Princeton and Rutgers Neurology, P.A.

A Center Of Excellence

DEMOGRAPHICS

Patient's Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Tel # (Cell): _____ Tel # (Home): _____ Tel # (Work) #: _____

Preferred Method Of Contact: [] Cell Phone [] Home Phone [] Work Phone

SS #: ____ / ___ / _____ DOB: ____ / ____/ _____ Age: ____ Email Address: _____

Sex: [] Male [] Female Marital Status: [] Single [] Married [] Divorced [] Widowed

These questions are optional, please mark declined if you do not wish to answer

Race: [] American Indian [] Asian [] African American [] Nat Hawaiian/Pacific Islander [] Caucasian

[] Unknown [] Declined [] Other Race: _____

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Declined [] Unknown

Primary Language: _____ (By default we will set to english unless otherwise specified)

Employed By: _____ Occupation: _____

City: _____ State: _____ Telephone: _____

INSURANCE INFO

Please circle if you are here today for a Workman's Comp or Motor Vehicle Accident visit

Medical Insurance: [] Yes [] No Co-Pay Amount: $ _____ Referral needed? [] Yes [] No

Insurance Company (**Primary**): _____ Address: _____

_____

Policy #: _____ Group #: _____ Phone #: _____

Insurance Company (**Secondary**): _____ Address: _____

_____

Policy #: _____ Group #: _____ Phone #: _____

Name Of Policyholder (If different from patient): _____ DOB: _____

Address of Policyholder: _____ SS #: _____

Primary Care Physician (First and Last Name:)

_____

Address: _____ Tel #: _____

Referring Physician (If different from Primary Care physician)

_____

EMERGENCY CONTACTS

Contact Name #1: _____ Relationship: _____ Phone #: _____

Contact Name #2: _____ Relationship: _____ Phone #: _____

PRIOR TESTING

TEST	DATE(S)	BODY PART STUDIED:	RESULTS:
XRAY			
MRI			
CT			
EMG			
OTHER			

HOSPITALIZATIONS

Have you had any recent hospitalizations? [] Yes [] No Date of Hospitalization: _____

If yes, Explain what hospital/facility and the reason(s) you were admitted: _____

_____

_____

ASSIGNMENT OF BENEFITS: I request that assignment of authorized Medicare/Other Insurance Company Benefits be paid either to me or on my behalf to Princeton & Rutgers Neurology for any services furnished me by that party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration any information needed for this or any related Medicare/Other Insurance Company claim. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsibility for all charges whether or not paid by said insurance. I also understand that regardless of my insurance status, I am ultimately responsible for the balance of my account. If I am using out of network benefits, I am responsible for any deductible and/or co-insurance.

SIGNED: _____ DATE: _____

REVIEW OF SYSTEMS

PATIENT NAME:_____ DATE: _____

Are you presently experiencing any of the following symptoms? (a check is required on each symptom)

Constitutional	**Eyes**	**Cardiovascular**	**Respiratory**
__ Fever	__ Loss of Vision	__ Short of Breath	__ Cough
__ Weight Loss	__ Blurred Vision	__ Swelling in legs	__ Asthma
__ Loss of Sleep	__ Double Vision	__ Chest pain	__ Coughing up blood
__ Fatigue	__ Jagged Lines	__ Palpitations	__ none
__ None	__ Kaleidoscopic colors	__ None	
	__ None		
Gastrointestinal	**Gastrointestinal (cont'd)**	**Genitourinary**	**Ears, Nose, Mouth, Throat**
__ Loss or excessive Appetite	__ Constipation	__ Burning urination	__ Hearing loss
__ Nausea	__ Diarrhea	__ Frequent urination	__ Ringing in ears
__ Vomiting	__ Blood in stool	__ Sexual dysfunction	__ Vertigo
__ Heartburn	__ None	__ None	__ light-headedness
__ Stomach Pain			__ Dizziness
			__ None
Neurological	**Integumentary**	**Psychiatric**	**Other**:
__ Tremor	__ Rash	__ Depression	_____
__ Paralysis	__ Itching in feet	__ Hallucinations	_____
__ Poor balance	__ None	__ Agitation	_____
__ Convulsions		__ Anxiety	_____
__ Restless legs		__ Phobias	_____
__ Memory Loss		__ None	
__ None			

PAST MEDICAL HISTORY

Why are you here today? _____

(a check is required on each line)

___ diabetes ___ high blood pressure ___ angina ___heart attack ___stroke ___bronchitis ___ fainting
___ epilepsy ___ infections ___ high cholesterol ___ neuropathy ___ arthritis ___ Pacemaker/Defibrillator
___Cancer ; if so explain: _____

Are you under a great deal of stress?

[] Yes [] No

Please list any non-drug allergies: _____

Please list any Surgical History: _____

FAMILY HISTORY

Please write the relationship of the famiy member on the line next to the illness or disease (i.e. Mother, Father, Brother, Sister, Grandparent)

_____ high blood pressure _____ diabetes _____ seizure disorder _____ migraines
_____ neuropathy _____stroke other: _____
Cancer: [] Yes [] No. If Yes, please explain: _____

SOCIAL HISTORY

	Present	Past	Age at Start	Amount (in packs per day
Do you smoke cigarettes?	[] Yes [] No	[] Yes [] No		
Do you drink alcohol?	[] Yes [] No	[] Yes [] No		

I have reviewed the above history: _____
Physician signature

MEDICATION LOG SHEET

Patient's Name: _____ DOB: ____ / ____ / _____

Pharmacy: _____ Pharmacy Phone #: _____ Town: _____

Being Seen By:

- ☐ Dr. Behar
- ☐ Dr. Menken
- ☐ Dr. Friedlander
- ☐ Dr. Greenberg
- ☐ Dr. Hersh
- ☐ Dr. Dixit

KNOWN DRUG ALLERGIES: _____

Current Medications:	mg / Strength:	Frequency:	Prescribed By:

Prepared By Date

OUR FINANCIAL POLICY
-IMPORTANT: PLEASE READ AND SIGN-

Thank you for choosing us as your health care providers. The following is a statement of our financial policy which we require that you read and sign prior to your office visit.

ALL INSURANCES

- We must have a copy of your current insurance card. Therefore it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying upon each visit to the office. **All co-pays are collected at the Reception window upon registering.**

- **If you have an HMO plan with whom we have a contract**, an appropriate referral from your Primary Care Physician is necessary in order for you to be seen. This referral must contain the diagnosis, number of visits allowed, and the expiration date of the referral. It is the patient's responsibility to keep track of the number of remaining referrals and expiration date. You may call our office at any time to verify this information prior to your visit. If you are seen without a valid referral, you will be responsible for the bill. If you have a co-pay you will be responsible for the payment of that co-pay at the time of your appointment.

- If you have a co-pay on your card, you will be responsible for the payment of that co-pay on the day of your appointment. All co-pays are collected at the reception window upon registering.

- **If you have a PPO plan with whom we have a contract**, you will be responsible for the co-pay listed on your card. **If you have not yet met your deductible, or if you have a co-insurance that remains after the insurance company has paid their portion, you will be responsible for this balance and payment will be expected at the time of visit.**

- You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

- You will be responsible for payment of services if your insurance has lapsed in coverage, or is not in effect at the time of service.

MEDICARE PATIENTS

- Patients are responsible for meeting their annual deductible each year.

- Once the deductible has been met, patients without secondary insurance will be required to pay their 20% portion at the time of their visit.

- If you have secondary/supplementary insurance, it is the responsibility of the patient to provide the receptionist with a copy of that card.

- We will file with secondary/supplementary carriers. However, in the event that the secondary insurance does not pay, patients will be billed for the balance.

DIAGNOSTIC TESTING

- Please be aware that following your office visit the doctor may order blood work or other diagnostic testing that may not be deemed "medically necessary" by either Medicare or your insurance carrier. It is possible that your insurance carrier has made its own determination as to what tests they deem to be "medically necessary". Therefore, there may be charges not covered by your carrier. In such event, these charges will become the responsibility of the patient.

SELF-PAY PATIENTS

- Patients without insurance are expected to pay their bill at the time of services unless prior arrangments have been made and approved by the Billing Manager.

- New Patients without insurance will be expected to pay a minimum level of service of $200.00 **by cash or credit card** upon registering at the Reception Desk. If a higher level visit is warranted by the physician, the balance of that visit will be collected from you at the time

NON-PARTICIPATING INSURANCES

- If you have presented us with a health insurance card with which we do not participate, you will be expected to pay 100% of our billed amount at the time the services are rendered.

- Once payment is made by you, the claim will be submitted to your health insurance carrier on your behalf. Any reimbursement due for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

PARTIAL PAYMENTS/PAYMENT PLANS

- Partial payments will only be accepted if prior arrangements have been made.

- If you wish to proceed with any necessary testing and would like to set up a payment plan, just ask to see someone in BILLING and this will be arranged for you.

- Once a payment plan is arranged, payments must be made consistently or the balance will be considered delinquent, and may then be subject to finance charges or eventually turned over to our collection agency.

DELINQUENT ACCOUNTS

- Delinquent accounts will be subject to monthly billing charges ($25) until the account is settled in full.

OUR CANCELLATION POLICY

- We require 24 hours notice for all cancelled appointments or your account will be charged $25.00. Please be aware that this charge is your responsibility and is not covered by your insurance.

- In addition, there will be a $25.00 charge for all no-shows.

I have read the above financial policy and understand and agree with it's terms. In the event that my insurance does not pay, I understand that I will be financially responsible for those charges:

Signature	**Print Name**	**Date**

Princeton and Rutgers Neurology, P.A.

NOTICE OF PRIVACY PRACTICES

We have an obligation to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices when requested.

Federal law provides that we may use your protected health information (PHI) for your treatment without further notice to you, and without further written authorization by you. (i.e. forwarding lab work to a doctor that we may be referring you to.)

Federal law provides that we may use your medical information or disclose your medical information to obtain the following:

- Payment for our services (i.e. submission of your diagnosis to your insurance);
- Health care operations (i.e. audits by our accountants);
- When required for public health purposes to avoid health or safety threat;
- When required by an agency such as Department of Health;
- When required by law in judicial or administrative proceedings;
- When required for law enforcement purposes;

You have the right to:

- Request restrictions on certain uses or disclosures described above. However, we are not required to agree to such restrictions;
- Obtain copies of your medical information;
- Request an accounting of any disclosures we make of your medical information with the exception of disclosures we make to you, or in order to carry out treatment, payment or health care operations;
- Opt out of getting fundraising communications although we do not hold such events;
- If you are a self-pay patient, you may request in writing that we not disclose any information to your insurance company;
- To be notified if any breach of your protected health information (PHI) has been compromised;

We may contact you by mail, phone or by e-mail to remind you of appointments or to provide information about treatment. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. If you have a preference, please check below:

( ) Home _____ ( ) Work _____ ( ) Cell _____

PLEASE COMPLETE (include contact information):
The people listed below have permission to speak to the physicians with regard to my treatment

_____

_____

My signature below represents that I have read this Notice of Privacy Practices.

Signature	**Print Name**	**Date**

77 Veronica Ave. Ste 102
Somerset, NJ 08873
(732) 246-1311

9 Centre Dr. Ste 130
Monroe, NJ 08831
(609) 395-7615

601 Ewing St., Ste B5
Princeton, NJ 08540
(609) 497-0300

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