## Please check all conditions that apply (present or past):

### General Questions
- ❑ Weight loss
- ❑ Weight gain
- ❑ Fever
- ❑ Chills
- ❑ Change in sleep pattern

### Skin
- ❑ Abscess
- ❑ Acne
- ❑ Boils
- ❑ Hives
- ❑ Lumps
- ❑ Jaundice
- ❑ Athlete's foot
- ❑ Excessive body odor
- ❑ Excessive sweating
- ❑ Fungal Infections
- ❑ Nail problems
- ❑ Moles - irregular
- ❑ Moles - change/new
- ❑ Dandruff
- ❑ Oily Skin
- ❑ Rashes
- ❑ Dry Skin
- ❑ Psoriasis

### Ears, Nose & Throat
- ❑ Hay fever
- ❑ Polyps
- ❑ Sinus infections
- ❑ Goiter
- ❑ Hoarseness
- ❑ Gum problems
- ❑ Ear infections
- ❑ Hearing loss
- ❑ Ear Discharge/pain
- ❑ Frequent nosebleeds
- ❑ Ringing in your ears

### Cardiovascular
- ❑ Angina/chest pain
- ❑ High or low blood pressure
- ❑ Ankle swelling
- ❑ Murmurs
- ❑ Leg cramps
- ❑ Irregular heart rates
- ❑ Heart Palpitations
- ❑ High Cholesterol
- ❑ High Triglycerides

### Respiratory
- ❑ Wheezing
- ❑ Prolonged cough
- ❑ Coughing up blood
- ❑ Shortness of breath
- ❑ Emphysema

### Endocrine
- ❑ Changes in skin texture
- ❑ Abnormal body hair
- ❑ Cold intolerance
- ❑ Heat intolerance
- ❑ History of diabetes
- ❑ Increased loss of hair

### Eyes
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Glasses/contacts
- ❑ Double vision
- ❑ Blurred vision
- ❑ Eye pain
- ❑ Loss of vision in one eye

### Kidneys & Urinary Tract
- ❑ Blood in urine
- ❑ Brown urine
- ❑ Dribbling after urine
- ❑ Painful urination
- ❑ Excessive thirst
- ❑ Kidney stone
- ❑ Urinating frequently (day)
- ❑ Urinating frequently (night)
- ❑ Urine hesitancy
- ❑ Weak flow
- ❑ Frequent bladder infections
- ❑ Kidney disease

### Neurologic and Psychiatric
- ❑ Anxiety
- ❑ Headaches
- ❑ Depression
- ❑ Seizures
- ❑ Memory loss
- ❑ Fainting spells, blackouts
- ❑ Head injuries
- ❑ Dizziness
- ❑ Change in sensation anywhere on your body
- ❑ Localized weakness or numbness

### Other
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

### Musculoskeletal
- ❑ Tendonitis
- ❑ Arthritis
- ❑ Back pain
- ❑ Gout
- ❑ Neck pain
- ❑ Joint aches
- ❑ Muscle aches
- ❑ Abnormal Blood Counts
- ❑ Blood clots in legs/lungs
- ❑ Easy bleeding/Bruising
- ❑ Joint swelling
- ❑ Morning stiffness

### Gastrointestinal
- ❑ Diarrhea
- ❑ Gallstones
- ❑ Reflux
- ❑ Vomiting
- ❑ Ulcers
- ❑ Heartburn
- ❑ Hepatitis
- ❑ Indigestion
- ❑ Abdominal pain
- ❑ Anal fissures
- ❑ Black tarry stools
- ❑ Vomiting blood
- ❑ Constipation
- ❑ Nausea
- ❑ Problems swallowing
- ❑ Hiatal Hernia
- ❑ Intestinal obstruction
- ❑ Hemorrhoids
- ❑ Red blood after bowel movements

Primary Care Physician:

Referring Physician:

**Patient Signature:**

**History of Present Illness** *(To be completed by physician):*

**Physician Signature:** **Date:**

See Back of Page

# Ontario Neurology Associates, LLP

## CONFIDENTIAL PATIENT HISTORY FORM

**Name:** **Birthdate:**

Phone numbers: HOME- WORK -

Height: Weight:

**What is the reason for your visit?**

**Past Medical History: (check those that apply)**

- ❑ Anemia
- ❑ Arthritis
- ❑ Bleeding Disorder
- ❑ Hypertension
- ❑ Cancer
- ❑ Diabetes
- ❑ Emphysema
- ❑ Lung Disease
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ HIV Positive
- ❑ Hepatitis
- ❑ Liver Disease
- ❑ Migraine Headaches
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ High Cholesterol
- ❑ Head Trauma
- ❑ Stroke/TIA

**Hospital / Surgical History:**

| Illness or Operation | Date | Illness or Operation | Date |
|---|---|---|---|
| 1) | | 4) | |
| 2) | | 5) | |
| 3) | | 6) | |

**Medications:**

Please list any prescription medications, over the counter medications, vitamins, herbs or nutritional supplements that you are now taking. Please include the dosage amount and the times a day you take them. (May provide separate list.)

| | | |
|---|---|---|
| 1 | 5 | 9 |
| 2 | 6 | 10 |
| 3 | 7 | 11 |
| 4 | 8 | 12 |

**Allergies:**

Please list any medications, food, contact or environmental substances to which you have had an allergic or bad reaction.

❑ None

**Social History:** Occupation: Marital Status:

Do you exercise regularly? YES NO What type? How often?

Have you ever smoked? YES NO I currently smoke _____ Packs a day. I have smoked for _____ years.

I formerly smoked but stopped in: (list year)

Do you use other forms of tobacco? YES NO Do you use illicit drugs? YES NO Do you drink alcohol? YES NO

How often/how much? How often/how much? How often/how much?

Do you have risk factors for HIV infection? YES NO Have you ever been exposed to anyone with tuberculosis? YES NO

Are you currently experiencing unusual stress? YES NO Explain?

Are there any environmental risks involved in your job or home environment? YES NO

**Family History:** Please include: brothers, sisters, parents and parent's brothers & sisters.

| | Relationship | | Relationship | | Relationship |
|---|---|---|---|---|---|
| | Stroke/TIA | | Carpal Tunnel | | Cancer - |
| | Seizures | | Huntington's | | Blood Clots |
| | Dementia | | Multiple Sclerosis | | Asthma/COPD |
| | Parkinson's | | Migraine/Headache | | Depression/Anxiety |
| | ALS | | Heart Disease | | Alcohol/Drug Abuse |
| | Aneurysm | | High Cholesterol | | Liver Disease |
| | Muscle Disease | | Diabetes | | Arthritis |
| | Tremor | | Thyroid Problems | | High Blood Pressure |
| | | | | | |

**Women Only:** Are you pregnant? YES NO

Pregnancies: No. of Children: Born Alive: Cesarean: Premature: Stillborn: Miscarriages:

Age of Menopause: Difficulty with periods? YES NO Specify:

See Back of Page

# Ontario Neurology Associates, LLP

## FINANCIAL POLICY

**Medicare/PPO/HMO/Managed Care:** You are responsible for remitting co-pays at the time of service and unless otherwise indicated, responsible for obtaining the necessary referrals/authorizations your plan requires. If you fail to do so, you will be responsible for payment. These are policy provisions which you agreed to adhere to when you signed up for the plan. We will submit all charges and follow-up with your carrier for payment. You are responsible for all deductibles, co-pays and any other non-covered charges.

**No-Fault/Workers Compensation:** You are responsible for providing our office with the necessary information needed to properly submit charges. If you fail to do so, the fees mandated by NY State will be changed to reflect our private fees and you will be responsible for payment. Some No-fault carriers have deductibles on medical charges, for which the **patient** (not the insured) is responsible.

**Medicaid:** You are responsible for providing our office with your ID# (begins with 2 alpha letters, followed by numerical digits & ending with 1 alpha letter). If you have a managed medicaid plan (Fidelis Care, Total Care, etc) you are responsible for obtaining a referral from your Primary Care Physician; otherwise payment will not be made. If you fail to do so, you will be responsible for payment.

**Non-participating Carriers:** You are ultimately responsible for all charges if we do not have a participation agreement with your insurance carrier. If you provide our office with the necessary information needed to properly bill, we will submit on your behalf. You are responsible for following-up with your insurance carrier for unpaid claims and/or appeals. You are responsible for all deductibles, co-pays, and non-covered charges.

**Liability:** Carriers usually remit payment to the patient or the patient's attorney if one has been retained. OUR POLICY DOES NOT ALLOW US TO HOLD ACCOUNTS WHICH ARE PENDING RESOLUTION OF ANY LIABILITY OR LITIGATION ISSUES. **WE DO NOT, UNDER ANY CIRCUMSTANCE, BILL ATTORNEYS.** If you provide a letter from the liability carrier indicating they accept full responsibility and will remit payment, we will submit on your behalf. Otherwise, you may either have charges submitted to your private carrier or pay for services and obtain reimbursement upon resolution/settlement.

**Self-pay:** If you are uninsured, you are responsible for remitting payment in full at the time of service, unless prior arrangements have been made with the Billing Dept. If you are unable to remit payment in full and need to discuss payment options available to you, you must contact our **Billing Department at: 585-905-0767 Monday-Friday, 7:30 am - 4:00 pm.**

**Collection Agency:** Prior to an account being sent to a collection agency, the process is to provide the patient with statements, letters and a phone call. If all attempts to collect a balance due are exhausted, the account will be sent to a collection agency for further processing. Any account balance sent to a Collection Agency will have a 33.3% collection fee added to the balance due. This will allow Ontario Neurology Associates to collect the full balance and the collection agency to collect their fee.

If you need further explanation of any of the above policies, please contact the Billing Department directly. Thank you for your cooperation in this matter.

Date: Crt Date Signature: Staff Initial:
**I have read and/or been advised to read the entire Financial Policy.**


**Gene A. Tolomeo, MD**
**Robert Knapp, MD**
**William J. Kingston, MD**
**L. Allen Pardee, MD**
**Amanda Dendis, NP**
195 Parrish Street, Suite 220
Canandaigua, NY 14424
(585) 394-6811
Fax: (585) 394-7497

**Ziad Rifai, MD**
200 North Street, Suite 302
Geneva, NY 14456
(315) 787-5377
Fax: (315) 787-5374

**Justin Rymanowski, MD**
**Amanda Dendis, NP**
106 High Street, Suite C
Newark, NY 14513
(315) 331-0806
Fax: (315) 331-9022

**L. Allen Pardee, MD**
**Gene A. Tolomeo, MD**
30 Hagen Drive, Suite 230
Rochester, NY 14625
(585) 381-0140
Fax: (585) 381-0582

OCA Official Form No.: 960

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

**[This form has been approved by the New York State Department of Health]**

| Patient Name | Date of Birth | Social Security Number N/A |
|---|---|---|
| Patient Address | | |

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

_____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

**Authorization to Discuss Health Information**

(b) ☐ By initialing here _____ (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

| 10. Reason for release of information: ☐ At request of individual ☐ Other: | 11. Date or event on which this authorization will expire: |
|---|---|
| 12. If not the patient, name of person signing form: | 13. Authority to sign on behalf of patient: |

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

PRESCRIPTION REQUESTS

Please call your pharmacy for all prescription refill requests, including refills for a controlled substance. Your pharmacy will contact us electronically with your request. We require a 48-hour notice for all refills and please be aware that refill requests may not be processed on the weekends and holidays.

If a patient requests a prescription refill and has not been seen in the recommended time frame, the prescription request will be denied until an appointment has been made and the patient seen.

CONTROLLED SUBSTANCE MEDICATION

Ontario Neurology Associates, LLP reserves the right to not prescribe a controlled substance. Any patient prescribed a controlled substance will be expected to sign a Controlled Substance Agreement.

NO SHOW/LATE CANCELATION APPOINTMENTS

Ontario Neurology Associates, LLP requires a 24-hour notice to cancel any appointment. Appointments that are not canceled with a 24-hour notice will be considered a no-show. The practice allows for 2 no-shows and after the 2nd no-show reserves the right to discharge the patient from the practice. Warning letters will be sent to the patient as well as a copy to the referring physician.

A $25.00 no show fee or late cancelation will be assessed.

COPAY/HIGH DEDUCTIBLE

Co-pays are expected at the time of service. If a co-pay is NOT paid at the time of service a $25.00 fee will be assessed. You may be expected to pay a separate co-pay dependent on your insurance if you have any testing or other services provided at the time of your visit.

For those patients with a high deductible insurance, staff will collect a portion of the balance due at the time of appointment. Staff will notify patient at the time of scheduling what they can expect to pay. The amount collected is dependent on the type of office visit the patient is scheduled for.

SELF-PAY

For those patients with no insurance, staff will collect the full amount due at the time of your office visit. Patients will be notified at the time of scheduling what they can expect to pay. The amount collected is dependent on the nature of the office visit the patient is scheduled for.

RETURNED CHECK FEE

A $25.00 returned check fee will be assessed to the account should a check be returned for insufficient funds.

# ONTARIO NEUROLOGY ASSOCIATES, LLP
# NO SHOW POLICY

Ontario Neurology Associates, LLP understands that there may be an occasion that conflicts arise, and a patient may be unable to keep their scheduled appointment. We request at least a 24-hour notice that you are unable to keep your appointment. This will allow us the opportunity to schedule those patients who are waiting for an appointment.

If you do not cancel or re-schedule your appointment and do not show for your scheduled appointment, a warning letter will be sent for the first no-show appointment. Any additional no-shows may result in discharge from the practice and it will be necessary to find another neurology practice to provide you with care.

If a patient no-shows for their initial consult visit, no further appointments will be scheduled and a letter will be sent informing you that you have been discharged from our care and a copy of this letter will be sent to the primary care physician or the referring physician.

A $25.00 No Show Fee may be assessed to your account.

**ONTARIO NEUROLOGY ASSOCIATES, LLP**

**PATIENT REGISTRATION**

***Please print and check where appropriate***

**Patient Name:** _____ **Date of Birth:** _____ __ **MALE** _ **FEMALE**

**Home Address:**

_____

**Social Security Number:** _____ **Marital Status: Single Married/Partnered Divorced Widowed**

**Home Phone:** _____ **Cell:** _____ **Work:** _____

**Pharmacy:** _____ **Mail Order Pharmacy:** _____

**Responsible Party (if under 18)** _____ **Phone:** _____

**Employer:** _____ **Address:** _____

**Primary Care Physicians:** _____ **Referring Physician** _____
***(if different than PCP)***

Information about your race and ethnicity helps us make sure we provide the highest quality of care for all patients. Studies show that our racial and ethnic backgrounds may place us at different risks for certain diseases. By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your health needs.

**Ethnicity** _____ **Race** _____ **Primary Language:** _____

**Is today's visit accident related? Yes No If yes, please check what type of accident:**

___ **Auto** ___ **Work** ____ **School** _____ **Liability**

## ONTARIO NEUROLOGY ASSOCIATES, LLP
## OFFICE HOURS

| | |
|---|---|
| MONDAY | 7:00 AM – 4:00 PM |
| TUESDAY | 7:00 AM – 4:00 PM |
| WEDNESDSAY | 7:00 AM – 4:00 PM |
| THURSDAY | 7:00 AM – 4:00 PM |
| FRIDAY | 7:00 AM – 4:00 PM |

We are open for telephone calls from 8:00 am Monday – Friday. The office is closed during the lunch hour from 12:00 – 1:00 pm

The office is closed on Saturday and Sundays and the practice observes the following holidays; New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving and Christmas Day. The office is also closed on the Friday after Thanksgiving and Christmas Eve.

## ONTARIO NEUROLOGY ASSOCIATES, LLP
## BASIC OFFICE INFORMATION

| | |
|---|---|
| Canandaigua Office | Phone: 585-394-6811<br>Fax: 585-394-7497 |
| Geneva Office | Phone: 315-787-5377<br>Fax: 315-787-5374 |
| Newark Office | Phone: 315-331-0806<br>Fax: 315-331-9022 |
| Penfield Office | Phone: 585-381-0140<br>Fax: 585-381-0582 |

ONTARIO NEUROLOGY ASSOCIATES, LLP
195 PARRISH STREET, SUITE 220
CANANDAIGUA, NY 14424
Phone: 585-394-6811 Fax: 585-394-7497

Dear Patient:

Welcome to ONTARIO NEUROLOGY ASSOCIATES, LLP! We are happy that you have chosen our practice to provide you with your neurological care and we look forward to meeting you.

Please note that Ontario Neurology Associates is a private practice and is NOT affiliated with any area hospital. Therefore, we are unable to obtain any of your information, test results, insurance information, office notes from other physicians or any paperwork completed in another office. We also do NOT participate with any of the area hospitals financial assistance programs.

Enclosed are practice policies relating to No Shows, Late Cancelations, Patient Demographic Form, Financial Information and a Medical History Form. Please return the Patient Demographic and Medical History form to the office PRIOR to your appointment.

If you are scheduled for a Nerve Conduction Study – DO NOT WEAR LOTION on the day of your appointment.

At your first office appointment please bring the following:

1) Photo ID
2) Insurance card(s)
3) Prescription (pill) bottles
4) Supplements (if applicable)
5) Payment (co-pay or payment with high deductible)

Please note: if you no show your initial appointment with Ontario Neurology Associates, you will **not** be rescheduled for another appointment and will need to find another neurology practice to provide you with your medical care.