Crouse Neuroscience Institute
Neurovascular & Stroke Center
Skull Base Microsurgery Center

New Patient Demographics **Today's Date**_____

Patient Name:_____ **Date of Birth:**_____

Social Security #:_____ **SEX:** □M □F

Home Address:_____ **Home Phone #:**_____

City/State/Zip:_____ **Cell Phone #:**_____

If under18 years of age: Name of parent/guardian:_____ **Relation:**_____

Parent/Guardian address:_____ **Phone #:**_____

Emergency Contact/Relationship:_____ **Phone #:**_____

Referring Doctor:_____ **Phone #:**_____

Street/City/State/Zip_____

Primary Doctor:_____ **Phone #:**_____

Street/City/State/Zip_____

Employer's Name:_____ **Phone #:**_____

Street/City/State/Zip_____

In compliance with the HITECh Act (HER) to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. The purpose of "Meaningful Use" is to improve quality, reduction of disparities, research and outreach I the use of HER) electronic medical record). The government requires we collect this information to better identify possible disparities (or differences) in access and quality of healthcare based on race and ethnicity. You may choose not to answer the following questions if you wish. Thank You.

___I do not wish to answer these questions. **Race of Patient: Choose one** **___Alaska Native ___Asian** **___American Indian ___Black or African American** **___White/Caucasian ___Native Hawaiian or other** **___More than one race Pacific Islander** **___Other race**	**Ethnicity of Patient: Are you Hispanic/Latino?** **Choose one** **___No, not Hispanic/Latino** **___Yes, Hispanic/Latino** **Preferred Language of Patient: Choose one** **___English** **___French** **___Spanish** **___Other**

Please turn this sheet over and complete all of your insurance information.

Crouse Neuroscience Institute

Neurovascular & Stroke Center
Skull Base Microsurgery Center

Patient Name: _____ Date of Birth: _____

If your visit is related to a work injury, please fill out the WORKERS COMPENSATION INSURANCE INFORMATION in addition to your primary and secondary insurance.
If your visit is related to a motor vehicle accident please fill out the NO FAULT INSURANCE INFORMATION In addition to your primary and secondary insurance. Thank you.

PRIMARY INSURANCE

Insurance Name: _____

Address: _____

City/State/Zip: _____

_____

_____

Name of policy holder: (If other than patient)

Employer of policy holder: _____

Policy Number: _____

Group Number: _____

Effective date of policy: _____

Policy holder date of birth: _____

Policy holder SSN#: _____

SECONDARY INSURANCE

Insurance Name: _____

Address: _____

City/State/Zip: _____

_____

_____

Name of policy holder: (If other than patient)

Employer of policy holder: _____

Policy Number: _____

Group Number: _____

Effective date of policy: _____

Policy holder date of birth: _____

Policy holder SSN#: _____

WORKERS COMPENSATION INSURANCE

Insurance Name: _____

Address: _____

City/State/Zip: _____

Date of Injury: _____ WCB#: _____

Carrier Case Number: _____

Employer at time of accident : _____

Employer Address/City/State/Zip: _____

County where injured: _____

Name of case manager/adjustor: _____

Adjustor contact Phone: ( ) _____

NO FAULT INSURANCE

Name of Policy Holder: _____

Insurance Name: _____

Address: _____

City/State/Zip: _____

Date of accident: _____ File No.: _____

Name of Attorney: _____

Address/City/State/Zip: _____

Phone: ( ) _____

Please turn form over to complete patient information →

Crouse Neuroscience Institute

Neurovascular & Stroke Center
Skull Base Microsurgery Center
739 Irving Ave. Suite 600
Syracuse, New York 13210
315- 701-2550

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Reason for today's visit (Chief Complaint): _____

_____

_____

Current problem is a result of a: (check all that apply) ☐ Car Accident ☐ Work Accident ☐ Accident ☐ Other

Personal Medical History: (check all that apply)

☐ Hypertension (High Blood Pressure) ☐ Diabetes - ☐ Type I or ☐ Type II

☐ High Cholesterol ☐ History of Stroke

☐ History of Kidney Failure ☐ History of Liver Failure ☐ History of MRSA Infection

☐ History of Cancer
Type / Description: _____

☐ Other Chronic Conditions (Please list any major illness/injuries):

_____

_____

List Surgeries or Hospitalizations: Have you ever had any problems/complications with anesthesia? ☐ Yes ☐ No

DATE	Description of Surgery or Hospitalization (Please attach a separate list if more than 5 procedures)

INFLUENZA IMMUNIZATION..... Date _____ Given By: _____

PNEUMONIA VACCINATION STATUS..... Date _____ Given By: _____

OSTEOPOROSIS WITH DEXA SCAN..... ☐ No ☐ Yes Date_____ ☐ Annual Screening or Diagnosis_____

COLON SCREENING..... ☐ No ☐ Yes Date_____ ☐ Annual Screening or Diagnosis_____

MAMMOGRAM (Females)..... ☐ No ☐ Yes Date_____ ☐ Annual Screening or Diagnosis_____

BMI CURRENT HEIGHT _____ CURRENT WEIGHT_____

TOBACCO CESSATION	OFFICE USE ONLY – COMPLETE ON PAGE 2
CURRENT MEDICATION RECORD	OFFICE USE ONLY – COMPLETE ON MEDICATION RECORD FORM

OFFICE USE ONLY: ODS:v82.81; C=v76.51; M= v76.12

Patient Name: _____ Date of Birth: _____

Regarding your Neck or Back only, have you had:

Physical Therapy: ☐ No ☐ Yes Date(s)_____ How many visits? _____

Pain Management: ☐ No ☐ Yes Date(s)_____ How many visits? _____

Type of Pain Management Treatment administered: _____

Chiropractic Treatment: ☐ No ☐ Yes Date(s)_____ How many visits? _____

Family History: (Include family history of any major illness in immediate family)

Family Member:	Illnesses:	Alive or Deceased?	Age Deceased if Applicable
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Mother			
Father			
Siblings			

SOCIAL HISTORY:

Are you currently working? ☐ Yes ☐ No

Occupation: _____

If no, what was the first date of your disability? _____

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

Do you have children? ☐ No ☐ Yes If yes, how many? _____

Do you live alone? ☐ Yes If no, who lives with you? _____

Do you smoke?

☐ Never Smoked

☐ Current Smoker

Packs Per Day: _____ Years Smoking: _____

☐ Former Smoker

Packs Per Day: _____ Years Smoking: _____ Year Quit: _____

Do You Drink Alcohol?

☐ Never ☐ History of Use: Years: _____ Year Quit: _____

☐ Yes

Amount: _____

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, or previous blood transfusion)? ☐ Yes ☐ No

Description: _____

PATIENT NAME_____ DATE OF BIRTH_____

REVIEW OF SYSTEMS: ARE YOU CURRENTLY HAVING OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? CHECK ALL THAT APPLY.

CONSTITUTIONAL:

- ☐ Recent fever or chills
- ☐ Excessive fatigue
- ☐ Trouble sleeping
- ☐ Night sweats
- ☐ Weight loss/gain
  Amount____ Time Frame___

HEAD:

- ☐ Headache
  Description:_____
- ☐ Head injury:
  Description:_____

EYES:

- ☐ Vision loss
  Contacts____ Glasses_____ Both_____
- ☐ Eye pain
- ☐ Blurry/Double vision
- ☐ Glaucoma
- ☐ Cataracts

EARS:

- ☐ Hearing loss
  Left ear___ Right ear___ Both___
  Hearing Aid___
- ☐ Ear pain
  Left ear___ Right ear___ Both___
- ☐ Ringing in ears
  Left ear___ Right ear___ Both___
- ☐ Balance disturbance (example vertigo, spinning)

NOSE:

- ☐ Nasal drainage
  Amount/frequency_____
  Color_____
- ☐ Nose bleeds
- ☐ Nasal Congestion
- ☐ Inability to smell
- ☐ Sinus pain

MOUTH:

- ☐ Non-healing sores
- ☐ Bleeding

NECK:

- ☐ Lumps
- ☐ Swollen glands

RESPIRATORY:

- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Painful breathing
- ☐ Snoring at night
- ☐ Shortness of breath
  Description:_____
- ☐ Wheezing

CARDIOVASCULAR:

- ☐ Chest pain
  Description:_____
- ☐ Difficulty breathing laying down
- ☐ Swelling
  Description:_____
- ☐ Palpitations
  Description:_____
- ☐ Heart Murmur
  Description:_____

GASTROINTESTINAL:

- ☐ Abdominal pain
- ☐ Blood in your stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heart burn/reflux
- ☐ Nausea
- ☐ Vomiting
- ☐ Indigestion or pain with eating
- ☐ Swallowing difficulty

PATIENT NAME_____ **DATE OF BIRTH**_____

REVIEW OF SYSTEMS (CONTINUED): ARE YOU CURRENTLY HAVING OR HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS? CHECK ALL THAT APPLY.

GENITOURINARY:

- ☐ Increased frequency
- ☐ Blood in urine
- ☐ Difficulty starting or stopping stream
- ☐ Increased urgency
- ☐ Incontinence
- ☐ Recurrent Urinary Tract Infections
- ☐ Painful urination
- ☐ History of kidney stones

MUSCULOSKELETAL:

- ☐ Back pain
  Description:_____
- ☐ Arm or leg weakness
  Description:_____
- ☐ Joing pain or swelling
  Description:_____
- ☐ Arm or leg pain:
  Description:_____
- ☐ Arthritis
- ☐ Broken bones
  Description:_____

INTEGUMENTARY:

- ☐ Skin disease
  Description:_____
- ☐ Skin cancer:
  Description:_____
- ☐ Breast pain, tenderness or swelling
- ☐ Nipple discharge
- ☐ Date & result of last mammogram (females)_____

PSYCHIATRIC:

- ☐ Anxiety
- ☐ Depression
- ☐ Other Psychiatric disorders/treatment
  Description:_____

NEUROLOGICAL:

- ☐ Coordination loss
- ☐ Problems with your memory
- ☐ Seizures
- ☐ Difficulty with your speech
- ☐ Fainting spells/"black outs"/near syncope
- ☐ Disorientation
- ☐ Inability to concentrate
- ☐ Facial weakness

ENDOCRINE:

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Increased/decreased appetite
- ☐ Excessive thirst or urination
- ☐ Hormone problems
  Description:_____

HEMATOLOGIC/LYMPHATIC

- ☐ History of Anemia
- ☐ Hemophilia
- ☐ Bleeding tendencies
  Description:_____
- ☐ Persistent swollen glands or lymph nodes
  Description:_____
- ☐ Blood transfusion; Date_____

ALLERGIC/IMMUNOLOGIC:

- ☐ Food allergies
  Description:_____
- ☐ Environmental allergies
  Description:_____
- ☐ Immunologic disorder (inability to fight disease/infection)
  Description:_____
- ☐ IV Contrast
  Description:_____

Patient signature:_____ **Date:**_____

Physician signature:_____ **Date:**_____

(I have reviewed the above information with this patient.)

When competing this form initially, please indicate ALL medications that you are currently taking. INCLUDE: dosage, frequency and the reason you are taking the medication (i.e. high blood pressure, high cholesterol, diabetes, etc.)

Patient Name:_____ **DOB:** _____ **Today's Date:**_____

MEDICATION NAME	DOSAGE	FREQUENCY	REASON FOR TAKING MED

NOT CURRENTLY TAKING ANY MEDICATIONS ☐

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO AND THE REACTION YOU GET FROM IT.

_____

_____

_____

PHARMACY NAME & ADDRESS: _____

PHARMACY PHONE NUMBER: _____

Crouse Neuroscience Institute

Neurovascular & Stroke Center
Skull Base Microsurgery Center
739 Irving Ave Suite 600
Syracuse, NY 13210
Phone: (315) 701-2550 Fax: (315) 701-2551

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 (optional)
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 TREATMENT, 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. Name and address of health provider or entity to release this information:

   Crouse Neuroscience Institute

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

8. Specific information to be released:
   - ☐ Medical Record from (insert date)_____ to (insert date)_____
   - ☐ Entire Medical Record, including patient histories, office 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

8(b)

☐ By initialing here_____ authorize____**Crouse Neurosciences**_____
Initials — Name of Individual health care provider

to discuss my health information with the individual(s) or agency listed here:

_____

(List family members, attorneys, PCP MD (if they weren't the referring MD), any individual, firm, government agency--anyone we can speak to, or send records to on your behalf)

9. Reason for release of information:
   - ☒ At request of individual
   - ☐ Other:

11. Date or event on which this authorization will expire:

10. 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.

_____ _____
Signature of patient or representative authorized by law. Date

- **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.**

Crouse Medical Practice, PLLC

Acknowledgement of Notice of Privacy
and
Consent to Treat and Patient Financial Responsibility

_____ _____

Patient Name Date of Birth

I acknowledge the forms listed below were provided to me.

- Notice of Privacy Practices
- Consent to Treat/Patient Financial Responsibility Form

I agree to the terms and conditions listed in these documents.

_____ _____

Signature of the patient or legal Representative Date

Crouse Medical Practice, PLLC

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.
YOU WILL BE ASKED TO SIGN AN ACKNOWLEDGMENT THAT WILL BE KEPT IN YOUR MEDICAL CHART.

We understand that your health information is personal to you, and we are committed to protecting the information about you. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care.

Who Will Follow This Notice
This Notice describes the privacy practices of Crouse Medical Practice PLLC and will be followed by our health care providers, employees, other personnel and our contractors (business associates) having access to your health information in order to provide the services we have hired them to do.

Our Duties
We are required by law to maintain the privacy of your health information, and to give you this Notice describing our legal duties and privacy practices. We are required to follow the terms of the Notice currently in effect. We are also required by law to provide you with notice of a breach of unsecured protected health information.

Revisions to this Notice
Crouse Medical Practice PLLC must abide by the terms of the Notice currently in effect, however, we reserve the right to change our privacy practices from time to time and to make the new Notice effective for all protected health information we maintain.

If we do revise the notice we will post the revised Notice in the patient waiting area, and also at www.Internist Associates of Central New York.com so you will have an accurate summary of our practices.

How We May Use and Disclose Your Health Information
When you register at our office, we typically obtain your general permission to use and disclose your information in connection with the services we provide to you. However, we may use or disclose your health information in the situations described below without your specific authorization. Please note, New York State law may have stricter requirements for the use and disclosure of certain types of information including HIV-related, alcohol and substances abuse, mental health and genetic information. We shall follow such additional requirements.

law we may disclose health information to funeral directors, coroners, and medical examiners to help them carry out their duties.

- *Organ Procurement Organizations*: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

- *Food and Drug Administration (FDA)*: We may disclose to the FDA health information relative to adverse events, product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

- *Public Health*: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse and neglect.

- *Victims of Abuse, Neglect or Domestic Violence*: As permitted by law, we may disclose your health information to appropriate governmental agencies, such as adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

- *Health Oversight*: In order to oversee the health care system, government benefits programs, entities subject to governmental regulation and civil rights laws for which health information is necessary to determine compliance, we may disclose your health information for oversight activities authorized by law, such as audits and civil, administrative, or criminal investigations.

- *Court Proceeding and Law Enforcement*: We may disclose your health information in response to requests made during judicial, legal, and administrative proceedings, such as following or acting on court orders or subpoenas, as permitted by law.

- *Threats to Public Health or Safety*: We may disclose or use health information when it is our good faith belief, consistent with ethical and legal standards, that it is necessary to prevent or lessen a serious and imminent threat or is necessary to identify or apprehend an individual.
- *Specialized Government Functions*: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
- *Workers Compensation*: We may disclose health information when authorized

the law, or if we terminate the agreement. You also have the right to revoke the restriction at any time. To request a restriction, please send a written request to the address below under "Contact".

- *To receive confidential communications of health information about you in a certain manner or at a certain location.* For instance, you may request that we only contact you at work or by mail. To make such a request, you must write to us at the address below, and tell us how or where you wish to be contacted. We will try to accommodate all reasonable requests.
- *To inspect medical information or receive a paper or electronic copy of your health information.* You must submit your request in writing to the address below. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances, we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. The treating physician of record will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- *To amend health information.* If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to us at the address below. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if: i) the information was not created by us, unless the person that created the information is no longer available to make the amendment; or ii) the information is not part of the health information kept by or for us, is not part of the information you would be permitted to inspect or copy or is accurate and complete.
- *To receive an accounting of disclosures of your health information.* You must submit a request in writing to the address below. Not all disclosures of health information are subject to this accounting requirement, including disclosures made: i) to you; ii) for treatment, payment or healthcare operations; iii) to your friends and family involved in your care; iv) to federal officials for national security and intelligence activities; v) to law enforcement or correctional institutions about inmates; or vi) made six years prior to your request. Your request must state a time period, no longer than 6 years. The first accounting you request within a 12-month period is free. For additional accountings, we may charge you the cost of providing the accounting. Upon request, we will estimate for you the cost and you may choose to withdraw or modify your request before charges are incurred.

- *To receive a paper copy of this Notice upon request, even if you have previously elected to receive this Notice electronically.* You may submit a request for a paper notice in writing to the address below, by calling the Privacy Officer at

Effective October 10, 2014

Crouse Medical Practice, PLLC
Consent for Treatment & Financial Responsibility Agreement

We are committed to providing you with the best possible care, and we are pleased to discuss our policies related to insurance and fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility. The following is our policy for accepting insurance and procedures for payment in the event that you no longer have insurance coverage including Medicaid Coverage.

Consent for Treatment

- I voluntarily consent to treatment at Crouse Medical Practice, PLLC. I hereby give permission to the physician or provider in charge of my care to administer any treatment deemed necessary or advisable. In addition to all other consents, I specifically consent to medical procedures and test necessary to aid and assist in my diagnosis and treatment.

Financial Agreement

- I agree to assume full, primary responsibility for payment of all charges for services I receive from Crouse Medical Practice, PLLC, if not paid by my insurance company or other party.
- I give permission to the Crouse Medical Practice, PLLC and its agents to disclose my protected health information and billing information to my insurance company or others as necessary to obtain payment for services, including confidential HIV-related and alcohol/substance abuse related information.
- I agree to pay any amount of money I owe for the services within 30 days after I receive a bill.

Assignment of Benefits

- I assign to Crouse Medical Practice, PLLC any monies and benefits payable to me under any health insurance or other insurance policy, governmental program, or other party providing benefits for all or a part of the services provided.
- I agree that any credit balance after payment from such sources may be applied on any account at Crouse Medical Practice, PLLC.
- I certify that the information I have provided regarding my insurance is correct and current.
- I agree to pay Crouse Medical Practice, PLLC within 30 days of receiving any payment made directly to me by my insurance company or other party that is connected to charges for services.
- I agree to complete any forms necessary to obtain payment or assignment of such monies or benefits.
- I give permission to Crouse Medical Practice, PLLC to request payment for services for no-fault benefits, workers compensation benefits, or any other benefits available to me under any governmental programs for any unpaid balance of my bill. This will be done for me if I am eligible for benefits and do not submit a request for payment of services from these government programs.
- I understand that payment for services rendered is subject to the deductibles, co-pays and in-network/out-network benefits specified by my individual insurance policy.

Patient Responsibility

- I understand that in the event that my insurance company pays me directly for services rendered by the practice, I must remit that payment to Crouse Medical Practice, PLLC.
- I agree that in the event my insurance coverage changes, I must notify Crouse Medical Practice, PLLC of the changes to determine whether Crouse Medical Practice, PLLC participates with my new insurance and/or whether services are covered by my insurance.
- I agree that I will bring my insurance card to each session for authorization and verification.
- I understand that I may be assessed a fee of $10.00 if I do not pay my co-payment at the time of service.
- I understand that if I do not pay the patients responsibility portion of my bill in a timely manner I may be referred to a collection agency as part of a continued collection effort.
- If agree that I will provide at least 24 hours notice for appointment cancellations.

I permit Crouse Medical Practice, PLLC to bill my insurance company, if any, for services rendered and to send the necessary reports, including my medical information, for payment of services. I accept financial responsibility for the patient responsibility portion of the fees.

If you are traveling North on Rte 81: Take exit 18 to Harrison St/ Adams St. At the end of the ramp, turn right onto E Adams Street. Head up the hill and take a right onto Irving Ave. The CNY Medical Building will be on the left, across from Crouse Hospital. Turn left into attached parking garage, which is just after the building.

If you are traveling South on Rte 81: Take exit 18 to Harrison St/Adams St. Keep left at the fork, go under bridge and take left onto East Adams. Head up the hill and take a right onto Irving Avenue. The CNY Medical Building will be on the left, across from Crouse Hospital. Turn left into attached parking garage, which is just after the building.

If you are traveling from the NYS Thruway: Take exit 36 to Route 81 South and follow directions for "If you are Traveling South on Rte 81."

If you are traveling West on 690: Take exit 13 to Townsend street. At the end of the ramp take a left onto Townsend. Go straight for about half a mile, and then turn left onto E. Adams Street. Head up the hill and take a right onto Irving Avenue. The CNY Medical Building will be on the left, across from Crouse Hospital. Turn left into attached parking garage, which is just after the building.