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.

SIGNATURE: ______________________ DATE: ______________

*** I consent to have Medical Services of Syracuse use and disclose my protected health information for payment, treatment, and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my explicit written authorization.*
*** I authorize payment of medical benefits to this practice and this physician of supplier for services rendered.*
*** I authorize Medical Services of Syracuse and its affiliates to bill my insurance and authorize any necessary release of information, reports and/or diagnostic studies. I authorize any appropriate medical testing, examinations, or referrals of services as needed. I understand that it is my responsibility to inform any changes of insurance or demographic information and that I am responsible.*

SIGNATURE: ______________________ DATE: ______________

HIPAA Release Form

Patient Name: ____________________ Data of Birth: __________

Release of Information

☐ 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

____________________ ____________________

Signature Date

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:
LEAVE THIS BLANK PLEASE

8. Name and address of person(s) or category of person to whom this information will be sent:
Medical Services of Syracuse PLLC, Phone # 315-498-5430 Fax # 315-299-5138

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.**

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)

____

____

Do you use tobacco? YES or NO If yes, how often, how much, and for how long?

____

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

Do you wear a seat-belt while in a vehicle? (Circle)

NEVER SOMETIMES ALWAYS

Circle: Left Handed or Right Handed

Patient Name: ______________________________ 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 may 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.
NYS No Fault – We will need your no fault insurance carrier, their address, date of accident, all claim numbers related to your claim, the claim adjuster's name, and his/her telephone number. You will be asked to sign a NF-3 application for No-Fault Benefits Form at your first apportionment

Liability – This is an injury due to another person's negligence. This would not be covered by your private insurance, no-fault, 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 – The fee for completing most disability forms are $5.00 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 $0.50 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 two days 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 three 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!

PLEASE NOTE IF YOUR INSURANCE IS NOT ACTIVE, YOU ARE RESPONSIBLE FOR THE BILL.

I have read the Financial & No Show Policy. I understand and agree to the financial policy.

______________________________ Printed Patient/Responsible Party Name

______________________________ Signature of Patient/Responsible Party

______________________________ Date