

EMAIL: _____

Marital Status: ( ) S ( )M ( ) W ( )D Home Phone: _____ Cell: _____

Are you employed? _____ If so, Employer Name: _____ Position: _____

INSURANCE INFORMATION

Is this visit related to a motor vehicle accident or work related accident? _____ If so, date? _____

Primary Insurance: _____ ID#: _____ Phone: _____

Insured's Name: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ ID#: _____ Phone: _____

Insured's Name: _____ Relationship: _____ Phone: _____

PRIMARY DOCTOR

Physician Name: _____ Phone: _____

Address: _____

SPOUSE/PARENT INFORMATION (If applicable)

Spouse/Parent Last Name: _____ First Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____ SS#: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship: _____

Address: _____ Phone: _____

I authorize the use of my signature for insurance submission. I also authorize the physician to release my information as required. I also authorize payment to be made to the physician directly. I also understand that I am responsible for my bill, which includes copayments, co-insurance/out-of-pocket and deductibles.

X_____ Date: _____

Patient Signature

Have you recently traveled out of the country?:_____ If so, where? _____
Do you currently have a fever?: _____

What language do you prefer? _____ English _____ Spanish _____ Other: _____

What is your race/Ethnicity? _____ American Indian _____Asian _____African American

_____White _____Hispanic or Latino _____Unknown _____ Other: _____

CHIEF COMPLAINT

Body Part(s): _____ Onset Date: _____

DO YOU HAVE AN ARTIFICIAL HEART VALVE, PACEMAKER, OR DEFIBRILLATOR? _____

CURRENT MEDICATIONS:(Including Vitamins) _____

_____

ALLERGIES (Food/Medication/Dye): _____

SURGICAL HISTORY (please include dates): _____

_____

PAST MEDICAL HISTORY

_____ Asthma _____High Blood Pressure _____High Cholesterol _____Diabetes _____Cancer

_____Heart Disease _____Thyroid Disorder _____Psychiatric Disorder _____ Other: _____

FAMILY HISTORY

____Stroke _____Relationship ___Alzheimer's _____Relationship

___Hypertension _____Relationship ___Diabetes _____Relationship

___Multiple Sclerosis _____Relationship ___Heart Disease _____Relationship

___Parkinson's Disease _____Relationship ___Cancer _____Relationship

___Other: _____ Relationship: _____

SOCIAL HISTORY

_____Employed _____ Unemployed _____On Disability Leave _____Retired _____Student

Do you intake any of the following?:
_____Tobacco _____Alcohol (Please circle one: Daily Socially Rarely) _____Illicit Drugs

Height: _____ Weight: _____ Right Handed: _____ Left Handed: _____

Do you have or are at high risk for HIV/AIDS or Lyme Disease? _____

Level of Education: _____

MASSAPEQUA NEUROLOGIC PC

DR. TERESA FARRUGIA, DO

KATHERINE A. CARROLL, PA-C

DR. TEJ-PREET SINGH, MD

95 GRAND AVENUE, MASSAPEQUA, NEW YORK 11758

(O) (516) 799-7500 (F) (516) 799-2075

Please indicate if you have any of the following:

CONSTITUTIONAL:	**YES**	**NO**
Fever	___	___
Chills	___	___
Weight Change	___	___
General Malaise	___	___

HEENT:	**YES**	**NO**
Headache	___	___
Dizziness	___	___
Blurred Vision	___	___
Ringing in Ears	___	___
Hearing Loss	___	___

RESPIRATORY:	**YES**	**NO**
Shortness of Breath	___	___
Cough	___	___
Wheezing	___	___

CARDIOVASCULAR:	**YES**	**NO**
Chest Pain	___	___
Palpitations	___	___
Syncope	___	___
Murmurs	___	___
Irregular Heartbeat	___	___
Atrial Fibrillation	___	___

GI/GU:	**YES**	**NO**
Nausea	___	___
Vomiting	___	___
Diarrhea	___	___
Constipation	___	___
Difficulty Swallowing	___	___
Dysphagia	___	___
Bowel Incontinence	___	___
Urine Incontinence	___	___

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MUSCULOSKELETAL:	**YES**	**NO**
Back Pain	___	___
Arthritis	___	___
Muscle Spasm	___	___
Muscle Pain	___	___
Muscle Weakness	___	___
Cramps	___	___
Atrophy	___	___

NEUROLOGICAL:	**YES**	**NO**
Stroke	___	___
Seizures	___	___
Difficulty Walking	___	___
Involuntary Movements	___	___
Migraines	___	___
Numbness/Parasthesia	___	___

PSYCHIATRIC:	**YES**	**NO**
Depression	___	___
Hallucinations	___	___
Delusions	___	___
Anxiety	___	___

INTEGUMENTARY:	**YES**	**NO**
Rash	___	___
Skin Lesions	___	___

ENDOCRINE:	**YES**	**NO**
Thyroid Disease	___	___
Fatigue	___	___
Obesity	___	___
Diabetic	___	___

ALLERGIC/IMMUNOLOGIC:	**YES**	**NO**
Asthma	___	___
Hay Fever	___	___
Other: _____	___	___

FEMALE PATIENTS ONLY:
ARE YOU PREGNANT? ___ YES ___ NO
PATIENT INITIALS: _____

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NARCOTIC AGREEMENT

I, _____, understand that if at any point throughout my care at Massapequa Neurologic, PC, I receive controlled medication I agree to comply with the following:

1) I will take medication(s) at the dose and frequency prescribed. Any changes in dose or frequency must be authorized by my physician or with another designated physician in my physician's absence.

2) I will not receive or take controlled substances for treatment of pain from any other source other than Massapequa Neurologic, PC.

3) I will communicate with my primary physician that I am on contract with Massapequa Neurologic, PC for pain medication(s).

4) I will safeguard my prescribed medication(s).

5) I will comply with my scheduled appointment(s).

6) I will only use the pharmacy listed below to fill my controlled substance prescription(s).

Name of Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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I, _____ grant permission for Massapequa Neurologic PC and affiliate of, to discuss my medical conditions (illness and/or treatment) and any relevant information, including sharing of written medical reports with: _____.

Relationship to Patient: _____

I understand that this authorization is voluntary, and that I have the right to revoke this authorization at any time by submitting a request in writing to Massapequa Neurologic PC.

This authorization expires: _____

Patient Signature: _____ Date: _____

****

Acknowledgement of Receipt of Notice of Privacy
(HIPAA)

I, _____ have received a copy of this office's Notice of Private Practices.

_____ X_____ _____
Patient Name Patient Signature Date

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	Date of Birth	Medical Record Number
Patient Address		

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

In accordance with New York State Law and the Privacy Rule of the Health Insurance 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 HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol, or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed 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. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED 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 form (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 care providers.
- ☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**
_____ **Genetic Testing**

Authorization to Discuss Health 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 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 on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of Patient or representative authorized by law.

*** Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

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Date: _____

Patient Name: _____

The physicians at Massapequa Neurologic PC are not Worker's Compensation Doctors. Therefore, we will not treat patients for any illness or injury related to a Worker's Compensation Case. I understand that my medical health insurance will be billed for medical services rendered to me and I am not being treated at Massapequa Neurologic PC for a Worker's Compensation Case. If my medical insurance declines payment to Massapequa Neurologic PC as they deem it is a Worker's Compensation injury, I will be personally responsible for the cost of any care and treatment rendered to me.

Patient Signature: _____

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INSURANCE WAIVER FORM

Date: _____

Patient Name: _____ DOB: _____

Please note, that patients are responsible for knowing their insurance plan details. This includes deductible, co-insurance, out-of-pocket and co-payment information. Our office will not negotiate balances applied to your account due to deductibles, co-insurance, out-of-pocket and co-payments. In addition, payments to your balances must be made within 60 days of your initial invoice to avoid a 30% interest. Failure to comply will result in the account being transferred to our collection agency, International Recovery Associates within 90 days of non-payment. Our office also holds the right to refuse treatment due to non-payment.

I acknowledge and agree to comply with the above noted policy.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS DATE