



Samuel Koszer, MD
Board Certified,
Neurology and Clinical
Neurophysiology

Glenn Castaneda, MD
Board Certified,
Pediatric Neurology

Alexandr Safarov, MD
Board Certified,
Neurology

Gregory Taylor, MD,
PhD
Board Certified,
Neurology and Clinical
Neurophysiology

Suzanne Brown, DO
Board Certified,
Neurology

Dr Paul Magda, DO
Board Certified,
Neurology and Clinical
Neurophysiology

E. Taylor Abel, MD
Board Certified
Physiatry

Tami L. Bergman,
NP-C

Kathleen Rendich,
FNP-C

Faith Goring-Britton,
FNP

Michelle S. Higgins,
FNP-C

Offices Located At:

21 Fox Street
Suite 102
Poughkeepsie, NY
12601

200 Westage
Business Center
Suite 320
Fishkill, NY
12524

67 Prospect Avenue
Suite 160
Hudson, NY
12534

670 Stoneleigh Avenue
Bldg 665, Suite 202
Carmel, NY
10512

Telephone Number:
845-452-9750

FAX Number:
845-452-9751

Welcome and we thank you for choosing eRiver Neurology of New York LLC

"eRiver Neurology of New York LLC does not discriminate against any person on the basis of race, color, national origin, disability or age in the provision of services and/or procedures."

eRiver Neurology of NY LLC participates with The Federal Red Flag Anti Identity Theft Program. We are required to confirm your identity at every office visit by valid photo ID, address, and Insurance card. Failure to have the above will result in you having to reschedule your appointment.

OFFICE POLICIES

- A. **EMERGENCIES:** IF YOU HAVE AN EMERGENCY PLEASE CALL 911 NOT OUR OFFICE.
- B. **OFFICE HOURS:** Our office hours are from 9:00 AM to 4:00 PM Monday through Friday, with the telephone turned off between 12:00 and 1:00 PM. Our office is closed on major holidays. Please call during our office hours.
- C. **APPOINTMENTS ARE SUBJECT TO CHANGE DUE TO HOSPITAL EMERGENCIES AND CHANGES IN THE DOCTOR'S SCHEDULE.**
- D. **PRESCRIPTIONS:**
 1. Please check prescriptions weekly and call at least **72 Hours** prior to running out of medications and at least **1 week** for controlled medicines.
 2. After calling our office for a refill, please allow **48 Hours** for the prescription to be called to the pharmacy.
 3. If you have not been seen by your Provider within six (6) months, **one (1) month** refill will be given and you **MUST** make a follow-up appointment in order to get any more refills. **Our Providers need to evaluate patients on a regular basis to make sure that medications continue to be effective for your care.**
 4. **PRESCRIPTIONS WILL NOT BE FILLED ON WEEKENDS.**
- E. **APPOINTMENTS:**
 1. **IMPORTANT NOTE:** If you can not keep a scheduled appointment, need to cancel or reschedule your appointment you need to contact our office at least **24 hours** prior to your scheduled appointment or you may be charged \$ 50.00 if you do not show for your scheduled appointment.
 2. Please make sure to bring your photo ID and Insurance Card and any needed referrals to each appointment. If you do not have these you will be required to pay for the visit or reschedule.
 3. Please bring all test results from other physicians to your appointment, including Lab results, MRI's, Cat Scans etc. This can aid our Providers with your evaluation and treatment and may reduce having tests repeated.
 4. Patients may be scheduled with a Nurse Practitioner for follow-up appointments. Our Nurse Practitioners consult with our Physicians on all patients.
- F. When calling and requesting a call back from a Provider, **PLEASE ALLOW 48 HOURS** for the call back unless it is an Emergency.
- G. **TEST RESULTS:** Please do not call for test results, all results will be discussed at your next appointment. **Your Provider will contact you concerning any abnormal results.**
- H. When requesting paperwork to be completed such as Disability Forms, Employer Forms, etc please allow a minimum of **10 Business Days** for these to be completed and mailed.

**Thank you and if you have any questions please feel
free to contact our office during Business hours.**



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www.eRiverNeurology.com

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The Federal Red Flag Anti Identity Theft Program.
We are required to confirm your identity at every office
visit by a valid photo ID, address and Insurance card.
Failure to provide proper identification will result in
you having to reschedule your appointment.

NO SHOW AND CANCELLATION POLICY

We reserve the right to charge for appointments cancelled or broken
within 24 hours advance notice. You may be subject to a fee of
\$50.00.

EMERGENCIES

We have a 24 hour answering service who is instructed to contact the
doctor in event of an emergency. Should your doctor not be available,
your call will be directed to the physician on call.

Prescription Refills: After calling our office for a refill, please allow **48
hours** for the prescription to be called to the pharmacy.

Your payment is to be paid in full at the time of each service unless
payment arrangements have been made or you have valid insurance that
pays the doctor directly.

All co-pays are due at the time of service. There is a **\$10.00** fee for
inability to pay co-payment at time of visit.

There is a **\$25.00** fee for all **returned checks.**

**IT IS YOUR RESPONSIBILITY TO HAVE CURRENT REFERRALS AT
THE TIME OF YOUR APPOINTMENT.**

I have read and agree to the terms stated above.

Print Patient Name: _____

Signature: _____ Date: _____



eRiver Neurology of New York, LLC
Board Certified Adult and Pediatric Neurologists

MEDICAL RECORD RELEASE FORM

Main office
Telephone (845) 452-9750
Fax:(845) 452-9751

Patient Name: _____ DOB _____

I hereby authorize the below listed entity to release medical information to eRiver Neurology LLC of New York.

Name: _____ Telephone #: _____

Address: _____

Medical Information Requested

- All Records
 Specific Records From _____ to _____
 Radiology (x-ray, ultrasound, CT, MRI etc.), labs reports

Signature of Patient or Legal Guardian

Date

I understand that these records are protected under Federal and/ or State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical and or/ mental illness, including treatment of alcohol or substance abuse, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admissions. I understand that I have the right to revoke this consent at any time unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.

<input type="checkbox"/> eRiver Poughkeepsie	21 Fox Street suite 102 Poughkeepsie, NY 12603	845.452.9750 Fax 845-452-9751
<input type="checkbox"/> eRiver Fishkill	200 Westage Business Center suite 320 Fishkill, NY 12524	845.452.9750 Fax 845-896-2760
<input type="checkbox"/> eRiver Hudson & Sleep Lab	67 Prospect Ave Suite 160 Hudson, NY 12534	518.822.8010 Fax 518-822-8020
<input type="checkbox"/> eRiver Carmel	670 Stoneleigh Ave Building 665, Suite 202 Camel, NY 10512	845.279-4144 Fax 845-279-4141



eRiver Neurology of New York, LLC
Board Certified Adult and Pediatric Neurologists

AUTHORIZATION FOR RELEASE OF INFORMATION/PRIVACY NOTICE

Medical information will be provided in accordance with Federal HIPPA regulations and concerning continuum of care.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

** Healthcare information will be provided to Healthcare Facilities, Physicians, Insurance Companies, and/ or State/Federal entities as a part of my continuum of care unless otherwise noted below under specific instructions.

eRiver Neurology of New York, LLC may release information to the following people/agencies.

Check all that apply.

- Pharmacy/Pharmacist
- Social worker
- Employers
- School Nurse
- School Administration
- P. E. Teacher/Coach
- Day Care Provider
- Lawyer/Attorney
- Parents/Family

_____ (Please list names and relationship)

Please Initial:

___ I understand that my health care and payment for my health care will not be affected if I do not wish to sign this form.

___ I understand that I may see a copy the information described on this form if I ask for it. And have a copy after I sign.

Patient Name _____ DOB _____

 Signature of Patient Or Patients Representative Date _____

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PATIENT FINANICAL POLICY

We are dedicated to providing the best possible care for you.
We ask that you read and agree to sign this policy prior to any treatment.

Copays and Balances

The patient is expected to present a valid insurance card at each visit. All copayments and patient balances are due at the time of service unless arrangements have been made in advance. We accept cash, check or credit card.

Participating Insurance Plans

Your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor (in other words, if you agree to have your insurance company pay the doctor directly). If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. A maximum of two plans will be billed.

We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Referrals

If your insurance has a designated primary care physician (PCP), you are required to have prior authorization from your PCP prior to our office visit in order to receive maximum benefits. If an authorization/referral is not provided at the time of service, you will be asked to either reschedule your appointment or pay for the visit at the time of service.

Self-pay Accounts

Payment is required at the time of service for all services. Self-pay accounts are:

- * Patients without insurance information of file.
- * Patients without an insurance card at the time of service.
- * Patients who are covered by an insurance that the practice does not participate in.

Non-participating Insurance Plans

The financial obligations of patients who are insured by carriers that the practice does not participate with are considered a self-pay account. If you are insured by a plan that we do not have a prior arrangement with, as a courtesy we will prepare claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

Refunds

The following criteria must be met prior to the practice issuing a refund. The patient has not been treated by the practice for 60 days, there are no outstanding insurance claims on the patient's account, and there are no outstanding patient balances on the account.

I have read and understand the practice's financial policy and I agree to be bound by it's terms.

Patient Name

Signature of patient (or responsible party, if minor)

Date

Patient Refused to Sign: _____

Signature of Staff Member Date