

NeuroCare

LONG ISLAND

Member of Northwell Health Physician Partners®

INITIAL VISIT INFORMATION

DATE: _____

NAME: _____ DOB: _____ AGE: _____

REASON FOR VISIT (Please be specific)

Have you completed Physical Therapy for this condition? () YES () NO If yes, # of weeks: ____ Facility: _____

Have you completed Pain Management Treatment for this condition? () YES () NO

If YES, Injections? _____ Medication? _____

Have you seen or are you seeing a chiropractor? YES or NO If yes, name: _____

MEDICAL HISTORY

Select and list relevant medical conditions:

- () Arthritis () Epilepsy
- () Asthma () Heart Disease
- () Bleeding Disorders () Hepatitis
- () Cancer () High Blood Pressure
- () Diabetes () Kidney Disease
- () Emphysema () Neurologic Disorder
- () Pacemaker () Stents
- () _____

MEDICATIONS

List all medications you are taking:

FAMILY HISTORY

Select and list all that apply:

- () Asthma () High Blood Pressure
- () Cancer () Kidney Disease
- () Diabetes () Strokes
- () Heart Disease
- () _____

SURGICAL HISTORY

List all surgeries you have undergone with dates:

ALLERGIES

Medications, food, contact, environmental:

() Adverse reaction to CT or MRI contrast (dye)

() Adverse reaction of Anesthesia

RELATED HEALTH

Are you a smoker? () YES () NO

Do you drink alcohol regularly? () YES () NO

Do you use drugs? () YES () NO

SOCIAL HISTORY

Are you currently working? () YES () NO

Occupation: _____

Do you have children? () YES () NO

Are you currently pregnant? () YES () NO

Please turn page over and complete reverse side.

Tell us about your symptoms

Do you have weakness in a foot or hand?

- Yes No

How long have you suffered from these symptoms?

- ≤6 weeks 7 to 12 weeks 4 months or more
or Specific Date: ___ / ___ / ___

Do you have pain radiating PAST your knee or elbow?

- Yes No

Does your leg or arm ever go numb?

- Yes No

Have you had back or neck surgery before?

- Yes No

Does your back or neck pain wake you up at night?

- Yes No

How many pills do you take each day for pain relief?

- no pills 1 to 4 pills 5 or more pills

How do symptoms affect your life?

Which of the following describes you currently?

- Working
 Not working due to back or neck problem
 Not working due to another health problem
 Homemaker, retired or unemployed

Did your back or neck injury happen at work?

- Yes No

The following are activities you might do in a day. Does your back or neck pain limit you in these activities, and if so, how much?

Lifting or carrying groceries

- Limited a lot Limited a little Not limited at all

Climbing several flights of stairs

- Limited a lot Limited a little Not limited at all

Standing for 30 minutes

- Limited a lot Limited a little Not limited at all

Your expectations

What results do you expect from your care?

Relief from pain symptoms Yes No Doesn't apply

Return to your job Yes No Doesn't apply

Return to leisure activities Yes No Doesn't apply

Improved sleep Yes No Doesn't apply

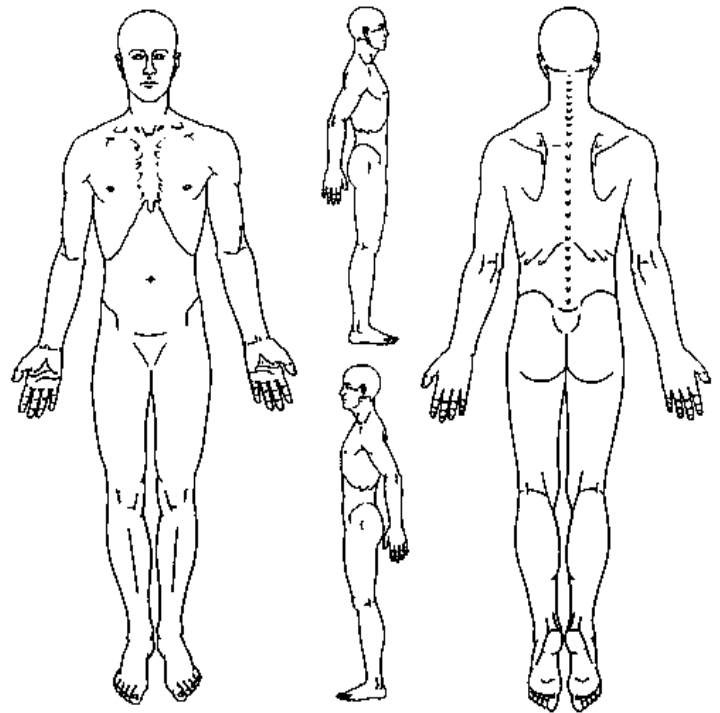
Where is your pain located?

Using the pictures, shade with a pen or pencil the parts of your body which are affected by pain.

Right ↓

Right ↓

Right ↓



Left ↑

Left ↑

Left ↑

We may have a nurse call you to follow up on your symptoms and check to see how you are doing 3 months from now. May we call you at the number you provided?

- Yes No

Kevin Mullins, MD ·Salvatore Zavarella, DO ·Joshua Ryan, MD, ·Salvatore Insinga, DO
 ·1175 Montauk Hwy, Suite 6, West Islip, NY 11795
 ·110 E. Main St. 2B, Huntington, NY 11743 ·4681 Veterans Memorial Highway, Holbrook, NY 11741
 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 (_____) _____
- Cell Phone (_____) _____
- Work Phone (_____) _____
- Alternate Phone (_____) _____

- Y N
- Y N
- Y N
- 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: _____

Attorney's Name & Phone Number _____

Signature of Patient

Date

I hereby authorize and direct Kevin J. Mullins, MD; Salvatore Zavarella, DO; Joshua Ryan, MD; Salvatore Insinga, DO.; (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 intermediaries 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

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. Our office determines charges based on 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 surgery 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 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. Our office determines charges based on/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 631-768-8148.**

I have read and understand the above financial policy. I understand that I may contact the billing department at 631-768-8148 with further questions.

Print Name

Signature

Date of Birth

Today's Date



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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; 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.NeuroCareLongIsland.com for me to read.

Signature of Patient or Personal Representative

Print Name of Patient

Description of Personal Representatives Authority

Date