South Suburban Neurology

Today' Date: ____________________ Patient's SSN: ________________

Patient Name: ____ Birthdate: ________________ Age: ________ Sex: _______

Home Address: ____ City: __________________ State: _____ Zip: ___________

Telephone #: _________________ Marital Status: _________ Student Status: _________ Employment Status: ___________

Insured Name: ____ Relationship to Patient: ________________________

Address (If different from Patient): ________________________________ City: _______________State: _____ Zip: _______

Telephone # (If different from Patient): _______________________ Marital Status: ______ Employment Status: ______

Insured Birthdate: * _________________ Insured SSN: * ________________ Occupation: _____________________________

Insured Employer: ____ Work Telephone #: __________________________

ID# ______________________________ Policy #: ________________________________ Group #: ___________________________

Type of Insurance: ____________ HMO: ______________ PPO: ______________ POS: ______________ SELF PAY

Name of Spouse
(If different from above): ____ Birthdate: ________________________

In case of Emergency, contact (other than above): ____

Relationship: _________________________Home Phone #: ____________________ Work Phone #: _____________________

Referred by: ____

Family Physician: ____ Phone #: ___________________________

Address: ____

On day of service private patients are responsible for all fees. PPO and HMO patients are responsible for deductibles and/or copay. PLEASE REMEMBER YOU ARE RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I authorize the release of any medical information necessary to process this claim.

Signature of patient or Legal Guardian: * ____ Date: _______________________

I authorize payment of medical benefits to South Suburban Neurology

Signed: * ____ Date: _______________________

Please present your insurance card to our staff so that we can make a copy for our records.

- INDICATES MUST BE FILLED IN *

THIS FORM MUST BE COMPLETED IN FULL

NAME: ____ DATE: _____________

LIST ANY ALLERGIES TO MEDICATIONS THAT YOU MAY HAVE:

LIST ANY PREVIOUS DIAGNOSES YOU HAVE BEEN GIVEN IN THE PAST:

LIST ANY MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

FINANCIAL POLICY

We accept payment by cash, personal check, Visa and MasterCard. There will be a $25.00 service charge on returned checks.

All co-payments are due at the time of check in for your appointment. If you do not have your co-payment and appropriate arrangements have not been made with our billing department, it is possible that we will have to reschedule your appointment.

As a courtesy, we will bill your insurance for you. You are responsible for your bill. If your insurance carrier has not paid your claim in full within 90 days, you will be responsible for payment.

Unpaid balances must be paid in full within 90 days of the date of service unless prior arrangements are made.

AUTHORIZATIONS TO: SOUTH SUBURBAN NEUROLOGY, LTD.

BENEFITS TO PHYSICIAN:

I hereby authorize payments directly to the physician of medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:

I hereby authorize release of information for insurance claim purposes.

I understand all of the above and hereby state that the insurance information I have given is correct and to the best of my knowledge. If my insurance changes, I will contact the office with the new insurance information to update my account. My signature indicates that I have read the above and grant the request of authorizations and acknowledge my financial responsibility.

Patient Name: ____

Patient Signature: ____

If minor, relationship to patient: ______________________________

Date: ____

SOUTH SUBURBAN NEUROLOGY, LTD.
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ____

If minor, relationship to patient: ________________________________

Signature: ____

Date: ____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices* acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Patient Name: ____

Address: ____

Phone Number: ____

Date of Birth: ____

SOUTH SUBURBAN NEUROLOGY, LTD

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize that the protected health information regarding the above-named person be forwarded:

FROM: Person/Institution: ____

Address: ____

City: _______________________________ State: ____________ Zip: _____________

TO: Person/Institution: ____

Address: ____

City: _______________________________ State: ____________ Zip: _____________

Purpose or need for information: ____

Disclosure will include: (check all that apply):

( ) History & Physical
( ) Progress/Physician Notes
( ) Nurses Notes
( ) Laboratory Report
( ) X-ray/Radiology Report
( ) EKG/EMG/EEG Report
( ) Consultation Report
( ) Other: ____________________

Records for the period (dated) from: ______________________________ to ______________________________

I must check one or more of the following types of health information that I do not want released to the above named Recipient. I understand that if I do not check any of the three (3) following boxes, the health information released to the named Recipient may include any of the following:

____ Diagnosis, evaluation and/or treatment for alcohol and/or drug abuse
____ Records of HTLV-III or HIV Testing (AIDS test) result, diagnosis and/or treatment
____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent that action has already been taken to release the information. This Authorization shall remain valid unless revoked but will expire in one (1) year after signing. I have a right to inspect a copy of the health information to be released and if I do not sign this Authorization, the institution named above will not release my health information. The above named person/institution will not refuse to treat me based on whether I agree to allow my health information to be used.

____ ____________________________
Signature of Patient Date

____ ____________________________
Signature of Parent/Legal Guardian/Personal Representative Relationship to Patient
(Required if Patient is not legally authorized to sign Authorization)

____ Fee: ______________________
Witness

REDISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that South Suburban Neurology cannot guarantee that the Recipient receiving the requested health information will not redisclose any or all of it to others. Notice is hereby given to the recipient that law prohibits the redisclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.

MEDICAL RECORDS: 1-25 pgs .78 26-36 pgs .52 37 & above pgs .15

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ______________________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone ______________________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number ________________

☐ Other ____________________________________
____

____ ___________________________

Patient Signature Date

____ ___________________________

Print Name Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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