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:<br>STATE: ZIP: |
| Date Of Birth: / / | Pharmacy:<br>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**

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# **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**