· Kevin Mullins, MD ·Salvatore Zavarella, DO ·Joshua Ryan, MD, ·Salvatore Insinga, DO ·Ahmad Latefi, DO ·Amrit Chiluwal, MD ·Raj Narayan, MD
·1175 Montauk Hwy, Suite 6, West Islip, NY 11795
·110 E. Main St. 2B, Huntington, NY 11743 ·4681 Veterans Memorial Highway, Holbrook, NY 11741
·220 Northern Blvd, Suite 230, East Hills, NY 11548 ·722 Montauk Highway, West Islip, NY 11795

Name _____ Date of Birth _____/_____/_____ Age_____ M / F

Address _____

SS# _____-_____-_____ Marital Status S M W D S Email _____

Preferred Contact Method			Message? (Y or N)	
☐	Home Phone	(_____) _____	Y	N
☐	Cell Phone	(_____) _____	Y	N
☐	Work Phone	(_____) _____	Y	N
☐	Alternate Phone	(_____) _____	Y	N

How would you like to receive your Appointment Confirmations? ☐ **Text to Cell Phone** ☐ **Call to HOME or CELL (Please circle)**

I authorize my physician and the medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Contact Information

Referring Doctor Name_____ Telephone #_____

Primary Care Physician _____ Telephone # _____

Pharmacy and Location _____ Telephone # _____

INSURANCE INFORMATION **If Change of Insurance: Effective DATE**_____

Primary Insurance _____ Member ID #_____

Policy Holder _____ Policy Holder SS# _____ Policy Holder DOB _____

Relationship to Patient _____ Policy Holder Employer_____

Secondary Insurance _____ ID # _____ Policy Holder _____

Policy Holder SS#_____ Policy Holder DOB _____ Relationship to Patient _____

WORKERS COMPENSATION or NO FAULT OR THIS IS NOT RELATED TO A CAR ACCIDENT OR INJURY AT WORK _____(initial)

Insurance Carrier_____ Claim Number_____

Date of Injury/Accident_____ Adjuster _____ Phone _____

Workers Compensation Only:

Employer _____ Employer Address_____

Job Title/Description_____ How did injury occur_____

On the date of injury, what were your usual work activities: _____

OVER

Attorney's Name & Phone Number _____

_____

_____ _____

Signature of Patient **Date**

Rev October 2022

I hereby authorize and direct Kevin J. Mullins, MD; Salvatore Zavarella, DO; Joshua Ryan, MD; Salvatore Insinga, DO.; Ahmad Latefi, DO; Amrit Chiluwal, MD; Raj Narayan, MD; (herein referred to as "the provider,") having treated me, to release to Medicare, Medicaid, governmental agencies, insurance carriers, or others who are financially liable for medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I hereby guarantee payment to the provider of all charges and fees incurred for services rendered to me. I understand that if an insurance company (non-participating) fails to pay all or part of this claim, that I am responsible, upon notice, for payment in consideration of the physician's services which have been or will be provided to the patient. I hereby assign to the provider all of the medical insurance benefits to which I may be entitled from Medicare, Medicaid, governmental agencies, insurance carriers, no-fault carriers, or others that are financially liable for my care. I hereby authorize to the provider authority to file claims for payment and appeals on determinations of those claims on my behalf.

I hereby designate, authorize, and convey to the provider, having treated me to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy including fines.

I request that payment of authorized benefits be made on my behalf to the provider.

_____ _____

Signature of Patient **Date**

_____ _____

Signature of Person/Guarantor (Other than Patient) **Witness**

E-PRESCRIBING / MEDICATION HISTORY CONSENT:

Your doctor uses an electronic medical record system that allows electronic prescribing of medications. Prescriptions are sent to your pharmacy through a secure connection which improves the accuracy and timely transmission of your medical information, and which complies with federal regulations. E-prescribing programs must include medication history which provides your doctor with information about previous and current medications you are taking to minimize the number of adverse drug reactions. Your signature certifies that you have read and understand the scope of your consent and you authorize the access of your medication history.

_____ _____

Signature of Patient **Date**

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates of carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Insured or Authorized Representative **Date**

NeuroCare
LONG ISLAND

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby acknowledge the offer to receive a copy of the Notice of Privacy Practices which describes how Kevin J. Mullins, MD; Salvatore Zavarella, DO; Joshua Ryan, MD; Salvatore Insinga, DO; Ahmad Latefi, DO, Amrit Chiluwal, MD, Raj Narayan, MD, may use and share my protected health information.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/ or
- Refuse to sign this authorization.

I have also been informed that the Notice of Privacy Practices is available in the waiting room and online at www.SpineCareLongIsland.com for me to read.

_____ _____

Signature of Patient or Personal Representative Print Name of Patient

_____ _____

Description of Personal Representatives Authority Date

Financial Policy

We are committed to providing all of our patients with the best available treatment and care. Please read through our financial policy which answers some frequently asked questions, and contact our office should you have any further questions.

Office Visits:

- At the time your initial appointment was scheduled, you were informed of your doctor's network status with your health insurance plan.
- A list of our insurance network affiliations is available online at www.neurocarelongisland.com or upon request.
- A list of the hospitals we are affiliated with is available online at www.neurocarelongisland.com or upon request.
- If your doctor participates with your plan, a co-payment may be due at the time of your appointment.
- If your doctor does not participate in your plan but your plan provides out of network benefits, we will file a claim on your behalf and work with your insurance carrier to obtain payment. As required by law, and in accordance with the terms of your policy, you may be responsible for any deductible or co-insurance amounts which may apply.
- An estimated amount for services to be performed, absent unforeseen circumstances, is available upon request.
- An estimated amount for services to be performed, absent unforeseen circumstances, is available upon request. Based on the No Surprises Act, effective 01/01/2022, our office determines charges based on/or about Fair Health Geographic pricing. This database is deemed an appropriate and viable reference, per Department of Financial Services and is available upon request by visiting www.fairhealthconsumer.org/medical

Surgical Procedures

In addition to all the policies listed above:

- If your doctor recommends surgical procedure, and your doctor is in-network, you may be responsible for any in-network fees or deductibles which may apply. Please consult with your insurance carrier.
- If you are scheduled for surgery, other providers from our office providing necessary services will submit a separate bill to your insurance carrier under the same conditions as above.
- If you are scheduled for hospital admission or outpatient hospital service, the name of the hospital and the name, practice name, address, and phone number of any other physician whose services will be arranged by us and are scheduled at the time of the preadmission testing, registration, or admission will be provided to you at the time that non-emergency services are scheduled along with information as to how to determine the plans in which the physician participates.
- An estimated amount for services to be performed, absent unforeseen circumstances, is available upon request. Based on the No Surprises Act, effective 01/01/2022, our office determines charges based on/or about Fair Health Geographic pricing. This database is deemed an appropriate and viable reference, per Department of Financial Services and is available upon request by visiting www.fairhealthconsumer.org/medical

The proper care and treatment of our patients is our top priority, and we will work with our patients to provide a fair and reasonable settlement of any financial obligation. We understand that personal financial circumstances vary from patient and to patient. If you are suffering from a financial hardship please discuss this with our billing department. **Our billing department is available to speak with patients who have questions at 833-666-6066.**

I have read and understand the above financial policy. I understand that I may contact the billing department at (833) 666-6066 with further questions.

_____ _____

Print Name Signature

_____ _____

Date of Birth Today's Date

Rev May 2023

NEW YORK STATE SURPRISE MEDICAL BILL CERTIFICATION FORM

You are protected from surprise medical bills. Your health plan must pay your health care provider, and your provider cannot bill you, except for any in-network cost-sharing.

- This form is required for surprise bills in (1) below for dates of service before 1/1/22 and for surprise bills in (2) below for all dates of service. This form is **NOT** required for surprise bills in (1) below for dates of service on and after 1/1/22 but helps identify when services are a surprise bill.
- Send a copy of this form to your **provider** and **health plan** (include a copy of any bill you received).
- Your provider may complete this form for a surprise bill described in (1) below for dates of service on and after 1/1/22, and your provider must send it to your **health plan**.

A surprise bill is when:

1. You're at an in-network hospital or ambulatory surgical facility and an in-network provider was not available; an out-of-network provider provided services without your knowledge; or you needed unforeseen medical services. Also, you did not choose to receive services from an out-of-network provider instead of from an available in-network provider before you went to the hospital or ambulatory surgical facility. (Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services in an in-network hospital or ambulatory surgical facility are usually a surprise bill.)
2. During a visit with your in-network doctor an out-of-network provider treats you; your in-network doctor takes a specimen from you and sends it to an out-of-network lab or pathologist; or your in-network doctor refers you to an out-of-network provider (and referrals are required under your health plan). Also, you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your health plan.

I certify to the best of my knowledge that (check one):

☐ I received services that are a surprise bill as described in (1) or (2) above and I want the provider to seek payment for this bill from my health plan (this is an "assignment") **OR**

☐ I am a **health care provider**, and the insured received services that are a surprise bill as described in (1) above for dates of service on and after 1/1/22.

Patient Name:		**Date of Service:**	
Patient Mailing Address:			
Insurer Name:		**Insurance ID No:**	
Provider Name:		**Provider Phone Number:**	
Provider Mailing Address:			
Provider Contact Name (if different from provider name)			
Provider Contact Email Address:			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.			
Signature (of patient or provider):		**Date signed:**	

If you have questions about this form, contact the Department of Financial Services at (800) 342-3736.