NEUROLOGY SPECIALISTS of Monmouth County, NJ
107 Monmouth Rd #110
West Long Branch, NJ 07764
732-935-1850

We are grateful that you have chosen our practice for your medical needs. We look forward to seeing you at your initial appointment.

It is extremely important to us that you bring all items necessary so that we may provide a comprehensive medical examination and correctly handle the financial aspects of your account.

Please bring with you:

Medical Information

- ✓ Results of any recent blood work
- ✓ MRI and/or CAT Scan reports
- ✓ MRI and/or CAT Scan films
- ✓ Any other recent test results and reports
- ✓ Completed Health History Form (included in this packet)
- ✓ List of all current medications

Financial Information

- ✓ Insurance card(s)
- ✓ Referral Form from your primary care physician and made out to Neurology Specialists (or the doctor you are scheduled with)
- ✓ Completed and Signed Registration Form (included in this packet)
- ✓ Signed Financial Policy (included in this packet)
- ✓ Completed and Signed Consent for Use and Disclosure of Private Health Information (included in this packet)
- ✓ Completed and Signed Records Release Authorization (included in this packet)

Directions to our office:

From Garden State Parkway North or South:
Exit 105 onto Route 36 East. Follow Route 36 East through 5 traffic lights. At the 6th light, you will make a left onto Route 71 North (Monmouth Road.) We are located in the Atlantic Executive Center which is approximately ¼ mile on the left. Our office is in the front building.

From Route 18 North and South:
Exit 13B onto Route 36 East. Follow Route 36 East through 5 traffic lights. At the 6th light, you will make a left onto Route 71 North (Monmouth Road.) We are located in the Atlantic Executive Center which is approximately ¼ mile on the left. Our office is in the front building.

Name: ______________________________ Date ____/____/____

• CONSTITUTIONAL SYMPTOMS

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

• EYES

Eye Pain	No	Yes
Wear glasses/contact lens	No	Yes
Blurred vision	No	Yes
Double vision	No	Yes

• EARS - NOSE - MOUTH - THROAT

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice changes	No	Yes
Swollen glands in neck	No	Yes

• CARDIOVASCULAR

Chest pain or angina pectoris	No	Yes
Palpitation	No	Yes
Shortness of breath with walking or lying flat	No	Yes
Swelling of feet, ankles or hands	No	Yes

• RESPIRATORY

Chronic or frequent coughs	No	Yes
Spitting up blood	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

• GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Painful bowel movements or constipation	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain or heartburn	No	Yes

• GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of stream when urinating	No	Yes
Incontinence or dribbling	No	Yes
Sexual difficulty	No	Yes
Male - testicle pain or lump	No	Yes
Female - pain with periods	No	Yes
Female - irregular periods	No	Yes
Female - vaginal discharge	No	Yes

Female - # pregnancies _____ # miscarriages _____

• MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

• INTEGUMENTARY (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

• NEUROLOGICAL

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

• PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

• ENDOCRINE

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

• HEMATOLOGICAL - LYMPHATIC

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

• ALLERGIC - IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin other antibiotics	No	Yes
Morphine, Demerol or other narcotics	No	Yes
Novacain or other anesthetics	No	Yes
Aspirin or other pain remedies	No	Yes
Tetanus antitoxin or other serums	No	Yes

Iodine, methiolate or other antiseptic

Other drugs / medications ______________________

____

Known food allergies: ______________________

____

HEALTH HISTORY

PAST MEDICAL HISTORY: *Check (✓) conditions you have or have had in the past;*

✓

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Drug Use
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Eye Disease or Injury
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Head Injury
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure / Hypertension
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease / Stones
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Polio
- ☐ Prostate Disease
- ☐ Psychiatric Disease
- ☐ Rheumatic Fever
- ☐ Sinus Disease
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Disease
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcer Disease
- ☐ Venereal Disease

Other Serious Illnesses or Injuries: ______________________________

____

____

MEDICATIONS - *List medications you are currently taking:*

____

____

____

____

____

Pharmacy Name: ______________________ *Phone :* ______________________

SOCIAL HISTORY:

# of children ________ Marital Status: ______________ Occupation: ______________

Family History:

✓ DISEASE	RELATIONSHIP TO YOU
☐ CANCER	
☐ DIABETES	
☐ EPILEPSY	
☐ HEART DISEASE	
☐ HIGH BLOOD PRESSURE	
☐ HIGH CHOLESTEROL	
☐ MIGRAINE	
☐ STROKES	
☐ OTHER	

NEUROLOGY SPECIALISTS PATIENT REGISTRATION FORM

Patient____Date____________________
(Full name)

Street:_________________________________City:_____________State:______Zip:________

Home Phone: (___)_______________________ Cell Phone: (__)_____________________________

Date of Birth: _____________________ Age:__________ Sex: Male_____ Female______________

Race:___________________Ethnicity:____________________Language:__________________

E-mail address:____

Marriage Status: Single Marriage Divorced Widowed Other

Your Pharmacy:_______________________Town:_______________Phone #:____________

Emergency Contact: Name:______________________________Phone:(____)_______________

Referred by:____________________Date of Last Physical:_______________ by Whom___________

Family M.D. ______________________Address:___________________________________

SS#:___________________________

Primary Ins. Co:____Policy #:_________________

Name of Insured:_________________________________Group #:______________________

SS. # of Insured: ___________________D.O.B of Insured___/___/____Relationship:_____________

Secondary Ins. Co.:_____________________________Policy #:_________________________

Name of Insured:___________________________________Group #:______________________

SS.# of Insured:__________________D.O.B of Insured:____/___/____Realtionship:______________

***Patient under 18/Responsible Party-Name:____

Date of Birth: ___/___/____ Address:____

Phone: (___)_______________________ Relationship to Patient:_________________________

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE, AND THAT FAILURE TO PAY BILLS OR RTURNED CHECKS MAY INCUR ADDITIONAL FEES AND/OR COLLECTION FEES. I AUTHORIZE NEUROLOGY SPECIALISTS TO FURNISH INFORMATION TO REFERRUNG OR CONSULTING DOCTORS CONCERNING MY ILLNESS AND/OR TREATMENT.

Patient Signature:______________________________________Date:______________________

NEUROLOGY SPECIALISTS of Monmouth County, NJ

FINANCIAL POLICY

We are pleased that you have chosen Neurology Specialists for your healthcare needs. It is our goal to provide you with the highest quality healthcare services possible. In choosing our services, you have accepted the financial responsibility to ensure full payment for our services.

OUR POLICY REGARDING:

- Copayments: Your copayment, as stated on your insurance card, will be collected from you prior to your visit. You may make your payment either by cash, check, or credit card. We gladly accept Visa, MasterCard, and Discover cards for payment.
- Private Pay: Patient agrees to pay Neurology Specialists at the time of treatment for services rendered. We will provide a statement which can be used to submit claims for reimbursement or kept for personal records.
- Medicare: Neurology Specialists is a participating provider with Medicare Part B program. We will bill Medicare directly for services rendered. You will be responsible for any deductibles and coinsurance.
- Medicaid: Neurology Specialists is a participating provider in Amerigroup only. Any other Medicaid insurance Neurology Specialists in a NON Participating provider and you will be given a patient waiver. You will be responsible to pay for any deductibles, coinsurance or copays stated by your primary health insurance. If you had a change in insurance and Amerigroup is no longer your primary insurance coverage you will be held responsible for the bill.
- HMO/PPO/POS: Our office participates in most HMO, PPO, and POS plans. You are responsible at the time of service for any copayment stated on your insurance identification card. Any additional amounts due by you will be billed to you once your insurance processes the bill.
- Major Medical: Your major medical insurance coverage is a contract between you and your insurer. As a courtesy to you Neurology Specialists will bill your insurance carriers directly. You are responsible for any deductible, co-payments, or coinsurance that is determined by your insurance carrier.
- Out of Network Carrier: Our practice does not participate with your plan. It is the policy of your carrier that you pay us at the time of your visit and receive reimbursement from them. We will provide you with a statement which you can submit to your carrier directly.
- Workers' Compensation/Motor Vehicle Accident: Neurology Specialists will bill your insurance carrier for you directly. Should your claim be found non- compensable, we will bill your private insurance. You will be responsible to pay for patient responsibility as stated by your health insurance. It is not our policy to await the results of your litigation to receive payment; we will not hold a Letter of Protection or Lien on your account. We do not waive any financial responsibility in litigation cases.
- Referrals/Authorization: You are responsible for obtaining a referral or authorization as required by your insurance for our services. You may be financially responsible for any charges denied due to absence of a referral or authorization. Your scheduled visit may also be rescheduled due to the absence of a referral or authorization.
- Cancellation Policy: If you fail to call and cancel you appointment, you will be billed a cancellation fee of $25.00 which your insurance company will not pay.
- Returned Checks: If your personal check is returned to us by your bank for any reason, you will be charged a fee of $25.00. Both your original payment and check fee are payable in cash or credit card. Any future payments you need to make to our office must be either cash or credit card.

I have read the above policy regarding my financial responsibility to Neurology Specialists for providing medical care to me or the below named patient. I understand that my failure to comply with the financial policies of Neurology Specialists may cause interruptions in my medical care. I understand that it is my responsibility to inform this office of any correspondence that I received from my insurance company notifying me of a change or cessation of my insurance coverage.

Patient Name_______________________________ Signature_______________________________ Date______________

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of *Practice's Notice of Privacy Practice*:

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practice (NPP), and that I have read (or had the opportunity to read if I choose) and understand the Notice of Privacy Practice (NPP) and agree to its terms.

______________________	__________	____________________________	________
Name of Patient	Date of Birth	Signature of Patient/Parent/Gaurdian	Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:____

Print Name:____

Print Name:____

III. Request to Receive Confidential Communications by Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____

___OK to leave detailed message

___Leave message with call back number

Cell Phone Number:

____

___OK to leave detailed message

___Leave Message with call back number

Written Communication Address:

____

____OK to mail to above address

____Email me at:________________

____________________________	________________________________	
Name of Patient (Print)	Signature	Date

Paul Gennaro, M.D.
Noah R. Gilson, M.D.
F. Bernard Ponce, M.D.
Joshua T. Mendelson, M.D.
Matthew I. Davis. M.D.

NEUROLOGY SPECIALISTS
of Monmouth County

107 Monmouth Road, Suite 110
West Long Branch, NJ 07764
732-935-1850
Fax: 732-544-0494

RECORDS RELEASE AUTHORIZATION

*Print Patients Name ______________________________ DOB __________

*Address ______________________________

*Signature of Patient or Patient Representative ______________________________

I hereby authorize

____
Name of Provider/Facility

____
Address

To release complete medical records in their possession with reference to my illness and/or treatment during the period: FROM ______________TO __________________

Send my medical records Personal and Confidential to:

Neurology Specialists of Monmouth County, NJ
107 Monmouth Road
West Long Branch, NJ 07740
Office: 732.935.1850 – Fax: 732.544.0494