

Children's Neurology Services LLC

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Name: _____

Day: _____ Date: _____ Time: _____

OFFICE DIRECTIONS

South I-91

I-91 South to exit 22S (left hand exit off I-91). This exit will place you on Route 9 South. Take exit 14 (Dekoven Drive/Harbor Area). At end of exit ramp go straight. (Distance to office from light at Davita Dialysis 1.1 mile) At light take left (Davita Dialysis on left) onto Main Street. (At 1st light YMCA on your left – further up CVS on left). You will go straight at all 4 traffic lights. Continue straight this will turn into Main Street Extension and becomes East Main Street which continues to Saybrook Road. After 5th traffic light you will see (Stop & Shop Plaza on right after the light). Our office will be the 5th house on the right hand side. 147 Saybrook Road. (Parking in Rear)

Route 9 South

Take Exit 13 for State Route 17S towards New Haven (go .3 miles) taking first exit on the right hand side you will come to a stop sign. (Baseball Field will be to the right and Middlesex Hospital will be in front). At the STOP sign make a left onto Main Street Extension eventually turns into Saybrook Road, but from Main Street Extension you will continue going straight through 3 lights. The 3rd light is at the Stop & Shop Plaza after that light we are the 5th house on the right hand side. 147 Saybrook Road. (Parking in Rear)

Route 9 North & Route 9 South

Take Exit 11 (Randolph Road). At end of exit ramp take a right. At light on top of hill turn left (Tommy's Pizza on left) (Distance to our office from this light 1.2 miles) this will be Saybrook Road. Continue to go straight after 1st light (this will include Bull Metal as a house) we will be the 8th house (house right after maroon office) on the left hand side. 147 Saybrook Road (Parking in Rear)

East I-84

Take Route 691 East. Continue on Route 691 which turns into Route 66. Continue on Route 66 into Middletown. Continue straight on Route 66 this will bring you to Main Street go by Main Street at the next light take a right (Looks like going on highway, but don't get on) right will be (Dekoven Drive). At 2nd light (Middletown Plate Glass on left) take right. At next traffic light take left (Distance to our office at this light 1.0 miles) (YMCA on left – Middlesex Hospital on right continue straight CVS on left) Crescent street will become Main Street Extension becomes East Main Street continues to Saybrook Road. Continue to go straight. There will be 3 traffic lights you will go by (Stop & Shop Plaza on right – after that light). Our office will be 5th house on right. 147 Saybrook Road (Parking in Rear)

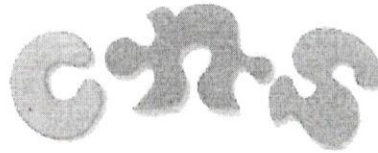
ALTERNATE ROUTE: Follow above directions Route 66 turn right at light onto Main Street (Distance to our office from this light will be 1.4 miles) continue to go straight on Main Street. (YMCA on left – Middlesex Hospital on right – CVS on left) At the light at CVS continue to go straight (Stop & Shop Plaza on right – after that light). Our office will be 5th house on right. 147 Saybrook Road (Parking in Rear)

West I-84

I-84 West to I-91 South to exit 22S (left hand exit off I-91). This exit will place you on Route 9 South. Take exit 14 (Dekoven Drive/Harbor Area). At end of exit ramp go straight. At light take left (Davita Dialysis on left) onto Main Street. (At 1st light YMCA on your left – further up CVS on left). You will go straight at all 4 traffic lights. Continue straight this will turn into Main Street Extension and becomes East Main Street which continues to Saybrook Road. After 5th traffic light you will see (Stop & Shop Plaza on right after the light). Our office will be the 5th house on the right hand side. 147 Saybrook Road. (Parking in Rear)

IMPORTANT: SEE 4TH PAGE FOR OTHER OFFICE POLICIES





Children's Neurology Services LLC

Patient Information Form

ACCT # _____

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BRING : The attached forms with you, your insurance card and child to office visit. It would be very useful to also bring information, EEG, MRI, IEP, PPT, Note from teachers explaining how your child is in the school setting, videos showing actions, etc.

Patient Name: _____
(Last) (First) (Middle)

Address: _____

(City) (State) (Zip)

Date of Birth: _____ Age: _____ Sex: Male Female Social Security#: _____

Phone:
Home: () _____ Work: () _____ Cell: () _____

PARENT INFORMATION

Name: _____ Social Security#: _____
(Last) (First) (Middle)

Employer: _____ Work#: () _____

Primary Insurance: _____ Insurer's Name: _____ ID#: _____

Secondary Insurance: _____ Insurer's Name: _____ ID#: _____

PCP Name: _____ City: _____ Phone#: () _____

Pharmacy Name : _____ Pharmacy Telephone # _____

Medical Authorization – Assignment of Benefits

I hereby authorize the release of any medical information necessary to process claims for any and all professional services rendered by Children's Neurology Services, LLC and understand co-pays, deductibles, and denied services will be my responsibility upon receiving the bill. These are expected to be paid in full. Our office does not accept budget plans.

Please Read Before Signing

I hereby understand that I will be billed for a missed appointment or last minute cancelation fee of \$25.00. (NO SHOW).

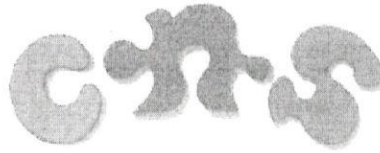
Three NO SHOW appointments patient will be discharged from our practice.

A fee of \$400.00 applies for New Patient appointments. (Applied only if appointment has not been canceled 24 hours prior).

STATE PATIENT'S WE CAN NOT CHARGE A NO SHOW FEE. OUR OFFICE POLICY IS TWO NO SHOWS OR LAST MINUTE CANCELATION'S AND YOUR CHILD WILL BE DISCHARGED.

*Signature: _____ *Date: _____

**** IMPORTANT ANY INSURANCE WITH DEDUCTIBLES**
** \$150.00 WILL BE DUE ON THE DAY OF NEW PATIENT VISIT**
(TO COVER SOME OF THE FUTURE DEDUCTIBLE)**



Children's Neurology Services LLC

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Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Children's Neurology Services, LLC Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand that Children's Neurology Services, LLC is only authorized to release information to my child's primary care physician unless I further authorize and sign a release to have records sent elsewhere. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of mine/my child's personal medical information.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments. **Signature next to the X.**

*Signature: X _____ *Date: _____

If not signed by patient, please indicate relationship to patient (e.g., parent/guardian)

Relationship: _____ Witnessed by: _____

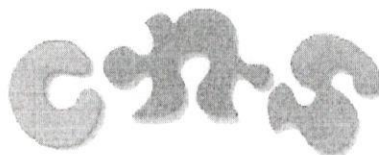
Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement or receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____ Time: _____

By: _____ Title: _____





Children's Neurology Services LLC

OFFICE POLICIES

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NEW PATIENT APPOINTMENTS

ALL NEW PATIENTS WILL BE MAILED A NEW PATIENT FORM WITH THEIR APPOINTMENT DATE AND TIME AS WELL AS DIRECTIONS TO OUR OFFICE. YOUR APPOINTMENT CAN BE CHANGED OR CANCELLED **48 HOURS PRIOR** TO THE DATE OF THE VISIT, IF THIS IS NOT DONE YOUR CHILD CAN NOT BE RESCHEDULED AND **YOU WILL BE BILLED FOR THE MISSED VISIT.**

LATE PATIENT ARRIVALS

PLEASE ARRIVE ON TIME FOR YOUR VISIT. IF YOU ARE LATE FOR YOUR APPOINTMENT, OUR OFFICE MAY HAVE TO RESCHEDULE YOU FOR ANOTHER DAY AND TIME.

IF YOU ARE A **NEW PATIENT** AND ARRIVE MORE THAN **15 MINUTE LATE** FOR A HALF HOUR CONSULTATION OR **20 MINUTES LATE** FOR AN HOUR LONG CONSULTATION THE APPOINTMENT WILL BE CANCELLED AND NOT RESCHEDULED. **YOU WILL ALSO BE BILLED FOR THE MISSED VISIT.**

FOLLOW-UP MEDICAL APPOINTMENTS

IF YOUR CHILD HAS BEEN SEEN IN OUR OFFICE BEFORE. IT IS YOUR RESPONSIBILITY TO CALL OUR OFFICE IN ADVANCE TO RESCHEDULE AN APPOINTMENT IF YOU ARE UNABLE TO COME AT YOUR SCHEDULED TIME. PLEASE MAKE SURE YOU HAVE ENOUGH MEDICATION UNTIL YOUR NEXT SCHEDULED APPOINTMENT. REFILLS **WILL NOT** BE CALLED IN OR MAILED. THEY WILL BE DISPENSED AT THE TIME OF APPOINTMENT ONLY. IN THE EVENT OUR OFFICE NEEDS TO RESCHEDULE YOUR APPOINTMENT, WE WILL PROVIDE A REFILL ON THE NECESSARY MEDICATION(S).YOUR APPOINTMENT CAN BE CHANGED OR CANCELLED **PRIOR TO 24 HOURS** OF THE VISIT. (UNLESS DUE TO ACUTE ILLNESS OR EMERGENCY) **IF NO SHOW OR NO PRIOR 24 HOUR NOTICE FOR APPOINTMENT A CHARGE OF \$25.00 WILL BE DUE.**

DISCHARGE POLICY

IF THERE ARE MISSED OR CANCELED APPOINTMENTS WITHOUT 24 HOURS NOTICE, TOTALING THREE TIMES, YOU WILL RECEIVE NOTICE OF DISCHARGE. DR KLEIMAN WILL PROVIDE ONE MONTH'S ASSISTANCE **FOR EMERGENCIES** WHILE YOU ARRANGE FOR AN EVALUATION BY ANOTHER PHYSICIAN.

REQUESTS FOR COPIES OF RECORDS

THERE IS A MINIMUM CHARGE OF \$20.00 FOR COPYING OF PATIENT RECORDS DEPENDING ON THE THICKNESS OF THE FILE. YOU WILL NEED TO REQUEST IN WRITING TO RELEASE YOUR CHILD'S RECORDS. PLEASE BE SURE TO PUT NAME, DATE OF BIRTH AND WHERE YOU WOULD LIKE RECORDS TO BE SENT AND ENCLOSE CHECK OR MONEY ORDER PAYABLE TO CNS. WE ASK THAT YOU SEND REQUESTS IN ADVANCE AS IT MAY TAKE UP TO 4-6 WEEKS.

