Three Village Neurology, PC

Verification of Insurance

Name:_____ SS# (Last 4 only) :_____ M/F:_____

Address:_____ City/NY:_____Zip:_____

Home phone:_____Cell:_____Work: _____

Date/Birth:_____Marital Status:_____Email:_____

Primary Insurance Info: Relationship to Insured: Self Spouse Child Other (circle one)

Insured:_____Insured Employer:_____

Date/Birth:_____SS#:_____ID#:_____Policy#:_____

Insurance Co:_____ Phone#:_____

Address:_____

Secondary Insurance Info: Relationship to Insured: Self Spouse Child Other (circle one)

Insured:_____Insured Employer:_____

Date/Birth:_____SS#:_____ID#:_____Policy#:_____

Insurance Co:_____ Phone#:_____

Add:_____

Eligibility Waiver

I, _____hereby certify that I am eligible for (Ins. Co)_____
as of (effective date)_____. I understand that if I am not eligible, I will be financially responsibility for services rendered and I agree to pay In full within 30 days of receiving a bill.

Signature of Member_____Date_____

Assignment of Benefits

I, _____hereby guarantee payment of all charges incurred at the office of James D. Bruno, MD. I hereby assign and direct to pay any and all benefits for medical services to the office of James D. Bruno, MD. I hereby authorize release of any medical information requested by the insurance company in order to facilitate payment of said claims.

Signature of Member_____Date_____

Three Village Neurology, P.C.
Authorization for Access by others to your PHI
(Personal Health Information)

Patient Name: _____ _____ _____
Last First Middle

Home Address: _____

_____

Best Telephone: _____ Date of Birth: _____

Please check all situations below where you would grant individual(s) listed below to access your Personal Health Information (P H I)

☐ Confirmation of Appointments/Schedule Appointments
☐ Pick up Medical Records - Person MUST provide photo ID

Last 4 digits of your SSN _____ (This will be your passcode for your PHI)

Please list individual(s) and their relation to you for whom you authorize your PHI

*** Please Note: We will ONLY release information to authorized individuals listed below

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

Acknowledgement: By submitting this form, I hereby permit this office to disclose my PHI to the individual(s) indicated above. I understand that each individual I have listed will be required to provide the passcode I have given this office to release my PHI. In addition, authorized individual(s) must present photo ID as proof that they are who they claim to be. I also understand that this office reserves the right to deny access.

Patient Signature: _____ Date of Authorization:_____

Please sign below if you DO NOT wish to grant anyone access to your PHI at this time

Patient Signature:_____ Date:_____

Three Village Neurology, P.C.
Office Policy and Procedure
Please read carefully

** Copays, co-insurance, and deductible balances are due and will be collected at time of service. We accept Cash, Check, and All Credit Cards

** If you are 10 minutes or more late for your appointment, we reserve the right to reschedule you to another day and/or time. If you experience an emergency, please go to the nearest hospital.

** If you have a question or concern for the Doctor, and have not been seen for over a month, please schedule an appointment.

** If you have left a message, please allow 1 to 2 business days for the staff or Doctor to return your call. If you leave a message and it is an emergency, and you have reached us outside our normal business hours or when closed due to inclement weather, etc, call **911.** If it is an urgent matter, follow the instructions at the end of leaving your message to mark your message "urgent".

** **For Refills:** Please note: You will be given the maximum allowed refills by law or at the Doctor's discretion. Please call for an appointment at least 1 month in advance for reevaluation. Refills require an office visit if last seen is greater than 2 weeks or at the Doctor's discretion. If you medication requires prior authorization, an office visit may be required.

** If your doctor orders any imaging tests that require authorization, we will obtain authorization from your insurance company. Please allow 5 to 6 business days for this process. After your test has been authorization, the facility will contact you, unless otherwise specified.

** To insure quality and continuity of care, follow up appointments are required for ALL test results, including labs unless otherwise specified. These are generally scheduled 1 to 2 weeks after your test date to allow time for this office to receive test results.

** There may be a charge for all forms that are filled out by the Doctor requiring his signature. This includes FMLA, disability forms, work notes, etc. Office staff will provide you with the fee schedule. Please be prepared to pay at the time the forms are delivered to us.

** I have received and read the Notice of Privacy Practices (HIPPA) as well as office policies.

*Patients Signature:*_____ *Date:*_____