Tal Mednick Integrative Neurology
350 Veterans Memorial Highway LL 2North
Commack, NY 11725

PATIENT INFORMATION

Name: _____
Address: _____
City: _____
State: _____ Zip: _____

Social Security #: _____
Emergency Contact: _____

E-Mail Address: _____

Primary Doctor: _____

Referring Doctor: _____

Date of Birth: _____ Age: _____
Male ___ Female ___

Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
Work Phone: (_____) _____-_____
Emergency Phone: (____) _____-_____

Pharmacy Name & address: _____

_____

INSURANCE INFORMATION

Primary Insurance Company: _____
Subscriber Name: _____ ID: _____

Secondary Insurance Company: _____
Subscriber Name: _____ ID: _____

Financial Responsibilities: I hereby authorize and assign all claims for payment of any insurance or third parties directly to TAL MEDNICK INTEGRATIVE NEUROLOGY for the services I received. I understand I am responsible for payment in full. I acknowledge I am responsible for any co-payments, deductibles, co-insurance, and non-covered services. I understand its TAL MEDNICK INTEGRATIVE NEUROLOGY choice to appeal any denied claims or seek payment from me. I authorize TAL MEDNICK INTEGRATIVE NEUROLOGY or any of its affiliated designee to contact me regarding my financial responsibilities in various methods such as email, text messages, the use of an automated dialing service or pre-recorded message. I understand it's my responsibility to update any changes to my contact information to TAL MEDNICK INTEGRATIVE NEUROLOGY change of insurance, home address, home number, cellular number, and email address.

Authorized 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 results, 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 with 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.**

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(631) 309-5222

Patient Name: _____ DOB: _____

Tal Mednick Integrative Neurology is authorized to release protected health information about the above-named patient below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Please list anyone we can discuss your medical information with.

NAME	RELATIONSHIP TO PATIENT	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

NO ONE ☐

Patient Information

I understand that I have the right to revoke this authorization at any time. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

_____ _____

Patient Signature Date

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Financial & Office Policies

Patient Financial & Office Policies:

We are dedicated to providing you with the best possible care and service. We regard your understanding of our financial policies as an essential element of your care and treatment. We are more than willing to provide care within the guidelines of your insurance plan. It is, however, your responsibility to know and understand those guidelines.

Appointments:

We make every effort to see all patients at their appointed time and request that you extend the same courtesy to us. We request that you notify our office immediately if you will be late for your scheduled appointment. This allows us to utilize the time to attend to other patients. We reserve the right to reschedule appointments to which the patient is more than 15 minutes late. The office tries to do everything possible to remind patients of their appointments, however, it is ultimately the patient's responsibility to know their scheduled appointment.

Canceling Appointments and "No-shows":

When a patient does not keep their scheduled appointment and does not call the office to cancel, we lose the opportunity to help someone else in need. A notice of at least **24 hours** is required should you be unable to keep your scheduled appointment. We reserve the right to charge a fee for missed appointments or appointments that are not cancelled **24 hours** prior to appointment time. **The current fee is $50.** Should you incur this fee, it must be paid in full prior to your next appointment.

Doctor-Patient Relations:

We will make a special effort to explain your condition, medication, treatment, etc. Should you have a question or if something is not clear, please do not hesitate to ask. Our personnel, office procedures and medical equipment were chosen with much thought and care to provide the best quality medical services in a pleasant, efficient and friendly atmosphere.

Prescriptions and Refills:

Have your pharmacy fax our office with routine requests for prescription refills during regular office hours. Monday through Friday. Every effort will be made to attend to your refill request within 24 hours. We do, however, ask that you please do not wait until you are out of medication to request a refill. Please be aware there will be times when your physician may wish to see you prior to authorizing a refill.

Returning Messages:

Our staff has been trained to answer many of your questions. When your call requires a response from your physician every effort will be made to return your call promptly, usually within **48 hours**. Non-emergency phone calls should be limited to our regular business hours.

Evenings, Weekends & Holiday Emergencies:

Dr. Mednick provides clinical care in the office during regular office hours but does not provide hospital care and is not available for emergency visits on nights, weekends or holidays. We recognize that outside of office hours, medical emergencies do occur. If that happens to you, please do not delay in calling 911 for assistance or present yourself to a hospital emergency room for evaluation. We will gladly speak to any treating physician during an emergency and forward any medical records to them if needed.

Health Insurance:

All health insurance deductibles, co-pays and co-ins are due at the time services are rendered. You must be prepared to provide your health insurance card at every visit. This office files primary health insurance for those in which we participate. If you have a secondary health insurance payer, we will file a medical claim to them as well. It is your responsibility for knowing your policy information such as co-payments, co-insurances, and deductibles. We will not become involved in disputes between you and your health insurance carrier. In the event your health plan determines a service to be 'not covered', you will be responsible for the complete charge. Payment is due at the time of service.

Personal Information:

It is imperative that our office be provided with current information on you. We must be able to contact you. Please keep us updated of new addresses, phone numbers, place of business and insurance information. We will require you to fill out an updated patient information sheet on an annual basis or anytime there are changes to your personal information.

Disability, Driving & Other Forms:

There is a **pre-payment fee of $15** for completion of each of these forms. Please allow 5–7 days processing for each form.

Acknowledgment of Receipt of Financial & Office Policies

I have read and understand that Tal Mednick Integrative Neurology requires a cancellation notice at least **24 hours** in advance when I am unable to keep an appointment. If a **cancellation notice 24 hours prior to my appointment time is not provided or I NO SHOW, I am aware there is a fee of $50 per occurrence**. I am also aware if I incur this fee, it must be paid in full prior to my next appointment.

By signing below, I acknowledge I have received this notice and understand the financial and office policies for

Tal Mednick Integrative Neurology.

_____ _____

Patient Name (or Legal Representative) Relationship to Patient

_____ _____

Patient Signature (or Legal Representative) Date

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To all our new and established patients: We have implemented a policy asking patients to keep a credit card on file at the office to make things more convenient for our patients and staff. Your card information will be held securely in your chart and the hard copy will be properly discarded. Once your insurance company has paid their portion and notified us of the amount of your share of the claim, a statement with any remaining balance owed will be mailed to the address you provided upon check in. You will also have received an explanation of medical benefits from your insurance company that would make you aware that there is a portion of the fee that is your responsibility, so this balance will not come as a surprise to you.

Healthcare is a personal relationship between a patient and physician. While we don't believe healthcare is just like any other product, practices of insurance companies have changed over the years and this policy is necessary and benefits everybody in helping to keep the cost of healthcare down. We thank you for your understanding of this policy.

Circle One	**Credit Card Number**	**Exp Date**	**Security Code**	**Billing Zip Code**
Visa, Mastercard, Amex, Discover				

I, (print) _____, have read the above and understand that my credit card will be charged for any balances, which are the patient's responsibility determined by my insurance as well as any fees associated with the practice's **cancellation policy**. I, the undersigned, authorize Tal Mednick Integrative Neurology to charge the credit card indicated on this authorization form according to the term outlined above.

I certify that I am an authorized user of this card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Signature (required):_____Date (required): _____