McMonigle Neurology Associates
554 Larkfield Rd., Suite 10G East Northport, NY 11731
Phone: 631-230-6644 Fax: 631-230-6645

INFORMACION DEL PACIENTE

NOMBRE:	**APELLIDO:**
DIRECCION:	**PUBLEO/CIUDAD:** **ESTADO:** **CODIGO POSTAL:**
FECHA DE NACIMIENTO: / /	**FARMACIA:** **DIRECCION:**
TELEFONO DE CASA: ( )	**TRABAJO NOMBRE:**
NUMERO CELLULAR: ( )	**CONTACTO DE EMERGENCIA:**
NUMERO DE TRABAJO: ( )	
CORREO ELECTRONICO: **_____**	**MEDICO DE** **ATENCION PRIMARIA:**

INFORMACION DEL SEGURO MEDICO

Primaria Seguro Medico	**Seguro Segundario Medico**
NOMBRE DEL SEGURO:	**NOMBRE DEL SEGURO:**
PERSONA RESPONSIBLE: **DOB:**	**PERSONA RESPONSIBLE:** **DOB:**
RELACION DEL PACIENTE:	**RELACION DEL PACIENTE:**

FIRMA DEL PACIENTE: _____ **FECHA: _____/_____/_____**

McMonigle Neurology Associates
554 Larkfield Rd., Suite 10G East Northport, NY 11731
Phone: 631-230-6644 Fax: 631-230-6645

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA) of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.**
- **Obtain payment from third party-payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have received, read, and understand your notice of privacy practices containing a more complete description of these uses and disclosures of my health information. I understand that this office has the right to change its notice of privacy practices from time to time and that I may contact this office at any time at the address listed above to obtain a copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carryout treatment, payment, or care operations. I also understand that you are not required to agree to my requested restrictions but if you do agree, then you are bound to abide by such restrictions.

ASSIGNMENT OF BENEFITS

I authorize insurance payments to be made directly to McMonigle Neurology Associates for services rendered. I understand that I am responsible for all balances not covered by my Insurance Carrier.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize McMonigle Neurology Associates to release medical or incidental information that may be necessary for medical care or processing of insurance claims.

I verify that all information provided regarding my insurance is accurate. I will notify McMonigle Neurology Associates office staff if any changes are made to my insurance. I authorize release of records upon request. A photocopy of these assignments shall be valid as the original.

Patient Name (Print): _____
Patient Signature: _____ Date: ____/_____/_____

McMonigle Neurology Associates
554 Larkfield Rd., Suite 10G East Northport, NY 11731
Phone: 631-230-6644 Fax: 631-230-6645

I,_____, understand that I must cancel my appointment with the office of McMonigle Neurology Associates at least 24 hours prior to my scheduled time. In the case that I do not cancel there will be a charge of $50 assessed. I am aware this fee must be paid at the time of my next appointment.

_____ **_____/_____/____**
Patient Signature **Today's Date**

_____ **_____/_____/____**
Employee Signature **Today's Date**

FOR NEW PATIENTS ONLY

IF YOU ARE AN ESTABLISHED PATIENT, PLEASE "X" OUT THIS HALF

I am aware that no Controlled Substances of any kind will be prescribed to me by McMonigle Neurology Associates until I become an established patient for at least 90 days. I understand that there will be no consideration given and if I feel that I need any type of special medication, I will accept being referred to a specialist upon the doctor's discretion.

_____ **_____/_____/____**
Patient Signature **Today's Date**

_____ **_____/_____/____**
Employee Signature **Today's Date**