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-Director-
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Alpha Neurology, P.C.
27 New Dorp Lane
Staten Island, NY 10306

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No Fault (Auto Accident) Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone #: () _____ Alt. Phone #: () _____ Male Female
Social Security #: _____ - _____ - _____ Date of Birth: _____ E-mail: _____

Provider Information

Referring Provider: _____ Address: _____ Phone #: () _____
Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Information

Emergency Contact Name: _____ Relationship to Patient: _____
Emergency Contact Phone #: () _____ Emergency Contact E-mail: _____

Date of injury:

____/____/____

Time of Injury:

AM
 PM

____:____

Injury Address & State:

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

How did the injury occur?: _____

Do you have a history of the same or similar condition?: Yes No If YES, state and describe: _____

SECTION "B" (No-Fault)

ENTER YOUR AUTO INSURANCE INFORMATION

Insurance Name: _____
Insurance Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Insurance Claim #: _____
Claim Adjuster Name: _____ Insurance Phone #: () _____

Lawyer's Name, address & telephone number if applicable: _____

Alpha Neurology PC

Patient Name _____ Date of Birth _____ Date _____

Reason for Today's Visit _____

<p>Statistics: Height _____ Weight _____ Right handed ___ Left handed ___</p> <p>Current Medications: _____ _____ _____ _____ _____ _____ _____</p> <p>NEUROLOGICAL ___ Dizziness ___ Vertigo ___ Memory loss ___ Disorientation ___ Speech or language dysfunction ___ Inability to concentrate ___ Seizures ___ Taste, smell or touch disturbance ___ Headache ___ Migraine headache ___ Numbness or Tingling ___ General weakness ___ Muscle weakness ___ Slurred Speech ___ Blurred vision ___ Loss of consciousness ___ Balance problems ___ Falls ___ Depression ___ Neck pain ___ Back pain</p> <p>CONSTITUTIONAL ___ Fatigue (sluggish, tired) ___ Weight loss ___ Weight gain ___ Weight stable ___ Night Sweats ___ All negative</p>	<p>MUSCULOSKELETAL ___ Muscle cramping ___ twitching or pain ___ Joint swelling ___ Joint stiffness ___ Joint pain ___ Noise with joint movement ___ Arm or leg pain ___ All negative</p> <p>SKIN ___ Itching ___ Scars ___ Moles or lesions ___ Changes in color of moles or lesions ___ Rashes ___ All negative</p> <p>PSYCHIATRIC ___ Anxiety ___ sleep disturbance ___ Hallucinations ___ All negative ___ Depression</p> <p>CARDIOVASCULAR ___ Chest pain ___ Palpations ___ Heart Murmur ___ Irregular pulse ___ High blood pressure ___ Low blood pressure ___ Swelling ___ Coldness/numbness in fingers or toes ___ All negative</p> <p>EYES ___ Itching ___ Excessive tearing ___ Double vision ___ Light sensitivity ___ All negative</p> <p>RESPIRATORY ___ Difficulty breathing ___ Chronic cough ___ Asthma ___ Bronchitis ___ All negative</p>	<p>GENITOURINARY ___ Painful urination ___ Frequent Urination ___ Night urination ___ Unable to control urination ___ All negative</p> <p>ENDOCRINE ___ Diabetes ___ Adrenal problems ___ Changes in height or weight ___ Increased appetite ___ Increased thirst ___ Hair change/loss ___ All negative</p> <p>HEMATOLOGIC/LYMPHATIC ___ Anemia ___ Bleeding tendencies ___ Easy bruising ___ Fatigue ___ Recurrent infections ___ Slow healing from cuts ___ All negative</p> <p>ALLERGIC/IMMUNOLOGIC ___ Hay fever ___ Itching ___ Sneezing ___ Chronic clear nasal drainage ___ Conjunctivitis ___ Allergies to Medication ___ All negative</p> <p>ENMT ___ Sensitivity to noise ___ Ear Pain ___ Ringing in the ear ___ Nosebleeds ___ Sinusitis ___ Vertigo ___ Post nasal drip ___ Bleeding gums ___ Hoarseness ___ Difficulty Swallowing ___ All negative</p> <p>GI ___ Frequent heartburn ___ Nausea ___ Vomiting ___ Constipation ___ Diarrhea ___ Bloating ___ All negative</p>
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Patient Signature _____ HealthCare Provider Signature _____

Alpha Neurology PC

Name _____ Date _____

PAST Medical History: Have you been diagnosed with any of the following?

- Heart Disease Parkinson's disease Neuropathy Lupus Obesity
 Coronary Artery Disease Multiple Sclerosis Stroke Gout COPD/Emphysema
 Diabetes Mellitus Pacemaker Rheumatoid Arthritis Carpal Tunnel High Cholesterol

Other _____

Previous Surgeries _____

Family History:

	Father	Mother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden, unexplained death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Smoking: Yes, how many packs per day? _____ No, never Quit, when _____

Alcohol Use: Daily Socially

Recreational Drug use: Yes No

Employment: Employed Part Time Unemployed Retired

Marital Status: Single Married/Cohabiting Divorced/Separated Widowed

Have you, or a close family member or friend recently suffered any emotional stress: such as losing a job, a divorce, moving to a new location? If yes, please explain _____

If a Physician referred you to our office, please list his/her name or list a Physician's name you would like us to send a report to.

Dr's Name _____

Address _____

Patient Signature

Reviewing Physician's Signature

Alpha Neurology, P.C.
27 New Dorp Lane
Staten Island, NY 10306
Voice 718-667-3800
Fax 718-667-3590

MEDICAL LIEN

To Attorney: _____

RE: Reports and Lien for: _____
(Patient's Name)

Date of Accident: _____

I do hereby authorize the above doctor/medical facility to furnish, you, my attorney, with a full report, diagnosis, treatment plan, prognosis, etc. for myself in regards to the accident in which I was involved.

I hereby authorize and direct, you, my attorney, to pay directly to said doctor/medical facility such sums as may be due and owing said doctor/medical facility for medical services rendered to me by reason of this accident and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility. I further give a lien on my case to said doctor/medical facility against any proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or to myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I fully understand that I am directly and fully responsible to said doctor/medical facility for all medical bills submitted by said doctor/medical facility for services rendered to me and that this agreement is made solely for said doctor/medical facility's additional protection and in consideration of said doctor/medical facility awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict from which I may eventually recover said fee.

In the case of automobile accidents, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

Date: ____ / ____ / ____ Patient's Signature: _____
(Guardian Signature if Patient is a Minor)

The undersigned, being the attorney of record for the above patient, does hereby agree to observe the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor/medical facility above named.

Date: ____ / ____ / ____ Attorney's Signature: _____

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA**

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

Alpha Neurology PC 27 New Dorp Lane Staten Island NY 10306

9(a). Specific information to be released:

- Medical Record from (insert date) _____ to (insert date) _____
- Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- Other: _____

Include: (Indicate by Initialing)

_____ Alcohol/Drug Treatment

_____ Mental Health Information

_____ HIV-Related Information

Authorization to Discuss Health Information

(b) By initialing here _____ I authorize _____

Initials Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:

- At request of individual
- Other:

11. Date or event on which this authorization will expire:

12. If not the patient, name of person signing form:

13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS.** The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.

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Ida Altshuler, M.D.
Arun Babu MD

Office Authorization

The term "health care provider" in this document refers to Alpha Neurology, PC, its agents and employees, members of the medical staff, their agents and employees and other health care practitioners who provide care to patients.

I understand that, as part of my health care, this organization originates and maintains health records describing my medical history, symptoms, examinations and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as:

- The basis for planning my treatment and care.
- Information used to file my claim with the insurance company (diagnosis and procedure).
- Means by which a third-party payer can verify that billed services were actually provided.
- A tool for routine health care operations including quality and reviewing competency of your staff and/or healthcare providers.

I understand the Notice of Privacy will provide more complete information of uses and disclosure. **The Notice of Privacy is available on our website, AlphaNeurology.com or at the office for you to read, prior to signing this consent.** I understand that Alpha Neurology, PC reserves the right to change their notice and practices and will provide a copy of that changed form to me, prior to treatment. At that time I will be required to sign a new consent before receiving any services. I understand I have the right to restrict how my health information may be used or disclosed to carry out payment, treatment or health care operations and that Alpha Neurology is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that Alpha Neurology has already taken action on my behalf. Permission is hereby granted to all healthcare providers involved in my care to administer such examination, treatment, testing and procedures as are deemed necessary in the course of my care.

We will disclose your protected health information without your verbal authorization per individual circumstance only with your written authorization, which you may fill in below.

I authorize the release of my protected health information with regard to the minimum necessary policy, to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

RELEASE OF INFORMATION

Information necessary to substantiate my insurance claims may be released by the healthcare provider in my care.

*New York Motor Vehicle NO-FAULT Insurance Assignment of Benefits Form to be signed in the office.