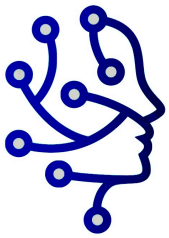
East End Neuropsych P.C.
2539 Middle Country Rd Suite 4
Centereach, NY 11720



Phone 631-737-6434
Fax 631-738-1226
www.eastendneuropsych.com

WELCOME

We would like to take this opportunity to welcome you to our practice and answer some questions you may have. Please mail back the forms that you have filled out prior to being scheduled for your appointment. An appointment date and time will be set upon receiving all of the attached paperwork.

In addition, please mail in the requested reservation check for $250.00 or fill out the credit card form provided to hold your appointment. The reservation check will be returned to you at the first appointment.This is to hold your appointment and these funds will be utilized if you cancel your first appointment with less than 24 hours notice. If less than 24 hour notice is provided you will be charged $250 dollars.

LOCATION

Our office is located at 2539 Middle Country Rd in Centereach at the corner of Crown Acres Rd. 1.5 miles west of Nicolls Rd (Rte 97) and 2 traffic lights east of Hawkins Ave. You may park in the street or in the adjacent church parking lot.

ABOUT YOUR FIRST APPOINTMENT

Please be sure to bring your insurance cards with you. If you have any current blood tests, MRI or CAT scans of your brain, or any testing that may be relevant please bring them with you or send in advance. Your first visit will be approximately 1 hour. We encourage you to bring your care givers, loved ones and health care proxy if you wish.

OFFICE HOURS:

Our practice is open Monday - Thursday 9-5PM. We are closed Friday, Saturday and Sunday Routine call backs will be done outside of office hours only.

FOLLOW-UP APPOINTMENTS

Your clinician will tell you when they would like to see you again for continued care. You will be assigned a different clinician from the one who completes you initial assessment. Follow up appointments are generally 15 minutes long. If you would like more time, please tell the person making your appointments. Anyone on a controlled substance must be seen monthly, no exceptions.

MESSAGES LEFT FOR THE CLINICIANS

In the interest of fairness to all of our patients we try not to interrupt your session for phone calls. With that in mind, we do reserve time at the end of the day to respond to these calls. Extended phone consultations and counseling sessions are available for a fee. For emergencies after hours, please call our office to get the contact information for the on call provider. Please be advised that all phone calls are subject to co-pays based and length and complexity. No changes to the treatment plans will be made via phone or portal.

The preferred method of communication with the treatment team is via the patient portal. You will be given that information at the time of your first appointment. E-mail and texts are not an acceptable forms of communication as it is not HIPPA secure. No forms will be be reviewed or completed unless done during an appointment.

BILLING AND INSURANCE

Questions regarding billing and insurance may be directed to our Billing Department. Co-payments, Co-insurance and deductibles are due at the time of your visit. We are not providers with any secondary insurance, therefore we do not send bills to them. If Medicare does not send the bills to your secondary insurance, you are responsible to remit payment. We do not send claims for these services. If we are requested to send records or bills, there will be a nominal fee.

We hope your experience and the bespoke care you receive at our office is always exemplary. If at any time you have any questions or concerns please feel free to contact our office or me directly.

Eric Spronz RN-BC, PMHNP, MSN

Practice Owner

PATIENT INFORMATION SHEET

Name _____ Sex _____ DOB _____

Address _____

City _____ State _____ Zip _____

Phone # _____ Cell # _____

Email _____SS#_____

Primary Doctor _____ Phone # _____

Preferred Contact:_____

Medicare ID Number: _____

Secondary Insurance _____ID #_____

Prescription Plan _____ ID # _____

CONTACT INFORMATION:

Name _____ Relationship to Pt _____
Home Phone # _____ Cell # _____
Work # _____

Name _____ Relationship to Pt _____
Home Phone # _____ Cell # _____
Work # _____

NAME: _____ DATE:_____
Referred by: _____
Primary care provider: _____ phone # _____

REASON FOR THIS CONSULTATION

_____

PERSONAL HISTORY

Date of birth: _____ Place of birth _____
How far did you go in school: _____
Military service: _____ Type of Work You Do/Did: _____
If retired, when: _____ Marital status: _____ How long: _____

Children:

Name: _____ age: _____Relevant Issues_____
Name: _____ age: _____Relevant Issues_____
Name: _____ age: _____Relevant Issues_____
Name: _____ age: _____Relevant Issues_____
Name: _____ age: _____Relevant Issues_____
Name: _____ age: _____Relevant Issues_____

Parents:

Mother: _____ If deceased, age and cause of death: _____

Father: _____If deceased, age and cause of death: _____

Brothers and Sisters:

		If deceased:
Name: _____	Age: _____	Cause of death:_____
Name: _____	Age: _____	Cause of death:_____
Name: _____	Age: _____	Cause of death:_____
Name: _____	Age: _____	Cause of death:_____
Name: _____	Age: _____	Cause of death:_____
Name: _____	Age: _____	Cause of death:_____

Any family members with Psychiatric history: _____

Have you ever seen a psychiatrist or neurologist before, if yes, when and why:

_____

_____

_____

MEDICAL HISTORY
Problems with the following:

Heart: _____ Lungs: _____ Thyroid: _____

Blood disorder: _____ Arthritis: _____ Diabetes: _____

Hearing loss: _____ Vision issues: _____ Stroke: _____

Lyme Disease: _____ COVID19_____Head trauma: _____

Exposure to toxins / occupational hazards: _____
Additional illnesses:_____

Hospital or Surgical History:_____

Have you ever had a brain MRI or CT scan, if yes, when and where: _____

Do / Did you smoke: Y/N How much: _____ Do you use alcohol: Y/N How much: ____

Do you require assistance with: **walking bathing dressing paying bills**

cooking laundry cleaning taking medication shopping

Who helps with these things: _____

Please circle any areas you are having trouble in:

sleep appetite energy interest motivation concentration boredom

memory tearfulness feelings of emptiness guilt helplessness irritability

hopelessness delusions thoughts of suicide suspiciousness hallucinations

agitation aggression impulsiveness getting lost losing things fearfulness

social withdrawal repetitive actions restlessness pacing or wandering

Are you basically satisfied with your life? YES / NO
Have you dropped many of your activities and interests? YES / NO
Do you feel that your life is empty? YES / NO
Do you often get bored? YES / NO
Are you in good spirits most of the time? YES / NO
Are you afraid that something bad is going to happen to you? YES / NO
Do you feel happy most of the time? YES / NO
Do you often feel helpless? YES / NO

Do you prefer to stay at home, rather than going out and doing new things? YES / NO
Do you feel you have more problems with memory than most? YES / NO
Do you think it is wonderful to be alive now? YES / NO
Do you feel pretty worthless the way you are now? YES / NO
Do you feel full of energy? YES / NO
Do you feel that your situation is hopeless? YES / NO
Do you think that most people are better off than you are? YES / NO

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Name of person completing form: _____

Relationship to patient: _____

Current Medications List.

Please bring your medication bottles with you to the intake

Name: _____DOB: _____

Primary Physician: _____

Medication Allergies: _____

Pharmacy: _____

Name of Medication	Strength and Frequency	Physician who Prescribed Med

East End Neuropsych.PC.
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At East End Neuropsych P.C. we participate in Medicare only. We do not accept Medicaid or other insurances. You will need to pay deductibles and applicable copayments. For those patients who are 65+ without straight Medicare, payment is due at the time of service at the full Medicare approved rates. Patients who are covered by Medicare are responsible for their deductibles, co-payments and non-covered services that are provided to you.

East End Neuropsych is not a provider with my insurance I will be responsible for all charges incurred at the time of the visit. A full fee scale is posted in the office and can be provide upon request. We will require a form of payment on file with the office. You may be sent to collections if there is a balance past 60 days.

No forms, evaluations or paperwork of any kind will be completed without an appointment. This is a legal requirement and cannot be waiver.

Patient Signature _____ Date _____

PLEASE BE ADVISED THAT WE REQUIRE 24 HOURS NOTICE FOR CANCELED APPOINTMENTS OR YOU WILL PAY A MISSED APPOINTMENT FEE. NO FURTHER APPOINTMENTS WILL BE MADE UNTIL PAID AND NO PRESCRIPTIONS OR FORMS WILL BE COMPLETED

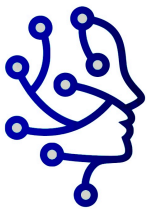
MISSED APPOINTMENT FEES ARE $75.00 FOR ROUTINE APPOINTMENTS AND $250 FOR NEW EVALUATIONS, $150 FOR KETAMINE INFUSIONS

AS A REMINDER: WE ARE HAPPY TO CONFIRM YOUR APPOINTMENTS BUT, THIS CONFIRMATION CALL IS A COURTESY AND YOU ARE STILL RESPONSIBLE FOR ATTENDING YOUR APPOINTMENT OR CANCELING PRIOR TO THE 24 HOUR PERIOD BEFORE YOUR APPOINTMENT

Repeated failure to keep appointments is grounds for termination from the practice for any reason. You time slot is for you and you only.

Patient Signature _____ Date _____

Health Care Proxy Signature_____ Date_____



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I _____ give permission for East End Neuropsych P.C. to disclose protected health information including mental health diagnosis, lab results and treatment plan recommendations to the following person(s) until further notice. This information can be released in person, via phone, patient portal or US Mail. I will not hold East End Neuropsych liable for the use and release of this information if made the following parties.

_____

_____

_____

_____

_____

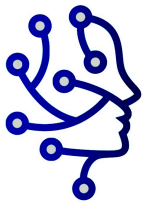
_____

_____

I have been made aware of the HIPPA policy of Eric Spronz, Psychiatric Nurse Practitioner P.C. d/b/a East End Neuropsych P.C. and given copies upon request of said policy.

_____ _____

Signature of Patient or Power of Attorney Date



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I _____ agree to the following:

☐ I would like to receive phone messages to confirm my appointments.

Phone Number_____

☐ I would like to receive text message to confirm my appointments.

Text Number_____

☐ I would like to receive emails to confirm my appointments.

E-mail address _____

If at any time you would like to change the method you receive confirmation for your appointments, you have the right to do so. Confirmations are a courtesy, any appointment canceled within 24 hours or missed will be subject to the missed appointment fee. Only one party can be notified of an appointment through the automated system.

Signature of Patient or POA or HCP

_____

Office Medication Policy

Please remember that it is your responsibility to monitor your medication usage and to plan for your follow up visits prior to needing refills. The clinicians do not consider it an emergency if you run out of medication as a result of a cancelled or missed follow up visit. If you arrive at the office without an appointment, an appointment will be scheduled for you and you will be asked to return at that time. Please plan your monthly follow up visits accordingly, taking holidays, weekends, and other non-clinic days into consideration.

Please allow for up to 3 business days for medication refills and always check with your pharmacy first to see if they have your medications.

There will be no controlled substance refills done without appointments. Patients on controlled substance may not receive controlled substances from other providers outside of East End Neuropsych without prior notice and approval. All patients are subject to random toxicology screenings at the patient's expense.

Office Hours Are: Monday to Thursday 9AM-5PM

CLOSED FRIDAY, SATURDAY and SUNDAY

All matters should be handled within your scheduled session times. Medication and treatment plan changes must be done during appointments only. The on call system is for emergency use only, repeated over use for non emergencies can result in patient terminations. Normal visit fees and co-pays may be charged for all after hours phone calls.

No forms, external evaluations or applications will be completed outside of an appointment. This is a legal requirement and cannot be waived.

I have read and understood the information above including the controlled substance policy and on call fees. I agree to the responsibilities and the terms of my treatment as outlined above.

_____ _____

Patient Name Signed / POA Date

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I agree to be responsible for any co-payments, missed appointment fees and deductibles for services rendered by the clinical staff of East End Neuropsych P.C. and Eric Spronz, Psychiatric Nurse Practitioner P.C. I have been made aware of the missed appointment fees of $75 for a 15 minute routine visit, $150 for a missed and $250 for a New Patient Evaluation. These time slots reserved for you and you only. East End Neuropsych NEVER double books patients with providers.

I agree to have my credit card information kept on file to cover any balance that may be due. You will be charged on the day the service is rendered, include the late cancellation charge if applicable. Credit card information is stored on our HIPPA secure platform only.

- ❑ MASTERCARD
- ❑ AMERICAN EXPRESS
- ❑ DISCOVER
- ❑ VISA

CREDIT CARD #_____

EXPIRATION DATE_____

CVC (found on back of card)_____

NAME OF CARDHOLDER (PLEASE PRINT)

_____

ADDRESS OF CARD HOLDER

_____

_____

_____

SIGNATURE _____ DATE _____

Additional Notes: