

# 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: \_\_\_\_\_

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

# SOUTH SUBURBAN NEUROLOGY, LTD

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

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

## 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):

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> History & Physical       | <input type="checkbox"/> Laboratory Report      | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Progress/Physician Notes | <input type="checkbox"/> X-ray/Radiology Report | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> Nurses Notes             | <input type="checkbox"/> EKG/EMG/EEG Report     |  |

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  
(Required if Patient is not legally authorized to sign Authorization)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

Fee: \_\_\_\_\_

**REDISCLASURE:** 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.

# 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):**

- |  |   |
|--|---|
| <input type="checkbox"/> Home Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only<br><br><input type="checkbox"/> Work Telephone _____<br><input type="checkbox"/> O.K. to leave message with detailed information<br><input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Written Communication<br><input type="checkbox"/> O.K. to mail to my home address<br><input type="checkbox"/> O.K. to mail to my work/office address<br><input type="checkbox"/> O.K. to fax to this number _____<br><br><input type="checkbox"/> Other _____<br>_____ |
|--|---|

_____	_____
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