NEUROLOGY ASSOCIATES OF NORWALK

605 West Avenue, Second Floor
Norwalk, CT 06850
(203) 853-5000 phone
(203) 853-5001 fax
NorwalkNeurology.com

Louis J. Cuzzone, MD
Irina Taraban, MD
Daryl R. Story, MD
James L. Thompson, Jr., MD

Dear ____________________,

Welcome to Neurology Associates of Norwalk. We are looking forward to seeing you at your consultation on _____________________________ with Dr. _______________________. We will call you 3 business days prior to confirm this appointment. **It is important that we hear from you to confirm.** If we do not reach you during that call, please return our call to confirm your appointment. If we do not hear from you by noon on of the prior business day, we will have to reschedule your appointment. The phone number(s) we have for you are ____________________ and ____________________. Please be sure your phone number(s) are accurate, in service and have working voicemail so we may reach you. All future appointments will be confirmed with a phone call from our automated system.

Please arrive 5 – 10 minutes early for your first appointment with the enclosed paperwork **completed**. Be sure to bring your medical insurance card(s) and photo identification. If you were provided with an electronic insurance card, please print a paper copy to present to our office at check in. Enclosed is a copy of our demographics and intake forms. If possible, please mail or fax this completed form to us prior to your appointment. Please include a list of all medications you are taking, including strength and dosing frequency, or be sure to complete that section on your new patient form. Also supply us with any relevant medical records prior to this visit. Doctor's notes, MRIs and other testing are crucial to a productive first visit and managing your care. If you are not able to fax or mail this information prior to your appointment, please be sure to arrive 15 minutes early and bring this **completed** information with you. You may also email us this information to checkin@NorwalkNeurology.com.

If you need to cancel or reschedule your appointment, please give us as much advanced notice as possible. Missed or cancelled appointments with less than 24 hours' notice, excluding weekends and holidays, will be charged a $50 fee. Thank you for giving us the opportunity to see you and trusting your care to Neurology Associates of Norwalk.

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2021 Demographics Form

Patient name: ______________________ **Date of Birth:** ____________ **Gender:** Male Female

Address: ______________________ **City:** ____________ **State:** _______ **Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Email: *(complete only to be enrolled in our Patient Portal)* ______________________

What is your marital status? Single Married Divorced Widowed Domestic Partner **Primary language:** English or other: ____________

Race: African American / Asian / Caucasian / Native American / Pacific Islander **Ethnicity**: Hispanic or Latino / not Hispanic or Latino

Primary Care Doctor: ______________________ **Referring Doctor:** ______________________

Primary Medical Insurance: ____________ **Policy #:** ____________ **Group #:** ____________

Secondary Medical Insurance: ____________ **Policy #:** ____________ **Group #:** ____________

Is your visit due to a motor vehicle or worker's compensation injury? **No:** _____ **Motor Vehicle** _____ **Worker's Comp** _____

Neurology Associates of Norwalk does not treat patients with Motor Vehicle or Workers Compensation claims

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Guarantor (person financially responsible for paying and medical bills) **LEAVE BLANK IF PATIENT IS GUARANTOR**

Guarantor name: ______________________ **Date of Birth:** ____________

Address: ______________________ **City:** ____________ **State:** _______ **Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________

Guarantor signature: ______________________ **Relationship:** ______________________

Patients often give us permission to discuss information with family or other individuals. If you want us to be able to talk to someone, we need to verify your permission. If you don't give permission for us to talk to anyone, leave it blank. Neurology Associates of Norwalk has my consent to communicate with the following person and/or discuss my personal medical information with the following person.

Name:______________________ **Relationship:**____________ **Phone:**____________

Name:______________________ **Relationship:**____________ **Phone:**____________

Name:______________________ **Relationship:**____________ **Phone:**____________

The information I have provided above is complete and accurate to the best of my knowledge. I have read and understand the Notice of Privacy Practices. I have also read and understand the Office Policies for Neurology Associates and been given a copy to keep for my reference.

Patient signature: ______________________ **Date:** ____________

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Office Policies

General: Please notify Neurology Associates of Norwalk of any changes in address, insurance, phone number, or primary care physician. Please request any medication refills directly with your pharmacy. I authorize the viewing of external prescription history information. Please allow up to 7 days for any refill request to be processed. If your insurance requires a prior authorization, please allow up to 7 days for us to complete the process with your insurance. Your insurance could take additional time, usually 2-15 days, to approve or deny any prior authorization request. Please check directly with your insurance as to the status of their approval or denial. Neurology Associates of Norwalk charges $25 for completion of forms which may be requested by your insurance, employer, DMV or any other third party. More extensive forms, such as disability determinations, may command a higher fee of $50. Depending on the timeframe of your last visit, your doctor may require you to be evaluated again in order to answer the questions being asked.

Insurance: I authorize my insurance to release benefits (payments) to Neurology Associates of Norwalk, P.C. I agree the insurance information provided by me is true and correct. If this information is invalid, I agreed to be fully responsible for payment. If my insurance carrier requires a referral and I do not obtain one, I will be responsible for payment. If my insurance carrier requires a precertification or predetermination I will be responsible to make sure one is approved by my insurance prior to having services provided to me. If this precertification or predetermination is not in place and I receive services, I agree to be responsible for payment in full. I further agree that if my physician does not participate with my insurance, I will be responsible for payment in full. I understand Neurology Associates of Norwalk does not participate with Medicaid (Husky). It is the patient's responsibility to determine if Neurology Associates is in network with your insurance plan. I understand even though Neurology Associates may participate with my insurance carrier, that carrier or employer may offer me a plan with does not include Neurology Associates of Norwalk as a network provider. It is the patient's responsibility to make us aware of any change in your insurance coverage at least 1 week in advance of any appointment. I will be responsible for any services my insurance denies as being considered experimental or not medically necessary. It is my responsibility to check with my insurance prior to treatment to determine what services they consider experimental or not medically necessary. If Neurology Associates does not participate with your insurance we will still be happy to submit claims to your insurance on your behalf. However, you are still financially responsible to us for all services rendered. In a situation where your claim is denied or only partial payment made by a non-participating insurance you will be responsible for the balance due. I understand that if I am a Qualified Medicare Beneficiary (QMB), I am responsible to give Neurology Associates of Norwalk a copy of such determination as provided by the State of Connecticut Department of Social Services prior to my visit(s) I order for my claims to be processed according to the program. These policies supersede any agreements with my insurance carrier.

Motor Vehicle or Workers Compensation: I understand Neurology Associates of Norwalk does not treat patients with Motor Vehicle or Workers Compensation claims. If you seek treatment from us as part of a Motor Vehicle or Workers Compensation claim, you will be responsible for payment in full for these services. You cannot choose to submit Motor Vehicle or Workers Compensation claims to your medical insurance carrier as these claims are not covered under your medical insurance.

Financial Obligations: Your co-pay or any previous balance is payable at time of service as this is a contract between you and your insurance company. I understand that I may be asked to reschedule my appointment or be charged an invoicing fee of $15 if I am unable to make my copayment at time of service. Patients who have insurance which we do not participate with must make payment in full at the time of service. Neurology Associates of Norwalk does not accept patients without medical insurance. I authorize Neurology Associates of Norwalk and any of its agents to use the information provided for billing and other issues related to my care. Neurology Associates accept all major credit cards, checks and cash. There is a $25 fee for any checks not honored by your bank. I understand and agree that if my account becomes delinquent and is transferred to a third-party collection agency that I will be assessed a fee of 15% of my balance being transferred to said agency. I understand that if my account becomes delinquent by 90 days I will not be able to receive care from Neurology Associates of Norwalk until my account is brought current. This includes medication refills. If your delinquent balance is transferred to a third-party collection agency more than once you will not be able to receive care from Neurology Associates of Norwalk even if your debt is later paid.

Missed Appointments: I understand there is a "No Show" fee for appointments missed or cancelled with less than 24 hours' notice, excluding weekends and holidays. I understand if I am 10 or more minutes late to my appointment that I will be considered a No Show. The No Show fee for a follow up appointment is $35 while the No Show fee for a new patient or testing appointment is $50. I understand the No Show fee will be assessed regardless of my reason for missing my appointment, even if that reason is beyond my control. I will also be charged a No Show fee if I come to my appointment but refused to have services rendered. If I miss 3 appointments within 18 months I understand I may not be offered any future appointments.

Please keep this form for your reference

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2021 Intake Form

Patient name:________________________________ **Date of Birth:**____________________

Explain the problem that prompted this visit to a neurologist: ________________________________

____

Onset/duration:____

What treatments have you had for this problem? ______________________________________

____

What tests have been done for this problem? ________________________ **Where?**____________________

What is your height? _________ft_______inches. **What is your weight?** ___________ lbs **Are you:** right-handed /left-handed / ambidextrous (both)

Medical problems: Please circle any medical problems you have had or currently have or please list if you have a condition that is not included

Neurological: Migraines Multiple Sclerosis Neuropathy Parkinson's disease Seizures Concussion Stroke TIA intracerebral hemorrhage
memory problems neck pain back pain sciatica learning disability other________________________

Cardiovascular: High blood pressure coronary artery disease heart attack atrial fibrillation cardiac stent bypass graft
Pacemaker Defibrillator peripheral vascular disease other________________________________

Respiratory: Asthma COPD emphysema lung cancer other____________________________________

Endocrine: Diabetes hypothyroidism hyperthyroidism other____________________________________

Gastrointestinal: Ulcers gastro esophageal reflux hepatitis colon cancer other______________________________

Hematologic: Anemia hemophilia leukemia lymphoma hypercoagulable state other__________________________

Psychiatric: Anxiety depression bipolar disorder ADHD schizophrenia substance abuse other______________________

Musculoskeletal: Osteoarthritis rheumatoid arthritis osteoporosis osteopenia other____________________________

Cancer : chemotherapy radiation cancer surgery What type of cancer?________________________________

Eyes and ears: Cataract glaucoma vision loss lazy eye double vision hearing loss other________________________

Previous surgeries: Tonsils appendix hysterectomy gallbladder hernia other______________________________

Review of systems: Please circle any symptoms you have recently had: Fever chills recent visual change cough shortness of breath
chest pain change in bowel or bladder habits bleeding joint pain Rash headache other:______________________

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Patient name:____ **Date of Birth:**_________________________________

Social History:

Alcohol use: Never Quit at _____________age Currently drink ________________ drinks per week or _____________drinks per year.

Tobacco use: Never Quit at ____________ age Currently smoke _______________ pack(s) per day or ____________ per year.

Any Illicit drug use?: ____

What is your occupation? Retired Student Homemaker On disability Employed as ____

Employer name & city: ____

List any allergies including medications, Latex or contrast dye. ___ **No Known Allergies**

Medication or product	Reaction

Please give us a list of your current medications. Include over-the-counter medications, like aspirin, and supplements (continue on reverse if needed or attach a list) PLEASE WRITE CLEARLY.

Medication Name & Strength	Dose	When Taken

Preferred Pharmacy: ____ **City & Street:** _______________________________________

Family History: Are you adopted? Yes or No

Please list medical problems in your family members such as; migraine, stroke, high blood pressure, heart disease, neuropathy, dementia, and cancer.

Mother:____

Father:____

Brother(s):____

Sister(s):____

Other family members:____