neurocare
Centers of America
Long Island Neurocare Therapy

Welcome to Long Island Neurocare Therapy! We appreciate you entrusting us with your healthcare needs.

Our team of skilled professionals is committed to providing you with the highest quality of care, and we look forward to supporting you and your loved ones throughout your counseling experience.

As a new patient, we encourage you to explore our services. To prepare for your initial appointment, please carefully review and complete all the documents. These forms are designed to support you and assist us in providing the best possible care and treatment.

If you are unsure about certain information, such as medication dosages, you may find it helpful to contact your pharmacy or doctor. Completing these forms in advance will allow us to maximize our time together to discuss your options and determine the best steps for your treatment. If you have any questions about the requested information, simply mark the area and move on to the next section. We can address it during your consultation.

If you cannot bring the completed forms with you, please let us know in advance, and we will have them ready for you in the reception area. In this case, please arrive half an hour early to allow sufficient time to complete them.

If you have any questions or need assistance, please do not hesitate to contact our staff. We are excited to work with you and support you on your health journey.

Long Island Neurocare Therapy Locations:

Levittown
3601 Hempstead Turnpike, Suite 405
Levittown, NY 11756
Phone Number: (631) 714-4100

Medford
1739 N. Ocean Ave. Suite A
Medford, NY 11763
Phone Number: (631) 714-4100

Melville
121 Broadhollow Rd. Suite 125
Melville, NY 11747
Phone Number: (631) 714-4100

New Patient Registration Form

Date: _____

Which location are you visiting today? ☐Medford ☐Melville ☐Levittown

How did you hear about our office? ☐Web site ☐Friend/Family member ☐ Referral from another provider

Name of provider who referred you:_____
☐ Psychiatrist ☐ Therapist ☐ Primary Doctor ☐ Self Referred

Do you have a diagnosis of Major Depression? ☐ Yes ☐ No

Patient Information

Patient's Full Name:_____**Date of Birth:** _____

Gender: ☐ Male ☐ Female ☐ Other: _____

Mailing Street & Apt #: _____

*I understand that by giving this address, statements and necessary forms will be mailed to the address provided. *

City:_____**State:**_____**Zip Code:** _____

Cell: *(Default)* _____ **Home:** _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Education Level: ☐ GED ☐ HS Graduate ☐ Some College/associate's degree ☐ Masters ☐ Doctorate or Higher

Occupation: ☐ Employed ☐ Retired ☐ Disabled ☐ Student

Emergency Contact Information

Name: _____ **Relationship to Patient:** _____

Phone Number: _____ **May we leave messages with this person:** ☐ Yes ☐ No

Insurance Information

Name of Insurance: _____**ID Number:** _____

Policy Holder Name:_____

Patient relationship with the insured: ☐Self ☐ Spouse ☐ Child ☐ Other

Please indicate if there is secondary insurance: ☐ Yes ☐ No

Secondary Insurance

Name of Insurance: _____**ID Number:** _____

Policy Holder Name:_____

Psychiatric Information

Are you currently seeing a psychiatrist or someone that manages your mental health medication? ☐Yes ☐No

If yes, please indicate name and phone number: _____

May we contact this person regarding your care here? ☐Yes ☐No

Therapist/Counselor Name:_____**Phone:** _____

Type of therapy? ☐Group ☐CBT ☐Individual ☐DBT ☐Other: _____

- **Has therapy helped to resolve depression symptoms?** ☐Yes ☐No
- **Do you have current thoughts of:** ☐self-harm ☐suicide ☐thoughts to harm someone else
- **Did you ever undergo TMS in the past?** ☐Yes ☐No
- **Any history of suicide attempts?** ☐Yes ☐No
- **Any history of violence?** ☐Yes ☐No
- **Any history of non-suicidal self-injurious behaviors?** ☐Yes ☐No
- **Do you have access to firearms?** ☐Yes ☐No
- **Any history of trauma/abuse?** ☐Yes ☐No
- **Any history of legal problems?** ☐Yes ☐No
-
- **At what age were you initially diagnosed with depression (estimate): _____**
- **Have you ever been in remission from depression?** ☐Yes ☐No

If you answer **YES,** *what time frame?* _____

Please list all your mental health conditions, the year that you were diagnosed (if able to remember)

Have you ever been hospitalized due to your mental health or participated in an inpatient or outpatient program within the last 5 years?

Inpatient Psychiatric Hospitalization	Intensive Outpatient
☐Yes ☐ No	☐ Yes ☐ No
If you answer, YES	***If you answer, YES***
Where:	*Where:*
When:	*When:*
How Long:	*How Long:*

Briefly describe what you most want help with now:

Current Substance Abuse

Object	No	Yes	Quantity per Day	Past Use
Tobacco				
Alcohol				
Recreational Drugs				

- **Have you ever suffered from substance dependence or abuse?** ☐ Yes ☐ No
- **Do you averagely consume more than 2 alcoholic servings a day?** ☐ Yes ☐ No

Medical Information

Primary Care Physician Name:_____**Phone:** _____

May we contact this person regarding your care here? ☐ Yes ☐ No

Please list all medications you are currently taking:

Please list any allergies:

Please check all that apply:

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Seizure
☐ Asthma ☐ Depression ☐ Stroke ☐ Cancer ☐ None

Do you have any of the following implants in your body?

Description	Yes	No
(metal) Plates and/or screws		
Vascular clips		
Artificial heart valve		
Metallic splinters/shrapnel/etc.		
Pacemaker		
Insulin pump		
Internal hearing aid (cochlear implant)		

Any other implants not mentioned above?
☐ Yes ☐ No

If you answered "yes" to any of the questions above, please specify:

Brief Symptom Screening Questionnaire

Persistently sad or lost interest in many things that you usually enjoy?

☐Yes ☐No

Frequently anxious, worried, tense, or unable to relax?

☐Yes ☐No

Persistently irritable, angry, hostile, or having mood swings?

☐Yes ☐No

Persistently overjoyed, exuberant, giddy, feeling on top of the world?

☐Yes ☐No

Wished you were dead or had suicidal thoughts?

☐Yes ☐No

Wanted very much to hurt someone else?

☐Yes ☐No

Using alcohol or drugs excessively or felt out of control with them?

☐Yes ☐No

Having recurrent thoughts or nightmares about a traumatic event?

☐Yes ☐No

Feeling suspicious or preoccupied with things others didn't believe were true?

☐Yes ☐No

Hearing voices or having visual hallucinations?

☐Yes ☐No

Having recurring obsessive thoughts that felt silly but unshakable?

☐Yes ☐No

Engaging in any compulsive behaviors that are hard to stop?

☐Yes ☐No

Having memory problems, difficulty with tasks you used to be able to do, getting lost or confused?

☐Yes ☐No

Are you currently taking any medications?

☐ Yes ☐ No

TMS Medication Checklist

*Below is a list of common medications that are used to treat depression. Please mark the medications you have been prescribed **in the past** or **are currently prescribed**. Provide estimated dates of use and the reasons for discontinuing. If you have brought a medication list or had your records sent from your physician's office, please fill out this form and bring those documents with your TMS therapy consult visit.*

SSRI (Selective Serotonin Reuptake Inhibitors) Medications

Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	citalopram	Celexa	☐20mg ☐40mg	/	/	
	escitalopram	Lexapro	☐10mg ☐20mg	/	/	
	fluoxetine	Prozac	☐20mg ☐40mg ☐60mg	/	/	
	fluvoxamine	Luvox	☐100mg ☐200mg ☐300mg	/	/	
	fluvoxamine CR	Luvox CR	☐100mg ☐200mg ☐300mg	/	/	
	paroxetine	Paxil	☐20mg ☐40mg ☐60mg	/	/	
	paroxetine CR	Paxil CR	☐12.5mg ☐25mg ☐50mg ☐62.5mg	/	/	
	sertraline	Zoloft	☐50mg ☐100mg ☐200mg	/	/	
	vortioxetine	Trintellix	☐5mg ☐10mg ☐20mg	/	/	
	vilazodone	Viibryd	☐20mg ☐40mg	/	/	

SNRI (Serotonin-Norepinephrine Reuptake Inhibitors)

Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	desvenlafaxine	Pristiq	☐50mg ☐100mg	/	/	
	duloxetine	Cymbalta	☐60mg ☐80mg	/	/	
	venlafaxine	Effexor	☐150mg ☐200mg ☐225mg	/	/	
	venlafaxine XR	Effexor XR	☐75mg ☐100mg ☐150mg	/	/	
	levomilnacipran	Fetzima	☐40mg ☐80mg ☐100mg	/	/	
	milnacipran	Savella	☐100mg	/	/	

(ATYPICAL) ANTIDEPRESSANTS / OTHER MEDICATIONS

Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	agomelatine	Valdoxan, Thymanax	☐25mg ☐50mg ☐75mg	/	/	
	esketamine	Spravato	☐56mg ☐84mg	/	/	
	brexanolone	Zulresso	☐Infusion	/	/	
	alprazolam	Xanax	☐0.25mg ☐0.5mg ☐mg ☐2mg	/	/	
	NRX-100	IV Ketamine	☐Infusion	/	/	

NDRI (Norepinephrine-Dopamine Reuptake Inhibitors) / Atypical Antidepressants

Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	bupropion	Wellbutrin	☐300mg	/	/	
	bupropion XL	Wellbutrin XL	☐150mg	/	/	
	bupropion SR	Wellbutrin SR	☐100mg ☐150mg	/	/	
	nefazodone	Serzone	☐200mg ☐300mg ☐400mg	/	/	
	mirtazapine	Remeron	☐100mg ☐150mg	/	/	

TCA (Tricyclic Antidepressants)						
Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	amitriptyline	Elavil	50mg 100mg 150mg	/	/	
	clomipramine	Anafranil	150mg	/	/	
	desipramine	Norpramin	00mg 200mg	/	/	
	imipramine	Tofranil	50mg 100mg 150mg	/	/	
	maprotiline	Ludiomil	25mg 50mg 75mg	/	/	
	nortriptyline	Pamelor	100mg 150mg	/	/	
	protriptyline	Vivadil / Vivactil	40mg 60mg	/	/	
	trimipramine	Surmontil	50mg 100mg 150mg	/	/	
	doxepin	Sinequan	50mg 100mg 150mg	/	/	

MAOI (Monoamine Oxidase Inhibitors)						
Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	phenelzine	Nardil	60mg 80mg 90mg	/	/	
	selegiline	Emsam	6mg 12mg	/	/	
	isocarboxazid	Marplan	30mg	/	/	
	tranylcypromine	Parnate	30mg 50mg 60mg	/	/	

SARI (Serotonin Antagonist and Reuptake Inhibitor)						
Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	desyrel	Trazodone	150mg 200mg 400mg	/	/	
	vortioxetine	Trintellix	10mg 20mg	/	/	
	nefazodone	Serzone	300mg 00mg 00mg	/	/	

MOOD STABILIZERS						
Office Use	GENERIC NAME	BRAND NAME	DOSE (MAX REACHED)	START DATE (MM/YY)	END DATE (MM/YY)	DISCONTINUE REASON
	aripprazole	Abilify	2mg 5mg 10mg 15mg 20mg 0mg	/	/	
	eskalith	Lithium	300mg 800mg 1000mg 1200mg 500mg	/	/	
	carbamazepine	Tetretol	300mg 800mg 000mg 1200mg 500mg	/	/	
	carbamazepine X	Equettro	00mg 800mg 1000mg 1200mg 500mg	/	/	
	divalproex	Depakote	750mg 1500mg	/	/	
	lamotrigine	Lamictal	50mg 100mg 200mg 300mg 400mg 500mg	/	/	
	brexpoprazole	Rexulti	1mg 2mg 3mg 4mg	/	/	
	oxcarbasepine	Trileptal	200mg 2400mg	/	/	
	quetiapine	Seroquel	25mg 50mg 100mg 200mg 00mg 00mg 500mg 00mg	/	/	
	lurasidone HCL	Latuda	40mg 80mg 80mg	/	/	
	olanzapine	Zyprexa	5mg .5mg 10mg 20mg	/	/	
	ziprasidone	Geodon	20mg	/	/	
	busperone	Buspar	10mg	/	/	
	asenapine	Saphris	mg g	/	/	

Please enter any medications to treat your depression not listed above

Consent to Treatment

I consent to be treated by Long Island Neurocare Therapy. I hereby consent hereby grant permission to Long Island Neurocare Therapy to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations. I understand that I am fully responsible for all charges and fees for services rendered to me by Long Island Neurocare Therapy. I will pay my co pay, coinsurance or deductible at the time of my appointment unless other arrangements have been made. I authorize payment by my insurance company to pay directly to Long Island Neurocare Therapy. I authorize Long Island Neurocare Therapy to release necessary information to my insurance company to receive payment of claims.

I am aware that the practice of medicine and mental health services are not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

_____ _____

Patient signature Date

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Date: _____

Signature: _____ Relationship to patient: _____

Medical Practice Commitments and Expectations

Welcome to Long Island Neurocare Therapy. Our primary goal is to provide all our patients with the best care possible in an effective and efficient fashion. Establishing commitments and expectations at the start of our work together will ensure a mutually satisfying treatment relationship. Please review the following items and sign at the end of the document to indicate your agreement with the terms. If you have any questions or concerns, please let us know so that we can address them.

(Initial please) _____

Keeping Appointments

Keeping your scheduled appointments is a crucial part of your treatment process. We understand that unexpected events can occur and may sometimes make it challenging to attend your appointment. Our TMS Technicians are committed to working with you to create a TMS schedule that best meets your needs.

If you find yourself unable to attend your appointment, we kindly request that you provide us with at least 24 hours' notice (during business days) so that we can adjust our schedule accordingly. Please note that Long Island Neurocare Therapy may charge a fee for missed visits on a case-by-case basis.

(Initial please) _____

Contacting the Clinic

You can reach us by phone at (631) 714-4100 or by fax at (631) 714-4191 during our regular office hours, Monday through Friday from 9:00 AM to 5:00 PM. If you call and we don't answer, please leave a message. We may be on the phone or away from our desk, but we'll return your call as soon as possible. For calls received after hours, we'll respond on the next business day. In the event of a life-threatening emergency, please call 911 or go to the nearest emergency room.

(Initial please) _____

Confidentiality

Please be assured that all information pertaining to your treatment will be kept strictly confidential. Your records will not be accessible to anyone without your explicit written consent, which would specify the release of particular information to a designated individual or entity. Please note that while we maintain strict confidentiality, there may be extraordinary circumstances where this confidentiality might need to be breached. This includes situations where your safety or the safety of others is at risk, or if a court of law subpoenas your records. In any such event, we will make every effort to contact you in advance.

(Initial please) _____

Our Agreement

It is possible that your treatment may involve multiple doctors within this practice. Our contract demonstrates our commitment to addressing your concerns and helping you achieve the goals we have mutually agreed upon. Your signature grants consent for communication between these doctors to coordinate your treatment effectively.

(Initial please) _____

Termination of Treatment

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your doctor.

(Initial please) _____

Medicare Primary Coverage (Assignment of Benefits)

I hereby assign to you all medical benefits to which I am entitled, including major medical benefits from Medicare and any secondary insurance provided as crossover.

This assignment will remain in effect until I revoke it in writing. I understand that I am financially responsible for all charges, regardless of whether they are paid by insurance. I authorize you to release any information necessary to secure the payment of these benefits.

(Initial please) _____

Special Circumstances

We make every effort possible to respect the wishes of our patients. However, Long Island Neurocare Therapy or any of its affiliates are not responsible for maintaining financial arrangements made between separated or divorced parents or couples under any circumstances. If there is a financial agreement between such parties, we respect your privacy and require that you manage those arrangements. For financial responsibility in these types of cases, the person whose signature is on file on the registration paperwork is deemed the party responsible for payment. We cannot acknowledge financial responsibility for a party who is not present to agree to the terms provided. (Statement can be provided to the responsible party, upon request, for proof of payment to other parties).

(Initial please) _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be your dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protection when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included by not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement official for any circumstance requires by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials to protect the Present, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights regarding your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to remove it.
- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION,
- The right to request an amendment to your PROTECTED HEALTH INFORMATION,
- The right to receive an accounting of disclosures of PROTECTIVE HEALTH INFORMATION outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice is upon request.

We are required by law to maintain the privacy of your PROTECTIVE HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

To comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ **Date:** _____

Signature: _____

Relationship to patient: _____

Insurance and Financial Policy

- Any outstanding balances, co-payments, and deductibles must be paid before your appointment.
- Long Island Neurocare Therapy accepts most insurance plans. Any contract that obligates your insurance carrier to pay for a portion of your healthcare is between you and your insurance carrier. Long Island Neurocare Therapy, in collaboration with the patient, will be in contact with insurance carriers to verify benefits and facilitate the reimbursement process for services rendered. Depending on the insurance plan, your financial responsibility for services rendered will vary based on deductibles and out of pocket maximums.
- A financial agreement between Long Island Neurocare Therapy and the patient will be reviewed, discussed and agreed upon prior to the start of treatment.
- Long Island Neurocare Therapy staff will obtain all authorizations on your behalf required by your insurance plan, including the clinical explanation for medical necessity. If it is necessary for insurance authorization and approval, Long Island Neurocare Therapy will request patient assistance.
- Long Island Neurocare Therapy will make every effort to verify your benefits and obtain pre-authorization and will communicate the results to you. However, benefit checks and pre-authorization do not guarantee payment. If your insurance provider denies coverage or provides different coverage than communicated to us, you may be responsible for payment.
- We accept all major credit cards including Visa, Master Card, American Express, Discover, Check and Cash payments.
- Insurance does not cover missed appointments. Therefore, we allow up to three (3) missed appointments with proper 24-hour notification. Any missed appointments beyond three, regardless of notification, will incur a cancellation fee. Please note that failure to receive a reminder does not waive this fee; you are responsible for remembering your appointment dates and times. Long Island Neurocare Therapy reserves the right to bill $75 for appointments cancelled with less than 24 hours' notice, as well as for scheduled appointments that you do not attend. Depending on your appointment type, you may receive a courtesy reminder call two nights prior to your appointment.
- In the unlikely event that you default on payment for any amount due, we will place your account in the hands of our attorney for collection or legal action. You will then be charged an additional fee equal to the cost of collection, including attorney fees and court costs incurred as permitted by the laws governing these transactions. Once this occurs you will forfeit the opportunity to be treated in our practice.

By signing this document, you agree to our policy and acknowledge that you have read and fully understood its contents.

Patient Name: _____ Date: _____

(Parent or guardian, if patient is a minor)

Patient 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:

8. Name and address of person(s) or category of person to whom this information will be sent:

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.**