

Niagara Neurological Services & Sleep Medicine

7220 Porter Road
Niagara Falls, NY 14304
716-575-0075

Today's date:

Primary Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):	Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Social Security no.:		Home phone no.: ()		
P.O. box:	City:	State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()		

How did you hear about our office?

Pharmacy Name & Phone Number:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()
Secondary:	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

HIPPA Compliance Form

Your confidentiality is very important to us. HIPPA privacy rules state that your authorization is required for our office to communicate with members of your family or other health care providers. We would like to give you prompt information regarding appointments, prescriptions, medical treatment, laboratory work, and imaging reports. The following questions will help us determine how we get this information to you:

1. May we call your home for the above? Yes / No
2. When we call, is it acceptable for us to identify that we are Niagara Neurology calling regarding the above, including when we leave a message? Yes / No
3. Do you authorize us to discuss the above with other members of you household? Please note we will not discuss or release any information to anyone unless they are listed below. Yes / No

Please list names and relationship of the individuals we may speak to on your behalf

▪

▪

Patient Name (Printed)

(Patient Signature)

(Date)

Witness: _____

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

APPOINTMENTS:

Niagara Neurology & Sleep Medicine is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates.

Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare care can be determined. If any testing needs to be order, an appointment may be required to see the provider.

PRIVACY PRACTICES:

I understand I have the right to review Niagara Neurology & Sleep Medicine's Notice of Privacy Practices signing this document, which would be provided to me upon request.

CANCELLATION & NO SHOW POLICY:

We require advanced notice for any appointment changes. If you miss an appointment there will be a \$25.00 fee, this charge will be the patients responsibility and will not be billed to your insurance company. Three "no shows" or "late cancellations" without 24 hours notice within one calendar year, may result in termination from the practice.

INSURANCE:

Niagara Neurology & Sleep Medicine accepts most insurance plans. If you have any questions regarding your insurance, please contact our billing department at **(716) 650-5745**.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Niagara Neurology & Sleep Medicine from medical services rendered to myself and/or my dependents.

It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of an insurance payment.

Patients are responsible for co-pays at the time of service. If applicable, you will be billed for services not covered by your insurance as stated in your insurance contract. Please note you are also responsible for all deductibles and coinsurance assigned by your plan.

When determined to be appropriate, a home sleep study can be an alternative to a study performed in a lab. Please be aware, both types of studies must be read by a board certified physician. According to the billing codes designated by the American Medical Association, the charge for the home sleep study or in lab sleep study does not include the interpretation. As such, is billed separately.

Our office DOES NOT accept Worker's Compensation of No Fault cases. If your condition is the result of an injury at work or a car accident, our providers will not be able to treat you.

PAYMENTS:

Niagara Neurology & Sleep Medicine accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Niagara Neurology & Sleep Medicine.

It is the policy of our office to make all reasonable attempts to collect outstanding balances' should they accrue, including, convenient payment arrangements.

Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection. Any check that is returned, I am responsible for the face value and a \$35.00 service charge.

FORMS/LETTERS:

We understand at times, various forms or letters may be required to assist you with your healthcare needs. Some forms or letters may require an appointment to see the provider. If an appointment is not required, please allow 5-7 business days for this to be completed, there may be a **\$10.00 fee**.

MEDICAL RECORDS:

Per HIPPA guidelines, copies of medical records must be requested in writing. To ensure privacy, a form for medical record release must be done in advance. All patients may request their medical records one time, free of charge. Any additional records that need to be printed will have a cost of \$0.75 per page.

PRESCRIPTION REFILLS / PHARMACY INFORMATION:

Please inform our office if your pharmacy information has changed. If you are in need of a refill please contact the office 1-2 days prior.

If your medication has changed please bring an updated list to your appointment.

Some medication changes or refills may not be done over the phone and may require an appointment.

By signing below, I acknowledge that I have received, reviewed, and understand, and will comply with the policies and procedures.

Printed Name

Signature

Date

Medication Agreement

This agreement between the patient and Niagara Neurology, PLLC is for the prescription medications. In an effort to best treat patients, we request that all patients review the information below and sign consent to our medication office policies.

1. Refills must be called into our office one week (seven days) before the current prescription runs out.
2. If your prescription coverage is through Medco please allow up to three weeks for a med refill.
3. If you are prescribed a medication, you will need routine follow up. This may be monthly, every six months or once a year depending on the medication.
4. Prescriptions will not be refilled over holidays or weekends.
5. Please notify the office immediately if you become pregnant, as several medications are unsafe during pregnancy.
6. We have the right to contact your pharmacy to verify medications.
7. Medications are to be taken only as directed. You agree to not increase the dose or frequency without discussing this with the physician. You also agree not to discontinue medication without discussing with the physician.
8. Only one pharmacy will be used to fill prescriptions.
9. You understand that the long-term advantages and disadvantages of chronic OPIOD therapy have yet to be scientifically determined and therefore treatment may change throughout your time as a patient.
10. You will not sell, share, or trade medication for money, goods or services.
11. You understand that we are under no obligation to provide medications, and that we reserve the right to discontinue these medications at any time.
12. You understand that medications have potential side effects and will review any concerns with the prescribing physician and pharmacist.
13. You agree to cooperate with random drug testing, which may be requested at any time. If you refuse, you understand the medication will be stopped and it may result in possible discharge from the practice.
14. You understand that lost or stolen medications will not be refilled under any circumstances. It is your responsibility to protect and secure any medications. This includes keeping the medication out of the reach of children. A copy of the police report will be required for any lost or stolen narcotics or narcotic prescriptions.
15. You understand that Niagara Neurology & Sleep does not specialize in pain management.
16. You will not forge or alter a prescription.

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

By signing, you are consenting and agree to abide by the rules reviewed above. Failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services.

Patient Name (Printed)

(Patient Signature) (Date)

Physician Signature _____ Date _____

Patient History Form

Note: This is a confidential record and will be kept in our office.

Chief Complaint (The reason for your visit today)

Medical History (Do you have any of the following? Please check all that apply to YOU)

- | | | | |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> A-fib | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Asthma/COPD |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Restless Legs | | | |
| <input type="checkbox"/> Other _____ | | | |

Surgical History

- Tonsillectomy (or T&A) Back/Neck surgery Pacemaker/Defibrillator
- Other _____

Are you taking any medications? YES / NO

Please list name of medication, strength, and frequency

Do you have any allergies? YES / NO

If yes please list _____

Review of Systems

Are you currently experiencing any of the following? (Please check all that apply)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Tired/Sluggish | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Back Pain | | | |

NONE of the above

Please Initial

For office use only:

HT: WT: BP: P:

Physician: _____ Date: _____

Next appt to be scheduled for: _____

Check PMP: _____

Testing ordered: _____

Patient Instructions: _____