NYSMI NEW YORK SPORTS MEDICINE INSTITUTE

Orthopedic Surgery | Physical Therapy | Concussion Care

CONCUSSION PATIENT INFORMATION FORM

NAME:_____
LAST FIRST

HOME ADDRESS:_____

_____
CITY STATE ZIP CODE

HOME PHONE:_____

MOBILE PHONE:_____

BUSINESS PHONE:_____

E-MAIL ADDRESS:_____

DATE OF BIRTH:_____

EMPLOYER:_____

OCCUPATION:_____

BUSINESS ADDRESS:_____

INJURED BODY PART(s): _____

_____

COMPLAINT:_____

_____

ALLERGIES:_____

CURRENT MEDICATIONS:_____

_____

SCHOOL:_____

SCHOOL NURSE/COACH:_____

PHONE #:_____

SPORT:_____

REFERRING PHYSICIAN/ED:_____

PHONE#:_____

ADDRESS:_____

PSYCHOLOGIST/GUIDANCE CNSLR:_____

PHONE #:_____

ADDRESS:_____

INSURANCE INFORMATION:

PRIMARY INSURANCE:_____

POLICY#:_____

GROUP#:_____

Policy Holder information:

NAME:_____
LAST FIRST

ADDRESS:_____

RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH:_____

SOCIAL SECURITY#:_____

EMPLOYER'S NAME:_____

SECONDARY INSURANCE:_____

POLICY#:_____ GROUP#:_____

Policy Holder Name: _____

IN CASE OF EMERGENCY WHO DO YOU AUTHORIZE WE RELEASE INFORMATION TO:

NAME:_____

RELATION:_____

PHONE #:_____

PREFERRED PHARMACY:_____

PHONE#:_____

OPTIONAL:

Preferred Language: _____

Race: __ American Indian __ Asian __ Black

__ Native Hawaiian __ White

Ethnicity: __ Hispanic Origin __ Non-Hispanic

ASSIGNMENT AND RELEASE OF MEDICAL INFORMATION STATEMENT: I certify that the information given by me is correct. I hereby authorize the release of any information related to my medical care, as requested by government agencies and/or insurance carriers, as well as the clinicians and school contacts listed above. I hereby assign benefits to Dr. Neil Roth MD PC and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered. I understand that the information above will be handled confidentially in compliance with all applicable federal laws. I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Neil Roth MD PC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or to the benefits payment for related services.

_____ _____
PATIENT SIGNATURE DATE

SIGNATURE OF PARENT/GUARDIAN (if patient is a minor): _____

New York Sports Medicine Institute | Concussion Care

Major Angela Gagliardi MD; Marie Serina, RN-BC,MA, FNP-BC; Neil S Roth MD

222 N. Westchester Ave. Suite 307, White Plains, NY 10604 Phone: 914-220-8711 Fax: 914-428-4101

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FINANCIAL POLICY

Thank you for choosing NEW YORK SPORTS MEDICINE INSTITUTE | CONCUSSION CARE as your healthcare provider. Our practice is committed to delivering the best treatment possible for each for our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.
NOTE: All billing will be performed as Neil S Roth MD PC.

Insurance

We must emphasize that as medical care providers, our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date the service is rendered are your responsibility. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.

If the physician participates with your managed care medical insurance, please remember that your co-payment is due at the time of service. This is a requirement of your insurance company. Please remember to have all necessary referrals completed prior to your appointment. If your insurance requires prior authorization or referral for any of your visits or treatment here, and if this authorization has not been obtained before your visit, you will be expected to pay for all charges incurred or your visit can be rescheduled.

If we do not participate with your insurance company, payment for office visits is due at the time of service. However, we will bill surgical procedures to this insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is paid in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the physician. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will allow our billing office to post accurate payments and reconcile your account.

We accept cash, checks and credit cards. If we do not have a copy of your most current insurance card on file, you will be considered a self-pay patient and will be expected to pay at the time of service. Please remember to bring your insurance card with you to each appointment.

Neurocognitive Baseline Testing

I understand there is a $75.00 charge for the testing, which must be paid at the time of visit.

Dependent Children

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of the Practice.

Workers Compensation / No Fault

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim.

We realize that temporary financial problems may affect timely payment for your account. If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of you account. If you have any questions, or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (212) 879-6124.

I have read and understood the above financial policy.

Patient Name (Print) _____

Parent Guardian Name (Print) _____

Signature (Patient/Parent/Guardian) _____***Date:*** _____

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Authorization for Release of Information

Patient Name: _____ DOB: _____

Address: _____

School: _____Grade:_____

I, _____ hereby give permission to the members of the **New York Sports Medicine Institute | Concussion Care** to speak with/share information/obtain medical and school records for the purpose of evaluating and treating _____ for the head injury sustained.

Please provide contact information for the individuals checked: name, address phone numbers, email address.

__ Athletic trainer_____

__ Athletic coordinator_____

__ Family Physician_____

__ Guidance counselor_____

__ Pediatrician_____

__ Psychologist_____

__ School administrator_____

__ Psychiatrist_____

__ School nurse_____

__ School physician/medical director_____

__ Teacher_____

__ Team coach_____

__ Other_____

I understand that the information will be handled confidentially in compliance with all applicable federal laws. I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the New York Sports Medicine Institute. It does not apply to information that has already been released in response to this authorization. .
I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient/Parent's Signature: _____ Date: _____

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