CENTRAL NEUROLOGY

HIPAA CONSENT FORM

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations per HIPAA Regulations
I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

* A basis for planning my care and treatment,
* A means of communication among the health professionals who contribute to my care, such as referrals,
* A source of information for applying my diagnosis and treatment information to my bill
* A means by which a third-party payer can verify that services billed were actually rendered
* A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.
*I have been provided with a "Notice of Patient Privacy Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:
* The right to review the "Notice prior to acknowledging this consent
* The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
* The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Restrictions:
I request the following restrictions to the use or disclosure of my health information:

_____

Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s)))

_____

_____

For messages or Appointment Reminders of a non-sensitive nature:

May we leave a telephone message at your home using doctor's/practice name: YES NO

May we leave a telephone message at your work using doctor's/practice name: YES NO

May we send a text message to your cell phone using doctor's/practice name: YES NO

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law

I fully understand and accept / decline (please circle one) the information of this consent.

_____
Patient/Guardian Signature

_____
Print Name of Person Signing

If other than the patient, _____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? YES NO

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REQUEST FOR CARE AND CONSENT FOR TREATMENT

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, x-ray examination, medical or surgical treatment or procedures, anesthesia, or other services rendered to the patient under the general and special instructions of the patient's physician. Central Neurology has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment directly to Central Neurology of any insurance benefits otherwise payable to me for services, at a rate not to exceed Central Neurology regular charges for such services.

FINANCIAL AGREEMENT

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expense.

MISSED APPOINTMENT FEES

Cancellation of appointments requires 24 hours' notice and failure to do so may result in a fee of $100 for missed consults and $50.00 for missed follow up appointments. Such fees are not covered services by insurance companies including Medicare.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical records and related information from Central Neurology to authorized representatives of my third party payer or physician related to my care. I authorize review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

The undersigned certifies that he/she has read the foregoing receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____

Signature of Patient or Authorized Person

_____

Relationship

_____

Date

If patient did not sign, please state reason: _____

CENTRAL NEUROLOGY

REASON FOR REFERRAL:

PAST MEDICAL HISTORY: (Please circle all that apply)

Asthma	Diabetes, Type 1	Liver Disease
Atrial Fibrillation	Diabetes, Type 2	Myocardial Infarction:
Anemia	Diverticulitis	Neurologic Disorder
Anxiety Disorder	D V T	Osteoarthritis
Autoimmune D i s o r d e r	G I Bleed:	Osteoporosis
Biliary Cirrhosis	G E R D	Peripheral Vascular Disease
Blood Transfusions	Hemochromatosis	P U D
Brain Tumor	Hyperlipidemia	Rheumatoid Arthritis
Cerebrovascular D i s e a s e	Hypertension	Seizure Disorder
Cirrhosis	Hypothyroidism	Thyroid Disorder
C V A / Stroke	Hyperthyroidism	Tuberculosis
C 0 P D	Hepatitis A	Valvular Heart Disease
Colon Cancer	Hepatitis B	U T I-Recurrent
Coronary Heart Disease	Hepatitis C	Varicose Veins/Phlebitis
Crohn's Disease	Infertility	Abnormal Pap Smear
Chronic Renal Failure	Kidney Disease	Breast Disease/Cancer
Depression	Kidney Stone	Cervical Cancer

Other Medical Problems: _____

PAST SURGICAL HISTORY: (Please circle all that apply and include date if known)

Abdominal Surgery:	Colon Resection:	Nephrectomy:Transplant
Amputation	Craniotomy :	Pacemaker:
AV Fistula Creation:	Gastric Bypass:	Parathyroidectomy
AV Graft:	Hemorrhoidectomy	Pneumonectomy
Aortic Valve Replacement:	Total Hip Arthroplasty	P T C A:
Appendectomy	Interventional pain procedure	Rotator Cuff Repair
Aorta-Femoral Bypass:	Knee Arthroscopy	T A H and B S 0
Back Surgery	Total Knee Arthroplasty	Abdominal Hysterectomy
Breast Surgery:	Kyphoplasty	Tonsillectomy
Bronchoscopy:	Lumpectomy	Tunneled Dialysis Catheter
C A B G:	Mastectomy	U P P P
Carotid Endarterectomy:	Mitral Valve Replacement:	Urinary incontinence surgery
Carpal Tunnel Release	Nephrectomy: Native	Vertebroplasty
Cataract Extraction		

OTHER SURGICAL PROCEDURES: _____

SOCIAL HISTORY:

Place of Birth:_____
Years resided here:_____
Marital status:_____
# of children (if any)_____
Occupation:_____
Highest level of education:_____
Are you Right or Left handed?__
Height:_____
Weight:_____

Tobacco use:
Current_____ Past_____(How much do you use?)

Alcohol Use:
Current_____ Past_____(How much do you use?)

MEDICATION: (Please list all medications including over the counter medications)

MEDICATION	DOSE	FREQUENCY

ALLERGIES: _____

FAMILY HISTORY: Please check box for family members with history of any of the below

	Father	Mother	Brother	Sister	Son	Daughter
Hypertension						
Heart disease						
Diabetes						
Stroke						
Headaches/migraine						
Tremor						
Dementia						
Breast cancer						
Lung cancer						
Colon cancer						
Prostate cancer						
Other cancer						

Other Family Medical Problems: _____

_____

REVIEW OF SYSTEMS: (please circle any symptoms you have)

General
Fever
Chills
Sweats
Anorexia
Fatigue
Weakness
Weight loss
Sleep disorder

Eyes
Visual loss one eye
Diplopia
Eye irritation
Visual loss-both eyes
Blurring
Eye pain
Halos
Discharge

Ear nose and throat
Ringing in ears
Ear discharge
Earache
Decreased hearing
Nasal congestion
Nose bleeds
Difficulty swallowing
Hoarseness

Respiratory
Insomnia due to breathing
Cough
Shortness of breath
Coughing up blood
Chest discomfort
Wheezing excessive sputum
Excessive snoring

Cardiovascular
Difficulty breathing at night
Near fainting
Chest pain or discomfort
Racing/skipped heartbeats
Fatigue
Lightheadedness
Shortness of breath on exertion
Palpitations swelling in hands or feet
Shortness of breath lying down
Fainting
Leg cramps with exertion
Bluish coloration of lips or nails
Weight gain

Gastrointestinal
Excessive appetite
Loss of appetite
Indigestion
Vomiting blood
Nausea
Vomiting
Yellow skin color
Gas abdominal pain
Hemorrhoids
Diarrhea
Change in bowel habits
Constipation
Dark or tarry stools

Genitourinary
Pain with urination
Hematuria
Discharge
Urinary frequency
Urinary hesitancy
Nocturia
Incontinence
Genital sores
Decreased libido
Erectile dysfunction

Musculoskeletal
Muscle cramps/aches
Joint pain
Joint swelling
Joint fluid
Back pain
Stiffness
Muscle weakness
Arthritis
Gout

Dermatology
Excessive perspiration
Night sweats
Suspicious lesions
Change in nail beds
Dryness
Poor wound healing
Unusual hair growth
Skin cancer
Itching
Change in skin color
Flushing
Rash

Endocrinologic
Excessive hunger
Cold intolerance
Heat intolerance
Excessive urination
Excessive thirst
Weight gain

Hematologic
Enlarged lymph nodes
Bleeding
Skin discoloration
Abnormal bruising
Fevers

Allergy
Persistent infections
Hives or rash
Seasonal allergies
HIV exposure

Psychiatric
Sense of great danger
Anxiety
Thoughts of suicide
Depression
Thoughts of violence

Neurologic
Poor coordination
Poor balance
Headache
Poor concentration
Inability to speak
Falling down
Tingling
Brief paralysis
Seizures
Weakness
Vertigo
Tremors

Central Neurology

Registration Information

Patient Name: _____

Date of Birth: _____ Sex: _____

Social Security Number: _____

Address: _____

Marital Status: Married / Single / Divorced / Widowed

Primary Language: _____

Race: _____ (White / African American / Hispanic / Asian / American Indian)

Ethnicity: _____ (Hispanic / Non-Hispanic)

Patient Email Address: _____

Patient Cell Phone: _____ Home Phone: _____ Work: _____

Referring Physician: _____ Phone: _____

Primary Care Doctor: _____ Phone: _____

Primary Insurance Information

Insurance Company Name: _____

Policy ID: _____ Group: _____

Claims Address: _____

Policy Holder if different than patient: _____

Patient's relationship to policy holder: _____

Emergency Contact Information

Name: _____

Mobile Phone: _____

Relationship: _____

By providing us with a telephone number for a cellular phone or other wireless device, you are expressly consenting to receiving communications – including but not limited to **prerecorded or artificial voice message calls**, text messages, and **calls made by an automatic telephone dialing system** – from us **and our affiliates and agents** at that number. This express consent applies to each such telephone number that you provide to us now or in the future and permits such calls regardless of their purpose. **Calls and messages may incur access fees from your cellular provider**.

Do you have hearing or visual problems that hinder verbal communication with your physician? YES NO

I have reviewed the above and certify that the information above is true and correct I also understand that patient information may be used to contact me by telephone or mail for the purpose of treatment, payment or health care operations. I authorize payment of medical benefits to the physician provider for services performed. I understand that I am ultimately responsible for the payment for my treatment and care. Payments of copays, coinsurance, deductibles and all other procedures or treatments not covered by my insurance plan are due at the time of service.

Signed: _____ Date: _____