Welcome and thank you for choosing
eRiver Neurology of New York, LLC
Phone: (845) 452-9750
Fax: (845) 452-9751

"eRiver Neurology of New York, LLC does not discriminate against any person on the basis of race, gender, national origin, disability, sexual orientation or age in the provision of services and/or procedures."

We are required to confirm your identity at every office visit with valid photo ID, address, and insurance card. Failure to provide this information may result in you having to reschedule your appointment.

Office Policies

A. **Emergencies: If you are experiencing a medical emergency please call 911 immediately.**
B. **Office Hours: Our office hours are from 9:00am-4:00pm Monday-Friday. Our telephones are turned over to our answering service during 12:00pm-1:00pm for lunch. The office is closed on major holidays.**
C. **Appointments: are subject to change due to hospital emergencies and changes in the provider's schedule. We apologize in advance for any inconvenience this may cause you and we will do our best to accommodate you.**
D. **Prescriptions:**
   1. Please check prescriptions weekly and call at least 72 hours prior to running out of medications and at least 1 week for controlled medications.
   2. Please allow 48 hours for prescriptions to be called into the pharmacy. Due to DEA regulations controlled substances cannot be refilled over the phone.
   3. If you have not been seen by your provider within six (6) months, a one (1) month refill will be given and you MUST make a follow-up appointment in order to get any more refills. **Our providers need to evaluate you on a regular basis to make sure that the medications continue to be effective for your care.**
   4. **We cannot fill prescriptions over the weekend** as our office is closed**.**
E. **Patient responsibilities for appointments:**
   1. If you cannot keep an appointment for any reason, we ask that you call our office 24 hours in advance. We are a very busy office and we have a waiting list for patients and would like the opportunity to fill your appointment spot in the event that you cannot come in. **A cancellation fee of $25.00 may be billed to your account for failure to cancel an office visit less than 24 hours in advance, and $50.00 may be billed to your account for failure to cancel a procedure (i.e.: EEG, EMG, Botox treatment, Sleep Study, etc) less than 24 hours in advance of your appointment.**
   2. Please make sure to bring your photo ID, Insurance card, and any needed referrals to each appointment.
   3. Please bring all test results from other physicians to your appointment. Including, lab results, CAT scans, etc. This can aid your provider in your evaluation and treatment and may reduce the need for tests to be repeated.
F. **Call backs:** When calling and requesting a call back from a provider; please allow 48 hours for your call back, unless it is an emergency.
G. **Test Results:** Test results will be discussed at your next appointment. **Clinical staff will contact you if something needs to be discussed prior to your next appointment**. Our office staff will not be able to discuss any test results with you.
H. **Forms:** When requesting paperwork to be completed, such as disability forms, employer forms, etc please allow a minimum of 10 business days for these to be completed and mailed.

Thank you and if you have any questions, please feel free to contact our office

_____ _____

Signature of patient or legal representative **Date**

eRiver Neurology of New York, LLC
Board Certified Adult and Pediatric Neurologists

Patient Name: _____ DOB_____
Last First IM

Address: _____ Gender F M Student Y N

City, State, Zip_____ Marital Status:_____

Best Number to be reached: _____ ALT Phone: _____

Work Phone: _____Employer:_____ SSN: _____

Primary Care Physician:_____
(Name of Physician) (Phone Number)

Emergency Contact _____Relation_____Phone_____

Primary Insurance:

Guarantor's Name: _____ Date of Birth:_____

If a minor, name of financially responsible Party: _____ Date of Birth_____

SSN: _____ Relationship to Patient:_____

Address_____

Patient's Insurance Co:_____ID#:_____ Group #_____

Guarantor's Employer: _____

Secondary Insurance:

Guarantor's Name;_____ Date of Birth:_____

If a minor, name of financially responsible Party: _____ Date of Birth: _____

SSN: _____ Relationship to Patient: _____

Address_____

Patient's Insurance Co: _____ ID#_____Group#_____

Guarantor's Employer_____

If you have a Third insurance please write on back.

"I hereby authorize my insurance benefits to be paid directly to the physician for any balance which I have not paid in full at time of service. I understand that I am financially responsible to the physician for charges not covered by my plan. I also authorize the physician to release any information required for claim processing.

Signature: _____ Date: _____
Signature of Patient Or Patients Representative

eRiver Neurology of New York, LLC
Board Certified Adult and Pediatric Neurologists

MEDICAL RECORD RELEASE FORM

Main office
Telephone (845) 452-9750
Fax :(845) 452-9751

Patient Name: _____ DOB _____

I hereby authorize the below listed entity to release medical information to eRiver Neurology LLC of New York.

Name: _____
(*Name of Physician or Entity to Retrieve Information From)*

Address: _____

Telephone #:_____ Fax #:_____

Medical Information Requested
( ) All Records
( ) Specific Records From _____ to_____
( ) Radiology (x-ray, ultrasound, CT, MRI etc.), labs reports
( ) Labs

_____ _____
Signature of Patient or Legal Guardian Date

I understand that these records are protected under Federal and/ or State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and or/ mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

Please fax or mail back to:

□eRiver Poughkeepsie 21 Fox Street suite 102 Poughkeepsie, NY 12603 845.452.9750 Fax 845-452-9751

□eRiver Fishkill 200 Westage Business Center suite 320 Fishkill, NY 12524 845.452.9750 Fax 845-896-2760

□eRiver Hudson & Sleep Lab 67 Prospect Ave Suite 160 Hudson, NY 12534 518.822.8021 Fax 518-822-8010

□eRiver Carmel 670 Stoneleigh Ave Building 665, Suite 202 Camel, NY 10512 845.279-4144 Fax 845-279-4141

www.eriverneurology.com

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AUTHORIZATION FOR RELEASE OF INFORMATION/PRIVACY NOTICE

Medical information will be provided in accordance with Federal HIPPA regulations and concerning continuum of care.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

** Healthcare information will be provided to Healthcare Facilities, Physicians, Insurance Companies, and/ or State/Federal entities as a part of my continuum of care unless otherwise noted below under specific instructions.

eRiver Neurology of New York, LLC may release information to the following people/agencies.

Check all that apply.

( ) Pharmacy/Pharmacist
( ) Social worker
( ) Employers
( ) School Nurse
( ) School Administration
( ) P. E. Teacher/Coach
( ) Day Care Provider
( ) Lawyer/Attorney
( ) Parents/Family _____

(Please list names and relationship)

Please Initial:

____ I understand that my health care and payment for my health care will not be affected if I do not wish to sign this form.

____ I understand that I may see a copy the information described on this form if I ask for it. And have a copy after I sign.

Patient Name _____ DOB _____

_____ Date _____

Signature of Patient Or Patients Representative

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Patient Financial Policy

We are dedicated to providing the best possible care for you.
We ask that you read and agree to sign this policy prior to any treatment.

Valid insurance cards are to be presented at the time of service, as well as photo identification for security purposes. It is the responsibility of the member to inform us of any changes in insurance or demographic information.

Copayments

All copayments are due at the time of service unless arrangements have been made in advance. We accept cash, check, and credit/debit card. There is a $25.00 fee for bank returned checks for processing fees.

Referrals/Authorizations

We are a specialty practice. Many insurance companies require referrals from the patient's primary care physician or pre-authorization before services are rendered by a specialty practitioner. This is the responsibility of the member to obtain before your appointment. If a referral/authorization was not obtained and is required by your insurance, you may be held liable for the charged amount in full. Please check with your insurance carrier prior to care to avoid excessive bills.

Participating Insurance Plans

Your insurance policy is a contract between you and your insurance company. We will file your medical claim with your insurance company on your behalf if you assign the benefits to the provider. (Meaning, that you have agreed for your insurance company to pay the practice directly.) We will also bill your insurance company for any services provided in the hospital. Please note that not all services may be covered by your insurance company. Any services that are denied stating that it is a non-covered service may be billed to the member.

Self-pay accounts

Self-pay accounts are classified as patients who do not have insurance coverage, or who have an insurance plan that we do not participate with and out of network benefits are not available. Patients who are self-pay are expected to pay for the visit in full at the time of service. A pricing list of self-pay rates is available upon request.

Non-Participating Insurance Plans

If you have an insurance plan that we are not participating with, and you have out of network benefits, you can choose to use those benefits or be classified as being self-pay and not use your insurance. Please note that out of network benefits may have deductibles, higher copayments or coinsurances that cost more than your in-network out of pocket expenses. Also, there are insurance plans that may pay the member directly for services, in which you will receive a bill from us that you will be responsible for paying.

Refunds

If there is a credit in your account, we will use this credit towards any future balances. In some instances a refund may be due to you from the practice. A refund check will only be issued if there are no claim balances due from the patient, there are no claims outstanding with the insurance company and that there are no future appointments in the schedule.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

Patient Name **Date**

Signature of patient (or responsible party, if patient is a minor) **Date**

Patient Refused to Sign:_____

_____

Signature of Staff Member Date