# ***Ginsburg Neurology***

## Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name ______________________________________ D.O.B _______________________

I acknowledge that I have received a copy of the Ginsburg Neurology Notice of Privacy Practices:

Signature of Patient/Personal Representative ______________________ Date_______________

## Documentation of Good Faith Efforts

**To obtain patient's acknowledgement that they received provider's Notice of Privacy Practices (For use when acknowledgement cannot be obtained)**

The patient presents to the office on _______(date) and was provided with a copy of the Ginsburg Neurology Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

_______ Patient refused to sign
_______ Patient was unable to sign or initial because:

_______ Patient had a medical emergency, and an attempt to obtain the Acknowledgement will be made at the next available opportunity

_______ Other reason. Describe: ____________________________________________________

Signature of Employee Completing Form ___________________________ Date_____________

7151 Cascade Valley Court, Suite 103, Las Vegas, NV 89128
Phone: 725-268-7151/Fax: 725-241-8401

**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 of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

**1. Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:**
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Facility Directories:** Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**2. Your Rights**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

**3. Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact your doctor if you have any other questions about privacy practices.

# *Ginsburg Neurology*
# New Patient Registration Form

Referring Doctor: ______________________________________________

Patient's Name/DOB: ____________________________________________
Last Name First Name D.O.B(mm/dd/yyyy)

Social Security Number: _________________________________________

Marital Status: ____ Single ____ Married ____Divorced ____Separated. _____ Widowed _____

Race: ____ American Indian/Alaska Native ____Asian ____ Black or African American

____ Pacific Islander ___ Native Hawaiian ____ White

Ethnicity: ____ Hispanic or Latino. ____Not Hispanic or Latino

Home Address: __________________________________________________
Street Apt# City State Zip Code

Home Phone: __________________Cell Phone: _______________Work Phone: _________

Email: ________________________________________________________

Preferred Method of Contact: _____________________________________

Emergency Contact: _________________________ Phone Number: _______________

Relationship to patient: _________________________________________

Employer: _________________________________ Phone: _______________________

Address: ______________________________________________________

City: __________________ State: __________ Zip Code: __________________________

Primary Insurance: _______________Subscriber's Name: ________________DOB:_______

Policy #: ___________________ Group #: _______________ Phone Number: ___________

Policy Holder Name: ___________________________ D.O.B________________________

Insurance Address: ______________________________________________

Secondary Insurance: _______________ Subscriber's Name: __________________ DOB: _______

Policy #: ______________________ Group #: _________________ Phone Number: _____________

Policy Holder Name: _______________________________ D.O.B ___________________________

Insurance Address: _________________________________________________________________

I, the undersigned, hereby: (a) certify that the above information is correct and current as of the date below, (b) authorize payment directly to Ginsburg Neurology and authorize the release of any medical information necessary to process insurance claims and for utilization review and quality assurance: (c) voluntarily consent to treatment for myself and/or third party payer and/or not paid to Ginsburg Neurology, and should the account be turned over to collections, I will pay all costs of collection including, but not limited to. Agency fees, attorney fees and court costs, and I further understand that a monthly finance charge of 1.5 % (18.00% annually) will be assessed on any unpaid balance.

Patient/ Guardian Signature ____________________________________ Date________________

Relationship to Patient ____________________________________________________________

7151 Cascade Valley Court, Suite 103, Las Vegas, NV 89128
Phone: 725-268-7151/ Fax: 725-241-8401

# Ginsburg Neurology Financial Policy

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

## Insurance

1. We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office's policy is to collect the copayment when you arrive for your appointment. If your insurance requires a referral, it is your responsibility to ensure we have received the referral prior to your appointment.

2. It is your responsibility to verify that Ginsburg Neurology PLLC participates with your health plan prior to scheduling your appointment.

3. You must bring your insurance card and photo ID with you and any authorizations you may have. Without these, we will be unable to see you. It is your responsibility to keep our office informed of any changes to your information – such as address changes, changes in insurance, etc.

4. If you have traditional Medicare Part B (not a Medicare Advantage Plan), you are responsible for your Medicare deductible, if not already paid. Once Medicare has paid their portion, you will be billed for the remainder of the balance as Medicare does not pay 100% of charges. If you have a secondary insurance to cover what Medicare does not, the claim will be automatically forwarded to your secondary insurance company by Medicare. You will be billed for any remaining balance.

## Self-Pay Patients

1. Patients without insurance – The estimated charges of the visit are due at the time of service. Ginsburg Neurology PLLC has a separate cash pay services rate that includes applicable discounts.

## No-Shows and Cancellations

1. In order to meet the appointment scheduling needs of Dr. Ginsburg's busy practice, Ginsburg Neurology has established a no-show fee for missed appointments. Should it become necessary to reschedule your appointment due to illness, please provide at least 24 hours' notice to the office. This will enable us to schedule another patient in the allotted time slot.

**The following fees apply to no-show patients:**

Neurology Visit: $50
Electromyography (EMG): $300
Electroencephalogram (EEG): $300
Botox Treatment: $50

**Please Note:**

1. If you are requesting Dr. Ginsburg to fill out any needed complex forms/documentation (i.e. FMLA, disability forms, DMV, etc.) you must do **ONE** of the following:

   a. Schedule a dedicated appointment to complete forms with Dr. Ginsburg OR
   b. Pay a $50 processing fee for the form to be completed by Dr. Ginsburg outside of a scheduled visit.

I have reviewed the Financial Policy of Ginsburg Neurology PLLC and agree to its terms.

Patient Name (Please Print): ______________________________

Patient Signature: ______________________ Date: ______________

## *Ginsburg Neurology*

**Pharmacy Information**

Pharmacy #1: ______________________________ Phone: ______________________

Address: ______________________________________________________________

City: __________________________ State: _______________ Zip: ______________

Major Cross Streets: _____________________________________________________

Pharmacy #2: ______________________________ Phone: ______________________

Address: ______________________________________________________________

City: __________________________ State: _______________ Zip: ______________

Major Cross Streets: _____________________________________________________

Patient's Name: _________________________________________________________

Patients Signature: ______________________________ Date: ___________________

# ***Ginsburg Neurology***

## Transfer of Medical Records

Name: ____________________ DOB: ____________________ Phone: ______________________

Release From:

Name: ______________________________

Address: ____________________________

_____________________________________

Phone: ___________ Fax: ____________

Release To:

Ginsburg Neurology
7151 Cascade Valley Court, Suite 103
Las Vegas, NV 89128
Phone: 725-268-7151/Fax: 725-241-8401

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*I request and authorize this transfer and release of my medical record to and from the medical practice listed above. I understand that this documentation includes all forms of Protected Health Information (PHI) and is also applicable to the electronic transfer of records if the requested recipient can accept and access encrypted information from Ginsburg Neurology's Electronic Medical Record. I understand that I may not be denied treatment for health care services if I do not sign this form.*

___ Entire Record – OR:
___ Doctor's notes
___ Medications
____ Lab Reports
____ Diagnostic Studies
____ X-ray reports
____ Diagnoses
____ Pathology Reports
____ Other

I understand that Ginsburg Neurology will no longer be responsible for the protection of the PHI in its original format in their records. I understand that my health information may be subject to re-disclosure by the recipient and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations. This authorization will expire one year from the date signed. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present the written revocation to Ginsburg Neurology. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

***PLEASE NOTE: THERE MAY BE A CHARGE FOR THE COPYING OF RECORDS***

*In accordance with NRS 629.061, the cost of this information cannot exceed $0.60 per page and a reasonable cost for copies of any x-ray photographs and other health care records produced by similar processes. Actual postage or shipping costs and applicable sales tax, if any, may be charged. We will not be able to process your request until payment is received.*

Patient/Legal Guardian Signature: ___________________________ Date: __________________

## *Ginsburg Neurology*

## Consent to Contact

Patient Name ________________________________ D.O.B ____________________

There may be times when the provider or staff members of Ginsburg Neurology may need to contact you. If you wish to allow us to leave messages and/or to speak with a trusted individual regarding your medical care, we need written consent in order to do so.

**Please indicate if we have your permission to leave phone messages regarding your medical care:**

______ I authorize Ginsburg Neurology to leave phone messages containing my Personal Health Information on the following telephone number(s):

Phone Number ____________________________________________________
Phone Number ____________________________________________________

______ No, I do not authorize Ginsburg Neurology to leave phone messages containing Personal Health Information on any of my telephone number(s).

I understand I have the right to revoke this consent at any time. I understand if I revoke this consent I must do so in writing and provide the written revocation to Ginsburg Neurology. I understand the revocation will not apply to information that has already been released in response to this consent. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that I may not be denied treatment or payment for health care services if I do not sign this form.

This consent will expire one year from the date I sign it. I understand that my information may be subject to redisclosure by the recipient and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations. I release Ginsburg Neurology from all liability and claims of any nature pertaining to the disclosure of requested information once a disclosure takes place.

**I certify that I have read and fully understand the above statements and consent fully and voluntarily to allow Ginsburg Neurology to contact me.**

Patient signature ____________________________________ Date ____________________

Personal Representative ________________________________ Date __________________

7151 Cascade Valley Court, Suite 103, Las Vegas, NV. 89128
Phone: 725-268-7151/Fax: 725-241-8401

# *Ginsburg Neurology*

## Authorization For Use or Disclosure of Health Information

By completing this document, you authorize the disclosure and/or use of your individual identifiable health information, as set forth below, consistent with Nevada and Federal law concerning the privacy of such information. Failure to provide all information may invalidate this authorization.

I, ____________________ (your name) authorize Ginsburg Neurology to disclose my health information with the following individual(s):

1. Name: ______________________________________________

Address: ______________________________________________

City, State, Zip: ______________________ phone: ________________

What relationship is this person to you: ______________________________

2. Name: ______________________________________________

Address: ______________________________________________

City, State, Zip: ______________________ phone: ________________

What relationship is this person to you: ______________________________

This Authorization applies to the following information (select one of the following options):

_____ **All Health Information** including health (e.g., diagnosis, providers, treatments, drugs) and financial information (e.g., medical claims, premium bills, copayments)

**OR**

_____ **Only Limited Information**

Specify type of information: ______________________________

Specify date range: ______________________________

Federal and State laws require us to obtain specific authorization to release especially sensitive information. Sensitive information is defined as treatment or documentation related to HIV and AIDS test results, psychiatric care, and treatment for alcohol or drug abuse. We will automatically try to exclude these types of information unless you specifically identify them for release. Please check below if you authorize Ginsburg Neurology to release any or all the following information.

_____ **I also specifically authorize the release** of the following types of sensitive information (check all that apply):

_____ Psychiatric Care _____ Substance Abuse ______ HIV and AIDS Test Results

## Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to your protected health information (PHI). Your personal representative is given all the privileges that you have with respect to your PHI. Your Personal Representative may receive your PHI and has the authority to modify your Ginsburg Neurology patient account (e.g., update your address, change your Primary Care Physician). A Personal Representative may be a spouse, relative, domestic partner, or friend. You are not required to have a Personal Representative, but if you want to designate someone who can receive your PHI and modify your Ginsburg Neurology patient account, please complete the information below.

**The person named below is to also be given all the privileges that would be given to me regarding my protected health information.**

Personal Representative Name: ____________________________________________

## Expiration

THIS AUTHORIZATION WILL EXPIRE ON (INSERT DATE): _______________. If no expiration date is selected, this document will be in effect until my relationship with Ginsburg Neurology ends or until I send a written request to revoke this authorization.

## Notice of Rights and Other Information

- I may refuse to sign this authorization.
- I may revoke this authorization at any time by signing the revocation section and sending this for to Ginsburg Neurology. My revocation will be effective upon receipt but will not be effective to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

- I understand that Ginsburg Neurology will not condition treatment, payment, enrollment or eligibility for benefits on my providing or refusing to provide this authorization, except under limited circumstances described in the Notice of Privacy Practices.
- I understand information disclosed pursuant to this authorization could be redisclosed by the recipient and might not be protected by federal confidentiality law (HIPAA). However, Nevada law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- I may inspect or obtain a copy of the health information that I am authorizing for use or disclosure.
- I understand that Ginsburg Neurology may not use or disclose my PHI other than for the purposes described on this form unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
- I hereby release Ginsburg Neurology from any and/all liability that may arise from the release of this information to the party named on this form.

Print Your Name: ________________________________________ Date: ________________

Signature: ____________________________________________ Date: ________________

**If signed by someone other than the Patient (such as guardian or conservator), please complete the following:**

Printed Name: __________________________________ Relationship: ________________

## Revocation

You may revoke this authorization at any time by signing and dating this section of the form and returning it to Ginsburg Neurology. You should only sign this section if you want to cancel this authorization.

I hereby revoke this authorization and/or designation of personal representative immediately.

Signature: ____________________________________________ Date: ________________

*Ginsburg Neurology*

Medical History Review

Patient Name: ______________________________ D.O.B ____________________

## Allergies

Name: ____________________ Reaction/Severity ______________________
Name: ____________________ Reaction/Severity ______________________
Name: ____________________ Reaction/Severity ______________________

## Medical History

Have you been diagnosed with any of the following: Please check Yes or No. Use the notes column to specify when you were diagnosed with that disease or when you last had symptoms.

| Name | Yes | No | Note |
|---|---|---|---|
| ALS | | | |
| Angina | | | |
| Aortic Stenosis | | | |
| Asthma | | | |
| Atrial Fibrillation | | | |
| Bipolar Disorder | | | |
| Cancer | | | |
| COPD | | | |
| Chronic Bronchitis | | | |
| Chronic Kidney Disease | | | |
| Congestive Heart Failure | | | |
| Depression | | | |
| Diabetes | | | |
| Eating Disorder | | | |
| Emphysema | | | |
| Gestational Diabetes | | | |
| Hallucinations/Delusions | | | |
| Heart Attack | | | |
| Heart Disease | | | |
| Insomnia | | | |
| Leukemia | | | |
| Mental Disorder | | | |
| Multiple Sclerosis | | | |

| | | | |
|---|---|---|---|
| Panic Disorder | | | |
| Personality Disorder | | | |
| PTSD | | | |
| Pre-diabetes | | | |
| Psychosis | | | |
| RLS | | | |
| Schizophrenia | | | |
| Sleep Apnea | | | |
| Social Phobia | | | |
| Other – not listed | | | |

## Family History

Has any of your family members been diagnosed with any of the following diseases? Please check Yes or No. If you answer Yes, please specify which family members were diagnosed with each disease.

| Name | Yes | No | Relative(s)/Notes |
|---|---|---|---|
| ALS | | | |
| Alzheimer's Disease | | | |
| Dementia | | | |
| Diabetes | | | |
| Epilepsy | | | |
| Frontotemporal Dementia | | | |
| Lewy Body Dementia | | | |
| Multiple Sclerosis | | | |
| Parkinson's Disease | | | |
| Stroke | | | |
| Type 1 Diabetes | | | |
| Type 2 Diabetes | | | |

## Smoking

Please place a check by the sentence that best describes your smoking status:

I have never smoked: _____
I currently smoke everyday: _____
I used to smoke: ____
I currently smoke on some days: ____

## Surgical/Hospitalization

Please list dates you were hospitalized and the reason for each hospitalization

| Date | Reason |
| --- | --- |
| | |
| | |
| | |

## Current Medications

Please list any medications you are currently taking. Please include the strength of medication. Also list any over the counter medications you are currently taking.

| Drug name & Strength | Frequency | Prescribing Doctor |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |

**Please attach additional page if necessary for medications.**

# Ginsburg Neurology

## General Consent for Care and Treatment

Patient Name________________________________ DOB___________________

**To the patient: You have the right, as a patient, to be informed about your condition and any recommended surgical, medical, or diagnostic treatment(s) and/or procedure(s) your provider believes you need. This will be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the potential risks involved. A this point in your care no specific treatment plan has been recommended.**

The purpose of this consent is to obtain your permission to perform reasonable and necessary medical examinations, testing and treatment. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Ginsburg Neurology. This consent will remain fully effective until it is revoked in writing.

I agree to provide accurate and complete information about my health history, condition(s) and presenting complaint, to agree upon a treatment plan and to follow that plan.

I understand that I have the right to discuss any treatment plan with my provider or members of his team to learn more about the purpose, potential risks and benefits of any test, treatment, or procedure recommended. I have the right to ask questions.

I agree that I am voluntarily requesting Dr Ginsburg or his designees to perform reasonable and necessary medical examinations, testing and treatment for the complaint that brought me to this office. I also agree that I understand that if additional testing, invasive or interventional procedures are recommended, I may be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed at Ginsburg Neurology.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Legal Guardian Signature ______________________________Date____________

Relationship to Patient________________________________________________________

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