WESTCHESTER NEUROLOGICAL CONSULTANT, PC.

PATIENT REGISTRATION

DATE: …… MN# ….....

First Name: …… Last Name: ……
D.O.B.: …….
Address: ……..
……..Zip Code: ……..

Sex: M F SS#: ……..
Race: Asian/AfricanAmerican/HispanicORLatino/PacificIslander/White/Unknown/Decline

Ethnicity: Hispanic or Latino/ Not Hispanic or Latino / Unknown/Other …… / Decline

Telephone: (check preferred) ( ) (HOME) ……..
( ) (WORK) ……..
( ) (CELL) ……..
Email Addr: ……..
Employer: …….
Address: …….
Phone number: ……
Employment Status: Employed/Unemployed/FTStudent/PTStudent/Other/Retired/Child

Emergency contact/Relationship: ……
Phone: …….

Primary Physician: ……..
Address: …….
Phone …… Fax ……..
Whom shall we thank for referring you: ……

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____
INSURED'S NAME_____ D.O.B.: _____
POLICY NUMBER _____
GROUP NUMBER _____

SECONDARY INSURANCE COMPANY _____
INSURED'S NAME_____ D.O.B.: _____
POLICY NUMBER _____
GROUP NUMBER _____

Pharmacy information:

Pharmacy Name: …… Tel: ……

Address: ……..

WESTCHESTER NEUROLOGICAL CONSULTANTS, PC

REASON FOR VISIT……

Past Medical/ Surgical History:

Diabetes Hypertension High cholesterol Heart Disease
Stroke/ TIA Seizure Head Injury Migraine Neck/ Back Pain Anemia
Reflux/ GERD Asthma COPD Depression
Anxiety Stroke Sleep Apnea Blood Clots

Other: ……..

Surgeries: ……..

Allergies: ……

Medications:
1……2……..……
3……4……..……
5……6……..……
7……8……..……
9……10……..

Family History:

Heart disease	Seizure/ Epilepsy	Multiple Sclerosis
High blood pressure	Alzheimer's disease	Lupus
Diabetes	Migraine/ Headaches	Rheumatoid Arthritis
High Cholesterol	Nerve or Muscle Disease	Osteoarthritis
Stroke	Mental Illness	Blood Clots
Cancer	Drug/ Alcohol Addiction	

Other ……..

Social History:
Employment: ……..
Marital Status: single married separated divorced
Children: yes no
Tobacco never past use current:
Alcohol: never rare/ occasional social frequent

WESTCHESTER NEUROLOGICAL CONSULTANT, PC.
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

Westchester Neurological Consultant, PC. Understands that your medical information is private and confidential. Further, we are required by law to maintain the privacy of "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 discuss the uses and disclosures we will make of your protected health information. We must comply with the processions of this notice as currently in affect, 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.

PERMITED 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 an 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 providers regarding your care and referrals for 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 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 activities we undertake to obtain reimbursement for the health care provided to you, including billing collections, claim management, determinations of eligibility and coverage and utilization review activities. For example, prior to providing health care services, we may need to provide information to your third party payer about your medical condition to determine whether the proposed course of treatment will be covered. When we subsequently bill the third party payer for the services rendered to you, we can provide the third party pay or with information regarding your case if necessary to obtain payment. Federal or state law may require us to obtain a written release from you prior to disclosing certain specially protected health information for payment purposes, and will ask you to sign a release when necessary under applicable law.

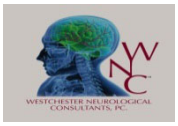
Health care operations means the support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient comment and complains, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your protected health information to evaluate the performance of our staff when caring for 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 to study health care and delivery without learning who you are.

ACKNOWLEDGMENT

I , acknowledge that I have been provided with a copy of Westchester Neurological Consultant's privacy notice.

Date: _____

Signature_____



WESTCHESTER NEUROLOGICAL CONSULTANTS, PC.

Emad F. Soliman, MD,MSc.

Financial Responsibility

At Westchester Neurological Consultant, PC. , we value you as a patient and appreciate that you have trusted us with your healthcare needs. In an effort to better inform you of our financial policies please review the information below and sign this form acknowledging that you understand our policies. Please know we are committed to protect your information and provide you with the best neurological care.

1. Acknowledgement of Our Billing Policy

Westchester Neurological Consultant, PC. Collects estimated financial patient responsibility at the time of service. Your insurance plan, co-insurance and deductible determine your financial responsibility. In the event you have a financial responsibility, you will be asked to pay this amount upon check-in. As an alternative, you may leave a credit card on file that will be charged per the Credit Card Authorization policy.

2. No-Show/Cancellation fees

As a courtesy to out Providers and other patients, please note that except in the case of understandable emergencies, our practice requires a ***24***-hour Notice for cancellations of Follow up appointments. And a ***48*** hour notice cancelation of procedures. We reserve the right to charge a non-refundable cancellation fee or no-show fee of ***$50.00*** for follow up appointments. And a ***$75.00*** fee for procedures to your account without 24 hours' notice to cancel or re-schedule an appointment. Or 48 hours 'notice for procedure cancelation.

3. Assignment of Benefits

I authorize Westchester Neurological Consultant, PC, to submit claims to my insurance company/companies on my behalf. And my insurance company/companies to make payments directly to Westchester Neurological Consultant, PC. For all covered services rendered by the group during the course of my medical treatment.

Authorization For Transfer of Medical Records and/or Information (WHEN APPLICABLE)

By signing this form I acknowledge that I wish to receive my healthcare at Westchester Neurological Consultant, PC. And, therefore, I authorize the transfer of all my medical records and/or information on file to Westchester Neurological Consultant, PC. I understand that I am authorizing the transfer of information regarding substance abuse, AIDSM HIV, or other communicable diseases to the extent such information is present in my records. I also consent to have my medical records released to other relevant health care providers, providing my healthcare from outside facilities when applicable, for the sole purpose of medical treatment.

NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patient of our practice may be used and disclosed as well as how you can access your health information. This is stipulated by the Privacy Regulation created by the Health Insurance Portability and Accounting Act of 1996 (HIPAA). We are committed to maintaining the privacy of your health information and we are required by law to ensure the confidentiality of your health information. These laws are complex therefore we have provided below the information we are required to provide for your understanding. The following circumstances may require us to use or disclose your health information:

1. To Provide Treatment:

We will use your PHI (private health information) within our office to impart the highest quality of healthcare possible. This may include administrative and clinical office procedures to schedule and coordinate care between physician, technicians, nurses, medical assistant and business office staff. This also includes pathology laboratories, pharmacies or

other health care personnel involved in your treatment and care. It may be necessary to release your test results to authorize healthcare providers treating patients even when the provider requesting results did not originally order the tests

To Obtain Payment:

We may include your health information with an invoice in order to collect payment for treatment you received in our office. This may include insurance forms filled for you by mail or electrically. Our office makes a concerted effort to work only with companies that maintain similar standards to protect and maintain the security of your health information.

2. Communications:

To assist in the coordination and payment of your care, we customarily contact patients to remind of scheduled appointments and of appointments that need to be scheduled. Methods of communication consist of postcards, letters, emails, and phone. In the event that the patient is unreachable, we may share your PHI via voice mail message and/or with the individuals authorized to assist you with regard to the manner in which this information is shared and with whom it can be shared with.

I authorize Westchester Neurological Consultant, PC. And its designated representatives to share my health information with the individual(ls) listed below:

_____

NAME/RELATIONSHIP CONTACT INFORMATION

3. Required by Law:

We may disclose your PHI to public health authorities and health oversight agencies that are authorized by law to collect information when required to do so by law enforcement officials, lawsuits and similar proceedings in response to a court or administrative order. This often times occurs when it becomes necessary to reduce to prevent a serious threat to your health and safety, that of another individual, the public or for Worker's Compensation and similar programs. Our patient medical records are kept confidential, secure and out of reach by unauthorized persons. All reports, consultations and correspondence are reviewed by Westchester Neurological Consultant, PC.prior to being filed in the medical records. A written release signed and dated by the patient/guardian must be obtained prior to the release of medical record information to comply with Privacy Regulations. We will let you know promptly if a breach occurs that may compromises the privacy or security of your information.

4. Medical Records

When it comes to your health information, you have rights to your medical records. You can ask to see or get a copy of your medical records and other health information we have about you. We may charge a ***reasonable fee of $0.75 per page***, Per New York state health care Regulations, to recover the cost of ink paper and labor.

_____ _____

Patient or Guardian Signature Date

_____

Patient or Guardian Printed Name

WESTCHESTER NEUROLOGICAL CONSULTANTS,

REQUEST FOR RELEASE OF MEDICAL RECORDS FROM WESTCHESTER NEUROLOGICAL CONSULTANTS

Patient Name: _____ DOB: _____

TO: _____

_____

PHONE: _____ FAX: _____

I, _____, authorize the release of my medical records from WESTCHESTER NEUROLOGICAL CONSULTANTS.

Thank you,

_____ _____

Patients Signature **Date**

I understand that this authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization shall remain valid until written notice is given by me revoking said authorization.

For any questions, please call 914-966-0505 and ask for

_____

WESTCHESTER NEUROLOGICAL CONSULTANTS, PC.

REQUEST FOR RELEASE OF MEDICAL RECORDS TO
WESTCHESTER NEUROLOGICAL CONSULTANTS

Patient Name: _____ DOB: _____

FROM: _____

_____

PHONE: _____ FAX:_____

I, _____, authorize the release of my medical records to WESTCHESTER NEUROLOGICAL CONSULTANTS.

Please mail or fax my medical records to:

Westchester Neurological Consultants
1915 Central Park Avenue Suite 103
Yonkers, NY 10710
Fax #: (914) 966-0515

Thank you,

_____

_____

Patients Signature Date

I understand that this authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law. This authorization shall remain valid until written notice is given by me revoking said authorization.

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