NORTHEAST REGIONAL EPILEPSY GROUP

Patient info: **ENMC PC/PA**

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 ☐ Insurance Carrier ☐ Internet ☐ Other _____

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				Date of Birth	
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		Date of Birth:	
Relationship to the Insured			
Policy #		Group #	

INSURANCE #2

Insurance Carrier			
Policy Holder		Date of Birth:	
Relationship to the Insured			
Policy #		Group #	

WORKERS COMPENSATION OR NO-FAULT SHEET

PATIENT

Last Name			
First Name		Middle Initial	
SSN			

WORKERS COMPENSATION

Where you injured on the job?	Yes ☐	No ☐	
Carrier Case #:			
WBC#			
Carrier I.D.#			
Date of Injury			
Employer's Name			
Carrier			
Address			
Contact			
Attorney			
Address		Phone	

NO-FAULT

Where you in an auto accident?	Yes ☐ No ☐
No-Fault Case#	
Date of Injury	
Policy Holder	
Carrier	
Address	
Contact	
Attorney	

I hereby authorize ENMC PC/PA to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to the provider. I understand that I am responsible for any part of the charges that are not covered by my medical insurance

Patient's Signature ……. Date …… / ..... / …….

NORTHEAST REGIONAL
EPILEPSY GROUP

ENMC PC/PA
CT Epilepsy Group

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, CT Epilepsy Group, 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, CT Epilepsy Group, 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, CT Epilepsy Group, 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_____

FINANCIAL POLICY

I hereby acknowledge that I am aware and accept the financial responsibility for self pay accounts or for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment. (see attached policy)

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _____DATE_____

NORTHEAST REGIONAL
EPILEPSY GROUP

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 honor that request.

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 or (201) 343-6676.

NORTHEAST REGIONAL
EPILEPSY GROUP

ACKNOWELEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

I, _____, hereby acknowledge that I have received and reviewed the "Notice of Health Information Privacy Practices" which describes the uses and disclosures that can be made of my personal health information for treatment, payment and routine health care operations.

_____ _____
Signature of patient or representative Date

_____
Print name of signer

_____
If representative, specify relationship

Please return THIS PAGE ONLY to the receptionist.

NORTHEAST REGIONAL
EPILEPSY GROUP

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 _____

NORTHEAST REGIONAL EPILEPSY GROUP

IMPORTANT INFORMATION FOR PATIENTS 16 YEARS OF AGE OR OLDER

One of the most uncomfortable discussions that doctors and nurses have with patients with epilepsy involve restriction of driving because a driver's license may seem essential to your independence. Although most state laws about driving and epilepsy are now less restrictive than they were many years ago, these laws were written to lessen the chance of harm to self or others resulting from having a seizure while driving.

Therefore, every state regulates driver's license eligibility for people with epilepsy. As a driver's license holder, it is your responsibility to know the regulations in your state. The most common requirement is that you must be seizure free for a certain period of time before you can be allowed to drive.

Although physicians can offer an opinion on your ability to drive safely, the department of motor vehicles makes the final decision. In some states, the physician can offer such an opinion if your seizures do not interfere with consciousness or control of movement. You may be able to continue driving if your seizures occur only at certain times, especially during sleep or if you always have an aura that would warn you to pull off of the road before a seizure begins.

If you are still having seizures, do not hide it from your doctor in order to keep your driver's license. Not reporting seizures makes it impossible for your doctor to treat your epilepsy effectively. The doctor may be able to prevent more seizures from occurring by making a small change in the dosage of your anti-seizure medicine, for instance, but that would not happen if the doctor did not know it was necessary. Inadequate treatment can lead to more seizures and the result may be that you or someone else may be injured. If your seizures are well controlled, use your driving privileges as a reason to take good care of yourself. If you always take your anti-seizure medicines as prescribed, get enough sleep, limit your alcohol consumption, and visit your doctor regularly, you will be more likely to be able to continue driving safely and legally.

Below is a brief description of the laws governing driving in our practice area:

NEW JERSEY:

- You must be seizure free for six months.
- Exceptions may be granted by the Neurological Disorder Committee.
- Periodic medical updates are required after licensing every six months for the first two years, thereafter annually.
- Your doctor must report recurrent convulsive seizures, recurrent periods of unconsciousness, or impairment or loss of motor coordination due to epilepsy, when the condition persists or recurs despite medical treatment.
- DMV appeal of license denial must be filed within 30 days.
- A person is disqualified from driving a commercial motor vehicle if he/she has an established medical history or diagnosis of epilepsy or any other condition which is likely to cause a loss of consciousness or loss of ability to control a commercial motor vehicle. Submitting a false CDL application is a federal offense.
- NJ Motor Vehicle Commission: 609-292-6500
- NJ Medical Review Unit: 888-486-3339

NEW YORK:

- You must be seizure free for one year.
- A person is disqualified from driving a commercial motor vehicle if that person has a medical history of epilepsy, has a current clinical diagnosis of epilepsy or is taking antiseizure medication.
- Doctors are not required to report epilepsy.
- Exceptions may be granted by the DMV's Medical Review Board.

- Periodic medical updates are required after licensing if determined by the DMV.
- DMV appeal of license denial must be filed within 30 days.
- NYS DOT for commercial licensing: 518-457-1010 OR 1016
- Medical Review Unit : 518-474-0774

PENNSYLVANIA:

- You must be seizure free for six months.
- Doctors are required to report epilepsy.
- Your physician will be required to complete a medical report stating that your seizures are controlled and send that report to the Pennsylvania Department of Transportation.
- The department may waive the seizure-free requirement upon request by the person's physician in the following situations:
  - You have a strictly nocturnal pattern of seizures or a pattern of seizures occurring immediately upon awakening that has been established for at least 2 years immediately preceding your application.
  - You experience a specific prolonged aura accompanied by a sufficient warning and this pattern has been established over a period of at least 2 years immediately preceding your application or suspension.
  - Your seizures had previously been controlled and the subsequent seizure or seizures occurred as a result of a prescribed change or removal from medication while under the supervision of a licensed physician.
  - Your seizures had been previously controlled for 6 or more months and the subsequent seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion, metabolic imbalance or nonrecurring trauma.
- Motor Vehicle Commission: 800-932-4600
- Medical Review Unit: 717-787-9662

CONNECTICUT:

- There is no set seizure-free period.
- Doctors are not required to report epilepsy.
- Periodic medical updates are required after licensing if determined by the DMV.
- DMV appeal of license denial must be filed within 30 days.
- Motor Vehicle Commission: 800-842-8222 or 800-263-5700
- Medical Review Unit: 860-263-5223I have read the above information and all questions have been answered to my satisfaction.

_____ _____

Printed Name Signature

_____

Date

NEREG 2014

( ) Pt refused to sign. _____(Employee initials)

NORTHEAST REGIONAL
EPILEPSY GROUP

Cultural/Language/Visual/Auditory Factors Affecting Care

Cultural/Linguistic needs are defined *as the identification of language barriers, visual and or auditory deficits, as well as cultural and religious customs that may impede the provider and or staff's ability to provide the patient's medical benefits.*

We ask that you please use the space below to list any of factors that may be classified as such:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

By signing below I acknowledge that I have disclosed any factors that may affect my medical care.

_____ _____
Patient Name Date

_____
Patient/ Guardian Signature

NEREG / ENMCPC

PARTICIPATING INSURANCE CARRIERS 11/1/2020

AETNA WHOLE HEALTH-MAINE
AETNA DC BRONZE, SILVER, GOLD HMO
AETNA DC BRONZE, SILVER, FOLD HN
AETNA DE BRONZE, SILVER, GOLD HN
AETNA DE BRONZE, SILVER, GOLD HN OPTION
AETNA DC BRONZE, SILVER, GOLD OPEN ACCESS
AETNA CHOICE POS
AETNA HEALTH NETWORK- ALTIUS NETWORK
AETNA HMO OPEN ACCESS
AETNA HEALTHY NY HMO
AETNA PCP REFERRAL PLAN (TX MEMBERS ONLY)
AETNA PEAK PREFERENCE HN ONLY & HN OPTION
AETNA QPOS
AETNA VALUE PERFORMANCE
AETNA PREMIER CARE MERCY HEALTH CINCINNATI
AETNA PREMIER CARE- ARIZONA CARE
AETNA PREMIER CARE- BANNER HEALTH
AETNA PREMIER CARE- BAYLOR SCOTT & WHITE QUALITY ALLIANCE
AETNA PREMIER CARE- SETON HEALTH ALLIANCE
AETNA PREMIER CARE- INNOVATION HEALTH
AETNA CHOICE POS II
AETNA MANAGED CHOICE
AETNA MANAGED CHOICE POS
AETNA ALTIUS NETWORK
AETNA WHOLE HEALTH
AETNA HARTFORD HEALTHCARE AND VALUE CARE ALLIANCE
AETNA DC BRONZE, SILVER, GOLD OAMC
AETNA MD BRONZE, SILVER, GOLD OAMC
AETNA MEDICARE HMP
AETNA ELECT CHOICE EPO
AETNA OPEN CHOICE
AMERICHOICE OF NY
AMERIHEALTH OF PA
CDPHP
ELDERPLAN
GENESIS/ AFFINITY **(Does not service, Dutchess County)**
HIP

HEALTH FIRST
MAGANACARE
MEDICARE
METROPLUS **(Does not service Westchester, Putnam, or Dutchess Counties)**
MULITPLAN **(Community Care Network for Veterans Affairs)**
MVP **(Does not service Bronx, Staten Island, Queens, & NYC)**
OSCAR
Oxford
RAILROAD MEDICARE
TRICARE
US FAMILY HEALTH
United Healthcare - NYS Empire Plan
VNS CHOICE **(Does not service Westchester, Putnam, or Dutchess Counties)**
WELLCARE OF NY

Signature below is acknowledgement of disclosure of health plans the practice participates with. If your plan is not on this list you will be financially responsible to pay your out of network bills.

PATIENT NAME:_____ **SIGNATURE:**_____ **DATE:**_____

CHART NUMBER: _____ **(OFFICE USE ONLY)**

New York State Out-of-Network Emergency and Surprise Medical Bill Assignment of Benefits Form

Use this form if you get a surprise medical bill or a bill for out-of-network emergency services and want the services to be treated as in-network. This form is used to protect consumers from certain surprise bills for health care services and out-of-network emergency charges, including inpatient services following an emergency room visit. **Please note:** This form is NOT required for out-of-network emergency services, but provides protection from bills for such services.

To use this form, complete and sign it. A copy must be sent to your health care provider and your insurer (include a copy of any bill you received for these services).

Use this form when:

- You received a bill for services from a non-participating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; a non-participating physician provided services without your knowledge; or unforeseen medical circumstances happened when the services were provided. You did not choose to receive services from a non-participating physician instead of from an available participating physician.
- You received a bill for services for which you were referred by a participating physician to a non-participating provider, but you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a non-participating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a non-participating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.
- You received emergency services from an out-of-network hospital or doctor, including inpatient services following an emergency room visit.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:
I (or my dependent) received emergency services, inpatient services following an emergency room visit, or a surprise bill from a provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any in-network copayment, coinsurance or deductible that I owe. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name:	**Date of Service:**
Patient Mailing Address:	**Patient City/State/ZIP:**
Insurer Name:	**Insurance ID No**:
Provider Name: Epilepsy and Neurophysiology Medical Consulting PC	**Provider Phone Number:** 914 428 3651
Provider Mailing Address: 333 Westchester Ave, White Plains New York	**Provider City/State/ZIP:** 10604

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

_____ _____

(Signature of patient) (Date of signature)

If you have questions regarding this form contact the Department of Financial Services at 1-800-342-3736.
NYS FORM OON-AOB (7/22/20)

NORTHEAST REGIONAL
EPILEPSY GROUP

NEREG Patient Financial Policy

No Show/Cancelations

If you are unable to keep your appointment for any reason, we ask that you call our office 24 hours in advance. Failure to cancel an office visit or procedure 24 hours in advance will result in a no-show fee billed to your account.

Neuropsychological Testing

A deposit of $250.00 is required in advance to hold your scheduled appointment. Failure to cancel testing 24 hours in advance will result in forfeit of your deposit.

Self-pay Accounts

A Self-pay account is classified as patient who does not have insurance coverage or who has no out of network benefits. Self- pay accounts are required to remit payment at time of check in for your appointment. If you are unable to make a payment at the time of, check in, then your appointment will be rescheduled. For Telemedicine appointments payment is required when your appointment is confirmed. If you no show to a Telemedicine appointment the payment will be applied toward your no-show fee and the remainder if any will be refunded. A pricing list is available upon request.

No-Show Fees

Office Visit: $50
EEG & EMG: $100
Ambulatory VEEG: $250
Neuropsychological Testing: $250

***Patients will not be able to schedule or receive any further services until no show is paid.**

We appreciate your understanding and cooperation.

Patient's Name:_____

Date of Birth: _____

Patient signature: _____

Date: _____

Effective: 8/15/21
Updated: 3/29/2024

NORTHEAST REGIONAL
EPILEPSY GROUP

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:	Date of Birth:	Chart#:
Patient Address:	City: State: Zip:	
Phone:	Date Consent Discussed:	
Practice Name: Northeast Regional Epilepsy Group	Location:	

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the courseof telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. NEREG has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform NEREG of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of New York and will be present in the state of New York during all telehealth encounters with NEREG.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Northeast Regional Epilepsy Group to use telemedicine in the course of my diagnosis and treatment.

_____ _____

PATIENT'S SIGNATURE **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ _____

WITNESS **DATE**

Please initial after reading this page: _____