Neurological Associates of Long Island, PC Office Policies and Procedures Acknowledgement

Co-payments and Deductibles:
Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances that are past due. Your account must remain in good standing before receiving further treatment and we will remain available to you for emergencies only.

Referral Information:
If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a valid referral for my visits; Neurological Associates will reschedule my appointment.

Insurance Cards:
New patients or those patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier at your convenience for reimbursement. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Patient Rights:
Neurological Associates of Long Island, PC is notifying you of your right to choose another facility for diagnostic testing purposes. If you are interested in going to another facility, a list of facilities in your area is available upon your request.

We are committed to ensuring that our patients receive appropriate medical care. You can get information regarding your rights and how to report professional misconduct at: https://www.health.ny.gov/professionals/doctors/conduct.

Cancellation Policy:
Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact the office 24 hours prior to your appointment will result in a fee of $150.00 for doctor appointments, $250 for MRI and $60 for physical therapy. This fee is not reimbursable by your insurance company. I am also aware that all unconfirmed appointments are subject to cancellation.

Insurance Authorization and Assignment of Benefits:
I hereby authorize my provider to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance carrier.

Authorization to Access Prescription History:
I hereby authorize Neurological Associates of LI, PC to access and download my prescription history for medical purposes.
Your signature below signifies your understanding and willingness to comply with these policies listed above.

Patient's Signature_____ **Date**_____

HIPAA Policy
Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Neurological Assoc. of LI from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual (please print)	**Relationship to Patient**
_____	_____

I acknowledge having been offered a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996. Patient's signature_____ Date_____

Do we have your permission to:	(Please circle)	
-Leave a message on your answering machine at home?	**Y**	**N**
-Leave a message at your place of employment?	**Y**	**N**
-Send you medical and billing information via email?	**Y**	**N**
-Send you medical information via text messaging?	**Y**	**N**

*** Emails/text messages can contain protected health information (medical records) from Neurological Associates of Long Island, PC. We are notifying you, the patient or patient representative that requesting these records to be sent via email is an insecure method of transmission that can be intercepted as it travels over the internet. We also are notifying you, the patient that once the records are received, they can be copied, redistributed and may no longer be protected by HIPAA rules and regulations. As a result of you informed consent indicated above, you are allowing us to send the requested protected health information to the patient via the email address they provided.
Please Note: Email accounts are subject to cybercriminal attack and any protected health information received could be viewed or stolen.