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

PATIENT INFORMATION

FIRST NAME:	**LAST NAME:**
STREET ADDRESS:	**CITY:** **STATE:** **ZIP:**
Date Of Birth: / /	**Pharmacy:** **Address:**
PHONE NUMBER: ( )	**Employer Name:**
CELL NUMBER: ( )	**Emergency Contact:**
WORK NUMBER: ( )	**Emergency Number:**
E-MAIL:	**Primary Care Physician:**

Patient's Insurance Information

Primary Insurance Company	**Secondary Insurance Company**
Insurance Name:	**Insurance Name:**
Policy Holder: **DOB:**	**Policy Holder:** **DOB:**
Relationship to Policy Holder:	**Relationship to Policy Holder:**

Patient's Signature: _____ **Today's Date_____/_____/_____**

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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: ____/_____/_____

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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

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PATIENT WAIVER

The undersigned ("you") stated you are covered by insurance. If you fail to provide your insurance information, provide the incorrect information, or fail to notify us of changes in your coverage, you will be financially responsible for the service provided to you if denied by your insurance carrier.

Your insurance company may require a referral to see a specialist. If your insurance plan requires you have a referral, it is your responsibility to have your PCP's office supply one for you. If you fail to obtain a referral before your visit, you will be held responsible for any bills your insurance refuses to pay.

If you fail to pay your health insurance premiums, resulting in loss of coverage you will be responsible for all medical fees. Please understand, it is not possible for our office to call every patient's insurance carrier prior to their visit to verify their coverage. We must hold the patient responsible for updating any insurance information necessary.

I understand I am responsible to know what my plan covers and does not cover. I am aware that some insurance companies do not cover some services and it is my responsibility to know what are or are not covered by my plan.

I understand that I am responsible to notify the staff if the reason for my visit is due to a motor vehicle accident or workers compensation. I am aware that Dr. McMonigle does not participate with worker's compensation insurance.

I give full consent for my insurance company to pay directly to the Physician provider all charges arising from mine or my dependent's visits. I agree that I will be liable for all fees not covered by my insurance. I also agree that if monies owed are not paid in within a timely fashion, I will be responsible for all costs associated in collecting those fees, including but not limited to all legal and collection fees.

I understand that the office requires 24-hour notice for all canceled or missed appointments. If such notice is not given, I am aware that I could be charged a "No Show" fee of $75.

_____ _____

Patient signature Date

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released 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 from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test result, 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**

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 Name 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.**