

**NORMAN B. TUROWSKY, M.D., P.C.**

3601 Hempstead Turnpike  
Levittown, New York 11756  
Phone 516-520-2900 Fax 516-520-1999

Name of Patient \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F

Address: \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status: M S W D

Drug Allergies: \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Have you fallen in the past 12 months?  Yes  No Do you have Dizziness?  Yes  No

Referring Doctor's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Primary Insurance Carrier \_\_\_\_\_ Insured's Name, DOB and SS# \_\_\_\_\_

ID number \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance Carrier \_\_\_\_\_ Insured's Name, DOB and SS# \_\_\_\_\_

ID number \_\_\_\_\_ Group Number \_\_\_\_\_

**AUTHORIZED METHODS OF COMMUNICATION  
PLEASE FILL IN ALL THAT APPLY**

___ RESIDENCE	___ WORK
NUMBER: (____) _____	NUMBER: (____) _____ ext _____
____ LEAVE CALL BACK NUMBER ONLY	____ LEAVE CALL BACK NUMBER ONLY
____ OK TO LEAVE DETAILED MESSAGE WITH A PERSON, PLEASE WRITE FULL NAMES BELOW AND RELATION _____	____ OK TO LEAVE DETAILED MESSAGE WITH A PERSON, PLEASE WRITE FULL NAMES BELOW AND RELATION _____
____ OK TO LEAVE DETAILED MESSAGE ON AN ANSWERING MACHINE/VOICE MAIL	____ OK TO LEAVE DETAILED MESSAGE ON AN ANSWERING MACHINE/VOICE MAIL

I understand that the services I receive from Norman B. Turowsky, M.D., P.C. may not be covered under my insurance plan(s). I understand that my insurance company determines the medical necessity of the services that I request and receive. I am also responsible for deductibles, co-payments, non-covered services and items considered not "medically necessary" by my insurance company. I understand that I must inform the office of any change in insurance coverage before services are rendered. Failure to inform the office will result in me being responsible for all fees for services rendered. I understand that if my plan requires a referral, it is my responsibility to contact the office at least 48 hours prior to the specialist appointment for non-urgent visits. I understand that it is my responsibility to notify the office at least 24 hours in advance of an appointment if I wish to cancel. Failure to do so will incur a fee, which will be no greater than one hundred dollars.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Norman Turowsky, M.D., P.C.  
3601 Hempstead Turnpike, Suite 121  
Levittown, New York 11756

Dear Patient,

This form and your signature below serve as a formal notification of our patient balance-billing policy.

Once your primary insurance carrier processes your claim (and secondary carrier, if you have additional coverage), you will receive a bill for the patient-owed portion of the bill. These balances are usually unpaid co-pays, deductibles, non-covered services per your particular plan's benefits, coordination-of-benefits, full-time student status issues, and if Dr. Norman Turowsky is not listed as your primary care physician and you failed to retain a referral from your primary care physician.

We will bill you after services have been processed by you insurance carrier(s). You may still have claims that are being processed for other dates of service. However, we will bill you based on services that have been processed by your insurance carrier.

**It is the policy of this office to send only three statements. Statements are sent out at 30-day intervals. If no payment is received from you during the 90-day period, your account may be turned over to our collection agency without additional notice. We feel that three months is a reasonable amount of time for you to make a payment on your account.**

Your signature below acknowledges that you have read and understand the above policy.

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Norman B. Turowsky, M.D., P.C.**

**Health Information Portability Accountability Act 1996, Acknowledgement Statement**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

I have been informed and understand my rights in regard to the Health Information Portability Accountability Act 1996. I have received a copy of Norman Turowsky, M.D., P.C. Confidentiality Policy and Uses and Disclosures in regard to my Protected Health Information (PHI).

With my consent, Norman B. Turowsky, M.D., P.C. may use and disclose protected health information (PHI) about myself to carry out treatment, payment and healthcare operations (TPO).

With my consent, Norman B. Turowsky, M.D., P.C. may call my home or other designated location and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Norman B. Turowsky, M.D., P.C. may mail to my home or other designated location any items that assist the practice in carrying out (TPO), such as appointment reminder cards and patient statements.

By signing this form, I am consenting to Norman B. Turowsky, M.D., P.C. to use and disclose of my (PHI) to carry out (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Norman B. Turowsky, M.D., P.C. may decline to provide treatment to me.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Print your name

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS**

I hereby authorize Norman B. Turowsky, M.D., P.C. to obtain any and all medical records concerning my care from any physician, hospital, or other health care professional that has provided medical care to me in the past.

I authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to my health at anytime.

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Print your name

**Norman Turowsky, M.D., P.C.  
3601 Hempstead Turnpike, Suite 121  
Levittown, New York 11756**

**Dear Managed Care Patient,**

**We appreciate your confidence in choosing our office for your medical care. Please take a moment to review our financial policy.**

**In the past few years the number of different health insurance programs has increased at an amazing rate. Even within one company there may be several programs with varying benefits and requirements. There is no way that we can possibly know or keep up with each program's provision and changes.**

- If you are an enrollee of a managed care plan that we are contracted with, you are required to pay the co-payment each time you are seen. The co-payment must be paid at time of visit.**
- Some plans also have an annual deductible. You are required to pay this at the time of service. In the event that there is a balance due from you after your insurance carrier has paid its portion, we will bill you. If you do not understand the reason you owe a balance, please do not hesitate to contact our office at 516-520-2900.**
- If your insurance requires a referral from your primary care physician, you must have the referral with you in order to be seen. If you arrive with no referral, you will be asked to reschedule. If you need a referral from us we require a 24 hour notice for a non-urgent appointment. Referrals cannot be backdated.**

**Please understand that if we have not been advised in advance of your program's requirements or conditions and we provide a service or use a facility that is outside of the program you will be responsible for the appropriate fees.**

**Our staff is dedicated to working with you and your insurance carrier to process your claim. We appreciate your assistance in working with our staff and your insurance carrier.**

**These are not our regulations, they are your insurance company's regulations and unless you follow them carefully the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a manual and a phone number for you to use if you have any questions about your coverage. Please be sure to keep this page with your insurance papers for future reference.**

**I have read the above and understand my obligations and acknowledgement receipt of this information.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**



# Symptom Checklist

Patient Name : \_\_\_\_\_

Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Signature : \_\_\_\_\_

Today's Date : \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please indicate which of the following symptoms you experience:**

Symptom	Side of the Body			
	Right	Left	Both	None
<b>Back and Leg Pain</b>				
Pain in your lower back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in your buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or burning in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of strength in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Foot Pain</b>				
Pain or burning in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feels like pins and needles in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased sensitivity to touch on your feet (for example, it hurts when bed covers touch them)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling hot or cold in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble feeling your feet when you walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort or pain at night in your feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hand, Finger or Wrist Pain</b>				
Pain or burning in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling in your fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty gripping things with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty forming a fist with your hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discomfort in hands wakes you at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Diabetes Mellitus

Do you have diabetes?     Type 1     Type 2     No

How long have you had diabetes? \_\_\_\_\_

## Office Use Only

### Clinical Assessment

Confirmed :  Yes     No

Exam Notes :

Confirmed :  Yes     No

Exam Notes :

Confirmed :  Yes     No

Exam Notes :

Notes :

## Clinician Use Only

Clinician Review \_\_\_\_\_

Notes :