Regional Neurological Associates, P.C.
4256 Bronx Boulevard Suite 5
Bronx, NY 10466

Randall Berliner, MD ~ Farhad K. Elyaderani, MD ~ Sandeep Gulati, DO ~ M. Mehdi Kazmi, MD

PATIENT INFORMATION:

Last Name (Apellido)_____ First Name (Primer Nombre)_____

DOB (Fecha de Nacimiento)_____ SS# (Seguro Social)____-____-_____ Sex(Sexo) M_____ F_____

Address (Direccion)_____ Apt#_____

City (Ciudad)_____ State(Estado)_____ Zip Code (Zona Postal)_____

Home Phone (Telefono de Casa)_____ Work/Mobile Phone(Telefono Secundario)_____

E-Mail Address (Correo Electronico)_____ How often checked?_____

Patient's Employer (Lugar de Empleo)_____

City (Ciudad)_____ State (Estado)_____ Zip Code (Zona Postal)_____

Marital Status (Estado Civil) Single (Soltero/a)___ Married(Casado/a)___Widow(Viudo/a)___Divorced(Divorciado/a)____

Spouse's Name (Nombre de Esposo/a)_____ Student (Estudiante) Y_____ N_____

Emergency Contact (Contacto de Emergencia)_____ Relation(Relacion)_____

Home Phone (Telefono de Casa)_____ Work/Alt Phone(Telefono Secundario)_____

Referring/Primary MD (Medico Referrente/Primario)_____

Pharmacy Name (Nombre de Farmacia):_____ Telephone (Telefono)_____

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Patient Name::_____

As a service to our patients, our office accepts assignments of most medical plans. However, in a increased managed care environment, reimbursement for certain services has become increasingly difficult to obtain. In addition, most in-office procedures now require some sort of pre-certification or referral. In an effort to continue to give our patients excellent, yet affordable care, we ask that you take time to read and sign the following agreement. This will enable us to continue to submit insurance claims on behalf of our patients.

1. I understand that I must have a current referral for every office visit, and that it is my responsibility to obtain referral forms from my Primary Care Physician (PCP), according to the guidelines of my plan.

2. I understand that co-payments must be paid at the time of service.

3. I understand that Dr. _____ has agreed to accept assignment from my insurance carrier for services rendered in the office. However, payment for services is ultimately my responsibility.

4. I understand that some services performed by the physician may not be covered under Medicare and/or my insurance carrier(s). If it is not covered, I agree to remit payment(s) in full. I also understand that disability and similar forms that I request a physician to complete on my behalf will incur a charge of at least $50.00 that is not payable by nor reimbursable by my insurance.

5. I understand that in the event that I am unable to keep my scheduled appointment, I will notify the office to cancel or reschedule within 24 hours. If I do not adhere to this policy, I will be subject to a $30 no show fee for follow up visits ($100 for Dr. Berliner in Manhattan) or a $50 no show fee for EMG/NCV testing.

Assignment & Release of Information Statement

Authorization for release of information by:
Dr. Berliner, Dr. Gulati, Dr. Elyaderani & Dr. Kazmi

I hereby authorize and direct the above named physicians, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical/hospital care, all information needed to substantiate payment for such services rendered during medical/hospital care, and to permit representative thereof to examine and make copies of all records relating to such care and treatment. I also transfer and set over to the above named physicians sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical/hospital care to cover the cost of the care and treatment rendered to my dependant or myself by the above mentioned physicians. A photostatic copy of this signature may be used as a substitute.

Date_____ Print Name_____ Signature_____

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Patient Name::____

My injuries are not a result of a car accident or work related accident. I have not reported any accidents to my insurance company or to my employer. At no time in the future will a no-fault or worker's compensation case be opened pertaining to this injury or illness.

Signature___________________

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PF-2000 Acknowledgement of Receipt of Notice of Privacy Practices

REGIONAL NEUROLOGICAL ASSOCIATES reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the **Notice of Privacy Practices** *for*
Regional Neurological Associates, P.C.

____
Name of Patient (Print or Type)

____
Signature

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

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Name_____ **Date**_____

Reason for visit: (*Describe symptoms and complaints*)
_____
_____
_____

Past medical problems:

Condition	***Yes***	***No***	***Condition***	***Yes***	***No***
Diabetes			Kidney Disease		
High Blood Pressure			Liver Disease		
Heart Condition			Arthritis		

OTHER:

Surgical History:

	Surgery/Procedure	**Date**	**Hospital**
1.			
2.			
3.			
4.			

Allergies to Medications:_____
Tobacco Use: *Currently Smoking___ Never Smoked___ Quit___*
Alcohol Use: *Social____ Moderate___ Daily___ None____*

List of current medications:

Medication Name	***Dosage (mg/mcg/g)***	***Frequency***