Epilepsy and Behavior Neurological Services

219 Livingston Ave Unit A Livingston , NJ 08901
732-258-0061 Fax 732-993-9497

Patient Information Sheet

Reason for Visit: _____

Demographics

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone (Cell): _____ (Home): _____ (Work): _____

Occupation: _____ Email (optional): _____

Preferred method of contact: CELL ☐ HOME ☐ WORK ☐ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Number of Children: ____ Date of Birth: _____ Social Security No.: _____

Insurance Information

Are you here for a Workers' Compensation visit? Yes ☐ No ☐

Are you here for a Motor Vehicle Collision? Yes ☐ No ☐

Do you have Medical Insurance? Yes ☐ No ☐

Copay Amount $____ Referral Needed? Yes ☐ No ☐

Insurance Company **(Primary):** _____ Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

Insurance Company **(Secondary):** _____ Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

Name of Policyholder (if different from patient): _____

Date of Birth: _____ Social Security No.: _____ Relationship: _____

Address: _____

Primary Care Physician (Full Name): _____ Phone Number: _____

Address: _____

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Referring Physician (if different from Primary): _____ Phone Number: _____

Emergency Contacts

Contact Name #1: _____ Relationship: _____ Phone: _____

Contact Name #2: _____ Relationship: _____ Phone: _____

Assignment of Benefits

I request that the assignment of authorized Medicare/Other Insurance Company Benefits be paid either to me or on my behalf to Princeton & Rutgers Neurology for any services furnished me by that party who accepts the assignment. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration any information needed for this or any related Medicare/Other Insurance Company claim. The assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also understand that regardless of my insurance status, I am ultimately responsible for the balance of my account. If I am using out of network benefits, I am responsible for any deductible and/or co-insurance.

Signature: _____ Patient Name: _____ Date: _____

Prior Testing

Test:	*Date(s):*	*Body Part Studied:*	*Results:*
X-RAY			
MRI			
CT			
EMG			
OTHER			

Medical History

Do we have permission to obtain your medical history? Yes ☐ No ☐ Are you under a great deal of stress? Yes ☐ No ☐

Do you smoke cigarettes? Yes ☐ No ☐ How many packs do you smoke in a day? ____ For how many years? ____

Do you drink alcohol? Yes ☐ No ☐

How often do you have a drink containing alcohol? Never ☐ Monthly or Less ☐ 2-4 times/mo ☐ 2-3 times/wk ☐ 4+ times/wk ☐

How often do you have 6+ drinks on one occasion? Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily ☐

Please list any non-drug allergies: _____

Please list recreational drugs of use: _____

Have you had any recent hospitalizations? Yes ☐ No ☐ Date(s) of Hospitalization: _____

If yes, explain which hospital/facility and the reasons(s) of admission: _____

Have you had any recent surgeries? Yes ☐ No ☐ Date(s) of Surgery: _____

If yes, explain which hospital/facility and the reasons(s) for surgery: _____

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Patient Information Sheet

Family History

Please indicate the relationship of the family member next to the illness or disease (i.e. mother, father, brother, sister, maternal/paternal grandmother, maternal/paternal grandfather).

	Yes	No			Yes	No	
High Blood Pressure	☐	☐		Cancer	☐	☐	
Diabetes	☐	☐		Asthma	☐	☐	
Seizure Disorder	☐	☐		Seasonal Allergies	☐	☐	
Migraines	☐	☐		Headaches	☐	☐	
Alcoholism	☐	☐		Psychiatric Disorder	☐	☐	

Review of Systems

Please check which of the following symptoms you are presently experiencing. One box must be indicated per section.

Constitutional	Fever ☐	Weight Loss ☐	Loss of Sleep ☐	Fatigue ☐		None ☐
Eyes	Loss of Vision ☐	Blurred Vision ☐	Double Vision ☐	Jagged Lines ☐	Kaleidoscopic Colors ☐	None ☐
Cardiovascular	Shortness of Breath ☐	Swelling of Legs ☐	Chest Pain ☐	Palpitations ☐		None ☐
Respiratory	Cough ☐	Asthma ☐	Coughing up Blood ☐			None ☐
Gastrointestinal	Loss of Excessive Appetite ☐	Nausea ☐	Vomiting ☐	Heartburn ☐	Stomach Pain ☐	None ☐
	Constipation ☐	Diarrhea ☐	Blood in Stool ☐			
Genitourinary	Burning Urination ☐	Frequent Urination ☐	Sexual Dysfunction ☐			None ☐
Ears, Nose, Mouth, Throat	Hearing Loss ☐	Ringing in Ears ☐	Vertigo ☐	Light-Headedness ☐		None ☐
Neurological	Tremor ☐	Paralysis ☐	Poor Balance ☐	Convulsions ☐	Insomnia ☐	None ☐
	Restless Legs ☐	Memory Loss ☐	Dizziness ☐			
Integumentary	Rash ☐	Itching in Feet ☐				None ☐
Psychiatric	Depression ☐	Hallucinations ☐	Agitation ☐	Anxiety ☐	Phobias ☐	None ☐

Please list any other symptom(s) of concern:

Past Medical History: Please circle

Head
- Trauma

Eyes
- Blindness
- Cataracts
- Glaucoma
- Wears glasses/contacts

Ears
- Hearing Aids

Nose/Sinuses
- Allergic Rhinitis
- Sinus Infections

Mouth/Throat/Teeth
- Dentures

Cardiovascular
- Aneurysm
- Angina
- DVT
- Dysrhythmia
- HTN
- Murmur
- Myocardial infarction
- Other Heart Disease

Respiratory
- Asthma
- Bronchitis
- COPD-Bronchitis/Emphysema
- Pleuritis
- Pneumonia

Gastrointestinal
- Cirrhosis
- GERD
- Gallbladder disease
- Heartburn
- Hemorrhoids
- Hepatitis
- Hiatal Hernia
- Jaundice
- Ulcer

Genitourinary
- Hernia
- Incontinence
- Nephrolithiasis
- Other kidney disease
- STDs
- UTI(s)
- Angina
- DVT
- Dysrhythmia
- HTN
- Murmur
- Myocardial infarction
- Other Heart Disease

Musculoskeletal
- Arthritis
- Gout
- M/S injury

Skin
- Dermatitis
- Mole(s)
- Other skin conditions(s)
- Psoriasis

Neurological
- Epilepsy
- Seizures
- Severe Headaches, migraines
- Stroke
- TIA
- Psychiatric
- Bipolar Disorder
- Depression
- Hallucinations, delusions
- Suicidal ideation
- Suicide attempts
- Endocrine
- Goiter
- Hyperlipidemia
- Hypothyroidism
- Thyroid disease
- Thyroiditis
- Type 1 DM
- Type 2 DM
- Heme/Onc
- Anemia
- Cancer
- Infectious
- HIV
- STDs
- Tuberculosis (dz)
- Tuberculosis (exposure)

Other Items
- Anxiety
- Attention Deficit
- Autism
- Sleep disorder/Insomnia
- Memory impairment
- Obesity
- Osteopenia or osteoporosis
- Seasonal Allergy
- Vitamin D deficiency

For women, age of menarche (first menstrual period) and last menstrual period:_____

COVID-19 infection: ☐ Yes (Date _____) ☐ No

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Patient Information Sheet

Medication Log Sheet

Patient Name: _____ Date of Birth: _____

Pharmacy: _____ Pharmacy Phone: _____ **Town:** _____

Any Drug Allergies? _____

Current Medications	*mg/Strength:*	*Frequency:*	*Condition to be Treated:*

Patient Signature _____ Date _____

OUR FINANCIAL POLICY
-IMPORTANT: PLEASE READ AND SIGN

Thank you for choosing us as your health care providers. The following is a statement of our financial policy which we require that you read and sign prior to your office visit.

• We must have a copy of your current insurance card. Therefore it is the responsibility of the patient to make sure you offer your insurance card to the Receptionist for copying upon each visit to the office. All co-pays are collected at the Reception window upon registering.

• **If you have a co-pay**, you will be responsible for the payment of that co-pay on the day of your appointment. All co-pays are collected at the reception window upon registering. Or, If it is a **Telehealth visit**, we will charge the card on file the day of your visit.

• **If you have an HM0 or Community / Medicaid plan** with whom we have a contract, an appropriate **referral** from your Primary Care Physician is necessary in order for you to be seen. This referral must contain the diagnosis, number of visits allowed, and the expiration date of the referral. It is the **patient's responsibility** to keep track of the number of remaining referrals and expiration date. You may call our office at any time to verify this information prior to your visit. If you are seen without a valid referral, you will be responsible for the bill. If you have a co-pay you will be responsible for the payment of that copay at the time of your appointment.

• **If you have a PPO plan with whom we have a contract,** you will be responsible for the co-pay listed on your card. If you have not met your deductible yet, or if you have a co-insurance that remains after the insurance company has paid their portion, you will be responsible for this balance and payment is expected at the time of visit

• You are responsible for payment regardless of any insurance company's determination of usual and customary rates

• You will be responsible for payment of services if your insurance has lapsed in coverage, or is not in effect at the time of service.

• Patients are responsible for meeting their annual deductible each year.

• **Medicare**. Once the deductible has been met, patients without secondary insurance will be required to pay their 20% portion at the time of their visit.

• If you have secondary/supplementary insurance, it is the responsibility of the patient to provide the receptionist with a copy of that card.

• We will file with secondary/supplementary carriers. However, in the event that the secondary insurance does not pay, patients will be billed for the balance.

•Please be aware that following your office visit the doctor may order blood work or other diagnostic testing that may not be deemed "medically necessary" by either Medicare or your insurance carrier. It is possible that your insurance carrier has made its own determination as to what tests they deem to be "medically necessary". Therefore, there may be charges not covered by your carrier. In such an event, these charges will become the responsibility of the patient.

• Patients without insurance are expected to pay their bill at the time of services unless prior arrangements have been made and approved by the Billing Manager.

• **New Patients** without insurance will be expected to pay a minimum level of service(office visit only, does not include studies done at the office) of $350.00 by cash or credit card upon registering at the Reception Desk. If a higher level visit is warranted by the physician, the balance of that visit will be collected from you at the time (Ask for self pay prices)

• If you have presented us with a health insurance card with which we do not participate, you will be expected to pay 100% of our billed amount at the time the services are rendered.

• Once payment is made by you, the claim will be submitted to your health insurance carrier on your behalf. Any reimbursement due for out of network benefits should be sent directly to you. If your insurance company mails the payment to our office, a refund check will be sent to you in the amount paid by the insurance company.

• **Partial payments** will only be accepted if prior arrangements have been made.

• If you wish to proceed with any necessary testing and would like to set up a payment plan, just ask to see someone in BILLING and this will be arranged for you.

• Once a payment plan is arranged, payments must be made consistently or the balance will be considered delinquent, and may then be subject to finance charges or eventually turned over to our collection agency.

• We require 24 hours notice for all canceled appointments or your account will be charged $25.00. Please be aware that this charge is your responsibility and is not covered by your insurance.

• All testing is subject to a$75.00 no-show fee. All regular office visits are subject to a $25.00 no show fee(min depending on type of visit/test etc- ask to see current fees)

I have read the above financial policy and understand and agree with its terms. In the event that my insurance does not pay, I understand that I Will be financially responsible for those charges:

Signature_____ **Print Name** _____**Date**_____

Epilepsy & Behavior Neurological Services

We have an obligation to maintain the privacy of protected health information (PHI) and to provide individuals with notice of our legal duties and privacy practices when requested.

Federal law provides that we may use your protected health information (PHI) for your treatment without further notice to you, and without further written authorization by you. (i.e. forwarding lab work to a doctor that we may be referring you to.)

Federal law provides that we may use your medical information or disclose your medical information to obtain the following:

- Payment for our services (i.e. submission of your diagnosis to your insurance); • Health care operations (i.e. audits by our accountants);
- When required for public health purposes to avoid health or safety threat;
- When required by an agency such as Department of Health;
- When required by law in judicial or administrative proceedings;
- When required for law enforcement purposes; You have the right to:
- Request restrictions on certain uses or disclosures described above.
- However, we are not required to agree to such restrictions;
- Obtain *copies* of your medical information;
- Request an accounting of any disclosures we make of your medical information with the exception of disclosures we make to you, or in order to carry out treatment, payment or health care operations;
- Opt out of getting fundraising communications although we do not hold such events;
- If you are a self-pay patient, you may request in writing that we not disclose any information to your insurance company;
- To be notified if any breach of your protected health information (PHI) has been compromised;

**We may contact you by mail, phone or by e-mail, text message to remind you of appointments or to provide information about treatment Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence. If you have a preference, please check below:

****Initial here to OPT IN text messages_____OPT OUT text messages_____**

You've subscribed to receive recurring messages from Epilepsy & Behavior Neurological Services, Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

( ) Home _____ ( ) Work _____ ( ) Cell_____

*Authorized Contact Person*_____

The people/person listed above have permission to speak to the physicians with regard to my treatment

My signature below represents that I have read this Notice of Privacy Practices.

Signature_____**Date**_____

Epilepsy & Behavior Neurological Services Brenda Y Wu MD PHD

219 Livingston Ave Unit A, New Brunswick, NJ 08901 PH: 7322580061 Fax : 7329939497

CREDIT CARD ON FILE POLICY

At Epilepsy Behavior Neurological Services, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurance, and the insurance portion of the claim has been paid and posted to the account.

- • A credit card/debit card number information will be required and be kept encrypted in compliance with HIPAA regulations until the balance is satisfied. • After services are rendered, your insurance company will be billed accordingly. • Epilepsy & Neurological Services will receive a check from your insurance with an Explanation of Benefits, which will provide exact information to us like how much is "Patient Responsibility" like the amount of your Deductible or Coinsurance.
- • You should receive a copy of your Explanation of Benefits as well that will clearly indicate the amount paid to Epilepsy & Neurological Services by your insurance and the amount of fee that will be applied to meet your deductible or coinsurance amount, which you are responsible for.
- • You will have fifteen(15) days to review any disagreement with your insurance company for the way they calculate your deductible or coinsurance. After that you will receive a copy of your insurance statement and a receipt of your credit card charge from our office.
- • Epilepsy & Behavior Neurological services giving you the guarantee that you will only be charged the amount that your insurance company states in accordance with your contract. Our billing department will respond in a prompt matter in case a question arises about your charges (732-441-1590, 732-258-0061) or email at
  - ***vismaya.patel4epilepsybehavior.org.***
- • If you are agreeing to pay as payment plan your credit card will be auto charged. • You will be asked to authorize by signature the transaction for each office visit.

- **Televisit Copay-** Even though you physically do not come into the office it is still a Doctor visit and your insurance requires a copay. The card will be charged the day of your telehealth visit. If you wish to use a different card the day of your telehealth appointment. Please call our office that morning or the day before._____***Initial Here***

Patient Name: _____Date of Visit : _____

I authorize Epilepsy Behavior Neurological Services to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Credit Card #_____

Expiration Date _____**CVV** _____

Cardholder Name _____

Billing Address _____**Zip**_____

Signature_____