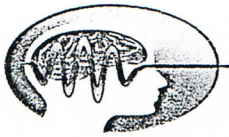

Neurophysiology Center

Patient Name:

_____

Last **First** **Middle**

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Primary Contact: □Home Phone □Cell Phone

Email Address: _____ Primary Care Dr._____

DOB: _____ Gender:□ Male □Female last 4# Social Security :_____

Employer: _____ Work Phone: _____

Race: □White Hispanic □ Black or African American □Asian □Decline to Report □Other_____

Ethnicity:□ Hispanic or Latino/a □Not Hispanic or Latino/a □ Decline to Report □ Other: _____

Whom may we call in Case of Emergency? Name: _____

Relationship to patient:_____ Primary Phone # _____

Practice Policy: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect copayments, coinsurance and deductibles at time of service. Once a balance reaches 90 days old without payment, the balance may be transferred to a third party for further collections or other actions. Our office will obtain your insurance benefits; however, it is your responsibility to know your benefits per your contract with your health insurance carrier. It is your responsibility to provider our office with new insurance information prior to your appointment to avoid unnecessary wait times. There will be a charge for filling out forms that require more than a signature and $15.00 for writing letters each time these services are provided. Any prescription request the office receives after 12pm on Fridays will refilled by the following Monday. **All refills must be done before Friday at noon.**

Canceling/Rescheduling Appointments: If you are unable to keep your appointment, please notify our office at least twenty four hours in advance to cancel or reschedule your appointment. Your courtesy will allow other patients seeking medical treatment the option to use your scheduled appointment time patients will be charged $50.00 for missed appointments unless the appointment was cancelled 24 or more hours in advance.

Insurance Information

Primary Insurance Company: _____ **Insurance Phone:** _____

Insured Name: _____ **DOB:** _____ **SS#:** _____

Patient Relationship to Insured: _____ **Insurance ID#:** _____ **Group#:** _____

Address of Insured: _____

Secondary Insurance Company: _____ **Insurance Phone:** _____

Insured Name: _____ **DOB:** _____ **SS#:** _____

Patient Relationship to Insured: _____ **Insurance ID#:** _____ **Group#:** _____

Address of Insured: _____

Consent for purpose of treatment, Payment, Health Care and Notice of Privacy Practices

Consent for Purpose of Treatment, Payment, Health Care Operations and Notice of Privacy Practices I consent to the use or disclosure of my protected health information by Neurophysiology Center, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Rafael M. Rodriguez, M.D. may be conditioned upon my consent as evidence by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Neurophysiology Center, is not required to agree to the restrictions that I may request. However, if Neurophysiology Center, agrees to a restriction that I request, the restriction is binding between Neurophysiology Center and

_____.

(Write patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that Rafael M. Rodriguez M.D., or Neurophysiology Center, has taken action in reliance on the consent. My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Neurophysiology Center, Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my medical claims or in the performance of health care operations of Neurophysiology Center. The Notice of Privacy Practices for Neurophysiology Center is also available at the front desk of the clinic. This Notice of Privacy Practices also describes my rights and the Neurophysiology Center duties with respect to my protected health information. Neurophysiology Center reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative **Name of Patient or Personal Representative**

_____ _____

Date **Description of Personal Representative's Authority**

I am giving authorization to Neurophysiology Center to disclose my medical and Insurance information to the below person(s).

_____ _____

Person(s) to whom information may be disclosed **Person(s) to whom information may be disclosed**

_____ _____

Signature of Patient or Personal Representative **Date**

PATIENT INTAKE FORM

Weight _____ Height _____

Reason for visit / Current Problem: _____

_____

Medication Allergies? □ Yes or □ No

If yes, what? _____

_____

Past Medical History: _____

_____

Surgical Medical History: _____

_____

Family History: _____

_____

Social History:

Smoker? □ Yes or □ No

If yes, how long? _____

Quantity: _____

Alcohol ? □ Yes or □ No

If yes, how often ? _____

Recreational Drug Use ? □ Yes □ No

If yes, how often? _____

PHARMACY NAME: _____

ADDRESS: _____ CITY _____

ZIPCODE _____ PHONE # _____

Medication Log

Name of Medication	Milligrams	Frequency

OFFICE AND COLLECTION POLICIES

Office Visits

We request that you make appointments for all your visits and be aware of the office hours. Our philosophy is to provide you the highest quality of care. We know that your time is as valuable as ours and we make every effort to keep our schedule on time. Please notify us in advance if you are unable to keep your appointment. Appointments not canceled at least three hours' prior the scheduled appointment time may be subject to a cancellation fee of $50.00 for office visits. Extenuating circumstance will be taken into consideration. There will be a $25.00 charge each page for filling out forms that require more than a signature.$15.00 for writing letters each time these services are provided.

Always bring a current list of all your medications with the exact dosages to each office visit.

Office Hours

Monday – Friday 8:30am-3:30pm (We do not closed for lunch)

Telephone Calls

Our office staff will be happy to answer your questions about office policy and scheduling. Medical questions will be referred to one of our providers. Extended phone consults or after hour and weekend calls resulting in telephone treatment, may be billed a telephone consultation fee.

Non-Urgent Pharmacy Request

It is very important that prescription medications are renewed in a timely manner. We operate a 24hour voicemail box for our patients to leave non-urgent prescription renewal requests. Prescription requests are retrieved twice daily during weekdays. Our policy is to complete your request by calling your pharmacy within 24 hours of the message being left.

Any prescription requested after 12pm on Friday will be refilled by the following Monday.

After Hours Calls

All routine matters should be handled during regular office hours. However, a physician from our call group can be reached at all times. If you believe your situation is critical, always go to an emergency room where you will receive assistance. Otherwise, call our office first before going to the emergence room; many problems can be handled over the telephone.

Privacy and Security

Neurophysiology Center holds all information pertaining to the care and treatment of our patients in the strictest confidence. All information in the patient's medical record is maintained with the utmost care and respect to preserve privacy and confidentiality. Neurophysiology Center fully complies with the Federal Government's mandated HIPAA requirements for patient confidentiality and privacy of healthcare information. As a new patient, you will be asked to review and acknowledge receipt of our Notice of HIPAA Privacy Practice that outlines the circumstance for which we can disclose protected health information without authorization. Only a patient can provide the authorization to release records necessary for Neurophysiology Center to disclose protected health information for instances not related to your ongoing treatment and/or payment of claims. A patient may request to view a copy of their medical record in the office.

Collection Policy

All payments are due at time of services rendered. Dr.Rodriguez and providers of Neurophysiology center have a legal obligation to the insurance companies they are contracted with to collect copayments, deductibles, and coinsurance. Once a balance reaches 90 days old, regardless of payment received, it may be transferred to a third party for further collections or other actions.

I have read and understand the office and collection policies of Neurophysiology Center

_____

Signature **Printed Name** **Date**

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that Neurophysiology Center provided me with a written copy of their Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Pr actices and ask
questions, which explains how my medical information will be used and disclosed.

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative and Relation (if not patient) Date

I am giving authorization to Neurophysiology center
to disclose my medical and insurance information to the below person(s).

_____

Person(s) to whom information may be disclosed

_____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative and Relation (if not patient) Date

HIPAA NOTICE OF PRIVACY PRACTICES

PRACTICE NAME NEUROPHYSIOLOGY CENTER, P. A.
Effective Date: March 26, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

This Notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 813-653-2775

II. We May Use or Disclose Your Health Information for Purposes of Treatment, Payment or Healthcare Operations without Obtaining Your Prior Authorization and Here is One Example of Each:

We may provide your Health Information to other health care professionals — including doctors, nurses and technicians — for purposes of providing you with care.

Our billing department may access your information — and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

We may access or send your information to our attorneys or accountants in the event we need the information in order to address one of our own business functions. Our attorneys and accountants are required to maintain confidentiality when they receive patient information.

III. We May Also Use or Disclose Your Health Information Under Certain Circumstances without Obtaining Your Prior Authorization. However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your Health Information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To Notify and/or Communicate with Your Family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information to Family and Friends form.

As Required By Law.

For Health Oversight Activities. We may use or disclose your Health Information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In Response to Civil Subpoenas or for Judicial Administrative Proceedings. We may use or disclose your Health Information, as directed, in the course of any civil administrative or judicial proceeding.
To Law Enforcement Personnel. We may use or disclose your Health Information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For Purposes of Organ Donation. We may use or disclose your Health Information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use or disclose your Health Information as necessary to comply with worker's compensation laws.

IV. For All Other Circumstances, We May Only Use or Disclose Your Health Information After You Have Signed an Authorization. If you authorize us to use or disclose your Health Information for another purpose, you may revoke your authorization in writing at any time.

Fundraising. Should our practice use patient information for fund raising we will inform individuals that they have the right to opt out of fundraising solicitations and explain that process. You do have the capability to opt back in with written notice.

- Marketing. Should our practice use patient information for marketing purposes we will first obtain your written authorization and fully explain the uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI will require a separate written authorization.

- Use or Disclosure of Psychotherapy Notes. *Written a*uthorization is required if our practice intends to use or disclose psychotherapy notes.

- Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPAA regulations.

Right to Request Restrictions for Disclosures Related to Self-Payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You Should Be Advised that We May Also Use or Disclose Your Health Information for the Following Purposes:

Appointment Reminders. We may use your Health Information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of Ownership. In the event that our Business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs and radiology groups through our EMR/EHR system as listed below:

1) (PROVIDER TO LIST) Electronic Exchange #1
2) (PROVIDER TO LIST) Electronic Exchange #2

VI. Our Duties.
We are required by law to maintain the privacy of your Health Information and to provide you with a copy of this Notice.

We are also required to abide by the terms of this Notice.

We reserve the right to amend this Notice at any time in the future and to make the new Notice provisions applicable to all your Health Information — even if it was created prior to the change in the Notice. If any such amendment is made that materially changes this Notice, we will send you another copy.

VII. Complaints to our Practice and the Government.
You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any complaint you make about our privacy practices.

VIII. Contact Information.
You may contact us about our privacy practices or file a complaint by calling our Privacy Officer: MARIA MICHELL at 813-653-2775.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S. W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775