FOR PROVIDER USE ONLY:
PRIVACY PRACTICES ACKNOWLEDGEMENT

SIGNED_____

David D. Van Slooten, M.D., P.A.
Lorraine S. Lira, M.D.
Patricia G. Klein, M.D.

PATIENT DATA FORM

PLEASE PRINT YOUR NAME AS IT APPEARS ON YOUR INSURANCE ID CARD

NAME_____ DATE OF BIRTH _____

SEX: MALE/FEMALE RACE _____ MARITAL STATUS _____ SOCIAL SECURITY# _____

PREF. LANGUAGE _____ EMAIL ADDRESS:_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

PRIMARY TELEPHONE NUMBER _____ HOME OR CELL

SECONDARY TELEPHONE NUMBER _____ HOME OR CELL

EMERGENCY CONTACT NAME AND PHONE#: _____

LOCAL PHARMACY NAME AND ADDRESS_____

_____PHONE #:_____

MAIL ORDER PHARMACY (EXACT NAME)_____

EMPLOYER NAME:_____ ADDRESSS_____

CITY_____ STATE_____ZIP CODE_____

WORK # _____OCCUPATION_____

NAME OF YOUR REFERRING DOCTOR:

NAME: _____

IF NO REFERRING DOCTOR PLEASE PROVIDE YOUR PRIMARY DOCTOR:

NAME #: _____

INSURANCE INFORMATION:

PRIMARY CARRIER NAME: _____

Insured Policyholder Name/DOB: _____

SECONDARY CARRIER NAME: _____

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I REALIZE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF BILLS INCURRED.

PATIENT'S SIGNATURE_____**DATE**_____

FINANCIAL POLICY

Our commitment is to provide the very best medical care to our patients while recognizing the need to limit services to only those that are necessary for each patient. To meet this commitment, we recognize the need for a definite understanding and agreement concerning our patient's healthcare and financial arrangements for that medical care. Your clear understanding of our financial policies is important to our professional relationship. Please contact your insurance company regarding coverage and financial responsibilities. Please contact our billing office regarding any questions about our fees and financial policies.

PROFESSIONAL FEES: Our fees for medical services are comparable to other similarly trained physicians in the community and reflect the complexity of your specific needs, the physician time dedicated to your care, the specialized nature of the doctor's education and training and support of costs associated with providing and coordinating your care. We also provide telephone appointments to help with your chronic healthcare needs (Covered by most insurance).

PATIENT PAYMENTS: Co-pays, Co-insurance, deductibles, services not covered by your insurance plans or outstanding balances are due at the time of your appointment. Payments may be made with cash, check or credit card. Returned checks will be subject to the fee allowed by state regulations. Please let us know if you are having a particular financial problem prior to your scheduled appointment and we will try our best to be understanding.

ADDITIONAL FEES: Missed Appointments: Please understand that when you reserve an appointment with one of our physicians, we are making a commitment to your medical care and this prevents another patient from receiving care at that time. To assist all of our patients with appropriate access to our physicians we may charge a fee for any office visit appointment cancelled with less than 24 hours' notice. Please note this fee is not covered by your insurance company. Medical Forms: The completion of disability forms, attending physician statements and other supplemental insurance forms all require physician and staff time to complete. Accordingly, a fee may be charged to complete most of these forms. Non-standard forms may be higher. Medical Records: applicable fees apply.

We will be happy to provide you with additional information at any time.

_____ _____

Signature of Responsible Person Date

CREDIT CARD PAYMENT INFORMATION

I authorize that any applicable medical fee can be processed to my credit/debit card information as provided below for outstanding balances, Co-pays, Co-Insurance, Deductibles, Tests and Office Visits up to the Allowed Amount which my insurance has not covered. I will receive a courtesy telephone call prior to the credit card transaction and will receive a mailed receipt.

CREDIT CARD NUMBER _____ **VISA**_____ **OR MASTERCARD** _____

3 DIGIT CVC CODE ON BACK OF CARD _____ **EXPIRATION DATE** _____

PATIENT'S NAME (PRINT) _____

PATIENT'S SIGNATURE _____ **DATE** _____

DAVID D. VAN SLOOTEN, M.D.
LORRAINE S. LIRA, M.D.
PATRICIA G. KLEIN, M.D.

~ Welcome to Our Office! ~

Name _____ Date _____/_____/_____

Age: _____ Height: _____ Weight: _____ Right or Left Handed
Circle One

What is the problem you're seeing the doctor for today?

_____

_____

_____

When did it start?

_____

Have you had any treatment?

_____

_____

Have you had any tests such as blood tests, MRI or CAT scan? If yes, please advise when & where.

_____

_____

Do you have any other problems? Please CIRCLE those you have and add any others.

High blood pressure; Diabetes; High cholesterol; Headaches; Dizziness; Vision problems; Loss of hearing; Trouble speaking; Memory problems; Balance problems; Falls; Pain; Fainting; Stomach problems; Bowel problems; Anemia; Kidney problems; Liver problems; Urinary problems; Lung problems; Heart problems; Fatigue; Stroke; Head injury; Fractures; Numbness or tingling; Cancer, Seizures; Leg or lung clots?

_____

_____

Have you had surgery? Please list any below.

_____

_____

Do you have an Advanced Health Care Directive / Living Will ? YES or NO

LLW 3/16

TURN OVER →

DAVID D. VAN SLOOTEN, M.D.
LORRAINE S. LIRA, M.D.
PATRICIA G. KLEIN, M.D.

Please list all the Prescribed Medications and Over-the-Counter Medications or Supplements you are taking. You can provide us with a copy.

_____

_____

Have you been in the hospital recently? YES or NO

Why? _____ **Where?** _____

Are you working or retired? _____

What kind of work have you done? _____

Did you Serve in the Military? _____

Who is living at home with you? _____

Please list any family diseases.

Mother: _____

Father: _____

Brother: _____

Sister: _____

Other (Specify): _____

Do you smoke? YES or NO. If so, when did you stop? _____

How long did you smoke? _____ **How many packs per day?** _____

Do you drink alcohol? YES or NO. If so, how much do you drink? _____

Do you drink caffeine such as coffee, tea, soda, energy drinks? _____

If so, how much per day? _____

Do you have any allergies? YES or NO. Please list them.

_____

Are there any other concerns? _____

LLW 7/15

TURN OVER →

David D. Van Slooten, M.D., P.A.
Lorraine S. Lira, M.D.
Patricia G. Klein, M.D.
99 Kinderkamack Rd. Suite 307
Westwood, NJ 07675

Privacy Practice, Patient Consent and Chronic Care Management Agreement

PRIVACY PRACTICE

By signing this form, you are granting consent to David D. Van Slooten, M.D., P.A. to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy practices provides more detailed information about how we may use and disclose this protected health information. By signing this form I acknowledge I have had the opportunity to review the Notice of Privacy Practices in the Patient Waiting Room and/or on the office website (neurologygroupnj.com). Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by asking any of our office staff or may contact the office at the above address.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance of your consent.

Patient Consent

I authorize David D. Van Slooten, M.D., P.A. to discuss my care and/or test results with the following family members, significant others and/or friends as listed below.

Chronic Care Management

You consent to the Practice of Dr. David D. Van Slooten, M.D., P.A. and all the rendering practice Provider's, providing chronic care management services (referred to as "CCM Services") to you as more fully described on the attached Chronic Care Management Agreement document.
By signing this Agreement, you agree to its terms and conditions. Including, but not limited to:
You consent to the Provider providing CCM Services to you.
You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.
By signing this form, I acknowledge that I have received the detailed Chronic Care Management Agreement and I have been provided an opportunity to review it with my provider.

Beneficiary, Beneficiary's Representative and/or Caregiver - Healthcare Proxy (if applicable)

Patient Consent Contacts 1._____ 2._____

3. _____ 4. _____

Patient's Signature: _____ Signature Other:_____

Print Patient's Name: _____ Print Name: _____

Date: _____ Date: _____

David D. Van Slooten, M.D.
Lorraine S. Lira, M.D.
Patricia G. Klein, M.D.
Signature on File

MEDICARE PATIENTS _____
Name of Patient (PRINT)

I request that payment of authorized Medicare benefits be made on my behalf to David D. Van Slooten, MD, PA for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient Signature ***Date***

NON MEDICARE PATIENTS _____
Name of Patient (PRINT)

I irrevocably assign to David D. Van Slooten, MD, PA. All my rights and benefit under any insurance contracts for payment for services rendered to me by David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD to be released to them. I irrevocably authorize David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD to file insurance claims on by behalf for services rendered to me. I irrevocably direct that all such payments go directly to David D. Van Slooten, MD, PA. I irrevocably authorize David D. Van Slooten, MD, Lorraine S. Lira, MD and Patricia G. Klein, MD to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

_____ _____
Patient Signature ***Date***

Chronic Care Management Agreement

You consent to the Practice of Dr. David D. Van Slooten, M.D., P.A. and all the rendering practice Provider's, providing chronic care management services (referred to as "CCM Services") to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months and which place you at significant risk of further decline.

Patient Benefits. CCM Services include 24/7 access (TeleHealth) to a health care provider to address chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings.

Provider's Obligations. When providing CCM Services, the Provider must:
Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are applicable to your conditions.
Provide to you a written or electronic copy of your care plan, upon request.
If you revoke this Agreement, we provide you with a written confirmation of the revocation effective date of the revocation.

Beneficiary Acknowledgment and Authorization. By providing your approval, you agree to the following:
You consent to the Provider providing CCM Services to you.
You authorize electronic communication of your medical info with other treating providers as part of coordination of your care.
You acknowledge that only one practitioner can furnish CCM Services to you during a calendar month.
You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not involve a face-to-face meeting with the Provider.

Beneficiary Rights. You have the following rights with respect to CCM Services:
The Provider will provide you with a written or electronic copy of your care plan, upon request.
You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current month.
You may revoke this agreement verbally by calling 201-261-6222, FAX 201-261-4411or in writing. Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

Medicare Billing Note 2017: CPT 99490 POS 02 - Not valid for Skilled Facilities or "In-Patient" - Save in Pt. Docs as "Medicare Phone Call Auth".