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-Director-
Ludmila Feldman, M.D.

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

Marina Amitina, M.D.
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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:**	**Injury Address & State:**
/ /	_____:_____ ☐ AM ☐ PM	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_____

Statistics:
Height_____
Weight_____

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____

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
__Fatigue
__Neck pain
__Back pain

CONSTITUTIONAL
__ Fatigue (sluggish, tired)
__ Weight loss
__Weight gain
__ Weight stable
__Night Sweats
__All negative

MUSCULOSKELETAL
__Muscle cramping
__twitching or pain
__Joint swelling
__Joint stiffness
__Joint pain
__Noise with joint movement
__Arm or leg pain
__All negative

SKIN
__Itching
__Scars
__Moles or lesions
__Changes in color of moles or lesions
__Rashes
__All negative

PSYCHIATRIC
__Anxiety
__sleep disturbance
__Hallucinations
__All negative

CARDIOVASCULAR
__Chest pain
__Palpations
__Heart Murmur
__Irregular pulse
__High blood pressure
__Low blood pressure
__Swelling
__Coldness/numbness in fingers or toes
__All negative

EYES
__Itching
__ Excessive tearing
__Double vision
__Light sensitivity
__All negative

RESPIRATORY
__ Difficulty breathing
__ Chronic cough
__ Asthma
__Bronchitis
__All negative

GENITOURINARY
__Painful urination
__Frequent Urination
__Night urination
__Unable to control urination
__All negative

ENDOCRINE
__Diabetes
__Adrenal problems
__Changes in height or weight
__Increased appetite
__Increased thirst
__Hair change/loss
__All negative

HEMATOLOGIC/LYMPHATIC
__Anemia
__Bleeding tendencies
__Easy bruising
__Fatigue
__Recurrent infections
__Slow healing from cuts
__All negative

ALLERGIC/IMMUNOLOGIC
__Hay fever
__Itching
__Sneezing
__Chronic clear nasal drainage
__Conjunctivitis
__Allergies to Medication
__All negative

ENMT
__Sensitivity to noise
__Ear Pain
__Ringing in the ear
__Nosebleeds
__Sinusitis
__Vertigo
__Post nasal drip
__Bleeding gums
__Hoarseness
__Difficulty Swallowing
__All negative

_____ _____

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	□	□	□	□	□	□
Seizure	□	□	□	□	□	□
Multiple Sclerosis	□	□	□	□	□	□
Parkinson's Disease	□	□	□	□	□	□
Migraine Headache	□	□	□	□	□	□
Neuropathy	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□
Respiratory Disease	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Psychiatric Disorder	□	□	□	□	□	□
Sudden, unexplained death	□	□	□	□	□	□

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/Cohabitating □ 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

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Medical Lien Form

TO: _____
_____
_____

RE: Reports and Liens for: _____
Patient Name

Date of Accident: _____

I do hereby authorize Alpha Neurology, P.C. and it's employees to furnish you, my attorney, with a full report, including, but not limited to: diagnosis, treatment plans, prognosis, etc., regarding myself and the recent accident in which I was involved.

I further authorize and direct you, as my attorney, to pay directly to said doctor/medical facility such sums as may be due and owing to said doctor/medical facility for medical services rendered to me due to this accident. It is also authorized to withhold such sums from any judgment, settlement or verdict as is necessary to adequately protect said doctor/medical facility. I therefore 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 a result of the injuries for which I have been treated in connection therewith.

I fully understand that I am both fully and directly responsible to said doctor/medical facililty for all medical bills submitted by said doctor/medical facility for services rendered to me. Consequently, I affirm that this agreement is being 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 an automobile accident, where no-fault regulations govern the medical reimbursement, this lien will be effective only to the extent of those applicable no-fault regulations.

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

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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.

Form Revision Date: 5/27/2013

OCA Official Form No.: 960

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.**

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.