DENT
NEUROLOGIC INSTITUTE

716.250.2000 | dentinstitute.com

Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 20 minutes prior to their appointment time to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit.

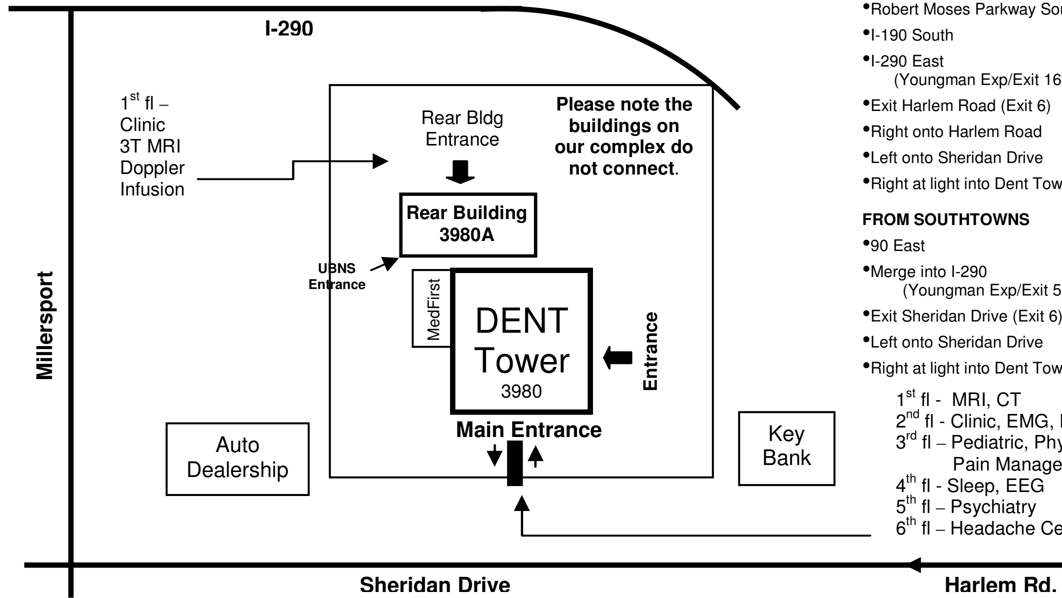
Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.

Amherst Location
3980 Sheridan Drive



FROM NIAGARA FALLS/NORTHTOWNS

- Robert Moses Parkway South
- I-190 South
- I-290 East
  (Youngman Exp/Exit 16 towards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- 90 East
- Merge into I-290
  (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower

1st fl - MRI, CT
2nd fl - Clinic, EMG, Dizziness Ctr
3rd fl – Pediatric, Physiatry, Pain Management
4th fl - Sleep, EEG
5th fl – Psychiatry
6th fl – Headache Center

Orchard Park

200 Sterling Drive
Orchard Park, New York 14127

FROM SOUTHTOWNS

Route 219 N to Milestrip Road East
(1st Exit onto Milestrip Road)
Left at traffic light onto Sterling Drive
Left on Red Tail
Left into parking lot

FROM BUFFALO

Thruway (90) West to Route 219
Exit Milestrip Road East
(2nd Exit onto Milestrip Road)
Left at traffic light onto Sterling Drive
Left on Red Tail
Left into parking lot

FROM PENNSYLVANIA

Thruway (90) East to Exit 56
Left onto Milestrip Road
Left onto Sterling Drive
Left on Red Tail
Left into parking lot

DENT NEUROLOGIC INSTITUTE 716.250.2000

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	

IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU MUST COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM

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
- 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

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:

Send reminders/information (*select all that apply*):	☐ Voice ( ) -		
	☐ SMS/text ( ) -		
	☐ E-mail address: ____________________ *Note: reminders not available via e-mail*		
Preferred Phone Number (**select one**):	☐ Home	☐ Cell	☐ Work
Preferred Language (**select one**):	☐ English	☐ Spanish	
Best time to contact me (**select one**):	☐ Morning	☐ Afternoon	☐ Evening
☐ 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.			

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.

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WORKERS COMPENSATION

SUPPLEMENTAL INFORMATION FORM

Today's Date:	Date of Birth:	
Patient Name:	Social Security No:	
Date of Injury:		
Employer Name:	Employer Address:	
Employer Phone Number: ( )	Your Job Title:	Are you out of work due to this injury: ❑ Yes ❑ No
COMPENSATION INSURANCE CARRIER INFORMATION		
Insurance Carrier Name:	Insurance Carrier Address:	
Carrier Claim Number:	WCB Case Number:	
Name of Case Manager:	Phone: ( )	
	Fax: ( )	
Briefly Describe the Injury you Sustained:		
Briefly Describe how Injury Occurred:		
ATTORNEY INFORMATION		
Attorney Name:	Attorney Address:	
Phone: ( )	Fax: ( )	

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth: Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: ❑ Yes ❑ No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ( )	Fax: ( )
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian	
If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted	
Have you Filed a Claim with your Carrier: ❑ Yes ❑ No	Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: ( ) Fax: ( )	
Signature:	**Date:**
FOR OFFICE USE ONLY	
PROVIDER: **DENT NEUROLOGIC GROUP** **PO Box 8000 Dept 057** **Buffalo, NY 14267** **Signature: ____________________________**	**CLAIM# ________________________** **DATE OF LOSS: __________________** **CARRIER: _______________________**

DENT NEUROLOGIC INSTITUTE

Instructions for Preparation of an Electroencephalogram (EEG)

What is an EEG?

Your doctor has ordered an EEG. This test allows your doctor to evaluate the electrical activity of your brain. There are several reasons your doctor may order this test. Most people have it done because they have had a seizure, passed out, or have unusual behavior.

What to expect during the test:

The test itself is painless and does not require any injections or special medications. Metal discs will be placed on your scalp, using a water-soluble paste. You will rest quietly in a reclining chair. You will be asked to open and close your eyes at various times. Toward the end of the test you will be asked to look at some flashing lights and breathe deeply and rapidly for a few minutes.

How to prepare for an EEG:

Please try to arrive 15 minutes before appointment time to fill out any necessary paperwork. Please note, if you have a **7 a.m.** appointment, there is **no need** to arrive 15 minutes early. Your hair must be clean for the test. Wash your hair either the night before or in the morning; please do not arrive with wet hair. **DO NOT APPLY ANY CONDITIONERS, GELS, SPRAYS, HAIR WEAVES OR HAIR BRAIDS**

Unless instructed by your doctor, you may take your usual medication and eat your usual meals prior to the test.

Do not use any stimulants (coffee, tea, soda) starting the night before the test. Decaffeinated beverages are allowed and you may eat before the test.

For your Information:

The test usually takes between 1-1½ hours, depending on the study that you are having. After the test is over, the technologist will remove the electrodes and clean off as much paste as possible. If you are planning to go to work after the test, please note that your hair will not look as it did when you arrived.

The doctor that referred you for the EEG will have the test results within 48 hours.

- ❑ **Routine EEG**

- ❑ **Sleep Deprived EEG**

For this test you should stay up us late as you can the night before the test. If you can stay up all night that is great, but you should do the best you can (without stimulants). The doctor may have ordered this type of EEG because he wants to view your brain waves when you are tired. Patients who are having this test done should make arrangements to be driven to the appointment, as you may be too tired to drive yourself.

- ❑ **24, 48, or 72 Hour Ambulatory EEG (please circle hours requested)**

  This study allows your doctor to view your brain waves for an extended period of time. After the electrodes are applied, your head will be wrapped with gauze to help the electrodes stay in place for the test. You will be given a diary to note any unusual symptoms you may have while wearing the monitor. You MUST wear a button down shirt. You may wish to bring a scarf, hat or baseball cap to wear over your head. You will return the next day to have the electrodes removed and return the recorder. **You will not be permitted to shower while wearing the monitor, or get it wet in any way. Water will damage the monitor as well as put you at risk for injury.**

□ **In-House Video EEG Monitoring (less than 12 hours)**
□ **In-House Video EEG Monitoring (24 hours)**

Co-payments and Deductibles are due at time of service

24-Hour Cancellation Notice is Required for all Appointments
If you cancel an appointment without adequate notice (at least 48 hours) or do not come in for this scheduled appointment, you will be assessed a rescheduling fee.

Thank you for choosing the DENT Neurologic Institute's EEG Department.
We look forward to caring for your medical needs.

Please call 250-2000 and ask for the EEG Department if you have any questions.