SHARON NEUROLOGY - REGISTRATION FORM

(Please Print)

Today's date:	PCP: / Referring Dr.:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	**Cell phone no.:** ( )
		Email:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑Internet search:	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]	❑ [Insurance]
❑ [Insurance]	❑ [Insurance]	❑ [Insurance]		❑ Other	

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Sharon Neurology or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

NAME_____ DATE:_____

AGE_____ DATE OF BIRTH _____

WEIGHT_____ HEIGHT_____ ALLERGIES_____

PREGNANT? _____ SMOKING_____

GENERAL MEDICAL INFORMATION

REASONS FOR VISIT

_____

_____

_____

ALL MEDICATIONS BEING TAKEN

_____

_____

_____

_____

OTHER PHYSICIANS TREATING YOU_____

PREVIOUS HOSPITALIZATIONS AND SURGERIES

_____

PAST MEDICAL HISTORY

	Mother	Father	Children	Siblings	Grandparents
Alcohol					
Blood pressure					
Back problems					
Headaches					
Stroke					
Diabetes					
Mental illness					
Heart Attack					
Stroke					
Epilepsy					
Cancer					
Arthritis					
Thyroid					

MEDICAL PROBLEMS (Please check all that apply)

__Arthritis
__Cataracts
__Memory
__Dizziness
__Balance
__Asthma
__Skin
__Vision
__Neck pain
__Back pain
__Legs
__Feet
__Chest pain
__Depression
__Hypertension
__Heart
__Fatigue
__Cancer
__Diabetes
__Stomach
__Headaches
__Ulcer
__Seizures
__Anxiety
__Balance
__Weakness
__Thyroid
__Chest pain
__Sensations

PHARMACY Name:
Pharmacy Address & Phone:

Medications and dosage:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

Allergies:

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Brooklyn, NY 11209
(718)680 8105

345 Seaview Avenue
Staten Island, NY 10305
212) 945 4554

Info@sharonneurology.com
www.sharonneurology.com

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth_____

I have received and understand Sharon Neurology Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, Sharon Neurology will provide me a revised Notice of Privacy Practices upon request.

Signature_____

Date_____

Relationship to patient (if signed by a personal representative of patient)

_____

New Patient

Office Guidelines

SHARON NEUROLOGY

From *9am to 5pm* ONLY
We can be reached at 718-680-8105 on Tuesdays and Wednesdays
We can be reached at 212-945-4554 on Mondays and Thursdays
We can email with all non-urgent medical matters: *isharonmd@nyc.rr.com*

1. I understand that Dr. Sharon will refer me to another physician specialist (and terminate my treatment) if I have failed to keep or cancelled three appointments without notifying this office. There is a mandatory cancellation charge that will be assessed at the next visit for any missed appointment.
2. I understand that Dr. Sharon can terminate my treatment if I am abusing any illegal drug or alcohol.
3. I understand that Dr. Sharon has no emergency service on Friday Saturday or Sunday. I understand that I will go to the emergency room of the closest hospital in my area in case of emergency.
4. I understand that it is my responsibility to make sure that I have enough medication and medication refills so that I do not run out of my medications prematurely at the last minute prior to the next appointment.
5. I understand that Dr. Sharon may terminate treatment if I do not comply with his recommendations for the management of my conditions.
6. I understand it is my responsibility to notify office immediately upon change in insurance.
7. I understand the following elements of informed decision-making
   discussion of my role in the decision-making process
   discussion of the clinical nature of my decision
   discussion of alternative treatments
   discussion of the potential benefits and risks of the alternatives
   discussion of uncertainties associated with my decision

Offices are closed on the following dates every year:
Fridays, Saturdays, Sundays
Jewish New Year (Rosh Hashanah) & Yom Kippur
Christmas week & New Year's week (last week of December and first week of January)
Passover & Easter weeks

Name Date

Idan Sharon, M.D. Date

Patient Name_____ DOB:_____ Date:_____

Patient Acknowledgements : IDAN SHARON MD PC Office Policies

To be completed by ALL PATIENTS. If the patient is under the age of 18, this form is to be filled out by his/her PARENT or Guardian. Please read each item below and initial the space provided.

-Insurance Information/ Co-payments and Deductible

Payment is required for all services at the time they are rendered. If this office accepts my insurance, I understand that I am still responsible for paying any co-payment and deductible that my insurance does not cover. **I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of treatment rendered.** Checks returned for insufficient funds will be charged an additional $50 fee. Your signature below signifies your understanding and wiliness to comply with this policy.

-Referral Information

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referral and obtain new ones as needed. **I understand that should I fail to present a valid referral, I may be responsible for any charges pursuant to for specialist treatment.**

-Insurance Cards

New Patients or those patients who change insurance plans must provide a valid insurance card at the time of the visit. Should you be unable to produce this documentation, patients may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. I understand that **I am responsible for notifying the office of any changes to my insurance or contact information.**

-Cancellation Policy

Should you be unable to keep your appointment, please contact our office. Failure to contact the office within 24 hours of your appointment will result in a $50 cancellation fee.

-Statement of Financial Responsibility

As a courtesy to our patients, our office will bill private insurance all procedures. A statement will be sent out explaining the status of your account, and following statements may reflect any remaining balance. Since the financial responsibility always resides with the patient, we want to keep you informed. For example: if your insurance has not paid within 30 days you may wish to call them directly to confirm payment within 60days. After 60 days we may no longer pursue your insurance company, but you the patient, for payment.

-HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of IDAN SHARON MD PC from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments, or obtain results for you, please indicate their name below.

Name of Individual (please print)	Relationship to Patient

By signing below, I, the patient or parent/guardian for those under the age 18, indicate that I have read, understand, and accept this Patient Acknowledgements listed above and hereby comply with its nature.

_____ Patient/ Guardian Signature

Sharon Neurology
NEUROLOGY & PSYCHIATRY

MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Sharon Neurology is committed to providing exceptional care. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen. **Should you need to cancel or reschedule an appointment, please call the office (Monday and Thursday @ 212-945-4554, Tuesday and Wednesday @ 718-680-8105) by 2pm on the day prior to your scheduled appointment or test to notify us of any changes or cancellations. To cancel a Monday appointment, please call the office by 2pm on Thursday, or email manager@sharonneurology.com.**

If no prior notification is given, or if the appointment is canceled on the same day, you will be charged **$50 fee.** The fee will be charged to the patient (not the insurance), and is due at the time of the next patient's visit.

Repeatedly missing appointments jeopardizes your care. For this reason, after **an established patient** misses three (3) appointments because of no-show or late cancellation, that patient **will be discharged** from practice.

Any **new** patient who fails to show for their initial visit, will **not** be rescheduled.

We understand that there may be times an unforeseen emergency occurs and you may not be able to keep your scheduled appointment or cancel in time. Should you experience difficult circumstances, please contact us at manager@sharonneurology.com, and we may be able to waive the fee.

I have read and understand Medical Appointment Cancellation/No Show policy and agree to its terms

Print name	Signature	Date
_____	_____	_____