MEDICAL SERVICES OF SYRACUSE

Name: _____Date of Birth: _____ Sex:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SS #: _____ E-Mail: _____

Employer: _____ Occupation: _____

Employers Address: _____ Phone: _____

Ethnicity: _____ Race:_____ Marital Status: _____

Spouse/Significant Others Name: _____ Spouse's Date of Birth: _____

Spouse/Significant Others Phone: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy & Address: _____ Phone: _____

Financial Guarantor's Name if other than Self: _____ DOB: _____

Relationship to Patient: _____ Phone Number: _____
As the financial guarantor, I authorize treatment of the named patient above and I will cover any and all fees and charges for such treatment.

Please sign below to verify the accuracy of the information listed above.

SIGNATURE: _____ DATE: _____

MEDICATIONS/ALLERGIES

Name: _____ DOB: _____

Medication List:
Please include prescription drugs, over the counter medication, and/or supplements

Medication	Dosage	Frequency

Medication ALLERGIES & Any Other ALLERGIES:

Medication/Other	Reaction

Are you allergic to latex? YES NO

Please initial if you do not have any known allergies _____

MEDICAL/SOCIAL HISTORY

What is the reason for your visit to the Neurologist (Chief Complaint)?

_____

_____

Have you seen a Neurologist? YES or NO If yes: Who & When?

_____

Family History:
List all serious illnesses in your immediate family.
Examples include Seizures, Headaches, Tremors, Dementia, etc.

Illness	**Relationship**
_____	_____
_____	_____

_____

Medical History: (please list all)

_____

_____

_____

Surgeries: (please list all with dates if possible)

_____

_____

_____

_____

Hospitalizations/ ER visit: (please list with dates and reasons)

_____

_____

Are you a current or former smoker (vape, tobacco, marijuana, etc.)? YES or NO If yes, please explain in detail.

_____

Do you drink alcoholic beverages (Circle) YES or NO If yes, how often _____

Do you drink caffeinated beverages (Circle) YES or NO

If yes, how many cups a day? 1-2 3-5 5+

Highest Level of Education (Circle)

Elementary School Middle School High School College

How many times a week do you exercise? 0-1 2-5 6-7

Circle: Left Handed or Right Handed

Patient Name: _____ Date: _____

Hipaa Release of Information

Patient Name: _____ Date of Birth: _____

___ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information.

This information may be released to:

__ Spouse _____
__ Child(ren): _____
_____
__ Other: _____
_____
__ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages
Please call:

___ My home
___ My work
___ My cell number: _____

If unable to reach me:

___ You may leave a detailed message
___ Please leave a message asking me to return your call
___ Do not leave a message

Patient signature: _____ Date: _____

Medical Services of Syracuse

NO SHOW/CANCELLATION FEE POLICY

Effective October 2023, you must give the office 24 hour notice of any cancellation or reschedule. There will be a fee of $50 charged if you cancel, reschedule or no show to your appointment without proper notice.
Please be advised 2 no shows will result in discharge from the practice.

In order to provide adequate continuity of care for all patients we thank you for your understanding on this matter.

Signing of this agreement confirms your consent to these terms.

Print Name: _____ **Date of Birth: _____**

Signature: _____ Date: _____

MEDICAL SERVICES OF SYRACUSE
OUR FINANCIAL POLICY & NO SHOW POLICY

Thank you for choosing Dr. Ijaz Rashid as your healthcare provider. Our physician, providers, and staff are dedicated to the best possible care for you, and we want you to completely understand our financial policies in order for us to give you the best possible medical care.

First Appointment/New Patient – You must bring **current insurance cards**, a **form of identification** and medical records pertinent to your visit**.** Failure to present this information at the time of your visit will result in rescheduling this appointment

At check in – Your copay is due at the time of service. We accept cash, checks, money orders, and all major credit cards. Please notify us of any address, phone, or insurance changes. Any returned checks will be charged a $35.00 fee for processing.

It is your responsibility to ensure that we participate with your insurance carrier and whether you need a referral from your Primary Care Physician prior to an appointment, our office cannot always tell you in advance whether your charges will be covered by your insurance plan. Each insurance carrier has multiple plans that can vary with employer group contracts. It will be your responsibility to pay for any charges not covered by your plan.

Referrals – If your insurance plan requires a referral; it is the responsibility of the patient/guarantor to obtain this from your Primary Care Physician before your appointment. If we have not received a valid referral to see you, you will be considered self-pay and payment is due at the time of the visit or your appointment will be rescheduled.

Minor Patients (under 18 years old) – Any patient under the age of 18 years must be accompanied by a parent or guardian. The parents(s), guardian(s), and or adult accompanying a minor is responsible for providing current insurance information for the minor and/or payment in full of any copay due at the time of services. Please be aware that we do not get involved in any child custody or divorce decrees. The adult accompanying the child is responsible for any co-pays or balance due at the time of services.

Participating Insurances – If we participate with your insurance company, we will bill them directly, providing you have given us complete billing information. **However, if your insurance requires a co-pay, this is expected at the time of service.**

Self-Pay Patients- Self pay patients will be required to make payment at the time of service. The patient will be required to sign a payment plan for any balance over the initial down payment.

Worker's Compensation – Your employer must file an injury report before an injury can be billed to Worker's Compensation. It is your responsibility to contact your employer. You will need to provide us with the compensation insurance carrier, their address, date off accident, WBC number, and all the claim numbers related to your compensation case. If we lack any of this information, you will be billed the full balance of charges rendered until we receive the information we need.

Liability – This is an injury due to another person's negligence. This would not be covered by your private insurance, or worker's compensation. We do not bill liability cases, therefore this would be considered self-pay and payment is due at the time of the appointment.

School Injury Insurance – If you are a student and was injured at a school function, your private insurance will be billed first and the school's insurance will be billed secondary. We will need to know what school the patient attends, the school insurance company's name, and any claim number assigned to this injury. You will be responsible for any follow up with the school insurance if payment is delayed.

Insurance Questionnaires – Your insurance carrier may require you to fill out an injury detail questionnaire regarding your injury. Your insurance carrier will not pay a claim until they receive this information. We will bill you for any rejected charges by your insurance carrier for this reason. It is your responsibility to make sure your carrier pays your claims.

Statements – You will receive a statement from our office for any self-pay balance due after your insurance carrier pays. We will gladly set up a payment arrangement on your account, however if two payments are missed,

your account will immediately go to collections. There is a $25.00 fee charged on an account that is sent to collections.

Disability Forms or any other forms to be filled out – The fee for completing most forms are $25.00 payable at the time they are dropped off at the office. Completion of these forms are 7-10 days. Please submit any forms to us as soon as you acquire them.

Medical Record Request – In order to comply with the HIPAA privacy laws, a signed and dated medical release must be completed prior to the release of any records. This includes records requested to be sent to attorney's, other medical providers, insurance companies, or for your own records. If you need physical copies, you will be charged $0.25 per page.

No Show Policy – We ask for your consideration regarding appointments. If you are unable to keep a scheduled appointment, we expect a call at least 24 hours prior to your appointment so that we may open the appointment slot for another patient. This improves appointment availability for both you and other patients. We recognize that emergencies occur and you may be unable to cancel an appointment in rare circumstances. It is important that our patients understand that their behavior and failure to keep appointments can have a negative impact on their health as well as the health of other people. We call to confirm upcoming appointments one day in advance. If you fail to cancel or are a no show for your appointment, a charge of $50.00 may be assessed to your account. If you are a no show without notification two times, you are subject to being discharged from our practice.

Please update your home, work, and cellular telephone numbers along with your current mailing address as we do make appointment reminder calls to patients.

Please be advised that consecutive no shows may lead to dismissal from Medical Services of Syracuse.

Thank you in advance for your cooperation and for choosing Medical Services of Syracuse!

YOU MAY KEEP THIS COPY OF THE FINANCIAL POLICY & NO SHOW POLICY*

FOR ACCESS TO OUR PATIENT PORTAL YOU MUST PUT IN A VALID E-MAIL ADDRESS. YOU WILL BE SENT A LINK WITH A PIN TO ACCESS THE PORTAL. YOU CAN ALSO DOWNLOAD THE TALKPHR APP ON YOUR SMARTPHONE!

PATIENT PORTAL: www.talkphr.com

YOU CAN VISIT OUR WEBSITE www.medicalservicessyracuse.com TO REQUEST FOR ACCESS TO THE PATIENT PORTAL. THANK YOU!