NY

ALL NEUROLOGICAL SERVICES, P.C.

IGOR KHELEMSKY, M.D.
SERGE KHELEMSKY, D.O.   SOFIA BRAYLOVSKY, P.A.

REGISTRATION
PATIENT INFORM (please print)

Date: ________________

Patient's last and first name: ____

Street Address: ____

City: ______________ State ___ Zip Code: ______ Home Phone: __________________

E-mail: ____ Cellphone: ________________

Sex [ ] M [ ] F Age: ___ Birth date: ______________ Single [ ] Married [ ] Windowed [ ]

Pharmacy Phone #: ____

Patient Employed by: __________________ Patient's Social Security # ______________

Business Name and Address: ____

Responsible party name: _________________________ Relationship to Patient: ____________

Birth date: ___________ Social Security # (for billing purposes) ______________

Occupation: _______________ Business Phone: ___________ ext. __________

Do you have Medical Insurance? [ ] No [ ] Yes If yes, please complete:

INSURANCE INFORMATION

Name of Primary Insurer: ____

Name of Secondary Insurer (if any): ____

In case of emergency, who should be noticed: _______________________ Phone: ___________

How did you learn of our practice? ____

ASSIGNMENT AND RELEASE

I, the undersigned, have Insurance coverage with ________________________ and assign directly to Dr. __________________ all medical benefits. If any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_________________________________ ___________

(Signature of Insured/Guardian) Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. ____________ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA--1500 or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge. And the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare

_________________________________ ___________

(Beneficiary Signature) Date

RECORD OF GOOD FAITH EFFORT OF OFFICE TO OBTAIN WRITTEN ACKNOWLEDGEMENT*

On ______________________ a copy of the Notice of Privacy Practices of
(Insert Date)

the office was given to ____________________________ together with an Acknowledgement
(Insert Patient's Name)

Form. Acknowledgement of the Patient's receipt of the Notice of Privacy Practices was

not obtained, however, because ____

____.

____
(Patient's Signature)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

I, ______________________________, (insert patient's name) acknowledge receipt this day from All Neurological Services P.C.

Date: ________________________

____
(Print Name of Staff Member)

____
(Signature of Staff Member)

* The completed form is to be placed in the patient's medical record

PATIENT AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

This office creates and maintains health information about our patients. The law gives certain privacy protections to this information that we will refer to as "protected health information." By signing this form, you will be authorizing our office to use or disclose certain specified protected health information. You are hereby advised that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be subject to legal protections.

I, ______________________________________ (insert patient name) acknowledge, understand and authorize the following:

1. All Neurological Services P.C is herby authorized to disclose my protected health information, specifically ______________________________________ (describe information), to the following person or entity:

   ____

2. This authorization will expire on ______________________________________.

3. I have the right to revoke this authorization but only as to information not already used or disclosed. Also, I may not revoke this authorization if this authorization was obtained as a condition of receiving insurance coverage. Any revocation of this authorization will only become effective if it is in writing, dated, and signed by me and delivered to the Privacy Administration of All Neurological Services P.C.

4. All Neurological Services P.C. will not condition treatment, payment enrollment or eligibility on obtaining this authorization except as described herein. I have the right to refuse to sign this authorization.

5. The use or disclosure will be for the following purpose(s):

   ____

6. I may inspect or copy the protected health information to be used or disclosed.

7. The use or disclosure described above will (__) will not (__) (check one) result in direct or indirect remuneration to

Print Name: ____________________ Signature: ____________________ Date: __________

If signatory is patient's personal representative, state authority to act for patient:

____

*If this form is used, the original is to be placed and maintained in the medical record of the patient.