

0104 0106 0107 0108 0181 0184 NCV EEG

DATE _____ GNA# _____ STAFF INITIALS _____

PATIENT NAME _____
(Last) (First) (Middle/Maiden)

PATIENT ADDRESS _____

HOME PHONE # _____ (City) (State) (Zip)
MALE _____ FEMALE _____

DATE OF BIRTH ____/____/____ DRIVER'S LICENSE # _____ STATE _____
(Mo) (Day) (Year)

SOCIAL SECURITY # _____ - _____ - _____

EMERGENCY CONTACT _____
(Name) (Relationship) (Phone)

RESPONSIBLE PARTY (If other than patient) _____

ADDRESS _____

REFERRING DR. _____ (City) (State) (Zip)
(Last Name, First Name) FAMILY DR. _____

PATIENT'S EMPLOYER NAME _____ ADDRESS _____

PHONE _____ DEPT. OR EXT. _____ OCCUPATION _____

PRIMARY INSURANCE COMPANY _____ ADDRESS _____

POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER DATE OF BIRTH _____

SUBSCRIBER'S EMPLOYER NAME & ADDRESS _____

SECONDARY INSURANCE COMPANY _____ ADDRESS _____

POLICY # _____ GROUP # _____

SUBSCRIBER'S NAME _____ SUBSCRIBER DATE OF BIRTH _____

SUBSCRIBER'S EMPLOYER NAME & ADDRESS _____

I hereby authorize Guilford Neurologic Associates, Inc. to release any information acquired in the course of my examination and treatment to the above listed insurance carriers and do assign payment from these carriers to GNA for medical services rendered. This authorization is valid until rescinded in writing or replaced by one of a later date. I understand that I am responsible for payment of my account in full, regardless of any non-payment by insurance carriers.

DATE _____ SIGNATURE _____

GUILFORD NEUROLOGIC ASSOCIATES, INC.
PAYMENT POLICY- PLEASE REVIEW CAREFULLY
PATIENT: PLEASE RETURN SIGNED SHEET TO THE RECEPTIONIST

Guilford Neurologic Associates, Inc., is dedicated to serving our patients with the highest quality of neurologic care at the lowest possible cost. We ask that you help us keep our fees at a competitive level by paying your balance promptly. Please note the following financial policy:

1. Payment is expected at time of service. As a courtesy, we will file your charges with your primary insurance carrier if your deductible has been met. Patients who have not met their deductible will be expected to pay in full and will be given appropriate paperwork to file their own insurance claim. Coinsurance payments accepted at the time of your visit are considered partial payment until your insurance carrier pays on your behalf. You should remember that, regardless of your insurance coverage, you are personally responsible for your bill.
2. If your total balance for services creates a financial hardship, we will be glad to establish a payment plan for you. Please call our billing office before your scheduled appointment to make payment arrangements. **Payment plans may not be established for accounts that have been reached delinquent status.** All accounts must have regular monthly balance reductions as agreed upon in the payment plan, or the account balance will become payable in full.
3. **Medicaid, HMO and PPO** copayments must be paid at check-in. If you do not present your Medicaid, HMO or PPO card, or cannot pay your copay, you may be asked to reschedule your appointment.
4. Guilford Neurologic Associates, Inc., does not accept referrals from attorneys, nor do we hold bills for pending litigation. If your service is required as a result of an accident and your health insurance plan has agreed to cover your medical expenses, we will file your primary insurance and will collect unmet deductibles and copays at that time of service. If your health insurance carrier will not pay because of automobile or other insurance coverage, we will ask for payment in full at time of service.
5. Your insurance coverage represents a contract between you and your insurance carrier. We will provide you with information necessary for you to request a review of a denied claim. However, disputed claims do not suspend payment requirements.
6. **WORKERS COMPENSATION** Our office does not treat patients under Workers Compensation. Please call our office to cancel your appointment if you are expecting Workers Compensation to pay for your service.
7. Please contact our patient accounting/ insurance department if you have any questions or need to discuss your charges in our office.

Patient Signature _____ **Date** _____

PERMISSISON TO DISCUSS PHI

Patient Name: _____ **Date of Birth:** _____

Account Number: _____

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent or Guardian

Date

In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

Patient Identifier: _____ **(DATE OF BIRTH OR SOCIAL SECURITY NUMBER)**

GUILFORD NEUROLOGIC ASSOCIATES

PATIENT CONSENT

Patient Name: _____ Date of Birth _____

Social Security Number: _____

By signing this consent you are giving the providers and office staff permission to use and disclose your health information. Your health information will be used and disclosed to provide your care and treatment, to bill and collect payment for the services provided, and to perform necessary routine office operations.

You have been provided with a copy of our "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the "Notice of Privacy Practices" and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be given a copy of the revised notice with your first office visit following any change. The most current notice is prominently posted in our waiting room and you may request a copy at any time.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing.

This consent must be signed by the patient and dated. If signed by a Legal Representative, a copy of the Power of Attorney, Guardianship, etc., must be provided.

Signature of Patient or Patient's Legal Representative

Relationship if Not Patient

Date

NOTICE OF PRIVACY PRACTICES

Guilford Neurologic Associates

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.

Effective: April 14, 2003

The physician and staff of Guilford Neurologic Associates are legally required to protect the privacy of your health information and to abide by the requirements stated in this document. This Notice of Privacy Practices describes our legal duty to protect the privacy of your health information and the policies and procedures this office has in place to do so.

Our office is required to prominently post the most current notice at all times. A copy of the current Notice of Privacy Practices for Guilford Neurologic Associates will be given to each patient on their first office visit following April 14, 2003. You will be asked to sign an acknowledgement that you received a copy. A copy of this notice will be provided to any individual upon request.

If you need additional information about anything contained in this notice please contact our Privacy Officer in writing. We encourage you to ask questions about anything that you do not understand.

Guilford Neurologic Associates reserves the right to change its Notice of Privacy Practices without advance notice to you and apply the revised Notice of Privacy Practices to your health information. Any changes that are made will be highlighted on the most current Notice of Privacy Practices that is posted in our office so that they are easily recognized. If changes are made to this Notice of Privacy Practices, you will be provided with a copy of the revised Notice on your first visit following the revision.

Guilford Neurologic Associates has policies and procedures to insure that your health information is protected. These include specific guidelines for how and when your health information is used, when and how it is disclosed, how confidentiality is maintained, who has access to your health information, and when your health information can be shared with others.

Our office will use and disclose your health information to provide your care and treatment, bill and collect payment for services received and carry out the routine health care operations of this office. The uses and disclosures include but are not limited to the following:

- *Administrative functions within the office – assembling health information, filing records, scheduling appointments, reminding patients of appointments and other scheduled activities, billing and collecting for services*
- *Record creation, documentation and monitoring of your health status*
- *Communication among the workforce of this office, either verbally or in writing, information that is required for them to perform the functions of their job*
- *Consulting with other providers and their workforce, providing health information as required and making referrals*
- *Verifying your benefits and eligibility with your insurance company*
- *Obtaining authorization from your insurance company as required*
- *Calling in prescriptions to your pharmacy*
- *Providing health information as needed for scheduling appointments for diagnostic tests, surgery, admission, consultations, home health and other services that you require*
- *Providing health information to your insurance company as requested for their administrative requirements*

Our office may contact you directly by phone, answering machine, fax, electronically or by mail for any of the following activities:

- *Providing appointment reminders for this office*
- *Scheduling appointments for this office and/or other offices as necessary and providing you with appointment information*
- *Describing or recommending treatment alternatives*
- *Providing pre-test instructions and test results*
- *Providing information about health related benefits and services that may be of interest to you such as classes or educational opportunities*

If Guilford Neurologic Associates needs to treat you in an emergency situation, you will be provided with a copy of the Notice after your emergency has been taken care of and a good faith effort will be made to obtain your acknowledgment of receipt of the Notice.

Your health information may be used and disclosed **without** your authorization in the following circumstances **if** you are informed and given the opportunity to agree or object. If you are not present or the opportunity for you to agree or object cannot be provided, we may decide whether the disclosure is in your best interest based on professional judgment.

- *To a family member or other relative, close personal friend, or other person identified by you, the health information relevant to that person's involvement in your care or payment*
- *To a family member, close personal friend, a personal representative, or other person responsible for your care regarding your location, general condition or death*
- *To a public or private organization authorized by law to assist in disaster relief efforts as required by law*

Your health information may be used and disclosed **without** your authorization or the opportunity for you to agree or object in the following circumstances as required by law.

- *For public health activities including but not limited to reporting of communicable diseases, reporting births and deaths, and public health surveillance as required by law*
- *For suspected child abuse and neglect as required by law*
- *To the Food and Drug Administration to report adverse events including adverse drug reactions and product defects or problems as required by law*
- *To your employer if you have a work related injury or illness or a workplace related medical surveillance as required by law*
- *To a government authority if you are a victim of abuse, neglect or domestic violence (You must be informed of such a report unless, in the exercise of professional judgment it puts you at risk of serious harm) as required by law*
- *To a health oversight agency as authorized by law including audits; civil, administrative or criminal investigations; inspections; licensure or disciplinary actions as required by law*
- *In response to a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, a grand jury subpoena or administrative request as required by law*
- *To law enforcement officials for the purpose of identifying or locating a suspect, fugitive, material witness or missing person as required by law*
- *To law enforcement officials if you are suspected to be a victim of a crime as required by law*
- *To law enforcement officials of a death if we suspect that the death may have resulted from criminal conduct as required by law*
- *To a coroner or medical examiner for the purpose of identification, determining a cause of death or other duties authorized by law*
- *To a funeral director as necessary to carry out their duties as required by law*
- *To organ procurement organizations engaged in procurement, banking or transplantation of cadaveric organs, eyes, or tissue as required by law*

All other uses and disclosures of your health information will require your specific authorization.

You have the following rights regarding your health information:

- The right to request restrictions on how your health information is used or disclosed. Every effort will be made to honor your request but we are not required to agree to a requested restriction
- The right to receive confidential communications of health information
- The right to see and receive a copy your health information
- The right to request an amendment or correction to your health information
- The right to receive an accounting or list of each time your health information has been disclosed. The first accounting within a twelve month period is provided at not cost to you. The provider may charge a reasonable cost-based fee for each subsequent request within the twelve month period

If you believe your privacy rights have been violated, you may make a complaint to our Privacy Officer by calling 336-273-2511 or in writing to the office address. You may also make a complaint to the Secretary of Health and Human Services at the address listed below. If you make a complaint to the Secretary of Health and Human Services to the address listed below. The complaint must be in writing and contain the name of the physician or office, describe the act or omission believed to be in violation and must be filed within 180 days of the incident. You will not suffer any retaliation for filing a complaint.

Secretary of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201