DENT NEUROLOGIC INSTITUTE
716.250.2000 | dentinstitute.com
Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Batavia | 35 Batavia City Center • Batavia, NY 14020
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127

DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Last Name:	Middle:	First:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one): Single / Mar / Div / Sep / Wid

Former Name:	Birth Date:	Age:	Sex: ❑ M ❑ F	Transgender: ❑ T

Street Address or P.O. Box:	E-mail Address:	Home Phone: ( ) Cell Phone: ( )
City:	State:	Zip Code:	Social Security Number:

Referring Physician:	Primary Physician:

Occupation:	Employer:	Employer Phone: ( ) ❑ Full Time ❑ Part Time
Race:	Ethnicity:	Language:
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone:

CONTACT PERSON IN CASE OF EMERGENCY

Name:	Relationship:	Home Phone: ( )	Work Phone: ( )

INSURANCE INFORMATION

You will need to give your insurance card to the receptionist

Person Responsible for Bill (if not self):	Address (if different):	Home Phone: ( ) Cell Phone: ( )
Birth Date: / /	Occupation:	
Responsible Party's Employer:	Employer Address:	Employer Phone: ( )

PRIMARY INSURANCE	Insurance Plan:			
Policy No:	Group No:			
Subscriber's Name (if not self):	Subscriber's SSN:			Co-pay Amount:
	Subscribers DOB: / /			
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
SECONDARY INSURANCE	Insurance Plan:			
Policy No:	Group No:			
Subscriber's Name (if not self):	Subscriber's SSN:			
	Subscribers DOB: / /			
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

PLEASE REVIEW AND SIGN OUR PRACTICE POLICIES

Insurance Information/Assignment of Benefits……………….……… Patients are required to provide DENT with current and accurate insurance information at every visit. Your **FAILURE** to provide us with accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorize DENT to furnish information to insurance carriers concerning your illnesses and treatments and hereby assign all payments for medical services rendered to you or your dependents to Dent Neurologic. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

Co-Pay, Deductibles, POS Plans, Private Payments and Unpaid Balances..……… In accordance with the provision of your insurance plan, you may be required to pay for a portion or all of your medical services. As a result, if you have a co-pay, deductible, or Point of Service Plan or you are a private paying patient, **payment is required at the time of service.** Should you need to discuss this payment policy, you may contact our Business Office at 250-2010 prior to your appointment. Please note it is within our discretion to take current payments and apply them to existing unpaid balances or move credit balances to future appointments. If for any reason, you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 90 days your account will be turned over to a collection agency, proceedings will begin and you will be discharged from our care. Accounts sent to collections will have a 30% collection fee added to the balance along with applicable attorney fees.

Identity Theft……………………………………………………….…… The Federal Trade Commissions, "Red Flag" rule requires health care providers to establish a program to prevent identity theft. As a result we will be asking all patients to provide photo identification when checking in for their appointment and will be taking a photograph to be used for the sole purpose of identification. If you are unable to provide us with proper identification at the time of your visit, we will need to **RESCHEDULE** your appointment.

Practice Communication Information…………………………….. Patients in our practice may be contacted via phone, email, and/or text messaging to remind of appointments, payment, treatment, and/or other healthcare information. By entering information below, you consent to receiving these communications from us:

<table>
<tr><td rowspan="3">Send reminders/information (select all that apply):</td><td>☐ Voice ( ) -</td></tr>
<tr><td>☐ SMS/text ( ) -</td></tr>
<tr><td>☐ E-mail address: ____________________________
Note: reminders not available via e-mail</td></tr>
<tr><td>Preferred Phone Number (select one):</td><td>☐ Home ☐ Cell ☐ Work</td></tr>
<tr><td>Preferred Language (select one):</td><td>☐ English ☐ Spanish</td></tr>
<tr><td>Best time to contact me (select one):</td><td>☐ Morning ☐ Afternoon ☐ Evening</td></tr>
<tr><td colspan="2">☐ I do NOT wish to receive any reminders or communications from Dent as outlined above. I understand the cancellation and no show policy as outlined below.</td></tr>
</table>

Medical Photography……………………………………………... Medical photography taken for diagnostic purposes will become a part of your medical record and remain confidential in accordance with regulatory requirements and Dent Policy. From time to time we may use de-identified medical imaging or photography for research or academic purposes. Dent retains all ownership rights in these programs.

Prescription Refills…………………..………………………….… Patients must contact their pharmacies to request any prescription refills for medications that DENT prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.

Appointment Cancellation and No Show Policy…………………… Your scheduled appointment is time reserved especially for you. **We require a minimum of 24-hours advance notice for cancellation or rescheduling of an appointment to allow us to offer this time to other patients**. Rescheduling fees are: $100-Imaging, VNG, Neuropsychology, Sleep Studies. $50-All other appointments.

General Consent to Treatment and Right to Refuse Treatment..… By signing below, I (or my authorized representative on my behalf) authorize DENT Neurologic Institute and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving my consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I have read and agree to all of the above policies. I understand that my failure to comply with any of these policies may result in discharge from the medical practice.

Print Patient Name: ____________________________ Date of Birth: _______________

Signature: ____________________________________ Date: _________________________

Statement of Financial Responsibility

Insurance Coverage.* The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of DENT fees. You are ultimately responsible for payment of your bill.

Due to the increasing complexity of insurance plans, DENT requires you to contact your insurer's Member Services for information on your coverage and out-of-pocket costs. For some services, DENT will collect a fee from you before the service is rendered. That amount will be credited against the cost of that service, but in many cases will not cover the full amount. Your insurance plan is the best place to find information on the ultimate cost to you.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. DENT expects these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved service period, you will be responsible for your balance in full.

Your signature below will also authorize your insurer to pay any benefits directly to DENT, the full and entire amount of the bill incurred by you or the named patient, or if applicable, any amount due after payment has been made by your insurance carrier.

Co-Pay Policy. It is expected that patients will pay co-pays at the time the service is rendered for each visit, typically during check-in.

Cancellation / No Show Policy. DENT understands there may be times when you miss an appointment due to emergencies or other obligations. However, patients who fail to provide adequate cancellation notice, at least 24 hours prior to the appointment time will be assessed a $50 reschedule fee (NOTE: $100 for Sleep Center, Neuropsychology testing and VNG testing appointments). All assessed fees are collected at the time of scheduling the next appointment. Patients will not be able to reschedule an appointment until all fees are paid.

By signing below, you acknowledge that you have read the above policies regarding financial responsibility to DENT for providing health care services to you or the named patient and that you understand and agree to the terms described.

Patient Name (please print): ____ DOB: _______

Patient or Guardian Signature: ____ Date: _______

*Patients with No Fault or Workers Compensation coverage will be handled in compliance with New York State law with regard to payment and benefits.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)
DENT NEUROLOGIC INSTITUTE

Acknowledgement of Receipt of Privacy Notice And Restrictions/Permissions

A copy of DENT Neurologic Institute's Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state laws has been made available to me.

I understand the contents of the Notice and I request the following exceptions:

RESTRICTIONS:

Please restrict the use and disclosure of my protected health information as follows:

____
____
____
____

PERMISSIONS:

I give permission to the following individuals to view, discuss, exchange, and/or receive my protected health information:

Name: ___________________________________ Relationship: ________________________

Name: ___________________________________ Relationship: ________________________

Name: ___________________________________ Relationship: ________________________

I authorize DENT Neurologic Institute and the DENT Neurosciences Research Center (DNRC) to access my health data and use my protected health information for clinical research purposes.

__________ **Yes**, DENT and DNRC may use my information to conduct clinical research.

Initial Here

This notice and consent will remain in effect until revoked in writing.

Patient Name (print): ____________________________ DOB: ______________________

Patient Signature: ____________________________ **Date:** ______________________

If signed by a person other than the patient, please indicate relationship: ______________________

NOTE: Power of Attorney and Legal Guardianship documents are required at the time of your appointment if you are signing on behalf of a patient over the age of 18.

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis(**Not Accepting New Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus/Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo