Patient Registration Form:

William Gaya, MD PA
801 SW First Avenue
Ocala, Florida, 34471

First Name: _____ Middle Name: _____ Last Name: _____
Date of Birth: _____ Gender: _____ Social Security Number: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Email address: _____
Phone Numbers: Home #: _____ Mobile #: _____ Work #: _____

1. Primary Insurance Plan: _____ Insurance ID Number: _____
Name of person on the Insurance Card: _____
2. Secondary Insurance Plan: _____ Insurance ID Number: _____
Name of person on the Insurance Card: _____

Name of Employer: _____ Last Job Before Retiring:_____
Emergency Contact Name: _____
Emergency Contact Phone Number: _____
Married Status (single, married, life partner, widow, divorced, separated): _____

Referring Physician Name: _____
Primary Care Physician Name: _____
Reason for this visit or consultation: _____
Preferred Pharmacy: _____
Preferred Pharmacy Phone Number: _____

Race: Other (specify): _ Ethnicity: Unknown Language: Other (specify) _

I certify that the information provided is correct and hereby authorize direct payments of benefits to William Gaya, MD PA for services rendered by their licensed providers under their direct care or supervision and understand that I am financially responsible for any balance not covered by my insurance company.

I authorize the release of medical and incidental information that may be necessary for either medical care or in processing application for financial benefit.

_____ _____
Patient Signature Date

If patient is under age 18 or if patient is unable to sign, then provide the following information:
Parent/Guardian or Healthcare Surrogate/ Power of Attorney Name: _____
Parent/Guardian or Healthcare Surrogate/ Power of Attorney Phone Number: _____
Parent/Guardian or Healthcare Surrogate/ Power of Attorney Signature: _____

An electronic or photocopy of these assignments and acknowledgements shall be valid as the original

WILLIAM GAYÁ, M.D., P.A.

Neurology, Neurophysiology and Neuromuscular Disorders

801 SW 1st Avenue

Ocala, Florida 34471

Tel (352) 732-7233 Fax (352) 732-0239

Updox Patient Portal Instructions

Our Updox Patient Portal allows you to access to your health care medical record. You will receive emails from our practice to setup your access and to view the Summary/Plan from our visits or encounters. To verify and open your patient portal you will need to follow these steps:

1. Open the **very first email** the practice sent you. There will be a link and a password included in this email. (If there is no password, please call the office to have this reset).

2. Once you click on the link you will be asked for the password. Once the password is entered you will need to enter your date of birth as follows: (for 01-01-2015= enter 01012015)

3. Send us a message through the portal to let us know you have successfully gained access.

4. Portal is only used for record access of office notes, labs drawn at Quest & Lab Corp. **This is not for emergencies or consultations.**

5. You **should** call the office at (352) 732-7233 for all questions, medical related issues,or appointments. I**f you are having a medical emergency you must call 911.**

Thank you for your assistance in meeting all government regulations on patient portal access.

I have read and received a copy of William Gaya, MD PA office policy.

Patient's Name:_____ Signature:_____

Date:_____

An electronic or photocopy of this acknowledgment shall be valid as the original

William Gaya, MD PA
801 SW First Avenue
Ocala, Florida 34471
Tel (352) 732-7233

Office Financial Policies

It is the policy of our office to file insurance claims as a courtesy to our patients. However, deductibles and co-payments are expected to be paid at the time of service. We do not accept responsibility for communications or collections from your insurance company. **We do not file Workers' Compensation claims or PIP insurance.**

Effective January 1, 2007, if your Medicare supplemental insurance does not automatically "cross over" from Medicare, you will be required to pay your deductibles and co-payments at the time of service. If we file your secondary insurance for you, we will wait 60 days for payment. After that, you will be required to pay our office your remaining balance and collect from your insurance company. If under any circumstances you are required to file your own insurance, you will be provided with all the required information.

Self Pay Accounts
If you do not have insurance, payment in full for all services is expected at the time the services are rendered. For new patients our practice accepts cash, credit or debit cards only. We accept all major credit cards.

All Accounts
If your account has a balance of $150 or more, a payment plan allowing 90 days can be arranged through our billing department. All payments under this plan are expected to be kept current as agreed. If your balance is not paid within the 90 day time limit, or if your installment payment is past due by 30 days, a finance charge of 1.5% of the outstanding balance will be added to your account each month that the balance remains outstanding. At this point our practice will refer an unpaid account to a collection agency or credit reporting agency. Any cost relating to the collection of such accounts will be added to the balance due. Our practice will no longer be able to schedule future appointments once the account is turned over to a collection agency until your account is paid in full.

Returned Checks
There will be a $25.00 charge for returned checks due to insufficient funds.

_____ _____

Signature Date

An electronic or photocopy of this acknowledgment shall be valid as the original

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We are required to abide by the terms of this Notice of Privacy Practices. This Notice will take effect on January 1, 2013 and will remain in effect until it is amended or replaced by us.

We reserve the right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Patty Cannon. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: While we are providing you with health care services, we may share your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support or data analysis. These business associates and subcontractors through signed contracts are required by Federal law to protect your health information. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be $1.00 for each page and the staff time charged will be $12.00 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for an explanation of our fee structure.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. Effective March 26, 2013, The Omnibus Rule restricts provider's refusal of an individual's request not to disclose PHI.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Fundraising: We may use certain information (name, address, telephone number or e-mail information, age, date of birth, gender, health insurance status, dates of service, department of service information, treating physician information or outcome information) to contact you for the purpose of raising money and you will have the right to opt out of receiving such communications with each solicitation. Effective March 26, 2013, PHI that requires a written patient authorization prior to fundraising communication include: diagnosis, nature of services and treatment. If you have elected to opt out we are prohibited from making fundraising communication under the HIPAA Privacy Rule.

Sale of PHI: We are prohibited to disclose PHI without an authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law. Corporate transactions (i.e., sale, transfer, merger, consolidation) are also excluded from the definition of "sale."

Appointment Reminders: We may use your health records to remind you of recommended services, treatment or scheduled appointments.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $_____for each page and the staff time charged will be $12.00 per hour including the time required to copy your health information. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: William Gaya MD PA Privacy Officer: Patty Cannon

Telephone: (352) 732-7233 Fax: (352) 732-0239

Address: 801 S.W. 1st Ave. Ocala, FL 34471

William Gayá, M.D., P.A.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices issued by William Gayá, MD PA. This Notice describes how the practice of William Gayá, MD PA will use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I have regarding my protected health information.

By signing this acknowledgment I agree that the practice of William Gayá, MD PA may use and disclose my protected health information as described. This acknowledgment and authorization will remain in effect indefinitely unless it is revoked in writing by me except to the extent of already used or disclosed information.

_____
Patient Name (please print)

_____ _____
Signature of Patient Date

-OR-

_____ _____
Signature of Personal Representative Date

_____
Relationship to the Patient

An electronic or photocopy of this acknowledgment shall be valid as the original

WILLIAM GAYÁ, M.D., P.A.

Neurology Neurophysiology and Neuromuscular Disorders

801 SW 1st Avenue
Ocala, Florida 34471

Tel (352) 732-7233 Fax (352) 732-0239

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETED AND SIGN BELOW

Patient Name: _____ Record Number: _____

Social Security #: _____ Date of Birth: _____

Information is to be obtained from:
Name of Physician_____ Tel:_____

Address: _____ Fax: _____

Health Information that may be used / disclosed is limited to the following:

o Progress Notes	o Emergency Room Record	o Discharge Summary	
o History & Physical	o Consultation(s)	o Lab	o Pathology Report
o Operative Note(s)	o Imaging/X-Ray	o X-Ray Reports	o Entire Record

o Other *(specify)*_____

Health information to be released to the above named agency is limited to continuity of care.

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.
o **Yes** o **No** If applicable, I agree to the release of my medical or billing records containing the **sensitive information** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will expire _____ after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

_____ _____
Patient or Parent/Guardian Signature Date

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

Under HIPAA with patients' written request, records must be provided within 30 days of a request.

HIPAA Authorization for Release of Information
This form does not constitute legal advice and covers only federal, not state, laws.

William Gaya MD PA
801 SW First Avenue
Ocala, Florida 34471
352-732-7233

ABOUT OUR PRACTICE

Our office hours are from 8:00 a.m. to 12:00 and 1:00 p.m. to 5:00 p.m. Monday through Thursday and 8:00 a.m. to 12:00p.m on Fridays.

This is an adult clinical neurology practice. Our work is limited to the diagnosis, management and counseling of neurological disorders. We recommend that you keep a regular follow up with your primary doctor, either a family practice or an internal medicine physician. We do not perform surgeries. However, we will refer you to a surgeon if it is clinically indicated.

Keep in mind that some unattended neurological conditions may result in irreversible or permanent medical consequences. It is important that you comply with our practice medical recommendations. If you do not understand our instructions and recommendations, please ask for clarification. Furthermore, it is your responsibility to reschedule any missed appointments at your earliest convenience. The tests requested by William Gayá, MD PA (including but not limited to laboratory or diagnostic imaging) are important in order to provide adequate diagnosis and treatment of your condition. Failure to obtain these tests or follow your physician's directions may result in delaying proper therapies leading to potentially irreversible neurological conditions or even death.

I understand the above statements and will keep my appointment and will be responsible to reschedule any missed appointment as soon as possible. I agree to comply with this practice recommendations including obtaining laboratory and diagnostic tests or imaging when advised to do so.

By signing this consent form, I have not waived any of my patient legal rights.

_____ _____

Patient Signature Date

An electronic or photocopy of this acknowledgment shall be valid as the original

William Gayá, M.D., P.A.
801 SW 1st Avenue
Ocala, FL 34471

LIST OF PERSONAL AUTHORIZED CONTACTS

Please, list any person (any family member, close friend or Power of Attorney) that you authorize us to discuss aspects of your medical condition. This conversation may include discussion of information in your medical records, prescriptions or medications, medical history and results of laboratory or radiological tests and outcome of procedures.

In order to protect the confidential nature of you medical record, if a person contacts our office for information about you and such person is not listed on this document, a separate medical release authorization form signed by you or your Power of Attorney will be required from us.

Name of authorized individual	Relationship to patient
1.	Other
2.	Other
3.	Other
4.	Other
5.	Other

_____ _____

Patient Signature Date

An electronic or photocopy of this acknowledgement shall be valid as the original