**Patient info:** **ENMC PC/PA**

| Last Name | | | |
|---|---|---|---|
| First Name | | Middle Initial | |
| Street Address | | | |
| City | | | |
| State | | Zip Code | |
| Home Phone | | Work Phone | |
| Cell Phone | | | |
| Email Address | | Would you like to receive emails? | Yes No |
| Birth Date | | Sex | M F |
| Social Security Number | | | |

EMERGENCY CONTACT:________________________________________

**How did you hear about us?** ☐ MD Ref ☐ Self Ref ☐ Yellow Pages ☐ Support Group ☐ Other __________
☐ Insurance Carrier ☐ Internet
PLEASE SPECIFY COMPLAINT:________________________________________

**REFERRING PHYSICIAN**

| Name | | | | | |
|---|---|---|---|---|---|
| Address | | City | | | |
| State | | Zip Code | | Phone | |

**PCP**

| Name | | | | | |
|---|---|---|---|---|---|
| Address | | City | | | |
| State | | Zip Code | | Phone | |

**GUARANTOR**

| Last Name | | | | | |
|---|---|---|---|---|---|
| First Name | | | | Date of Birth | |
| Street Address | If the same leave it blank | | | | |
| City | | | | State | |
| Zip Code | | Phone | | | |
| Birth Date | | | | Sex | |
| Social Security Number | | | | | |
| Guarantor Employer | | | | | |
| Employer's Address | | | | City | |
| State | | Zip Code | | Phone | |
| | | | | | |

Is your illness related to worker's compensation or no fault? Yes / No If yes, please contact receptionist.

## INSURANCE #1

| Insurance Carrier | | | |
|---|---|---|---|
| Policy Holder | Date of Birth: | | |
| Relationship to the Insured | | | |
| Policy # | | Group # | |

## INSURANCE #2

| Insurance Carrier | | | |
|---|---|---|---|
| Policy Holder | Date of Birth: | | |
| Relationship to the Insured | | | |
| Policy # | | Group # | |

WORKERS COMPENSATION OR NO-FAULT SHEET

## PATIENT

| Last Name | | | |
|---|---|---|---|
| First Name | | Middle Initial | |
| SSN | | | |

## WORKERS COMPENSATION

| Where you injured on the job? | Yes ☐ | No ☐ | |
|---|---|---|---|
| Carrier Case #: | | | |
| WBC# | | | |
| Carrier I.D.# | | | |
| | | | |
| Date of Injury | | | |
| Employer's Name | | | |
| Carrier | | | |
| Address | | | |
| | | | |
| Contact | | | |
| Attorney | | | |
| Address | | Phone | |

## NO-FAULT

| Where you in an auto accident? | Yes ☐ | No ☐ |
|---|---|---|
| No-Fault Case# | | |
| Date of Injury | | |
| Policy Holder | | |
| Carrier | | |
| Address | | |
| | | |
| Contact | | |
| Attorney | | |

I hereby authorize ENMC PC/PA to furnish information concerning my illness and treatment to my insurance carriers. I authorize payment of medical benefits to the provider. I understand that I am responsible for any part of the charges that are not covered by my medical insurance

Patient's Signature ............................................................ Date ...... / ...... / ...............

**ENMC PC/PA**
**CT Epilepsy Group**

**PATIENT NAME**: ____________________________________________________________

**ASSIGNMENT OF BENEFITS**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to ENMC PC/PA, CT Epilepsy Group, AND ITS PHYSICIANS. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) ________________________________ DATE___________

**FINANCIAL POLICY**

I hereby acknowledge that I am aware and accept the financial responsibility for self-pay accounts and that I have read, understand and agree to the practices Cancellation and No Show policy.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) ________________________________ DATE___________

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize ENMC PC/PA, CT Epilepsy Group, AND ITS PHYSICIANS to furnish all necessary information they may have regarding my condition under their observation or treatment, including the history obtained, x-ray, laboratory, and physical findings, diagnosis and prognosis to my insurance company (ies) and/or physicians.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) ______________________________DATE___________

**MEDICAL APPEAL**

I authorize to ENMC PC/PA, CT Epilepsy Group, AND ITS PHYSICIANS to pursue a written appeal to my insurance carrier on my behalf.

**SIGNATURE (PATIENT OR LEGAL GUARDIAN)** _____________________________ DATE___________

**ELIGIBILITY WAIVER**

I understand that my eligibility for coverage by (name of insurance company) cannot be confirmed at this time. I wish to receive medical service from (name of physician). If it is determined that I am not eligible for coverage, I understand that I will be responsible for payment of all services provided.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) ________________________________ DATE___________

**REFERRAL WAIVER**

I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral within two days, I understand that I am responsible for paying for the services I am requesting.

SIGNATURE (PATIENT OR LEGAL GUARDIAN) ________________________________ DATE___________

NORTHEAST REGIONAL
EPILEPSY GROUP

# NEREG Patient Financial Policy

## No Show

If you are unable to keep your appointment for any reason we ask that you call our office 24 hours in advance. Failure to cancel an office visit 24 hours in advance will result in $30.00 billed to your account. Failure to cancel a procedure will result in $50.00 billed to your account.

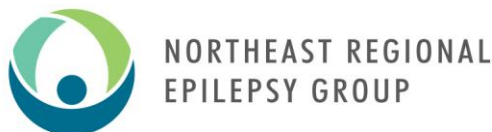
## Self-pay Accounts

A Self-pay account is classified as patient who does not have insurance coverage or who has no out of network benefits. Self- pay accounts are required to remit payment at time of service. A pricing list is available upon request.

## Neuropsychological Testing

A deposit of $100.00 is required in advance to hold your scheduled appointment. Failure to cancel testing 24 hours in advance will result in forfeit of your deposit.

*Patients will not be able to schedule or receive any further services until no show fee is paid.




# Notice of Health Information Privacy Practices

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED WITHIN THE ORGANIZATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE READ THIS CAREFULLY.**

Northeast Regional Epilepsy Group is required by law to maintain the privacy of your Personal Health Information (PHI) and to provide you with this notice of our privacy policies.

**USES AND DISCLOSURE**:

**Treatment:**
We may use your information to provide or coordinate your care. We may disclose all or any portion of your health information to any of our Physicians, Registered nurses, Technologists, other consulting or referring physicians, pharmacists and to any other employees who have a legitimate need for such information to provide or coordinate your care.

**Payment:**
We may release your information to determine coverage by an insurer for our services, and for billing and claims processing. The information may be released to any other organization involved in the payment of your bill. This information may include copies or excerpts of your PHI that is necessary to receive payment.

**Routine Operations:**
We may use and disclose your information during routine operation of the practice. An example of routine operation would be to contact you to remind you of an appointment or to disclose information to transcriptionists, attorneys or consultants working for the practice. These entities are called "Business Associates". We require our Business Associates to treat your information in the same manner that we do.

**Regulatory Agencies:**
We may disclose your information to state, local or federal agencies authorized by law to conduct inspections, audits, or investigations of the practice.

**Law Enforcement/litigation:**
We may disclose your information for valid law enforcement purposes as required by laws or in response to a court order or subpoena.

**Public Health:**
We may disclose your information to public health authorities as authorized by law and related to the prevention or control of certain diseases.

**Worker's Compensation:**
We may release your information to Worker's Compensation agencies in the event that your illness or injury may be related to your work

**Military/Veteran's:**
If you are a member of the armed forces or a veteran, we may release your information as required by military command authorities.

**As Otherwise required:**
We May disclose your information in any situation in which such disclosure is required by law (for example: child or domestic abuse)

**Prohibited Uses:**
We will not disclose your information to persons outside the practice for purposes other than treatment, payment or healthcare operations with out your authorization in writing. If you provide such an authorization to us, you may revoke it in writing at any time in the future and we will honor that request.

**YOUR RIGHTS RELATED TO YOUR PERSONAL HEALTH INFORMATION:**
Although all records concerning your treatment here are the property of our office, you have certain rights concerning this information as follows:

**Right to Confidentiality:**
You generally have the right to inspect and receive a copy of your health information from us, unless that is restricted by law or your physician. You will need to pay for copies of any records we provide.

**Right to Amend:**
You have the right to request an amendment or correction to your health information. If we agree that information is appropriate, we will include that information in your medical record.

**Right to Accounting**
You have the right to obtain a record of disclosures that we make of your health information for other than treatment, payment or routine operation of this practice.

**Right to Request Restrictions:**
**Changes to this notice:**
We will abide by the terms of this notice currently in effect. However, we reserve the right to change the terms of this notice at any time. Any new notice provisions will be effective for all health from the time that the changes are effective within our office.

**Effective Date of this Notice: June 1, 2003**
You have the right to request restrictions on certain uses and disclosures of this health information. We will abide by these requests to the extent that we are able.

**Right to Revoke Authorization:**
You have the right to revoke your prior authorization to release your health information except to the extent action was taken in reliance on your original authorization.

**Right to Complain:**
You have the right to formally complain about our handling of your health information. You may contact Doctor Lancman at the number listed below. (If you complain, we will not retaliate against you in any way)
**For more information regarding this privacy policy please contact Northeast Regional Epilepsy Grp at (914) 428-9213 or (201) 343-6676.**

**ACKNOWELEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**:

I, _____________________________________, hereby acknowledge that I have received and reviewed the "Notice of Health Information Privacy Practices" which describes the uses and disclosures that can be made of my personal health information for treatment, payment and routine health care operations.

_______________________________________________ ____________________

Signature of patient or representative Date

_______________________________________________

Print name of signer

_______________________________________________

If representative, specify relationship

***Please fill out FRONT & BACK of this page*** Thank you

# Northeast Regional Epilepsy Group

To Our Patients:

As you are aware, there are very strict government mandated rules concerning patient health information, confidentiality and release of information. In our continuing efforts to improve patient care and communication, our practice can offer you additional ways to receive information, with your signed authorization, concerning your care and treatment. In addition, a copy of our 'Privacy Policy' is posted in our waiting room and given to all of our patients.

If there are any others persons (family members/friends/health care professionals) with whom we may discuss or to whom we may release information please list them here:

☐ **No One**

| Name: | Relationship: |
|---|---|
| 1 ______________________________ | ______________________________ |
| 2 ______________________________ | ______________________________ |
| 3 ______________________________ | ______________________________ |

I understand that I may revoke or change this authorization at any time in writing.

Signature ______________________________ Date____________

Print Name ____________________________

# IMPORTANT INFORMATION FOR PATIENTS 16 YEARS OF AGE OR OLDER

One of the most uncomfortable discussions that doctors and nurses have with patients with epilepsy involve restriction of driving because a driver's license may seem essential to your independence. Although most state laws about driving and epilepsy are now less restrictive than they were many years ago, these laws were written to lessen the chance of harm to self or others resulting from having a seizure while driving.

Therefore, every state regulates driver's license eligibility for people with epilepsy. As a driver's license holder, it is your responsibility to know the regulations in your state. The most common requirement is that you must be seizure free for a certain period of time before you can be allowed to drive.

Although physicians can offer an opinion on your ability to drive safely, the department of motor vehicles makes the final decision. In some states, the physician can offer such an opinion if your seizures do not interfere with consciousness or control of movement. You may be able to continue driving if your seizures occur only at certain times, especially during sleep or if you always have an aura that would warn you to pull off of the road before a seizure begins.

If you are still having seizures, do not hide it from your doctor in order to keep your driver's license. Not reporting seizures makes it impossible for your doctor to treat your epilepsy effectively. The doctor may be able to prevent more seizures from occurring by making a small change in the dosage of your anti-seizure medicine, for instance, but that would not happen if the doctor did not know it was necessary. Inadequate treatment can lead to more seizures and the result may be that you or someone else may be injured. If your seizures are well controlled, use your driving privileges as a reason to take good care of yourself. If you always take your anti-seizure medicines as prescribed, get enough sleep, limit your alcohol consumption, and visit your doctor regularly, you will be more likely to be able to continue driving safely and legally.

Below is a brief description of the laws governing driving in our practice area:

**NEW JERSEY:**

- You must be seizure free for one year.
- Exceptions may be granted by the Neurological Disorder Committee.
- Periodic medical updates are required after licensing every six months for the first two years, thereafter annually.
- Your doctor must report recurrent convulsive seizures, recurrent periods of unconsciousness, or impairment or loss of motor coordination due to epilepsy, when the condition persists or recurs despite medical treatment.
- DMV appeal of license denial must be filed within 30 days.
- A person is disqualified from driving a commercial motor vehicle if he/she has an established medical history or diagnosis of epilepsy or any other condition which is likely to cause a loss of consciousness or loss of ability to control a commercial motor vehicle. Submitting a false CDL application is a federal offense.
- NJ Motor Vehicle Commission: 609-292-6500
- NJ Medical Review Unit: 888-486-3339

**NEW YORK:**

- You must be seizure free for one year.
- A person is disqualified from driving a commercial motor vehicle if that person has a medical history of epilepsy, has a current clinical diagnosis of epilepsy or is taking antiseizure medication.
- Doctors are not required to report epilepsy.
- Exceptions may be granted by the DMV's Medical Review Board.

(over)

- Periodic medical updates are required after licensing if determined by the DMV.
- DMV appeal of license denial must be filed within 30 days.
- NYS DOT for commercial licensing: 518-457-1010 OR 1016
- Medical Review Unit : 518-474-0774

**PENNSYLVANIA:**

- You must be seizure free for six months.
- Doctors are required to report epilepsy.
- Your physician will be required to complete a medical report stating that your seizures are controlled and send that report to the Pennsylvania Department of Transportation.
- The department may waive the seizure-free requirement upon request by the person's physician in the following situations:
  - You have a strictly nocturnal pattern of seizures or a pattern of seizures occurring immediately upon awakening that has been established for at least 2 years immediately preceding your application.
  - You experience a specific prolonged aura accompanied by a sufficient warning and this pattern has been established over a period of at least 2 years immediately preceding your application or suspension.
  - Your seizures had previously been controlled and the subsequent seizure or seizures occurred as a result of a prescribed change or removal from medication while under the supervision of a licensed physician.
  - Your seizures had been previously controlled for 6 or more months and the subsequent seizure occurred during or concurrent with a nonrecurring transient illness, toxic ingestion, metabolic imbalance or nonrecurring trauma.
- Motor Vehicle Commission: 800-932-4600
- Medical Review Unit: 717-787-9662

**CONNECTICUT:**

- There is no set seizure-free period.
- Doctors are not required to report epilepsy.
- Periodic medical updates are required after licensing if determined by the DMV.
- DMV appeal of license denial must be filed within 30 days.
- Motor Vehicle Commission: 800-842-8222 or 800-263-5700
- Medical Review Unit: 860-263-5223I have read the above information and all questions have been answered to my satisfaction.

---

| ______________________________ | ______________________________ |
|---|---|
| Printed Name | Signature |

______________________________
Date

NEREG 2014

(  ) Pt refused to sign. ________ (Employee initials)

NORTHEAST REGIONAL
EPILEPSY GROUP

# Cultural/Language/Visual/Auditory Factors Affecting Care

Cultural/Linguistic needs are defined *as the identification of language barriers, visual and or auditory deficits, as well as cultural and religious customs that may impede the provider and or staff's ability to provide the patient's medical benefits.*

We ask that you please use the space below to list any of factors that may be classified as such:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________

By signing below I acknowledge that I have disclosed any factors that may affect my medical care.

________________________ _________________
Patient Name Date

________________________
Patient/ Guardian Signature

# Northeast Regional Epilepsy Group

## Patient Form – New Patient

**Date:** ________________

**Allergies:** ______________________________________

**Handedness:** ☐ Right ☐ Left ☐ Ambidextrous (using both hands) ☐ Unknown

**Name:** ________________________

**DOB:** __________________ **Age:** _______

**Gender:** ☐ Male ☐ Female

**Referring Physician Name and Address:**

___________________________________

___________________________________

**Primary Care Physician Name and Address:**

___________________________________

___________________________________

**Reason for visit:**

- ☐ Find out if I have seizures
- ☐ Be treated for seizures
- ☐ Stop seizure medications
- ☐ Be evaluated for surgery
- ☐ Other (please explain) _________________________

_____________________________________

**Please describe your events:**

_________________________________________

_________________________________________

_________________________________________

**Seizure Risk Factors** (Check all that applies and describe):

- ☐ Problems during your mother's pregnancy with you ______________________________
- ☐ Problems during your birth ______________________________
- ☐ Problems immediately after you were born ______________________________
- ☐ Meningitis / Encephalitis ______________________________
- ☐ Convulsions with fevers ______________________________
- ☐ Severe head trauma ______________________________
  - ☐ Loss of consciousness ______________________________
- ☐ Learning disability ______________________________
- ☐ Delay in language/motor development ______________________________
- ☐ Brain surgery ______________________________
- ☐ Stroke ______________________________

## Previous Testing:

| Test | When | Where |
|---|---|---|
| ☐ MRI brain | | |
| ☐ CT Scan | | |
| ☐ PET Scan | | |
| ☐ SPECT Scan | | |
| ☐ Routine EEG | | |
| ☐ Video-EEG Monitoring | | |
| ☐ Ambulatory EEG | | |
| ☐ Other tests | | |

**Do you have a Vagus Nerve Stimulator?** ☐ Yes ☐ No Since when? __________________________

**Have you ever been on ketogenic diet?** ☐ Yes ☐ No When? ______________________________

Patient Name: ___________________________ Date: ______________

## Current Seizure Medications

| Medication | Morning Dose | Afternoon Dose | Evening Dose | Since When? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Previous Seizure Medications** — **When and why was it stopped?**

- ☐ ACTH/Steroids ______________________________
- ☐ Ativan (Lorazepam) ______________________________
- ☐ Carbatrol (Carbamazepine) ______________________________
- ☐ Depakene (Valproate) ______________________________
- ☐ Depakote (Valproate) ______________________________
- ☐ Depakote ER (Valproate) ______________________________
- ☐ Diamox (Acetazolamide) ______________________________
- ☐ Diastat (Diazepam) ______________________________
- ☐ Dilantin (Phenytoin) ______________________________
- ☐ Frisium (Clobazam) ______________________________
- ☐ Gabitril (Tiagabine) ______________________________
- ☐ Keppra (Levetiracetam) ______________________________
- ☐ Klonopin (Clonazepam) ______________________________
- ☐ Lamictal (Lamotrigine) ______________________________
- ☐ Lyrica (Pregabalin) ______________________________
- ☐ Mysoline (Primidone) ______________________________
- ☐ Neurontin (Gabapentin) ______________________________
- ☐ Phenobarbital ______________________________
- ☐ Phenytek (Phenytoin) ______________________________
- ☐ Rufinamide (Banzel) ______________________________
- ☐ Sabril (Vigabatrin) ______________________________
- ☐ Tegretol (Carbamazepine) ______________________________
- ☐ Tegretol XR (Carbamazepine) ______________________________
- ☐ Topamax (Topiramate) ______________________________
- ☐ Trileptal (Oxcarbazepine) ______________________________
- ☐ Valium (Diazepam) ______________________________
- ☐ Vimpat (Lacosamide) ______________________________
- ☐ Zarontin (Ethosuxamide) ______________________________
- ☐ Zonegran (Zonisamide) ______________________________

**Other medications**

______________________________
______________________________
______________________________
______________________________
______________________________
______________________________
______________________________

## Social History:

Tobacco: ☐ Yes ☐ No How much: ____________
Alcohol: ☐ Yes ☐ No How much: ____________
Drugs: ☐ Yes ☐ No Specify: ______________
Driving: ☐ Yes ☐ No

Education: ______________________________
Current Job: ______________________________

Date of last menstrual period:____________________
Planning pregnancy: ☐ Yes ☐ No

Patient Name: ____________________________ Date: _______________

**Family History:** (Indicate diseases present in your family. F: Father, M: Mother, S: Sister, B: Brother, C: Cousin, O: Other)

____ High Blood Pressure
____ Heart Disease
____ Diabetes
____ Cancer
____ Kidney Stones
____ Depression
____ Stroke
____ Seizures
____ Brain Surgery
____ Liver problems
____other

## Past Medical / Surgical History (Check all that applies):

☐ High Blood Pressure
☐ Heart Disease
☐ Diabetes
☐ Ulcer
☐ Stroke
☐ Migraine
☐ Sleep apnea
☐ Asthma
☐ Miscarriages
☐ Kidney disease
☐ Kidney stones
☐ Liver disease
☐ Appendix
☐ Gall bladder
☐ Hernia
☐ Hysterectomy
☐ Prostate
☐ C-Section
☐ Breast surgery
☐ Brain Surgery
☐ Cancer: ____________
☐ Psychiatric problems
☐ Other: ____________
___________________

## Review of Symptoms: (Check all that applies)

General Health
☐ Tiredness
☐ Fevers
☐ Night sweats
☐ Weight gain
☐ Weight loss

Visual System
☐ Blurred vision
☐ Double vision
☐ Decreased vision
☐ Eye pain
☐ Eye redness
☐ Visual hallucinations
☐ Visual loss

Auditory System
☐ Hearing loss
☐ Ringing
☐ Dizziness

Skin
☐ Large moles
☐ Rash
☐ Hair loss

Gastrointestinal
☐ Belly pain
☐ Diarrhea
☐ Constipation
☐ Loss of appetite
☐ Black stools
☐ Blood in stools
☐ Nausea
☐ Vomiting

Respiratory
☐ Chronic cough
☐ Shortness of breath
☐ Coughing blood

Cardiovascular
☐ Chest pain
☐ Ankle swelling
☐ Palpitations

Musculoskeletal
☐ Joint paint
☐ Joint swelling
☐ Joint stiffness
☐ Muscle pain

Head and Neck
☐ Nasal congestion
☐ Neck pain
☐ Neck stiffness
☐ Seasonal allergies
☐ Sinus pain
☐ Gum problems

Genitourinary
☐ Blood in urine
☐ Difficulty urinating
☐ Pain during urination
☐ Trouble holding urine
☐ Waking up at night to urinate
☐ Erectile dysfunction
☐ PMS

Psychiatric
☐ Anxiety
☐ Depression
☐ Panic attacks
☐ Irritability
☐ Inner sadness
☐ Loss of usual pleasures
☐ Aggression
☐ Restlessness

Sleep Symptoms
☐ Daytime sleepiness
☐ Daytime fatigue
☐ Frequent awakenings
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Snoring
☐ Leg movements in sleep
☐ Restless legs
☐ Sleep talking
☐ Sleep walking

Neurological
☐ Headache
☐ Trouble walking
☐ Unsteadiness
☐ Poor coordination
☐ Memory difficulties
☐ Concentration problems
☐ Difficulty finding words
☐ Difficulty speaking
☐ Numbness
☐ Tingling
☐ Weakness
☐ Shaky hands

☐ Other:________________________________________________________________________

Do you have any questions/concerns that you want to be addressed on today's visit?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
_____________________

Name: ______________________________ Signature: _________________________ Date: _________