

Neurology Consultants of NY, P.C.

Jaydeep Bhatt, M.D.
Myrna Cardiel, M.D.
Fang-Yang Foo, M.D.
Sun-Hoo Foo, M.D.
Govidan Gopinathan, M.D.
Andreas Neophytides, M.D.
Harold Weinberg, M.D.

650 First Avenue
New York, NY 10016

NAME _____ BIRTHDATE _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ BUSINESS # _____

CELL PHONE # _____ EMPLOYER _____

ADDRESS _____ AGE _____ SEX _____

SOCIAL SECURITY NUMBER _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

REFERRING DOCTOR _____ PHONE # _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____

PHONE# _____ RELATIONSHIP _____

We see patients by appointments only. We will make every effort to see you at the scheduled time and we would appreciate you also coming in on time to fill out the necessary paper work. **APPOINTMENT CANCELLATIONS REQUIRE 24-HOUR PRIOR NOTICE IN ORDER TO AVOID A MISSED APPOINTMENT FEE. IF YOU DO NOT CALL TO CANCEL OR DO NOT SHOW UP FOR YOUR APPOINTMENT, YOU WILL BE CHARGED \$ 75.00 FOR THAT MISSED APPOINTMENT.** Please understand this charge will not be covered by your insurance company and will be your personal responsibility

SIGNATURE: _____

DATE : _____

Neurology Consultants of NY, P.C.

INSURANCE PAYMENT AUTHORIZATION

FOR MEDICARE RECIPIENTS

I request that payment of authorized Medicare benefits be made directly to the doctor for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits. If other health insurance is indicated in item 9 of the HCFA-1500 form or electronically submitted claims, I authorize the release of information to that insurer. I agree to be responsible for the deductible, coinsurance and noncovered services as determined by the Medicare carrier.

FOR INDEMNITY, PPO OR HMO PLAN HOLDERS

Your health benefit plan is an agreement between you, the enrollee and the insurance company, HMO or your employer. While we will try to be helpful, and we may be participants in the plan, your health benefit plan determines your coverage for medical services.

You agree to accept financial responsibility for Co-Payments, Deductibles, Medical Care and Other Services that are provided to you which are not specifically covered by your health benefit plan or not covered due to absence of any authorizations or referrals you are obligated to obtain, prior to seeing the doctor as stated under your health benefit plan. The services, plans and benefits under your health plan may be subject to and governed by applicable contracts and government regulations. This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including, any provisions regarding grievance procedures that may be available to you.

I hereby agree to the above and authorize my insurer to pay directly to the doctor, benefits due out of indemnity under the terms of my policy issued by that company. Payment is authorized upon receipt of his itemized statement for services rendered to me.

NAME _____

SIGNATURE _____

DATE _____

Neurology Consultants of NY, P.C.

HIPAA CONSENT FORM

Our Notice of Privacy Practices information is about how we may use or disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I have been informed by you of your Notice of Privacy Practices and I have been given a right to review it before signing this consent. I also was provided with a copy. I hereby, knowingly and voluntarily authorize the Practice to use or disclose my health information in the manner described above.

This Consent was signed by: _____
Please Print Name (If you are patient)

Signature _____ Date _____

Witness: _____ Date _____