Neurological Surgery & Pain Management 1175 Montauk Highway, Suite 6, West Islip, NY 11795 631-422-5371
Patient Information Sheet

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

Address _____City/State_____ ZIP Code_____

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

☐ **OPT OUT OF TEXT MESSAGE CONFIRMATIONS**

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 # _____

How did you hear about our office? (Circle One) **Friends/Family** **Website/Google** **Newspaper** **Radio** **TV** **Direct Mail**

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 <u>OR</u> 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**

OVER →

I hereby authorize as follows:

I hereby authorize and direct Kevin Mullins MD, Salvatore Palumbo MD, William McCormick MD, Borimir Darakchiev MD, George Kakoulides MD, Salvatore Zavarella DO, Kimon Bekelis MD, Joshua Ryan MD, Salvatore Insinga DO, Symeon Missios MD, Brian McHugh MD, Amit Sharma MD, Eric Fanaee MD, Michael Hershey MD, Reginald Rousseau MD, Jaspreet Toor 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

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

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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.linps.com or upon request.
- A list of the hospitals we are affiliated with is available online at www.linps.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.

Surgery or Pain Management Procedures
In addition to all the policies listed above:

- If your doctor recommends surgery or a pain management 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 or for a pain management procedure, 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.

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) 482-9977.**

I have read and understand the above financial policy. I understand that I may contact the billing department at (631) 482-9977 with further questions.

_____ _____
Print Name Signature

_____ _____
Date of Birth Today's Date

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 J. Palumbo, MD; William E. McCormick, MD; Borimir J. Darakchiev, MD; George Kakoulides, MD; Salvatore Zavarella, DO; Kimon Bekelis, MD; Joshua Ryan, MD; Salvatore Insinga, DO; Symeon Missios, MD; Brian McHugh, MD; Amit Sharma, MD; Eric Fanaee, MD; Michael Hershey, MD; Reginald Rousseau, MD and Jaspreet Toor, 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 for me to read.

_____ Date _____
Signature of Patient or Personal Representative

_____
Description of Personal Representatives Authority

Medical Record Release

Release Information to:

Name	Relationship to Patient	Contact Information/Fax Number

THIS INFORMATION REFERS TO INFORMATION DATED:

From_____ To_____

Patients Signature_____ DOB_____

Print name of patient _____

Authorization of Designated Representative to Appeal A Determination

TO:

Date: _____

Name: _____ Member #: _____
(Please Print)

I hereby authorize _____ to appeal determination
(Print Doctor's Name or Representative)

concerning my medical bills on my behalf, as my Designated Representative, and as part of the appeal, I hereby authorize my insurance company to disclose and furnish to my Designated Representative:

All medical and financial information contained in my insurance file including but not limited to treatment for venereal disease, alcoholism and drug abuse, abortion, mental disorder or developmental disability, cancer and HIV status relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed. I understand this information is privileged and confidential and will only be released as specified in this authorization. This authorization is valid for a period of one year.

Signature of Member or Legal Guardian/Representative: _____

Signature of Witness/Designated Representative (Circle One) _____

Name of Witness/Designated Representative (Please Print) _____

Title (if on provider's staff) or Relationship to member: _____

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in-network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at 1-800-342-3736.

A surprise bill is when:

1. You received services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a non-participating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician; OR

2. You were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ **Provider Telephone Number:** _____

Provider Address: _____

Date of Service: _____

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 five thousand dollars and the stated value of the claim for each such violation.

_____ _____

(Signature of patient) (Date of signature)