Crouse NeuroSciences
475 Irving Avenue, Suite 418
Syracuse, NY 13210

C / R

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. Provide the name and address of health provider/entity **to release your** information:

CROUSE NEUROSCIENCES

7. Provide the name and address of person(s) or category of person **to whom your 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 (except psychotherapy 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_____
Initials — Name of Individual health care provider

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

_____
(Individual/Attorney/Firm Name/Governmental Agency Name)

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 NEUROSCIENCE DEMOGRAPHIC INFORMATION

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 in access and quality of healthcare based on race and ethnicity. You may choose not to answer if you wish. Thank You.

*disparity: difference

Patient Name_____ **DOB:**_____

Check here if you do not want to answer

☐ I do not wish to answer these questions

Race of Patient: (Choose one)

☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American

☐ White/Caucasian ☐ More than on race ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race:_____ ☐ Patient Declined/Unknown

Ethnicity of Patient: Are you Hispanic/Latino? (Choose only one)

☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino ☐ Patient Declined/Unknown

Preferred language or Patient: (Please Circle One)

English French Spanish Other:_____ ☐ Patient Declined/Unknown

Crouse Neurosciences

New Patient Demographics

Today's Date:_____

Patient Name:_____ Date of Birth:_____

Home Phone #:_____ Social Security #:_____ SEX: ☐M ☐F

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Home Address:_____

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

Are you under the age of 18? ☐Yes ☐No

If YES, Name of responsible party:_____ Relation:_____

Responsible party address:_____ Phone #:_____

Is this person authorized to receive your health information? ☐Yes ☐No

Emergency Contact:_____ Phone #:_____

Referring Doctor:_____ Phone #:_____

Street/City/State/Zip_____

Primary Doctor:_____ Phone #:_____

Street/City/State/Zip_____

Employer's Name:_____ Phone #:_____

Street/City/State/Zip_____

Your Ocupation:_____

_____ _____

Patient Name (Please Print) Patient Signature/Date (Parent or Guardian)

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

Insurance Information

Primary Insurance:_____

Street/City/State/Zip:_____

Name of policy holder IF other than patient:_____

Policy holder date of birth:_____ Policy holder social security #:_____

Employer of policy holder:_____

Policy #:_____ Group #:_____

Secondary Insurance:_____

Street/City/State/Zip:_____

Name of policy holder IF other than patient:_____

Policy holder date of birth:_____ Policy holder social security #:_____

Third Insurance:_____

Street/City/State/Zip:_____

Name of policy holder IF other than patient:_____

Policy holder date of birth:_____ Policy holder social security #:_____

No Fault Information Only

Name of Insurance Carrier:_____

Street/City/State/Zip:_____

Insurance company phone #:_____ Fax#: _____

Adjuster or claim representative name: _____

Date of accident/injury: _____ State:

NF Claim #: _____

*******ALL WORKERS COMP INFO CAN BE FILLED OUT ON NEXT PAGE PLEASE. THANK YOU. *******

Crouse Neurosciences

475 Irving Ave. Suite 418 (Madison Irving Medical Bldg)
Syracuse, New York 13210
315- 475-3999

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, or have you had problems with: (Please check yes or no)

	YES	NO
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	☐	☐
☐ Glasses ☐ Contacts ☐ Both		
Eye Pain	☐	☐
Blurry/Double Vision	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Ears		
Hearing Loss	☐	☐
☐ Left Ear ☐ Right Ear ☐ Both ☐ Use of Hearing Aids		
Ear pain	☐	☐
☐ Left Ear ☐ Right Ear ☐ Both		
Ringing in ears	☐	☐
☐ Left Ear ☐ Right Ear ☐ Both		
Balance disturbance (ex: Vertigo, Spinning)	☐	☐
Nose		
Nasal drainage	☐	☐
Amount _____ Color _____		
Nose Bleeds	☐	☐
Nasal congestion	☐	☐
Inability to smell	☐	☐
Sinus pain	☐	☐
Mouth		
Non-Healing Sores	☐	☐
Bleeding	☐	☐
Neck		
Lumps	☐	☐
Swollen Glands	☐	☐

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS (continued)
Are you currently, or have you had problems with: (Please check all that apply)

	YES	NO
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	☐	☐
Genitourinary		
Increased Frequency	☐	☐
Blood in Urine	☐	☐
Difficulty starting or stopping stream	☐	☐
Increased Urgency	☐	☐
Incontinence	☐	☐
Recurrent Urinary Tract Infections	☐	☐
Painful Urination	☐	☐
History of Kidney Stones	☐	☐

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS (continued)
Are you currently, or have you had problems with: (Please check all that apply)

	YES	NO
Musculoskeletal		
Back pain	☐	☐
Description: _____		
Arm or Leg Weakness	☐	☐
Description: _____		
Joint 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) RESULT _____		
Date _____		
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	☐	☐
Face weakness	☐	☐

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS (continued)

Are you currently, or have you had problems with: (Please check all that apply)	YES	NO
Endocrine		
Diabetes	☐	☐
Thyroid disease	☐	☐
Description: _____		
Increased / decreased appetite	☐	☐
Excessive thirst or urination	☐	☐
Hormone problems	☐	☐
Description: _____		
Hematologic / Lymphatic		
History of Anemia	☐	☐
Description: _____		
Hemophilia	☐	☐
Description: _____		
Bleeding tendencies	☐	☐
Description: _____		
Persistent swollen glands or lymph nodes	☐	☐
Description: _____		
Blood transfusion	☐	☐
Date: _____		
Allergic / Immunologic		
Food allergies	☐	☐
Description: _____		
Environmental allergies	☐	☐
Description: _____		
Immunologic disorders (inability to fight disease/infection)	☐	☐
Description: _____		
IV Contrast	☐	☐
Description: _____		

_____ _____

Patient signature Date

_____ _____

Physician signature (I have reviewed the above info with this patient) Date

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 Neurosciences
NARCOTIC POLICY

Adequate relief of pain is an important priority for all of our patients. We have established the following guidelines for those patients that rely on chronic medication to relieve pain and improve functioning in their daily lives.

We will provide medication for operative patients only. Prior to surgery, your primary care physician or referring doctor should prescribe any necessary pain medications. ***Narcotics will not be given to patients who are not having surgery with us.***

The Maximum Daily Dose or (MDD) allowed for your pain medication will be listed on your prescription bottle. Taking additional doses without talking to us first is **NOT** acceptable and refills will **NOT** be given early because of self-medicating.

YOU are responsible for all narcotic medications prescribed. We recommend that you lock up all medications. You will not be given prescriptions before your 30-day supply is due.

MEDICATION REFILL POLICY: UPDATED July 18, 2013

NON-NARCOTICS: Patients are to call the office **5 days prior to refill being due.**

NARCOTICS: NYS Controlled Substance policy has eliminated automatic refills and limits the amount prescribed to a 30-day supply. **Due to these changes, any patient receiving narcotics from our office will now be seen in the clinic prior to refilling the prescription.** You should have a return appointment made when you receive the prescription. You will need to bring your meds to each office visit. We will also be performing random drug screenings. You will not receive a prescription refill unless you attend your appointment. 5-day supplies will only be called in on an EMERGENCY basis. This does not include running out because you forgot your appointment. **No refills will be given on Saturdays, Sundays nor holidays.**

It is your responsibility to inform us if you are also receiving narcotics from another physician while under our care. **Patients receiving narcotics from other Physicians or multiple pharmacies, and have not informed us of this, will be found in direct Violation of this policy and will be discharged from the practice.**

☐ I _____ have read and understand the above narcotic policy
(Print Patient Name)

_____ _____
Patient Signature Date

_____ _____
Crouse -Witness Signature (Office Only) Date

CROUSE NEUROSCIENCES
475 Irving Ave. Suite 481 (Madison-Irving Medical Bldg)
Syracuse, NY 13210
315-475-3999 Fax: 315-475-4014

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

1. I authorize and assign direct payment to **Crouse Neurosciences**, by any insurance company obligated to reimburse me or make payments to me for the charges incurred by me.

2. I authorize you to release any information you deem appropriate concerning my health condition to any insurance company, attorney, or adjuster, in order to process any claim for reimbursement of charges incurred by me.

3. I authorize and assign direct payment by my attorney to **Crouse Neurosciences,** for the charges incurred by me, to be paid out of the proceeds of any settlement of my case or any other proceeds my attorney may receive relating to my case including, without limitation, personal injury protection or other insurance benefits.

4. I hereby assign and authorize a lien upon any claims against a third party whose negligence may have caused my injury, up to the amount of my bill, for the charges incurred by me.

5. I hereby assign and transfer to **Crouse Neurosciences,** any and all claims and/or causes of action that exist now and hereafter in my favor against any insurance company in the event that any such insurance company obligated by law or by contractual agreement to make payment to **Crouse Neurosciences,** for the charges incurred by me.

6. I further authorize you to prosecute, compromise, settle, or otherwise resolve any such claims or causes of action as you see fit, either in my name or your name.

7. I understand whatever amounts owed by me to **Crouse Neurosciences,** not collected from insurance or settlement proceeds represent a debt I personally owe.

8. I further agree that this authorization and assignments of benefits is irrevocable until all monies owed for services rendered by **Crouse Neurosciences,** are paid in full.

_____

PRINTED NAME of Patient or Guardian

_____ _____

SIGNATURE of Patient or Guardian **Today's Date**

ATTENTION ALL PATIENTS

DISABILITY FORM FEE POLICY

Please be advised that a **$10.00 form completion fee** is charged for disability forms processed by our office. (Accident, Life, Credit, Loan, etc.) However, as a courtesy to our patients, the first form will be processed at no charge, the form completion fee will apply to every form submitted thereafter. This includes forms sent directly from the disability insurance companies or directly from patient.

Allow **at least 7 – 10 business days** for disability form processing. We ask that the **$10.00 payment, along with a self-addressed stamped envelope accompany each form**. If the form is to be faxed, the patient will need to include the fax number. If payment is not received, your disability form will not be filled out and will be returned.

PLEASE BE ADVISED THAT IT IS THE PATIENT'S RESPONSIBILITY TO FOLLOW-UP ON BEHALF OF ALL DISABILITY CLAIMS

_____ _____

Patient Name: Print & Sign ***Date***