Gomez Neurology, PLLC

110 Wolf Rd.
Albany, NY 12205-1244
GomezNeurology.com
voice: 518-650-2090 *fax: 888-698-2021*

Patient Information Form
Neurology
*** Physician Referral Required ***

Chief Complaint (reason for being seen)	
Patient	Responsible Party
Name	Name
Mailing Address	Mailing address
Phone Number: Hm: Cell:	Phone Number: Hm: Cell:
Employer Work Phone	Employer Work Phone
DOB Gender SSN	DOB Gender SSN
Primary Ins	Subscriber Name
Group/Policy #	Relationship to Patient
Secondary Ins	Subscriber Name
Group/Policy #	Relationship to Patient
Marital Status: ☐ Single ☐ Married ☐ Widow	Marital Status: ☐ Single ☐ Married
Race: ☐ Asian ☐ Black/African American ☐ Native American/Alaskan Native ☐ Multi-Racial ☐ Caucasian ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ Unknown/Refused	
Ethnicity: ☐ Latino/Hispanic ☐ Non-Latino/Non-Hispanic ☐ Unknown/Refused	
Preferred Language: ☐ English ☐ Arabic ☐ Armenian ☐ Chinese ☐ French ☐ German ☐ Greek ☐ Gujarati ☐ Hindi ☐ Italian ☐ Japanese ☐ Korean ☐ Persian ☐ Polish ☐ Portuguese ☐ Russian ☐ Spanish ☐ Tagalog ☐ Urdu ☐ Vietnamese ☐Other _____ Patient information form vs. 1.17.18	

Who May We Contact in Case of Emergency

Name	Patient Relationship to Contact?	Primary Phone Number	Secondary Phone Number

PATIENT'S FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

NOTICE OF NOT ACCEPTING WORKER'S COMPENSATION AND NO-FAUL INSURANCE I hereby state that my condition is not covered under a Worker's Compensation or No-Fault insurance plan, and understand that Gomez Neurology does not accept such plans as payment.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS I hereby authorize and direct payment of my medical benefits to Gomez Neurology on my behalf for any service furnished to me by the providers.

Signature _____ Date_____

Obtaining Verbal/Written Permission to Use or Disclose Protected Health Information

From time to time Gomez Neurology may need to collect or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by the Title 45, Section 164.10, we are permitted to make such uses or disclosures after we have obtained your verbal or written permission.

Gomez Neurology is authorized to: (please check all that apply)

☐ Collect Protected Health Information from:

Practice Name _____

Practice Address _____

Practice phone _____ Fax _____

☐ Notify or speak regarding treatment or proposed treatment with

(please specify name): _____

(please specify name): _____

Other (please specify): _____

_____

Name of Patient

_____

Signature of Patient

_____

Email address

_____

Date

How may we contact you with reference to your appointments, proposed treatment, follow-up appointments, billing questions/problems, surgery scheduling, lab testing, radiology, and other situations regarding your protected health information?

HIPAA-compliant email permission Statement

☐ I authorize Gomez Neurology its providers and employees to leave detailed messages specific to my medical care, including test results, through HIPAA-Compliant email at the email address listed below.

I understand that this authorization can be revoked at any time by submitting a written request to Gomez Neurology. This authorization is not required to receive care at Gomez Neurology. Patients opting not to sign this authorization will receive medical information such as test results through the phone or USPS mail rather than a voice messaging system or email.

_____

Name of Patient Signature of Patient

_____

Email address

_____

Date

Voicemail Permission Statement

☐ I authorize Gomez Neurology its providers and employees to leave detailed messages specific to my medical care, including test results, on the telephone number listed below. I understand that when a voicemail message exists, it is no longer covered under the Health Insurance Portability and Accountability Act of 1996 and therefore is not protected from unauthorized access.

I understand that this authorization can be revoked at any time by submitting a written request to Gomez Neurology. This authorization is not required to receive care at Gomez Neurology. Patients opting not to sign this authorization will receive medical information such as test results through the phone or USPS mail rather than a voice messaging system or email.

_____

Name of Patient Signature of Patient

_____

Email address

_____

Date