ALL ISLAND NEUROLOGY
Anila Siddiqui MD Board certified Neurologist Board certified Sleep Specialis Clinical Neurophysiologist[1]

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name	Last Name
Preferred Name	Preferred Pronouns

Address	City	State	Zip

Cell Phone Number	Home Phone Number

Email Address

Preferred Language	Race

PRIMARY CARE INFORMATION

PCP Name	PCP Phone

PHARMACY INFORMATION

Pharmacy Name	Pharmacy Address

EMERGENCY INFORMATION

Name	Phone	Relation

INSURANCE INFORMATION

Primary Insurance Name
Secondary Insurance Name

REASON FOR TODAY'S VISIT

Reason for today's visit
When did your symptoms start:

Hospital visits, stays and Surgery

Please list any and all Emergency Room, Urgent Care, Hospital Admissions and Surgeries, including C Sections

Reason	Date

COVID

Have you HAD COVID	Yes No
Were you hospitalized?	How Long?
Have you received the COVID vaccine?	If yes, which brand

[1] 116-17 Atlantic Ave Richmond Hill NY 11418| 910 NY 109 Suite B Lindenhurst NY 11757| 380 Merrick Ave East Meadow NY 11554

MEDICATIONS

Please list ALL medications that you are CURRENTLY taking. Please include any over the counter medication, vitamins, birth control pills, and herbal supplements.

Name	Dosage (MG)	How Often

FAMILY HISTORY

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____

ALLERGIES

_____ACE Inhibitors
_____Anesthetics
_____Barbiturates
_____Iodine (contrast Dye)
_____NSAIDS (Advil, Aleve, Motrin)
_____Seizure Medications
_____Adhesive Tape
_____ Aspirin
_____Codeine
_____Latex
_____Penicillin
_____Sulfa

WOMEN ONLY

No. of Pregnancies		No. of Miscarriages	
No. of living children		No. of abortions	

Birth Control: ______________________________

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

ACID REFLUX		HEAD INJURY	
AIDS/HIV		HEART DISEASE	
ALCOHOLISM		HEART VALVE	
ALZHEIMERS		HEPATITIS B or C	
ANEMIA		HERPES	
ANEURYSM		HIGH BLOOD PRESSURE	
ANXIETY		HIGH CHOLESTEROL	
ARTHRITIS		JOINT DISORDER	
ASTHMA		KIDNEY DISORDER	
A-FIB		LIVER DISORDER	
AUTO IMMUNE		LUPUS	
BACK PROBLEMS		MIGRAINES	
BLEEDING DISORDER		MILD COG IMPAIR	
BLOOD CLOT		MULTIPLE SCLEROSIS	
CANCER (TYPE)			
CAROTID ARTERY		NEUROPATHY	
CATARACTS		OSTEOPOROSIS	
CHRONIC FATIGUE		PACEMAKER	
CHRONIC PAIN		PARKINSON'S	
CONCUSSION		VASCULAR DISEASE	
CONGENITAL HEART DISEASE		PNEUMONIA	
COPD		PTSD	
DEPRESSION		SHINGLES	
DIABETES		SKIN DISORDER	
EATING DISORDER		SLEEP APNEA	
EPILEPSY		STROKE	
ERECTILE DYSFUNCTION		SUBSTANCE ABUSE	
FIBROMYALGIA		THYROID DISORDER	
GLAUCOMA		TUBERCULOSIS	
GOUT			

HIPAA Acknowledgement and Compliance Consent Form

Our notice of privacy practices provides information about how we may use or disclose protected health information. This notice contains a patient's rights section, describing your rights under the law. You ascertain with your signature that you have reviewed our notice.

The terms of the notice may change, if this happens, you will be notified at your next visit, and asked to sign and date the updated policy.

You have the right to restrict how your Protected Health Information (PHI) is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA **(**Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your PHI and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, at any time. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- PHI may be disclosed or used for treatment, payment or healthcare operations
- This practice reserves the right to change the privacy policy as allowed by law
- This practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions
- You, the patient have the right to revoke this consent in writing at any time and any and all disclosures will cease
- This practice may condition receipt of treatment upon execution of this consent

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Which Phone number should we use to confirm appointments: ______________________________

May we leave a voice message on this number? Please circle one YES NO

Can we send you Text Message reminders? Please circle one YES NO

Which number can we send text messages to? ______________________________

May we discuss your medical condition with a member of your family? Please circle one YES NO

If yes, please list the names here: ______________________________

This consent was signed by: ______________________________
Print Patient Name

Signature: ______________________________ Date: ______________

Witness: ______________________________ Date: ______________

ALL ISLAND

NEUR LOGY

Anila Siddiqui MD

Board certified Neurologist
Board certified Sleep Specialis
Clinical Neurophysiologist

Our providers may order multiple tests for each patient to ensure the most accurate diagnosis. If you are asked to take a machine home with you, such as the 48 hour EEG machine or the Sleep Study machine, you must bring the machine back to our office on the day requested. There will be a $100 a day fine for every day that you do not bring the machine back.

The machine MUST be in the same, working order as when we gave it to you. If there are any missing or broken pieces, you, the patient will be held financially responsible. The MINIMUM financial penalty charge will be $500, due at the time of drop off. Please treat our equipment with respect.

Thank you,
All Island Neurology Management

Patient Signature and Date

Please read and initial next to each section:

______ **Office Hours**: Our office hours for each location change often, times for each location are listed on Google and on our voicemail.

______ **Appointments:** We see patients by appointment only, same day appointments are available occasionally.

______ **Running on time:** your appointment will be canceled if you are more than 10 minutes late for your scheduled time

______ **After Hours and Emergencies:** Please call 911 if you are having an emergency.

______ **Refills:** Please ask for refills of **ALL** of your medication at the time of your visit. We do NOT call in RX's after hours

______ **Narcotics:** We do NOT prescribe narcotics for chronic use in this practice.

______ **Insurance Information:** Insurance card(s) must be presented at time of visit. Cards will be scanned and entered into our medical record system. It is your responsibility to provide any updated information or changes regarding your insurance at the time of service. If accurate insurance information is not provided at the time of service, the charges will be your responsibility.

______ **Referrals:** In the case that your insurance requires a referral, you are responsible for obtaining the referral from your primary care doctor **prior** to your scheduled appointment. If your insurance requires a referral, and you do not obtain one, you will not be seen, or be required to pay for the visit out of pocket.

______ **Co-Payments-** Copays are due BEFORE you are seen by the doctor. It is your responsibility to know your co-pay for a specialist BEFORE your appointment.

______ **Self Pay:** in the case that you do not have an active insurance policy or have a policy that All Island Neurology does not participate with, you will be fully responsible for all charges due at the time of service.

______ **Spend Downs**: If your insurance policy has a yearly spend down, it is your responsibility to inform the staff at the front desk BEFORE you are seen by the doctor. You will be required to pay for your appointments in full until your spend down amount is met. If you do not inform the staff of your spend down, YOU will be charged the full amount before you can visit our office again.

______ **Payments**: All Island Neurology accepts cash, or credit cards. Payment plans can be arranged BEFORE a service is performed, full payment must be made before the service is performed. Please speak with our Practice Manager if you have questions.

______ **Dismissal Reasons:** Failure to keep appointments, Non-compliance, Physically or verbally abusive towards staff, failure to pay your bill.

NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that, if you must cancel your appointment, you provide a 36 hour notice. Patients that do not show up, or cancel without proper notice will be considered a NO SHOW. Patients who no-show will be subjected to a fee of:

Follow up appointment-$40

Testing Appointment- $50

If you have 2 or more no show appointments in a 12- month period, may be dismissed from the practice.

You will be asked to pay this fee BEFORE we can schedule you for a new appointment.

By signing this agreement, you agree that you have read and understood All Island Neurology's No Show Policy. You also understand that such terms may be amended by the practice at any time.

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Print Name of Patient

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Signature of Patient Date

PATIENT FINANCIAL AGREEMENT FOR DEDUCTIBLES AND COINSURANCE

All Island Neurology believes that part of good health care practice is to establish and communicate an office financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to have a full understanding of our financial policies.

1. **INSURANCE**: Please contact your insurance plan to be sure All Island Neurology is In-Network with your plan. It is also your responsibility to be aware of any deductibles, spend downs, coinsurance or copayments you are required to pay**.** Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. As a courtesy to our patients, we will verify your insurance coverage, however, our verification is not a guarantee of benefits payable by your insurance. If you have a managed care plan that requires a referral, it is your responsibility to obtain a referral in order for your office visit to be covered under medical insurance. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit prior to being seen by our providers.
2. Payment: Is expected at the time of your visit. We accept cash and credit cards. Payment will include any unmet deductible, co-insurance, co-payment amount or any other charges not covered by your insurance.

By signing this agreement, you agree that you have read and understood All Island Neurology's financial agreement and you are bound by its terms. You also understand that such terms may be amended by the practice at any time.

Signature of Patient　　　　　　　　　　　　　　　　　　Date

Insurance will be verified before each visit for referral, deductible and to be it has not termed

Patient Initials	Date	Staff	Date

All Forms Last Updated: 9.1.2021