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.

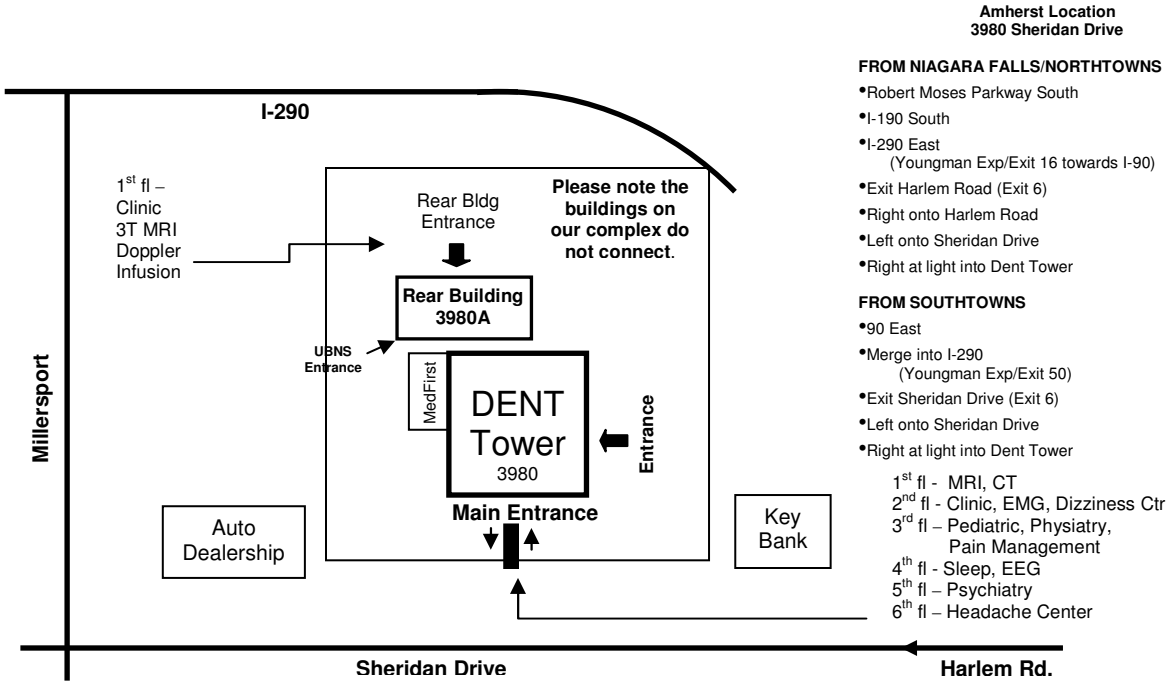
★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit.

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.



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.

DENT NEUROLOGIC INSTITUTE

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: _____**

EMG ASSESSMENT

Please complete and bring with you to your visit – Exam information on reverse side

Name: _____ DOB: _____ Age: _____

Reason for Test:

When did your symptoms begin?

What were they like at the beginning?

Have they changed? ❑ Yes ❑ No If yes, please explain:

Please indicate if you have any of the following symptoms, where and how long:

Symptom			**Location/How Long**
Weakness	❑ Yes	❑ No	_____
Pain	❑ Yes	❑ No	_____
Tingling	❑ Yes	❑ No	_____
Numbness	❑ Yes	❑ No	_____
Difficulty Walking	❑ Yes	❑ No	_____

Does anything make your symptoms it better or worse?

Other testing performed for this problem:

Please list all current medications:

Other medications tried for this problem:

Have you ever had or been diagnosed with:

❑ Diabetes ❑ Thyroid Condition ❑ Muscle Problem
❑ Nerve Problem ❑ Lower Back Problem ❑ Neck Pain
❑ Herniated Disc ❑ Other Neurologic Disorder

PHYSICIAN NOTES:

Date of Service: _____

PATIENT INFORMATION SHEET FOR EMG

You are scheduled to have a test called electromyography (EMG). This test measures electrical activity in your nerves and muscles. The information it provides gives us clues about nerve and muscle disorders.

We use the EMG to help us determine the cause of problems such as muscle weakness, spasm, numbness, paralysis, and pain in the arms, hands, legs, feet and face.

On the day of your test please **do** the following:

- Eat your regular meals
- Continue taking any medications you usually take
- If you are taking MESTINON for myasthenia gravis please call us
- Take a shower or bath, being sure to remove any body oils
- Do **not** use any bath oils, lotions or creams

AT THE DENT NEUROLOGIC INSITUTE:
Please register at the reception desk. A technician will take you to an exam room, explain the test in detail to you, and ask you to put on a hospital gown.

Please feel free to ask the technician any questions you may have.

THE EMG EXAMINATION:
The length of time that an EMG takes can vary from person to person, depending on what is involved and what information is sought.

In general, the test consists of two parts and last from one hour to one and a half hours. The first part of the test involves nerve conduction studies. While you are lying down, the technician will place small stick-on recording tabs to your skin. The nerves will be stimulated on the skin and the response will be measured. The sensation caused by the stimulation has been compared by some patients to a slap or rubber band hitting them.

Following the nerve conduction studies, the technician will remove the recording tabs and the physician will administer the second part of the test. While you are lying down, a small, thin, flexible, sterile disposable needle will be inserted into the muscles that will be tested. Nothing is injected through it. The physician will then measure the muscle's electrical activity.

You will be asked to relax and contract the muscle while it is being assessed. The more relaxed you are, the easier the test will be. We will try to make you as comfortable as possible.

AFTER THE TEST:
Following the test you may get dressed and go home. The EMG physician will gather the data from your test and have a report sent to your physician. Your doctor will let you know the results of your test.

You may have some minor soreness in the muscles tested for several days following the exam. Mild analgesics such as Tylenol can be used, but usually are not necessary.

If you have any questions or need further information, please do not hesitate to ask us at (716)250-2000.