ENMC PC/PA
PATIENT

Last Name			
First Name		Middle Initial	
Street Address			
City			
State		Zip Code	
Home Phone		Work Phone	
Cell Phone			
Email Address		Would you like to receive emails?	Yes No
Birth Date		Sex	M F
Social Security Number			

EMERGENCY CONTACT:____

How did you hear about us? ☐ MD Ref ☐ Self Ref ☐ Yellow Pages ☐ Support Group ☐ Other __________
☐ Insurance Carrier ☐ Internet

PLEASE SPECIFY COMPLAINT:____

REFERRING PHYSICIAN

Name					
Address				City	
State		Zip Code		Phone	

PCP

Name					
Address				City	
State		Zip Code		Phone	

GUARANTOR

Last Name					
First Name				Middle Initial	
Street Address	If the same leave it blank				
City				State	
Zip Code		Phone			
Birth Date		Sex			
Social Security Number					
Guarantor Employer					
Employer's Address				City	
State		Zip Code		Phone	

Is your illness related to worker's compensation or no fault? Yes ☐ No ☐ . If yes, please contact receptionist.

INSURANCE #1

Insurance Carrier			
Policy Holder			
Relationship to the Insured			
Policy #		Group #	

INSURANCE #2

Insurance Carrier			
Policy Holder			
Relationship to the Insured			
Policy #		Group #	

ENMC PC/PA

PATIENT NAME:____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to: ENMC PC/PA, AND ITS PHYSICIANS. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _________________________________ DATE___________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize ENMC PC/PA, AND ITS PHYSICIANS to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company (ies) and/or physicians.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _________________________________ DATE___________

MEDICAL APPEAL

I authorize to ENMC PC/PA, AND ITS PHYSICIANS to pursue a written appeal to my insurance carrier on my behalf.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _________________________________ DATE___________

ELIGIBILITY WAIVER

I understand that my eligibility for coverage by (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from (name of physician). If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _________________________________ DATE___________

REFERRAL WAIVER

I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral within two days, I understand that I am responsible for paying for the services I am requesting.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _________________________________ DATE___________

Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THE ORGANIZATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.

Northeast Regional Epilepsy Group is required by law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this notice of our privacy policies.

USES AND DISCLOSURE:

Treatment:
We may use your information to provide or coordinate your care. We may disclose all or any portion of your health information to any of our Physicians, Registered nurses, Technologists, other consulting or referring physicians, pharmacists and to any other employees who have a legitimate need for such information to provide or coordinate your care.

Payment:
We may release your information to determine coverage by an insurer for our services, and for billing and claims processing. The information may be released to any other organization involved in the payment of your bill. This information may include copies or excerpts of your PHI that is necessary to receive payment.

Routine Operations:
We may use and disclose your information during routine operation of the practice. An example of routine operation would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorneys or consultants working for the practice. These entities are called "Business Associates". We require our Business Associates to treat your information in the same manner that we do.

Regulatory Agencies:
We may disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

Law Enforcement/litigation:
We may disclose your information for valid law enforcement purposes as required by laws or in response to a court order or subpoena.

Public Health:
We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

Worker's Compensation:
We may release your information to Worker's Compensation agencies in the event that your illness or injury may be related to your work

Military/Veteran's:
If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

As Otherwise required:
We May disclose your information in any situation in which such disclosure is required by law (for example: child or domestic abuse)

Prohibited Uses:
We will not disclose your information to persons outside the practice for purposes other than treatment, payment or healthcare operations with out your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at any time in the future and we will hor that request.

*****SEE COLORED PAGE – 2**

YOUR RIGHTS RELATED TO YOUR PERSONAL HEALTH INFORMATION:
Although all records concerning your treatment here are the property of our office, you have certain rights concerning this information as follows:

Right to Confidentiality:
You generally have the right to inspect and receive a copy of your health information from us, unless that is restricted by law or your physician. You will need to pay for copies of any records we provide.

Right to Amend:
You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your medical record.

Right to Accounting
You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment or routine operation of this practice.

Right to Request Restrictions:
Changes to this notice:
We will abide by the terms of this notice currently in effect. However, we reserve the right to change the terms of this notice at any time. Any new notice provisions will be effective for all health from the time that the changes are effective within our office.

Effective Date of this Notice: June 1, 2003
You have the right to request restrictions on certain uses and disclosures of this health information. We will abide by these requests to the extent that we are able.

Right to Revoke Authorization:
You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance on your original authorization.

Right to Complain:
You have the right to formally complain about our handling of your health information. You may contact Doctor Lancman at the number listed below. (If you complain, we will not retaliate against you in any way)

For more information regarding this privacy policy please contact Northeast Regional Epilepsy Grp at (914) 428-9213.

Northeast Regional Epilepsy Group

To Our Patients:

As you are aware, there are very strict government mandated rules concerning patient health information, confidentiality and release of information. In our continuing efforts to improve patient care and communication, our practice can offer you additional ways to receive information, with your signed authorization, concerning your care and treatment. In addition, a copy of our 'Privacy Policy' is posted in our waiting room and given to all of our patients.

If there are any others persons (family members/friends/health care professionals) with whom we may discuss or to whom we may release information please list them here:

☐ **No One**

Name:	Relationship:
1 ________________________________	____________________________
2 ________________________________	____________________________
3 ________________________________	____________________________

I understand that I may revoke or change this authorization at any time in writing.

Signature ______________________________ Date____________

Print Name ____________________________