Naomi Feuer, M.D.

General Neurology
Neuromuscular Diseases & Electrodiagnostic Center
635 Madison Avenue, New York, NY 10022
Tel: 212-857-4505 Fax: (212) 759-1635

Name (last, first)_____ Social Security:____ _ _____ _____

Street Address:_____ APT#_____

City:_____ State:_____ Zip_____

Marital Status: Single/ Married/ Other Date of Birth:_____/__ Gender:_____

Home Phone:_____ Cell Phone: (__) _____ Employer: _____

Occupation:_____ Business Phone:(___ _____

E-Mail Address we can contact _____

Referring Doctor:_____ Tel:_____

Primary Physician/Internist: Tel: _ _ _ _ _ _ _ _ _ _

1n case of emergency we may contact:_____

Phone number and Relation of your emergency contact:

_____

PRIMARY INSURANCE and ID#: _____

SECONDARY INSURANCE and ID#: _____

Financial Agreement

I understand that, **Naomi Feuer, MD,** does not accept insurance directly and has opted out of Medicare. Due to the fact, Dr. Feuer does not bill insurance companies directly, payment for services rendered, is expected from patients at the time of services.

I understand that my health insurance is a contract between the insurance company and myself (the insured patient). It is not a contract between the patient and the doctor, nor between the doctor and the insurance company. Naomi Feuer MD, **is not responsible** for any reimbursement issues and outcomes that I may have with my chosen insurance company.

Payment Due in Full at the Time of Service:

All charges for services rendered are due and payable in full at the time of service, regardless of whether you have insurance. You hereby waive any and all claims against this Practice with respect to the processing of insurance claims and the payment of benefits from the insurance company to you.
Acceptable payment methods include cash, credit card or check.

By signing below. you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party. Your signature verifies that you have read this Patient Financial Responsibility statement, understand your responsibilities, and agree to these terms. A photocopy of this document shall be as effective and valid as the original.

_____ _____
Patient's Name (Print) Date of Birth (mm/dd/yyyy)

_____ ____/____/____
Signature of Patient/Responsible Party (Representative Status) Date (mm/dd/yyyy)

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Thank you for choosing me to be your doctor. In an effort to perfom1 a comprehensive evaluation of you and the problem which brings you to see me, please fill out the following questionnaire as comprehensively as possible prior to your visit with me. This will greatly assist me in caring for you. Thank you for your time - **Naomi Feuer, MD,**

NEW PATIENT QUESTIONNAIRE

Have you had previous consultations for this problem" YES / NO with who? _____

- **Chief Complaint**

I. What is your age_____ Height: ___ Weight:___ _

2. Which hand do you write with?_____

3. What is the reason you are seeing the doctor today?

_____

_____

4. How long have you had your symptoms" 1 2 3 4 5 6 7 8 9 10 11 weeks/months/years (Please circle)

5. Prior medical history: please list all medical conditions and hospitalizations you have ever had
Please try to include dates:

_____

_____

_____

6. Prior surgical history: please list all major surgeries and procedures you have ever had
Please include dates:

_____

_____

7. Do you have any allergies (food, latex? medications, etc.:) No ___ Yes - If yes, please list **them and describe any reaction it causes.**

_____

_____

_____

Do you use tobacco products/ Alcohol: If yes, describe?_____

_____

Do you use any cannabis products? If yes, please describe what and how often:

_____

Do you have children: .....

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- **Do you have any of the problems below?**

_ **Do you have a headache**
_ Do your headaches wake you up at night?
_ Do you have seizures?
_ **Have you ever lost consciousness for any reason?**
_ Do you have weakness?
_ Do you have numbness?
_ Do you have Dizziness?
_ Do you have double vision9
_ Do you have blurred Vision"
_ Do you have confusion?
_ Do you have memory Loss?
_ Do you have trouble walking?
_ Do you fall?

_ Do you have neck pain?
_ Do you have back pain?
_ Do you have joint pain?
Where: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

_ Do you have fevers?
_ Do you have night sweats?
_ Do you have fatigue?
_ Changes in activites?
_ Do you have a cough?
_ Do you have any voice changes?
_ Do you have any difficulty swallowing?
_ Do you have a rash?

- **Do you have any of the problems below?**

_ Do you feel depressed?
_ Do you have trouble sleeping"
_ Do you feel anxious 0
_ Do you feel threatened by anyone"
_ Are you being mentally abused by anyone?

_ Do you have chest pains"
_ Do you have palpitations?
_ Have you lost your appetite"
_ Have you lost weigh unexpectedly"
_ Do you have indigestion or heartburn"
_ Do you have constipation or diarrhea 9
_ **Do you have nausea or vomiting?**

_ Do you have burning while urinating"
_ Do you have blood in your urine?
_ Do you wake up at night to urinate?
_ Do you rush to urinate?
_ Do you lose control over urinating or stool 9

_ Do you have any nasal discharge?
_ Do you have any ear pain?
Tinnitus"
_ Hearing Loss?
_ Do you have stomach pains?

- **Family History**

Has anyone in your family ever had a brain tumor, seizure or epilepsy, dementia, Parkinson's, Multiple Sclerosis. muscle disease, neuropathy, other neurological disorder? If yes, please describe and give relationship of family member:

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Pharmacy Name:____

Pharmacy Phone: ____

Drug Name	Condition	Dose	Frequency

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CANCELLATION POLICY

Naomi Feuer, MD has a 24-hour cancellation /rescheduling policy. If you miss your appointment, cancel or change your appointment with less than 24 hours' notice, you will be charged **$100.00.**

This policy is in place out of respect for all of our patients. By signing below, you acknowledge that you have read and understand the Cancellation Policy.

Signature:_____ Date: _____

CREDIT CARD AUTHORIZATION

For your convenience, you **may** keep your credit card or debit card on file as a convenient method of payment for any services or supplies that have been rendered.

Your credit card information is kept confidential and secure. Payments to your card will be processed at the time of service:

Name on Card: _____

Billing Address:

_____

_____

Credit Card Type: Visa Mastercard Discover _American Express

Credit card number: .....

Exp Date:_____ CID: _____

I authorize and understand that **Naomi Feuer, MD,** will charge for services and products rendered to the credit card provided. I agree to pay for this in accordance with the issuing bank cardholder agreement.

This authorization relates to all payments for services provided to me by Naomi Feuer, MD.

This authorization will remain in effect until a written notice of cancellation is provided. The account must be in good standing to cancel this authorization.

Signature:_____Date:_____

Naomi Feuer, ·, MD
Neurology & Neuromuscular, · Disease
New York Physicians **LLP**
635 Madison Avenue• New York, New York 10022
Tele (212) 857-4505 • Fax (212) 759-163S

Acknowledg1nent of Notice of Privacy Practices

Effective April 14, 2003

This acknowledgment form is provided to you as required by the Privacy Rules and related Regulations under the Health Insurance Portability and Accountability act of 1996 ("HIPAA.")

You are asked to sign this form so that we can confirm that you have received it. Your signature only confirms that you have received this form. Your signature does not mean that you agree with any of the policies and procedures outlined herein.

You may refuse to sign this Acknowledgment Form, at which time our staff is required to document the date and time of your refusal, as well as your reason for not signing.

I acknowledge that I have received a copy of New York Physicians LLP Notice of Privacy Practices, as of the date indicated below.

Patient signature:_____ Date:_____

Print name: _____

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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

1,_____, hereby authorize and consent to communication between myself and:

_____

_____

_____

_____

_____

_____

As parties that are authorized to communicate, each party may disclose information to the other party or receive information from the other party in accordance with the terms of this Consent.

Information to be disclosed for the purposes of coordination of care (check all that are appropriate):

D Radiology reports
D Lab reports
D Confidential HIV information/reports
D Medical evaluations and/or reports

Email: I authorize the use of unsecured (non-HIPM-compliant) email for communication.
Yes___ No__ _

Expiration: This consent will NOT expire until the patient provides written documentation to the physician.

Patient signature:_____Date:_____

Print name: _____