



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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth Date		Sex	<input type="checkbox"/> M <input type="checkbox"/> F
Social Security Number			

EMERGENCY CONTACT: _____

How did you hear about us? MD Ref Self Ref Yellow Pages Support Group Insurance Carrier
 Internet Other _____

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 <input type="checkbox"/> No <input type="checkbox"/>			
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 <input type="checkbox"/> No <input type="checkbox"/>			
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 _____

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 _____

FINANCIAL POLICY

I hereby acknowledge that I am aware and accept the financial responsibility for self pay accounts or for fees assessed to my account for failing to provide a 24 hour cancellation notice of any scheduled appointment. (see attached policy)

SIGNATURE (PATIENT OR LEGAL GUARDIAN) _____ DATE _____





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.



ACKNOWLEDGEMENT 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 return THIS PAGE ONLY to the receptionist.





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 six months.
- 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.

- 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)

NEREG / ENMCPA

PARTICIPATING INSURANCE CARRIERS 2025

Aetna

****NOT PARTICIPATING WITH****

Premier Care Network (APCN)
Premier Care Network Plus
Savings Plus

Aetna Better Health

Aetna Assure Premier Plus HMO D-SNP

Amerigroup Wellpoint

Amerihealth NJ

Clover Health

GHI/EMBLEM HEALTH VIA QUALCARE

Horizon NJ Health

Horizon BCBS

****NOT PARTICIPATING WITH ****

Prefix YKO & YKB

Horizon Medicare Blue Advantage HMO

Braven Medicare Plus HMO

Horizon Medicare Blue Select POS

Horizon Value Access Plan

Humana NJ

****NOT PARTICIPATING WITH:**

Humana Medicare

Magnacare

Medicare/ Railroad Palmetto GBA

Medicaid-NJ

Oscar

Oxford

****NOT-PARTICIPATING WITH****

Metroplan

Qualcare

Tricare

US Family Health

United Health Care

Wellcare

NON-PARTICIPATING WITH:

CIGNA

HIP

UNITEDHEALTHCARE COMMUNITY PLAN/AMERICHOICE

MEDICAID NY

Signature below is acknowledgement of disclosure of health plans the practice participates with. If your plan is not on this list or listed as not participating, you will be financially responsible to pay your out of network bills.

PATIENT
NAME: _____ SIGNATURE: _____ DATE: _____

CHART NUMBER: _____ (OFFICE USE ONLY)



NEREG Patient Financial Policy

No Show/Cancelations

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 or procedure 24 hours in advance will result in a no-show fee billed to your account.

Neuropsychological Testing

A deposit of \$250.00 is required in advance to hold your scheduled appointment. Failure to cancel testing 24 hours in advance will result in forfeit of your deposit.

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 check in for your appointment. If you are unable to make a payment at the time of, check in, then your appointment will be rescheduled. For Telemedicine appointments payment is required when your appointment is confirmed. If you no show to a Telemedicine appointment the payment will be applied toward your no-show fee and the remainder if any will be refunded. A pricing list is available upon request.

No-Show Fees

Office Visit: \$50

EEG & EMG: \$100

Ambulatory VEEG: \$250

Neuropsychological Testing: \$250

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

We appreciate your understanding and cooperation.

Patient's Name: _____

Date of Birth: _____

Patient signature: _____

Date: _____



INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name:	Date of Birth:	Chart#:
Patient Address:	City:	State: Zip:
Phone:	Date Consent Discussed:	
Practice Name:	Location:	

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

Please initial after reading this page: _____



BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. NEREG has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform NEREG of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of New Jersey and will be present in the state of New Jersey during all telehealth encounters with NEREG.

**PATIENT CONSENT TO THE USE OF
TELEMEDICINE**

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Northeast Regional Epilepsy Group to use telemedicine in the course of my diagnosis and treatment.

PATIENT’S SIGNATURE
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

DATE

IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

WITNESS

DATE

Please initial after reading this page: _____



Consent for Recording of Medical Consultations

Patient Name: _____

Date of Birth: _____

Purpose of Recording

I hereby consent to the audio recording of my current and future medical consultations by Northeast Regional Epilepsy Group using secure, HIPAA-compliant audio recording and documentation technologies, including artificial intelligence–assisted tools, for the purpose of creating, documenting, and maintaining accurate medical records.

Use and Access to Recordings

I understand and acknowledge that:

- Recordings will be used solely for clinical documentation and record-keeping purposes.
- Recordings may be accessed by Northeast Regional Epilepsy Group and authorized personnel involved in my care or in medical documentation.
- Authorized personnel may include physicians, nurse practitioners, scribes, and administrative staff.
- Any third-party technology vendors used are required to comply with applicable privacy laws and maintain appropriate safeguards, including Business Associate Agreements where required.
- Recordings will not be used for non-clinical purposes (such as marketing, research, or training) without my separate written authorization.

Privacy and Confidentiality

I understand that:

- Recordings will be stored and handled in accordance with applicable privacy and confidentiality laws and regulations.
- Reasonable safeguards will be used to protect my personal health information.
- Recordings may become part of my confidential medical record or may be deleted after documentation is completed, in accordance with applicable policies and legal requirements.

Voluntary Consent

- I understand that my consent is voluntary.
- I may withdraw my consent at any time by providing written notice. Withdrawal will not affect my care, but future consultations will not be recorded.
- I understand that declining consent will not affect my right to receive medical treatment.
- I understand that my consultation may be recorded in real time and consent to such recording.

Acknowledgment

By signing below, I confirm that I have read and understood this consent form, have had the opportunity to ask questions, and voluntarily agree to the recording of my medical consultations as described above.

Patient Signature: _____

Date: _____

Printed Name: _____

Parent/Guardian (if applicable): _____

Date: _____