Niagara Neurological Services & Sleep Medicine
7220 Porter Road
Niagara Falls, NY 14304
716-575-0075

Today's date:	**Primary Doctor:**

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.:	Home phone no.: ( )

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

Occupation:	Employer:	Employer phone no.: ( )

How did you hear about our office?

Pharmacy Name & Phone Number:

IN CASE OF EMERGENCY

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

HIPPA Compliance Form

Your confidentiality is very important to us. HIPPA privacy rules state that your authorization is required for our office to communicate with members of your family or other health care providers. We would like to give you prompt information regarding appointments, prescriptions, medical treatment, laboratory work, and imaging reports. The following questions will help us determine how we get this information to you:

1. May we call your home for the above? Yes / No
2. When we call, is it acceptable for us to identify that we are Niagara Neurology calling regarding the above, including when we leave a message? Yes / No
3. Do you authorize us to discuss the above with other members of you household? Please note we will not discuss or release any information to anyone unless they are listed below. Yes / No

Please list names and relationship of the individuals we may speak to on your behalf

-
-

_____
Patient Name (Printed)

_____ Witness: _____
(Patient Signature) (Date)

OFFICE POLICIES & PROCEDURES FOR OUR PATIENTS

APPOINTMENTS:
Niagara Neurology & Sleep Medicine is committed to providing quality care to our patients. To ensure timely continued care, we encourage patients to schedule appointments in advance of follow-up due dates.
Follow up may be required to be scheduled after testing has been completed, so that results may be reviewed together, so an effective and appropriate plan for your healthcare care can be determined. If any testing needs to be order, an appointment may be required to see the provider.

PRIVACY PRACTICES:
I understand I have the right to review Niagara Neurology & Sleep Medicine's Notice of Privacy Practices signing this document, which would be provided to me upon request.

CANCELLATION & NO SHOW POLICY:
We require advanced notice for any appointment changes. If you miss an appointment there will be a $25.00 fee, this charge will be the patients responsibility and will not be billed to your insurance company. ****Failure to reschedule your canceled or missed appointment; may result in discharge from the practice.****

INSURANCE:
Niagara Neurology & Sleep Medicine accepts most insurance plans. If you have any questions regarding your insurance, please contact our billing department at **(716) 650-5745**.
I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan, to issue payment check(s) directly to Niagara Neurology & Sleep Medicine from medical services rendered to myself and/or my dependents.
It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so could cause delay or denial of an insurance payment.
Patients are responsible for co-pays at the time of service. If applicable, you will be billed for services not covered by your insurance as stated in your insurance contract. Please note you are also responsible for all deductibles and coinsurance assigned by your plan.
When determined to be appropriate, a home sleep study can be an alternative to a study performed in a lab. Please be aware, both types of studies must be read by a board certified physician. According to the billing codes designated by the American Medical Association, the charge for the home sleep study or in lab sleep study does not include the interpretation. As such, is billed separately.

*Our office ***DOES NOT*** accept Worker's Compensation of No Fault cases. If your condition is the result of an injury at work or a car accident, our providers will not be able to treat you.*

PAYMENTS:
Niagara Neurology & Sleep Medicine accepts cash, personal checks, MasterCard, Discover, Visa and American Express. Checks can be made out to Niagara Neurology & Sleep Medicine.
It is the policy of our office to make all reasonable attempts to collect outstanding balances' should they accrue, including, convenient payment arrangements. Patients with an outstanding balance of 120 days may be discharged from our practice unless a payment arrangement is made. If your insurance is a high deductible plan, you will be required to pay a deposit prior to services being rendered. The deposit will be applied to your total cost, you will be billed for the balance owed or issued a refund for overpayment.
Following these attempts, accounts in poor standing will be outsourced to a third party for the purpose of collection. Any check that is returned, I am responsible for the face value and a $35.00 service charge.

FORMS/LETTERS:
We understand at times, various forms or letters may be required to assist you with your healthcare needs. Some forms or letters may require an appointment to see the provider. If an appointment is not required, please allow 5-7 business days for this to be completed, there may be a **$10.00 fee.**

MEDICAL RECORDS:
Per HIPPA guidelines, copies of medical records must be requested in writing. To ensure privacy, a form for medical record release must be done in advance. All patients may request their medical records one time, free of charge. Any additional records that need to be printed will have a cost of $0.75 per page.

PRESCRIPTION REFILLS / PHARMACY INFORMATION:
Please inform our office if your pharmacy information has changed. If you are in need of a refill please contact the office 1-2 days prior.
If your medication has changed please bring an updated list to your appointment.
Some medication changes or refills may not be done over the phone and may require an appointment.

We must assure a safe work environment for our employees. Sexual advances of any kind upon any of our staff members will result in immediate discharge from our clinic. Discharge in these cases will be at the sole discretion of the treating provider.

By signing below, I acknowledge that I have received, reviewed, and understand, and will comply with the policies and procedures.

_____

Printed Name

_____ _____

Signature Date

Medication Agreement

This agreement is between the patient and Niagara Neurology & Sleep Medicine, PLLC is for the prescription of all medications**.** In an effort to best treat patients we request that all patients review the below, sign and consent to our medication office policies.

1. Refills must be called into our office one week (seven days) before the current prescription runs out.
2. If your prescription coverage is through Medco please allow up to three weeks for a med refills
3. Prescriptions will be provided only during regularly scheduled appointments, this may be every month or every six months.
4. Prescriptions will not be refilled over holidays or weekends, please call our office before 4pm if you need a refill.
5. Please notify the office if you become pregnant as several medications are unsafe during pregnancy
6. We have the right to contact your pharmacy to verify medications.
7. Medications are to be taken only as directed. I will not increase my dose or frequency without discussing this with my physician. I will not discontinue medication without discussing with my physician.
8. Only one pharmacy will be used to fill prescriptions.
9. I understand that the long-term advantages and disadvantages of chronic OPIOD therapy have yet to be scientifically determined and therefore treatment may change throughout my time as a patient. I understand and accept that there may be unknown risks associated with the use of these medications and my doctor will advise me as knowledge advances and I agree to treatment changes on my doctor's recommendations.
10. I will not sell, share, or trade my medication for money, goods or services.
11. I understand that my doctor is under no obligation to provide these medications to me, and that she or he reserves the right to discontinue these medications at any time.
12. I understand that medications have potential side effects & will review any concerns with the prescribing physician and pharmacist.
13. I agree to cooperate with random drug testing, which may be requested at any time. If you refuse, you understand the medication will be stopped and it may result in possible discharge from the practice.
14. I understand lost or stolen medications will not be refilled under any circumstances. It is your responsibility to protect and secure any medications. This includes keeping the medication out of the reach of children. A copy of the police report will be required for any lost or stolen narcotics or narcotic prescriptions.
15. I understand that Niagara Neurology & Sleep Medicine does not specialize in pain management.
16. You will not forge or alter prescriptions.
17. I agree to fill my prescription at only at the pharmacy I list below. If I change pharmacies, I will contact my doctor's office and provide them with the name, address, and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. In order to verify appropriate medication use, my doctor's office will provide my chosen pharmacy with a copy of this agreement.

Pharmacy Name & Address: _____

Pharmacy Phone Number: _____

I understand that by signing this agreement I must abide by the rules reviewed above and that failure to abide by these agreements will result in the termination of medication prescriptions and possibly the termination of services from my doctor and his or her practice.

_____
Patient Name (Printed)

_____
(Patient Signature) (Date)

Physician Signature _____ Date _____

Patient History Form

Note: This is a confidential record and will be kept in our office.
Chief Complaint (The reason for your visit today)

_____
_____

Medical History (Do you have any of the following? Please check all that apply to YOU

___High Blood Pressure ___Stroke ___Heart Failure ___Heart Attack
___A-fib ___Diabetes ___High Cholesterol ___Asthma/COPD
___Migraines ___Sleep apnea ___Liver Disease ___Seizure
___Blood clots ___Thyroid disease ___Cancer ___Fibromyalgia
___Restless Legs

___Other_____

Surgical History

___Tonsillectomy (or T&A) ___Back/Neck surgery ___Pacemaker/Defibrillator

___Other_____

Are you taking any medications? YES / NO
Please list name of medication, strength, and frequency

_____
_____
_____
_____
_____

Do you have any allergies? If so, please list reactions. **YES / NO**

If yes please list _____

Review of Systems

Are you currently experiencing any of the following? (Please check all that apply)

___ Fever ___ Blurred vision ___ Skin Rash ___ Sore throat
___ Shortness of breath ___ Numbness/tingling ___ Chest pain ___ Excessive thirst
___ Tired/Sluggish ___ Neck Pain ___ Nausea/vomiting ___ Anxiety
___ Back Pain

____**NONE** of the above
____Please Initial

For office use only:

HT: WT: BP: P:

Physician:_____ Date: _____

Next appt scheduled for: _____
Check PMP: _____
Testing Order: _____
Patient Instructions: _____