NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588/NeuroRoc.com

Your appointment is on _____ with an ARRIVAL TIME of _____

with Dr. _____

Please arrive promptly at your scheduled time in order to process all the necessary paperwork now mandated by insurance / legal regulations. This will allow you to make the most of your scheduled appointment time with the doctor. The doctor will typically call you directly from the waiting room. Other than for the NCV testing, we do not use nurses or physician assistants. We may request that your appointment be rescheduled if you arrive more than 10 minutes late.

Please:

- **Complete the attached medical information form and be sure to bring it with you to your visit**
- **SIGN and DATE the FINANCIAL AGREEMENT**
- **Have all your pertinent medical information (e.g. MRI/CT reports, bloodwork) faxed to our office at 585-586-7588 prior to your visit.**

CANCELLATION POLICY: We require **48 hours** prior notification if you are unable to keep an appointment. For late cancellations or "no shows":

- **New patients will be billed $100**
- **Returning patients will be billed $40**
- Patients may be discharged from the practice after two "no shows" or same day cancellations. We will provide written notice upon discharge.
- Please call the office if you have questions about these policies

We do not see motor vehicle related NO FAULT cases.

We do accept Workers Compensation cases but PRIOR AUTHORIZATION IS REQUIRED BEFORE SCHEDULING YOUR APPOINTMENT.

There have been recent updates to the HIPAA regulations. These are available upon request.

Payment Information: You must present with an up-to-date insurance card at the time of each visit. You may be asked to reschedule your appointment if your insurance card is not available. Please see our Financial Agreement for important further information.

- Co-payments must be paid **at the time of each visit** (per insurance guidelines).
- If you have a **deductible plan,** you may be responsible for some or all of the costs associated with your visit **at the time of your visit,** just as with your co-pamyents.

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588 /NeuroRoc.com

Directions to our office:

From the WEST:

- Take 490E, exit at Rt. 441/Linden Avenue
- Turn left onto Rt. 441.
- At the third traffic light turn left onto Linden Avenue (Linden Oaks Medical Campus).
- Take the first right onto Hagen Drive.
- We are Building 20, half way up the drive on the right before you climb the hill

From the EAST:

- Take 490W, exit at Rt. 441/Linden Avenue.
- Turn right onto Rt. 441.
- At the second traffic light turn left onto Linden Avenue (Linden Oaks Medical Campus). Take the first right onto Hagen Drive.
- We are Building 20, half way up the drive on the right before you climb the hill

From the City of Rochester:

- Take East Avenue to Rt. 441.
- Turn left onto 441.
- At the fourth traffic light turn left onto Linden Avenue (Linden Oaks Medical Campus). Take the first right onto Hagen Drive.
- We are Building 20, half way up the drive on the right before you climb the hill

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588 /NeuroRoc.com

Please be sure to fill out the following information prior to your visit.

Today's date_____

Name_____

Date of Birth_____Current Age_____

Address _____City_____Zipcode_____

Home Phone # _____

Mobile Phone # _____

Work #_____

Primary Care Doctor _____

Referring Physician _____

Pharmacy you use: Name _____Phone #_____

Occupation: _____If retired, former occupation: _____

Who lives at home with you? _____

Marital Status _____Spouse's name _____

Are you right or left-handed? _____

Briefly state the reason for your visit.

_____

_____

Is this a work-related injury? Yes No

Please circle any of the following medical problems you have had:

Migraine Headaches	Obesity	Celiac Disease
Seizures/Epilepsy	Sleep Apnea	Crohns/UC
Stroke	Asthma	Reflux (GERD)
Restless Leg Syndrome	Emphysema/COPD	Gout
Concussion		Lupus
Depression	High Cholesterol	Rheumatoid Arthritis
Anxiety	High Blood Pressure	
Bipolar Disorder	Heart Disease	Tuberculosis
	Atrial Fibrillation	HIV/AIDS
Anemia	Pacemaker/Defibrillator	
Clotting disorder	Kidney Failure	Cancer: _____
Diabetes	Liver Disease/Hepatitis	
Thyroid Disorder	Bariatric Surgery	Other: _____

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588 /NeuroRoc.com

Please list any surgeries/extended hospitalizations

Illness/ Operation Date(year)

_____
_____
_____
_____

Medications: attach separate list if needed

_____
_____
_____
_____

Medication Allergies: _____

How tall are you?_____How much do you weigh?_____

Have you <u>RECENTLY</u> experienced any of the following symptoms? Please circle all that apply.

General:
Weight loss
Weight gain
Fever
Chills
Rash

Eyes/ENT:
Dry eyes
Blurry vision
Double vision
Nasal drip/congestion
Ear ache/infection
Dental problems
Trouble swallowing
Ringing in ears
Hearing loss
Loss of taste/smell

Respiratory:
Shortness of breath
Cough
Snoring

Cardiovascular:
Chest Pain
Palpitations
Swelling of limbs

GI/GU:
Urinary frequency
Urinary incontinence
Abdominal pain
Heartburn
Nausea/Vomiting
Diarrhea
Constipation

Musculoskeletal:
Back pain
Neck pain
Joint Pain / Swelling
Muscle Pain / Cramps

Neurological:
Headaches
Seizures
Vertigo/dizziness
Slurred speech
Weakness
Numbness
Incoordination
Balance trouble
Tremors
Trouble sleeping
Falls
Restless dream sleep

Psychiatric:
Anxiety
Depression
Hallucinations

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588/NeuroRoc.com

Social:
Do you drink alcohol? Yes / No
If so, what (beer/wine etc.)? _____#drinks per day/week_____

I currently smoke ____ packs/day.
Do you want to quit?

Have you ever smoked? Yes/No Quite date _____(year)
Do you want to quit?

Caffeine intake _____/day

Do you use any other recreational drugs or health supplements?
_____
_____
_____

Family History:
Have any of your **parents, brothers or sisters** had any of the following conditions?
Please specify relationship.

	Relationship		Relationship
Stroke		Seizures	
Dementia		Parkinson's Disease	
Neuropathy		Aneurysm	
Muscle disease		Tremor	
Huntington's Disease		MS	
Migraine/headache		Heart disease	
High cholesterol		Diabetes	
Thyroid problems		Cancer	
Blood clots		Depression/anxiety	
Alcohol/drug abuse		Liver disease	
Arthritis		Hypertension	

Women Only:
Are you pregnant? yes / no
Number of Pregnancies:
Do you have regular periods? yes / no
Any History of Miscarriage/Stillbirth? yes /no

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588 /NeuroRoc.com

Telemedicine Consent Form

We are defining Telemedicine to include communication via phone, video or using a patient portal for providers to communicate with patients to review their results, address their concerns, questions and medication management etc. Telemedicine also includes our providers using electronic interfaces such as phone discussions or video conferencing with your PCP and other specialists when deemed medically necessary.

On March 17, 2020 the federal government announced that Medicare would make these kinds of services a covered benefit during the duration of the COVID19 pandemic (possibly with a small copay depending on the plan). Most commercial insurers are expected to also cover these visits.

Insurances do require that you give us consent to proceed with billing your insurance for telemedicine/phone/patient portal services.

I give Neurology Associates of Rochester permission to utilize Telemedicine services including video visit, phone visits, patient portal communications and bill my insurance.

_____ _____

Printed Name of Patient **Date**

_____

Signature of Patient or Legal Guardian

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588 /NeuroRoc.com

Medical Services Financial Agreement

Insurance Coverage

This office makes no claim that your insurance policy will cover all services provided. Insurance policies may vary greatly in terms of deductible and percentage of coverage for neurology consultation and testing. We require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances to this office. After verification of your insurance coverage, we will fill your insurance provider for the services that you receive.

Payment Arrangements

If you have a contracted amount for copayment, that amount is due at the time of each visit. If you have a deductible, we require that you pay 50% in advance towards each visit. Your full portion of the bill is expected to be paid after payment is received from your insurance provider. Any unpaid balance will be considered past due 30 days following insurance reimbursement. Past due balances may have an interest charge of 2% applied per month. Any positive balances will be refunded to you within 30 days of receiving your insurance explanation of benefits (EOB).

Assignment of Benefits

By signing this form, you authorize payment of medical benefits to be made directly to this office. If your insurance provider sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

Release of Information

By signing this form, you were also authorizing this office, upon request from your health insurance provider, to release any medical or other necessary information necessary to process your insurance claim. You also acknowledge and requests payment of government medical benefits to this office.

Termination of Care

If you are discharged from this practice or voluntarily suspend or terminate your care at any time, all charges for professional services are immediately due and payable to this office. All services rendered by this office will be charged directly to you. You are personally responsible for payment regardless of your health insurance coverage.

REFERRALS & CONTRACTED FACILITIES

If you have an insurance plan that requires a referral (e.g., an HMO plan), it is your responsibility to obtain a referral from your primary care provider prior to your first scheduled appointment and keep it current for every visit thereafter. If we do not have a referral, services can only be rendered if you sign an "Advanced Beneficiary Notice," stating that you understand that a referral was not obtained and payment in full is expected the day of service. If you require the use of a specific lab or x-ray facility, you must notify the nurse to ensure the proper facility is used.

NEUROLOGY ASSOCIATES OF ROCHESTER, P.C.
20 Hagen Drive, Suite 300
Rochester NY 14625
Telephone (585)586-7550 /Fax (585)586-7588 /NeuroRoc.com

CANCELLED APPOINTMENTS

Missed appointments represent a cost to us and to other patients who could have been seen in the time that was set aside for you. Therefore, cancellations must be requested at least 48 hours prior to the scheduled appointment time. Failure to cancel or show for a scheduled follow up appointment may result in a $40 fee. Failure to cancel or show for a scheduled New Patient visit or procedure may result in a $100 fee. These fees are not billable to your insurance.

GENERAL

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage or benefits, please do not hesitate to speak to one of our receptionists about your concerns.

Acceptance of the Medical Services Financial Agreement

I have received, read, and understand the "Medical Services Financial Agreement" of Neurology Associates of Rochester, PC. All questions that I have concerning the Financial Agreement have been answered to my satisfaction. I understand if any services or charges are not covered by my insurance carrier or my eligibility cannot be verified that I am responsible for all charges incurred.

_____ _____

Printed Name of Patient **Date**

_____

Signature of Patient or Legal Guardian