

# PRINCETON AND RUTGERS NEUROLOGY, P.A.

## MEDICATION LOG SHEET

Patient's Name: \_\_\_\_\_ Acct #: \_\_\_\_\_ DOB: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

Being seen by:

- Dr. Behar
- Dr. Menken
- Dr. Friedlander
- Dr. Greenberg
- Dr. Hersh
- Dr. Dixit

**KNOWN ALLERGIES:** \_\_\_\_\_

Current Medications:	Strength/Dose:	Prescribed by:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\_\_\_\_\_  
Prepared by

\_\_\_\_\_  
Date

**PRINCETON & RUTGERS NEUROLOGY, P.A.**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Last City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
First

Tel # (h): \_\_\_\_\_ Tel # (w): \_\_\_\_\_ CELL #: \_\_\_\_\_

**Preferred method of contact: ( ) Home phone; ( ) Work phone; ( ) cell phone**

S.S. #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Email Address: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Single: \_\_\_\_\_ Married: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Race:  American Indian  Asian  Black/African American  Nat Hawaiian / Pacific Islander  Other  
race  Unknown  White  Declined

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown  Declined

Religion: \_\_\_\_\_

Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: \_\_\_\_\_

MEDICAL INSURANCE Yes: \_\_\_\_\_ No: \_\_\_\_\_ Co- pay Amount: \_\_\_\_\_ Referral Plan? \_\_Y \_\_N

**Are your injuries sustained from a motor vehicle accident no ( ) yes ( ) If yes please notify receptionist**  
**Are your injuries sustained from a Worker's Comp case no ( ) yes ( ) If yes please notify receptionist**

Insurance Company (**Primary**): \_\_\_\_\_ Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance Company (**Secondary**): \_\_\_\_\_ Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Name of Policyholder (If different from patient):** \_\_\_\_\_

Address of Policyholder: \_\_\_\_\_

Birth Date of Policyholder: \_\_\_\_\_ Social Security #: \_\_\_\_\_

**Referring Physician** (First and Last Name):  
\_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Primary Care Physician (**If different from referring physician**): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**Pharmacy Phone #:** \_\_\_\_\_ **Pharmacy Fax #:** \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name

Relationship

ASSIGNMENT OF BENEFITS: I request that assignment of authorized Medicare/Other Insurance Company benefits be paid either to me or on my behalf Princeton & Rutgers Neurology for any services furnished me by that party who accepts 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.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

**PRINCETON & RUTGERS NEUROLOGY, P.A.**

**PATIENT INFORMATION FORM**

NAME: \_\_\_\_\_ DATE OF EXAM: \_\_\_\_\_

**Review of Systems:**

***Are you presently experiencing any of the following symptoms? (a check is required on each line)***

- fever  weight loss  loss of sleep  fatigue  not applicable
- loss of vision  blurred or double vision  jagged lines  kaleidoscopic colors  none
- shortness of breath  swelling in legs  chest pain  palpitations  none
- hearing loss  ringing in ears  vertigo  lightheadedness  dizziness  none
- cough  asthma  coughing up blood  not applicable
- loss or excessive appetite  nausea  vomiting  heartburn  stomach pain  none
- constipation  diarrhea  blood in stools  none
- burning with urination  frequent urination  sexual dysfunction  none
- tremor  paralysis  poor balance  convulsions  restless legs  memory loss  none
- rash  itching in feet  none
- depression  hallucinations  agitation  anxiety  phobias  none

***Are you under a great deal of stress?***

- yes  no

***Past Medical History (a check is required on each line)***

- diabetes  high blood pressure  angina  heart attack  stroke  bronchitis  none
- fainting  cancer  epilepsy  infections  high cholesterol  none
- other (please explain) \_\_\_\_\_

***Do you smoke cigarettes?***  no  yes (how many) \_\_\_\_\_

***Do you drink alcohol?***  no  yes (how much and how often) \_\_\_\_\_

***Family History: (please check if yes)***

- high blood pressure  diabetes  seizure disorder  migraines  none
- other (please explain) \_\_\_\_\_

***Do you have any allergies?***  no  yes (please explain) \_\_\_\_\_

***Why are you here today?*** \_\_\_\_\_

I have reviewed the above history: \_\_\_\_\_

Physician

## **PRINCETON & RUTGERS NEUROLOGY, P.A.**

Matthew Menken, M.D./Roger Behar, M.D.

Devin Friedlander, M.D./Jeffrey Greenberg, M.D.

Seema Dixit, D.O./Joshua Hersh, M.D.

### **OUR FINANCIAL POLICY**

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.

#### **REGARDING INSURANCES:**

- 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.
- If you have an HMO plan with whom we have a contract, a proper referral from your Primary Care Physician is necessary 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 on your card, 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.
- If you have a PPO plan with whom we have a contract, you will be responsible for the co-pay if listed on your card. **If you have not met your deductible, 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 will be expected.**
- 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.

#### **REGARDING MEDICARE PATIENTS:**

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

**NON PARTICIPATING INSURANCES AND SELF-PAY PATIENTS:**

- 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 you 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/PAYMENT PLANS:**

- 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.

**DELINQUENT ACCOUNTS:**

- Delinquent accounts will be subject to monthly billing charges until the account is settled in full.

**OUR CANCELLATION POLICY:**

- We require 24 hours' notice for all cancelled 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.
- In addition there will be a \$25.00 charge for all no-shows.

**Thank you for your understanding of our financial policy. Please let us know if you have any questions or concerns and you will be referred to the appropriate individual.**

---

I have read the above Financial Policy and understand and agree with its terms.

Signature	Print Name	Date
51 Veronica Avenue Somerset, NJ 08873 732-246-1311 Fax 732-214-9657	9 Centre Drive, Suite 130 Monroe Twp, NJ 08831 609-395-7615 Fax 609-395-1885	601 Ewing Street, Bldg B, Ste 5 Princeton, NJ 08540 609-497-0300 Fax 609-497-0339

**PRINCETON & RUTGERS NEUROLOGY, P.A.**

Matthew Menken, M.D./Roger Behar, M.D.

Devin Friedlander, M.D./Jeffrey Greenberg, M.D.

Seema Dixit, D.O./Joshua Hersh, M.D.

**M' CARE & INSURANCE AUTHORIZATION & ASSIGNMENT → (ALL PATIENTS TO SIGN)**

I request payment of Medicare and/or participating managed care products be made payable to Princeton and Rutgers Neurology on my behalf for any services provided to me by this Practice. I authorize the release of any information about me to Medicare and/or other participating managed care products and its agents that may be needed to determine these benefits.

**DIAGNOSTIC TESTING → (ALL PATIENTS TO SIGN)**

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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**MANAGED CARE PLANS → (PATIENTS WITH MANAGED CARE PLANS)**

In order for your visit and/or testing to be covered by your insurance, you may be required to provide this office with a valid referral issued by your primary care physician. If the referral we have for you on file has expired, or you do not bring a referral with you as needed, you will have two options; to reschedule your appointment, or pay upfront for all services provided to you today.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**NON PAR INSURANCES → ( PATIENTS WHOSE INSURANCES WE DO NOT PAR WITH)**

I am aware that Princeton and Rutgers Neurology does not participate with my health insurance. Therefore, payment is expected at the time of service unless prior arrangements have been made.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

❖ **FINANCIAL RESPONSIBILITY FOR PAYMENT**

I am aware that due to any of the reasons listed below, it may be possible that my insurance carrier will deny payment for services rendered to me today. In that event, I understand that I will be financially responsible for those charges.

- I do not have my insurance card with me.
- I do not have a valid referral for this visit.
- This office does not participate with my insurance carrier.
- I do not have health insurance and will pay for my visit today.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

# PRINCETON AND RUTGERS NEUROLOGY

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

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.

We may contact you by mail or phone 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:

( ) Home \_\_\_\_\_ ( ) Work \_\_\_\_\_ ( ) Cell \_\_\_\_\_

*The people listed below 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**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**