Neurological Surgery & Pain Management 1175 Montauk Highway, Suite 6, West Islip, NY 11795 631-422-5371
Patient Information Sheet

Name_____Date of Birth_____/_____/_____Age_____M / F

Address_____City/State__ ZIP Code_

SS#_____-_____-_____ Marital Status S M W D S Email _____

Preferred Contact Method		Message? (Y or N)	
Home Phone	(_____)_____	Y	N
Cell Phone	(_____)_____	Y	N
Work Phone	(_____)_____	Y	N
Alternate Phone	(_____)_____	Y	N

OPT OUT OF TEXT MESSAGE CONFIRMATIONS

I authorize my physician and the medical staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Contact Information

Referring Doctor Name_____ Telephone #_____

Primary Care Physician_____Telephone # _____

Pharmacy and Location_____ Telephone #_____

How did you hear about our office? (Circle One) **Friends/Family** **Website/Google** **Newspaper** **Radio** **TV** **Direct Mail**

INSURANCE INFORMATION **If Change of Insurance: Effective DATE**_____

Primary Insurance_____ Member ID #_____

Policy Holder_____ Policy Holder SS#_____Policy Holder DOB _____

Relationship to Patient_____Policy Holder Employer_____

Secondary Insurance_____ID #_____Policy Holder _____

Policy Holder SS#_____Policy Holder DOB_____Relationship to Patient _____

WORKERS COMPENSATION or NO FAULT OR THIS IS NOT RELATED TO A CAR ACCIDENT OR INJURY AT WORK_____(initial)

Insurance Carrier_____Claim Number_____

Date of Injury/Accident_____Adjuster_____Phone _____

Workers Compensation Only:

Employer _____ Employer Address_____

Job Title/Description_____How did injury occur_____

On the date of injury, what were your usual work activities: _____

Attorney's Name & Phone Number _____

_____ _____

Signature of Patient **Date**

OVER →

I hereby authorize as follows:

I hereby authorize and direct Borimir Darakchiev MD, (herein referred to as "the provider,") having treated me, to release to Medicare, Medicaid, governmental agencies, insurance carriers, or others who are financially liable for medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I hereby guarantee payment to the provider of all charges and fees incurred for services rendered to me. I understand that if an insurance company (non-participating) fails to pay all or part of this claim, that I am responsible, upon notice, for payment in consideration of the physician's services which have been or will be provided to the patient. I hereby assign to the provider all of the medical insurance benefits to which I may be entitled from Medicare, Medicaid, governmental agencies, insurance carriers, no-fault carriers, or others that are financially liable for my care. I hereby authorize to the provider authority to file claims for payment and appeals on determinations of those claims on my behalf.

I hereby designate, authorize, and convey to the provider, having treated me to the full extent permissible under law and under any applicable insurance policy and/or employee health care benefit plan, as my Authorized Representative: (1) the right and ability to act on my behalf in connection with any claim, right, or cause in action that I may have under such insurance policy and/or benefit plan; and (2) the right and ability to act on my behalf to pursue such claim, right, or cause of action in connection with said insurance policy and/or benefit plan (including but not limited to, the right to act on my behalf in respect to a benefit plan governed by the provisions of ERISA as provided in 29 C.F.R. §2560.5031(b)(4)) with respect to any healthcare expense incurred as a result of the services I received from Provider and, to the extent permissible under the law, to claim on my behalf, such benefits, claims, or reimbursement, and any other applicable remedy including fines.

I request that payment of authorized benefits be made on my behalf to the provider.

_____ _____

Signature of Patient Date

_____ _____

Signature of Person/Guarantor (Other than Patient) Witness

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediates of carriers any information needed for this or a related Medicare claim. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

_____ _____

Signature of Insured or Authorized Representative Date