Highland Medical, P.C.

ROCKLAND NEUROLOGICAL ASSOCIATES

Dear Patient,

Welcome to our practice and thank you for choosing the Highland Medical, P.C., providers for your health care needs.

In order to expedite the registration process, please complete the new patient forms and bring with you to your first appointment. This will ensure that you are seen quickly and help us finalize the registration process efficiently and thoroughly. Also, please remember to bring the following items with you to your appointment:

- Your insurance card(s)
- Photo ID such as driver's license or passport
- Co-payment or deductible that your insurance requires (cash, check, or credit cards are accepted)
- List of all current medications, including dosage and frequency, and allergies
- Referrals that might be required prior to services rendered

We look forward to meeting and providing you with the quality healthcare services you deserve.

Sincerely,

The Staff at Highland Medical, P.C.

Highland Medical, P.C.

ROCKLAND NEUROLOGICAL ASSOCIATES

PATIENT INFORMATION:

last name	first name	middle initial

marital status	gender

street address	city/state/zip

home phone	cell	work

email address

date of birth	race	ethnicity	preferred language

occupation	employer

INSURANCE INFORMATION:

primary insurance	policy/ID number

cardholder's name	relationship	cardholder's date of birth

street address	city/state/zip

secondary insurance	policy/ID number

cardholder's name	relationship	cardholder's date of birth

street address	city/state/zip

Is this a work-related injury or illness? (please circle) YES NO

REFERRING PHYSICIAN INFORMATION (if any):

referring physician

telephone	fax

referring physician street address	city/state/zip

Highland Medical, P.C.

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ASSIGNMENT OF BENEFITS:

I hereby authorize direct payment of medical benefits to Highland Medical, P.C., for services rendered. I understand that I am financially responsible for any charges not covered by my insurance carrier(s). This may include deductibles, co-payments, co-insurance, and denied (non-covered) services.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as an original.

signature date

name date of birth

signature of legal representative date

RELEASE OF INFORMATION:

I authorize Highland Medical, P.C., to release any necessary medical information to process my insurance claims.

signature date

signature of legal representative date

GUARANTEE OF PAYMENT:

In consideration of services rendered by Highland Medical, P.C., I, the undersigned, agree to pay Highland Medical, P.C., any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided that I am informed of same prior to rendering of said services.

signature date

signature of legal representative date

PATIENT COMMUNICATIONS:

In accordance with state and federal regulations, Highland Medical, P.C., wants to assure you that your personal medical information will be held in confidence and with the utmost respect. Please assist us in maintaining that confidence by completing this form. Please provide below the phone number(s) which we should use to contact you.

home phone cell work

Highland Medical, P.C.

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LEAVING A CONFIDENTIAL MESSAGE:

Please indicate at which number, if any, you authorize us to leave a confidential voice message if we are unable to speak to you:

Phone Number for Confidential Message: ______________________________

Initial Here: __________

USE OF EMAIL:

Please indicate whether we can send information to you by email: YES NO

____

email address

EMERGENCY CONTACT:

Is there any person that you want us to contact in the event of an emergency or if we are unable to reach you?

____

name relationship phone number

____

street address city/state/zip

☐ I give Highland Medical, P.C., permission to discuss my personal health information with the individual listed above if I cannot be reached.

____

name relationship phone number

____

street address city/state/zip

☐ I give Highland Medical, P.C., permission to discuss my personal health information with the individual listed above if I cannot be reached.

I understand that Highland Medical, P.C., will adhere to the regulations outlined by HIPAA and will follow the guidelines I have outlined above.

____

signature date

____

signature of legal representative date

Over the past few years, the number of different health insurance programs has increased at a significant rate. Even within one insurance company, there may be several programs with varying benefits and requirements. There is no way we can possibly know, or keep up to date with each insurance company's policies, programs, and provisions.

Some programs require a specific facility be used for your radiology and laboratory tests.
Some programs require pre-authorizations and notification of hospital and ER visits.
It is your responsibility to know:

1. Whether this office is participating with your insurance company and if they will cover physicals, immunizations, surgeries, etc.
2. To advise this office of your insurance requirements in advance, each and every time we provide a service. We will do our very best to comply with any responsible requirements your insurance company may have.

Please understand that if we have not been advised in advance of your insurance requirements or conditions and we provide a service or use a laboratory that is outside your insurance, you will be responsible for the appropriate fees. In addition, there may be times where we may not be able to obtain a consultant or laboratory that participates with your insurance. It is up to you to work this out with your insurance company.

Unless you carefully follow your insurance company's regulations, they may decline all or part of your claim. Your insurance carrier should have provided you with a phone number to use if you have any questions about your coverage.

I acknowledge receipt of this information.

____

patient signature　　　　　　　　　　　　date

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I have received a copy of the Highland Medical, P.C., Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

I understand that Highland Medical, P.C., reserves the right to change terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me with a revised Notice of Privacy Practices upon request. Furthermore, I understand that without my signed consent, medical information will not be released to any unauthorized individuals.

patient name — date of birth

patient signature — date

signature of legal representative — date

Highland Medical, P.C.

ROCKLAND NEUROLOGICAL ASSOCIATES

MEDICAL HISTORY

patient name　　　　　　　　　　　　　　　　　　date of birth

MEDICAL PROBLEMS: Check all that apply.

	Alcoholism		Dementia		Heart Disease		Pancreatitis
	Alzheimer's		Depression		Hepatitis – Jaundice		Pneumonia
	Anemia		Diabetes		High Blood Pressure		Rashes
	Anxiety		Down's Syndrome		High Cholesterol		Reflux
	Arthritis		Drug Abuse		HIV		Rheumatic Fever
	Asthma		Eating Disorder		Irritable Bowel		Schizophrenia
	Attention Deficit Disorder		Emphysema		Kidney Disease		Sleep Apnea
	Bleeding Tendencies		Family Abuse		Kidney Stones		Stroke
	Cancer - Tumor		Gallbladder Problems		Leukemia		Suicide Attempt
	Cataracts		Gastritis		Loss of Consciousness		Thyroid Disorder
	Colitis		Glaucoma		Melanoma		Ulcers
	Crohn's Disease		Heart Attack		Migraine		

HOSPITALIZATIONS/SURGERIES:

Where	Year	Reason

Highland Medical, P.C.

ROCKLAND NEUROLOGICAL ASSOCIATES

patient name date of birth

LIST ALLERGIES:

Drug Allergies	Other Allergies

SOCIAL/PERSONAL HISTORY:

	No	If yes, complete below:	
Do you smoke now?		How much?	
Did you ever smoke?		How much?	When did you quit?
Do you drink alcohol?		How much?	
Do you use recreational drugs?		How much?	
Do you consume caffeine?		How much?	

FAMILY MEDICAL HISTORY:

	Father	Mother	Siblings				Children			
			1	2	3	4	1	2	3	4
Alcoholism/Drug Abuse										
Alzheimer's Disease/Dementia										
Anemia/Blood Disease										
Arthritis										
Brain Tumors										
Cancer										
Diabetes										
Genetic Conditions										
Headaches										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Muscle Disease										
Neuropathy										
Parkinson's Disease										
Psychiatric Disease										
Seizures										
Stroke										
Tremor										
Other (Specify)										

Highland Medical, P.C.

ROCKLAND NEUROLOGICAL ASSOCIATES

MEDICATION LIST

name ____________________ date of birth ____________________

pharmacy ____________________ pharmacy phone number ____________________

Please include all prescriptions, as well as all over the counter (OTC) medications, and vitamins/supplements taken on a regular basis.

Medication Name	Dose	Frequency

I do not take any medications consistently. (check here) ______________

Consent to check medication history? Yes____ No ____

11.17

Highland Medical, P.C.

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CURRENT HEALTH

patient name date of birth height weight

What is the reason for your visit today? ______________________

____

REVIEW OF SYSTEMS: Please check all that apply at this time only.

Constitutional Symptoms		Gastrointestinal		Neurological	
	Chills		Blood In Stool		Clumsiness
	Fatigue		Bowel Incontinence		Concentration Problems
	Fever		Constipation		Confusion
	Night Sweats		Diarrhea		Dizziness
	Weight Change		Loss Of Appetite		Facial Numbness
Eyes			Nausea		Headaches
	Blurred Vision		Vomiting		Memory Loss
	Cataracts		Vomiting Blood		Numbness/Tingling – Arms
	Double Vision	Genitourinary			Numbness/Tingling – Legs
	Eye Pain		Burning		Passing Out
	Vision Loss		Hesitancy		Pins/Needles (Where):
Ears, Nose, Mouth & Throat			Incontinence		Speech-Slurring
	Hearing Loss		Nocturia		Stiffness
	Hoarseness		Urgency		Swallowing Problems
	Nose Bleeds		Urinary Frequency		Tremor
	Ringing In Ears	Women Genitourinary			Weakness – Legs
	Sinus Pain		Planning Pregnancy	Hematologic/Lymphatic	
Cardiovascular			Post Menopause		Anemia
	Chest Pain		Pregnant		Abnormal Clotting
	Palpitations	Psychiatric			Bleeding Disorders
	Heart Murmur		Anxiety		Cancer
Respiratory			Depression		Frequent Infections
	Chronic Cough		Hallucinations		Immunodeficiency
	Coughing Up Blood		Personality Changes	Musculoskeletal	
	Shortness Of Breath		Sleep Disturbances		Arthritis
Skin		Endocrine			Joint Swelling
	Color Changes		Diabetes		Muscle Aches
	Easy Bruising		Thyroid Problems		Osteoporosis
	Itching				Pain - Back
	Rashes				Pain - Neck
					Spine Deformity

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SLEEP DISORDER SCREENING

patient name age date

EPWORTH SLEEPINESS SCALE:

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent months.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of Dozing (0 – 3)
Sitting and reading	
Watching television	
Sitting inactive in a public place, for example, a theatre or meeting	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total Score	

PLEASE ANSWER THE FOLLOWING TWO QUESTIONS:

Do you snore?
Yes ____________ No ____________

Do you ever wake up during the night choking or gasping for breath?
Yes ____________ No ____________

patient signature date

Highland Medical, P.C.

ROCKLAND NEUROLOGICAL ASSOCIATES

Doctor-Patient communication is extremely important for your care
and treatment, including the following:

AT ANY TIME, IN A MEDICAL EMERGENCY, CALL 911
Before and after our regularly scheduled hours our telephone lines are forwarded to our service. Our regular telephone hours are Monday thru Friday, 9 AM – 5 PM. Our service is able to reach us if you need a call back. The emergency room physician can reach us if a neurological evaluation is needed.

FOR NON-EMERGENT ISSUES:
Please call the office at 845.353.4344 during regular telephone hours 9 AM – 5 PM, Monday thru Friday. A message will be taken and you will receive a return call within two business days.

FOR REFILLS OF MEDICATIONS:
Call the office and select the prompt for the Prescription Line. It is your responsibility to allow sufficient time for the prescription to be called in or mailed. Messages are taken off of the prescription line Monday thru Friday from 9 AM – 4 PM. Please do not call after hours to have non-emergent prescriptions filled.

TEST RESULTS:
Your doctor will give you instructions of how to obtain your test results. If for any reason you are having difficulty getting your test results, please call the office and ask to speak with our practice manager.

URGENT ASSISTANCE:
If, after a regular hours, a problem arises that cannot wait until the next office day, call the office number 845.353.4344, and speak with our service, who will be able to reach us. Once again, if it is a medical emergency, always call 911.

SCHEDULED APPOINTMENTS:
Please remember to keep all scheduled follow-up appointments, and if for some reason you need to cancel or change a scheduled appointment, kindly give us 48 hours notice. Keeping scheduled appointments is important to ensure your continuous care in our office. By telling us in a timely manner that you cannot keep an appointment, we can offer your appointment to someone else. This helps us reduce waiting times and means everyone can be seen sooner.

INSURANCE/REFERRALS:
Please remember to bring your insurance card(s) and any referrals with you to your scheduled appointments, as we cannot see you if you do not
have the appropriate paperwork, therefore, delaying your continued care. A valid up to date referral is needed to be seen in our office, and it is always the patient's responsibility to make sure that they have this referral.

CONFIDENTIALITY/INSURANCE:
To ensure confidentiality and privacy, any type of electronic and video recording, picture taking, and use of cell phones or smart phones is strictly prohibited at any location within our office.

I have read the above and I understand the appropriate procedures or communication with Rockland Neurological Associates.

____

patient signature date

Highland Medical, P.C.

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Dear Patient,

According to HIPAA Federal Regulations, each patient must be assured that his/her medical records are held in the strictest confidence. In order for Highland Medical, P.C., to comply with regulations, we ask that you take a moment to complete the following questionnaire.

Your signature is required where requested.

With what individuals may we discuss medical history, test, or lab results?

name	relationship to patient	phone number
name	relationship to patient	phone number
name	relationship to patient	phone number

Where may we contact you?: (please circle)

Home Phone: YES NO Phone Number: ______________________________

Cell Phone: YES NO Phone Number: ______________________________

Work Phone: YES NO Phone Number: ______________________________

Email: YES NO Email Address: ______________________________

I understand the Highland Medical, P.C., will adhere to the regulations as outlined by HIPAA and will follow the guidelines I have outlined above.

I have received Highland Medical, P.C., notice of Privacy Practices written in plain language. This notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

I understand that Highland Medical, P.C., reserves the right to change the terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request. I also understand that without a signed consent form the patient, medical information will not be released to any unauthorized individuals.

patient name ______________________ date of birth ______________________

patient signature ______________________ date ______________________

signature of parent/guardian (if minor) ______________________ date ______________________

Highland Medical, P.C.

RECORDS RELEASE AUTHORIZATION

TO: ____

____

I hereby authorize and request that my medical records be released to
Highland Medical, P.C., at the following practices:

practice name

address

city/state/zip

phone number

practice name

address

city/state/zip

phone number

practice name

address

city/state/zip

phone number

practice name

address

city/state/zip

phone number

Please send the medical records in your possession for the time period ________________ concerning my treatment and/or illness.

*This authorization may include disclosures of information relating to alcohol and drug abuse, mental health treatment, and confidential HIV-related information ONLY if I initial below:

_______ Alcohol/Drug Treatment _______ Mental Health information _______ HIV-related information

patient name

address city/state/zip

patient signature date

witness date