# PLEASE READ BEFORE FILLING OUT PAPERWORK

This paperwork is very important to the Doctor to have as much information about you as he possibly can.

We ask that you please fill out each and every question.

We have reserved 30 minutes for you to fill out this paperwork so please take the time to make sure that you have answered everything and have signed in all the places that is marked for a signature.

If it is incomplete, it will be given back to you to finish.

# Arizona Institute of Neurology — New Patient Registration

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

**Date**: _____/_____/_____

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

**Street Address**: _____ **City**: _____ **State**: _____ **Zip**: _____

**Gender**: ☐ Male ☐ Female

**Home Phone**: _____ ☐ Home phone is the same as mobile phone

**Mobile Phone**: _____ ☐ None

**Work Phone**: _____ ☐ None

**Email**: _____ ☐ No Email

**What is your preferred way for us to contact you?**

☐ Home phone ☐ Okay to leave message

☐ Work phone ☐ Okay to leave message

☐ Mobile phone ☐ Okay to leave message

☐ Text message

☐ Mail

**The U.S. Government would like the following information:**

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Race: _____ ☐ Decline

Ethnicity: _____ ☐ Decline

Primary Language: _____ ☐ Decline

**Which Pharmacy would you like us to send your prescriptions to?**

_____ _____

Pharmacy Cross Streets or Address or Phone Number

**Which Laboratory would you like to go to if we send you for blood work?**

_____ _____

Lab Cross Streets or Address or Phone Number

**Family Doctor**: _____ Which Office? _____

**Referring Doctor**: _____ Which Office? _____

**Emergency Contact**: _____ Relation: _____

**Emergency Contact Phone**: _____

**Primary Insurance**: _____ **Insurance ID #** _____

**Secondary Insurance**: _____

**Please bring your insurance card for us to copy**

**If the patient is not the primary policy holder…**

Name of Policy Holder: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female

The patient is the policy holder's: ☐ Spouse ☐ Child ☐ Other

**Patient Signature**: _____ **Date**: _____

# Arizona Institute of Neurology Financial Responsibility

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is a not a guarantee of payment of benefits. Your insurance company determines insurance benefit payments I understand I will be responsible for the portion not covered by my insurance.

I understand that Arizona Institute of Neurology and Polysomnography *does not* accept liens, workers compensation or MVA/auto claims and I am responsible for any insurance claims denied for such. If my medical insurance denies or takes back any money provided, I understand I am responsible to pay all claims in full in a timely manner.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days of the billing date. In the event my account is turned over for collection, I will pay all reasonable collection, court, and attorney costs at the time the account is considered delinquent.

Patients are responsible for making sure that Dr. Habib Khan is *in network* with your insurance provider. We verify insurance eligibility, but *we do not verify* that we are in each individual network.

Due to the large amount of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered b your plan. Please call your insurance company for an explanation of your benefits.

**This is what you need to know:**

- **You have to pay for services that your insurance company says are your responsibility.**
- **If your insurance is not active on the day of your appointment, you will have to pay the whole bill.**
- **Your co-pay must be paid before each visit.**
- **We will charge you $50 if you miss your appointment unless 24-hour notice is given.**
- **There is a $25 charge for a Non-Sufficient Funds (NSF) check.**

**I hereby authorize the release of information that may be necessary in the processing of any insurance claims.**

**I hereby authorize my insurance company to make payment directly to: Arizona Institute of Neurology and Polysomnography**

| _____ | _____ | _____ |
|---|---|---|
| Patient Signature | Patient Name | Date |

# Arizona Institute of Neurology — Patient History

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

**Patient Name**: _____ **Date**: _____

**What is the main problem you are having?**

_____

**Is this due to an accident?** ☐ Yes ☐ No **Is a legal case pending?** ☐ Yes ☐ No ☐ Maybe

**Age**: _____ **Date of Birth**: _____

PLEASE LEAVE THIS BOX BLANK

**Please list any prior testing you have had:**

| TEST | DATE(S) | BODY PART STUDIED | RESULTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Do you have any allergies to any medicine?** ☐ Yes ☐ No

If Yes, list allergies to any medicine: _____

**What <u>medicine</u> or <u>drug store products</u> are you taking?**

| Name of Medicine: | Dosage: | Frequency: | Reason: | Approx. Date Started |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

**Do you take birth control pills, patch or implant?** ☐ Yes ☐ No If Yes, explain: _____

# Arizona Institute of Neurology — Patient History

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

**Patient Name**: _____ **Date**: _____

**PAST MEDICAL HISTORY:**

**Do you have any other medical problems such as:**

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Diabetes | ☐ | ☐ | Ulcers | ☐ | ☐ | Heart Problem |
| ☐ | ☐ | Kidney Problem | ☐ | ☐ | Hepatitis | ☐ | ☐ | Stroke |
| ☐ | ☐ | Thyroid Problem | ☐ | ☐ | Cancer | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Fibromyalgia | ☐ | ☐ | Seizures | ☐ | ☐ | Asthma/Emphysema |
| ☐ | ☐ | TMJ | ☐ | ☐ | Depression | ☐ | ☐ | Anxiety |
| ☐ | ☐ | Lung Disease | ☐ | ☐ | High Cholesterol | ☐ | ☐ | Headache |
| ☐ | ☐ | Eye Disease | ☐ | ☐ | Osteoporosis | ☐ | ☐ | Chronic Pain in: |
| ☐ | ☐ | Anemia | ☐ | ☐ | High Blood Pressure | | | ☐ Back ☐ Neck |
| | | | | | | | | ☐ Other: _____ |

**Have you had any other surgeries, hospitalizations or other medical problems?** ☐ Yes ☐ No

If Yes, explain: _____

**Do you have any other problems for which you have been seeing a *doctor* or *chiropractor* on a regular basis?** ☐Yes☐No

If Yes, explain: _____

**FAMILY HISTORY:**

**Do you have any family members with similar problems as you?** ☐ Yes ☐ No

**Do you have any family members with**:

| | | | | | |
|---|---|---|---|---|---|
| Brain Tumor | ☐ Yes ☐ No | Who? _____ | Stroke | ☐ Yes ☐ No | Who? _____ |
| Seizures | ☐ Yes ☐ No | Who? _____ | Heart Attack | ☐ Yes ☐ No | Who? _____ |
| Headaches | ☐ Yes ☐ No | Who? _____ | Aneurysm | ☐ Yes ☐ No | Who? _____ |

**SOCIAL HISTORY:**

Do you use tobacco? ☐ Yes ☐ No How much? _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____

What is your occupation or major daytime activity? _____

Have you been unable to work or carry out your usual daytime activities due to this problem?

☐ Able to work ☐ Have trouble working ☐ Have missed some work ☐ Less productive

☐ Cannot work ☐ Have not worked since: _____

In the **past 3 months**:

How much work or school have you missed because of this problem? _____

How man visits to the ER, Urgent Care treatment? _____

How many cups/drinks per day of: Coffee _____ Colas _____ Tea _____ Alcohol _____

Do you drink diet drinks or use Nutrasweet/Equal (aspartame) or other artificial sweeteners? ☐ Yes ☐ No

Have you ever abused drugs or alcohol? ☐ Yes ☐ No If Yes, explain: _____

**If you are pregnant or thinking of getting pregnant, please check here**: ☐ Yes ☐ No

Do you have any other symptoms that you feel are important but have not already mentioned?

| | | | |
|---|---|---|---|
| ____ Fever/Chills | ____ Blurred Vision | ____ Double Vision | ____ Jaw pain with chewing |
| ____ Chest Pain | ____ Eye Pain | ____ Trouble Urinating | ____ Difficulty Swallowing |
| ____ Palpitations | ____ Constipation | ____ Diarrhea | ____ Shortness of Breath |
| ____ Joint Pain | ____ Stomach Pain | ____ Trouble Sleeping | ____ Excessive Sweating |
| ____ Numbness/Tingling | ____ Dizziness | ____ Swollen Glands | ____ Other (explain): _____ |

# Arizona Institute of Neurology — Patient History

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

**Patient Name**: _____ **Date**: _____

**HEADACHE: If headaches are one of your big problems, please answer the following questions**

When did the headaches first start? _____ Is the headache due to an injury? ☐ Yes ☐ No

Are your headaches getting worse? ☐ Yes ☐ No

When did this change occur? _____

Do you know why? _____

How often do your headaches come?

| | **Mild to Moderate** | **Moderate to Severe** |
|---|---|---|
| Daily or almost daily | ☐ | ☐ |
| 4 – 5 days per week | ☐ | ☐ |
| 2 – 3 days per week | ☐ | ☐ |
| 2 – 3 days per month | ☐ | ☐ |
| Other: _____ | ☐ | ☐ |

How long do the headaches typically last?

**Mild to moderate headaches**: ☐ hours ☐ all day ☐ several days ☐ weeks ☐ constant

**Moderate to severe headaches**: ☐ hours ☐ all day ☐ several days ☐ weeks ☐ constant

Where in your head do these headaches occur?

**Mild to moderate**: ☐ one side ☐ both sides ☐ top ☐ back of head ☐ neck ☐ front ☐ eye

**Moderate to severe**: ☐ one side ☐ both sides ☐ top ☐ back of head ☐ neck ☐ front ☐ eye

The pain is usually:

**Mild to moderate**: ☐ throbbing or pulsating ☐ constant pressing like a tight band ☐ other: _____

**Moderate to severe**: ☐ throbbing or pulsating ☐ constant pressing like a tight band ☐ other: _____

Along with the headaches do you have:

☐ upset stomach ☐ sensitivity to light ☐ droopy eye lid ☐ eye tearing ☐ vomiting
☐ sensitivity to noise ☐ red eye ☐ stuffy nose

Does your routine physical activity like walking make the headache worse? ☐ Yes ☐ No

Do you experience any other symptoms **with the headache**?

☐ blind spots ☐ blurred vision ☐ numbness/tingling ☐ weakness ☐ flashing lights
☐ zigzag lines ☐ trouble talking ☐ other: _____

Are your headaches affected by your menstrual cycle? ☐ Yes ☐ No If Yes, explain how: _____

What other treatments have you received for your headaches?

☐ chiropractor ☐ herbal therapy ☐ biofeedback ☐ acupuncture ☐ trigger-point injections
☐ stress management ☐ physical therapy ☐ nerve blocks ☐ other: _____

# Arizona Institute of Neurology Patient History

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

**Patient Name**: _____ **Date**: _____

**MUSCLE/JOINT PAIN: If you have diffuse muscle or joint pain, please answer the following questions**

Where is your pain? ☐ left side of body ☐ right side of body
☐ above waist ☐ below waist ☐ neck, back, or spine

Do you have tender points? ☐ Yes ☐ No If Yes, where? _____

**FATIGUE: If you have chronic fatigue please answer the following questions**

Is the fatigue: ☐ persistent ☐ relapsing

When did it start? _____

Do you feel better if you get rest? ☐ Yes ☐ No

Does the fatigue interfere with your desired daily activities? ☐ Yes ☐ No

Have you had any of the following lasting off and on or constant for over 6 months?

- ☐ Memory loss or trouble concentrating, "brain fog"
- ☐ Chronic sore throat
- ☐ Tender lymph nodes in neck or armpits
- ☐ Diffuse muscle achiness
- ☐ Multiple joint pains
- ☐ New or worsened headache
- ☐ Unrefreshing sleep
- ☐ Post-exercise fatigue lasting more than 24 hours if you try to exercise

# Arizona Institute of Neurology — Medication History

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

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

Please check those medications that you have **tried in the past**

| **ANTI-INFLAMMATORY** | Date | Effectiveness |
|---|---|---|
| ☐Aspirin (Bayer, Ecotrin) | _____ | _____ |
| ☐Ibuprofen (Motrin/Advil/Nuprin) | _____ | _____ |
| ☐Naproxyn (Naprosyn/Aleve/Anaprox) | _____ | _____ |
| ☐Celecoxib (Celebrex) | _____ | _____ |
| ☐Diclofenac (Voltaren, Cambia) | _____ | _____ |
| ☐Indomethacin (Indocin) pills/suppos. | _____ | _____ |
| ☐Ketorolac (Toradol) pills/injection | _____ | _____ |
| ☐Steroids (Prednisone) | _____ | _____ |
| ☐Other: _____ | _____ | _____ |

| **MIXED ANALGESICS** | Date | Effectiveness |
|---|---|---|
| ☐Butalbital (Fioricet/Esgic Plus) | _____ | _____ |
| ☐Excedrine (Any form) | _____ | _____ |
| ☐Tramadol (Ultram/Ultracet) | _____ | _____ |
| ☐Other: _____ | _____ | _____ |

| **NARCOTIC PAIN** | Date | Effectiveness |
|---|---|---|
| ☐Codeine | _____ | _____ |
| ☐Hydrocodone(Vicodin/Lortab/Norco) | _____ | _____ |
| ☐Oxycodone(Percocet/Endocet/Roxicet) | _____ | _____ |
| ☐Meperidine (Demerol) pills/shots | _____ | _____ |
| ☐Other: _____ | _____ | _____ |

| **LONG ACTING NARCOTICS** | Date | Effectiveness |
|---|---|---|
| ☐Methadone (Dolphine/Methadose) | _____ | _____ |
| ☐OxyContin | _____ | _____ |
| ☐MS Contin (Avinza/Kadian/MSIR) | _____ | _____ |
| ☐Fentanyl Patch (Duragesic Patch) | _____ | _____ |
| ☐Hydromorphone (Exalgo/Dilaudid) | _____ | _____ |
| ☐Other: _____ | _____ | _____ |

| **MUSCLE RELAXANTS** | Date | Effectiveness |
|---|---|---|
| ☐Baclofen (Lioresal) | _____ | _____ |
| ☐Cyclobenzaprine (Flexeril, Amrix) | _____ | _____ |
| ☐Tizanidine (Zanaflex) | _____ | _____ |
| ☐Other: _____ | _____ | _____ |

| **ALTERNATIVE TREATMENTS** | Date | Effectiveness |
|---|---|---|
| ☐Botulinum Toxin (Botox) | _____ | _____ |
| ☐Lidocaine 5% (Lidoderm Patch) | _____ | _____ |
| ☐IV Therapy for Migraine | _____ | _____ |
| ☐Acupuncture | _____ | _____ |
| ☐Trigger Point Injections | _____ | _____ |
| ☐Nerve blocks (occipital/neck/back) | _____ | _____ |
| ☐Physical Therapy | _____ | _____ |
| ☐Massage | _____ | _____ |
| ☐Oxygen | _____ | _____ |
| ☐Vitamins/Minerals (B, D, Magnesium) | _____ | _____ |
| ☐Biofeedback | _____ | _____ |
| ☐Meditation | _____ | _____ |
| ☐Ice/Heat | _____ | _____ |
| ☐Other: _____ | _____ | _____ |

| **MIGRAINE MEDICINE** | Date | Effectiveness |
|---|---|---|
| ☐Sumatriptan (Imitrex/Treximet) (pills/shot/nasal spray) | _____ | _____ |
| ☐Rizatriptan (Maxalt) | _____ | _____ |
| ☐Eletriptan (Relpax) | _____ | _____ |
| ☐Frovatriptan (Frova) | _____ | _____ |
| ☐Zolmitriptan (Zomig) | _____ | _____ |
| ☐Naratriptan (Amerge) | _____ | _____ |
| ☐Almotriptan (Axert) | _____ | _____ |
| ☐Dihydroergotamine (DHE/ Migranal) | _____ | _____ |

| **ANTI-CONVULSANTS** | Date | Duration Tx | Effectiveness |
|---|---|---|---|
| ☐Valproic acid (Depakote) | _____ | _____ | _____ |
| ☐Zonisamide (Zonagram) | _____ | _____ | _____ |
| ☐Gabapentin (Neurontin) | _____ | _____ | _____ |
| ☐Oxcarbazepine (Trileptal) | _____ | _____ | _____ |
| ☐Lamotrigene (Lamictal) | _____ | _____ | _____ |
| ☐Levetiracetam (Keppra) | _____ | _____ | _____ |
| ☐Topiramate (Topamax) | _____ | _____ | _____ |
| ☐Pregabalin (Lyrica) | _____ | _____ | _____ |
| ☐Tiagabine (Gabitril) | _____ | _____ | _____ |
| ☐Lacosamide (Vimpat) | _____ | _____ | _____ |
| ☐Other: _____ | _____ | _____ | _____ |

| **TRICYLIC ANTIDEPR** | Date | Duration Tx | Effectiveness |
|---|---|---|---|
| ☐Amitriptyline (Elavil) | _____ | _____ | _____ |
| ☐Nortriptyline (Pamelor) | _____ | _____ | _____ |
| ☐Doxepin (Sinequan) | _____ | _____ | _____ |
| ☐Trazodone (Desyrel) | _____ | _____ | _____ |
| ☐Other: _____ | _____ | _____ | _____ |

| **SRI/DOPA INHIBITORS** | Date | Duration Tx | Effectiveness |
|---|---|---|---|
| ☐Bupropion (Wellbutrin) | _____ | _____ | _____ |
| ☐Venlafaxine (Effexor) | _____ | _____ | _____ |
| ☐Milnacipran (Savella) | _____ | _____ | _____ |
| ☐Duloxetine (Cymbalta) | _____ | _____ | _____ |
| ☐Other: _____ | _____ | _____ | _____ |

| **BETA BLOCKERS** | Date | Duration Tx | Effectiveness |
|---|---|---|---|
| ☐Propranolol (Inderal) | _____ | _____ | _____ |
| ☐Atenolol (Tenormin) | _____ | _____ | _____ |
| ☐Nadolol (Corgard) | _____ | _____ | _____ |
| ☐Metoprolol (Lopressor) | _____ | _____ | _____ |
| ☐Other: _____ | _____ | _____ | _____ |

| **CALCIUM BLOCKERS** | Date | Duration Tx | Effectiveness |
|---|---|---|---|
| ☐Verapamil (Calan, Veralan) | _____ | _____ | _____ |
| ☐Nicardipine (Cardene) | _____ | _____ | _____ |

**ALLERGIES** Medication & Reaction

_____

_____

_____

# Arizona Institute of Neurology — New Exam

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

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

**Constitutional**

____ Vital signs – BP, Pulse, Weight, Respirations
____ Well appearing, Pleasant, Cooperative

**Cardiovascular**

____ Extremities – Norm pulses, no edema, good cap refill
____ Heart RRR
____ Carotid arteries without bruits

VITAL SIGNS STICKER

**MSE**

____ Orientation normal
____ Recent and remote memory intact
____ Attention and concentration normal
____ Speech fluent without aphasia
____ Fund of knowledge appears normal

**Cranial Nerves**

____ **Eyes: ophthalmoscopic examination exam:** discs normal without papilledema or pallor
____ Confrontations normal (CN II) ____ Visual acuity normal ____ Pupils equal and react normally
____ Eye movements full (CN III, IX, VI) ____ Saccades accurate
____ Face sensation symmetric (CN, V) ____ Corneal reflexes normal
____ Face movement symmetric (CN VII)
____ Hearing appears normal ____ Weber midline ____ René' normal
____ Palate raises symmetrically (CN IX, X)
____ Shoulder shrug symmetric (CN XI) ____ SCM muscles symmetric
____ Tongue midline (CN XII)

**Musculoskeletal**

____ Strength in UE & LE normal ____ Pronator drift negative ____ No fasciculations noted
____ Tone in UE & LE normal w/o rigidity or spasticity
____ Rapid fine movements norm ____ No abnormal movements ____ Gait & station normal
____ Tremor absent ____ C-spine full ROM

**Sensory Exam**

____ Sensation to LT norm ____ Vibratory norm ____ Pin prick norm ____ Position sense norm
____ Rhomberg neg

**Reflexes**

____ DTRs in UE & LE norm ____ Plantar reflexes flexor ____ Finger flexor reflexes norm
____ Homan sign neg

**Coordination**

____ FTN normal ____ HTS normal ____ RAM normal ____ Tandem gait normal

**Impression**

prob. focused = 1+ expanded = 6+ detailed = 12+ comprehensive = all

**Recommendations**

- 
- 
- 

**Follow up: _____ wk / mon** **Consider at next visit: _____**

**More than _____ minutes was spent face to face with the patient, over half of which was spent discussing:**

_____

**Examiner's Signature: _____** ☐ Dictated

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

# HIPAA Privacy Notice

## Purpose of this Notice

At Arizona Institute of Neurology and Polysomnography we are committed to treating and using protected health information about you responsibly. We are also required by federal law to take reasonable steps to ensure the privacy of your health information.

The use and disclosure of Protected Health Information (PHI) is regulated by the federal law, the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules in 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulation will supersede this Notice if there is any discrepancy between the information in this Notice and the regulation.

## Effective Date

The effective date of this Notice is April 14, 2003.

## Privacy Officer

Arizona Institute of Neurology and Polysomnography has designated a Privacy Officer to oversee the administration of privacy at this office and to receive complaints. The Privacy Officer may be contacted as follows:

Arizona Institute of Neurology and Polysomnography
Attn: HIPAA Privacy Officer
1653 E McMurray Blvd. Suite 139
Casa Grande, AZ 85122
Tel: (520) 423-2046

## Your Protected Health Information

Each time you visit Arizona Institute of Neurology and Polysomnography a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information serves as the basis for planning your care and treatment. It is also a means for communicating among the many health professionals who contribute to your care, is a legal document describing the care you received, and is the means by which you or a third-part payer can verify that services billed were actually provided.

The term "Protected Health Information" (PHI) includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by Arizona Institute of Neurology and Polysomnography in spoke, written, electronic, or any other form.

## When Arizona Institute of Neurology and Polysomnography can disclose your PHI

Under the law, Arizona Institute of Neurology and Polysomnography may disclose your PHI, without authorization, in the following cases:

*At your request*. If you request it, Arizona Institute of Neurology and Polysomnography is required to give you access to you or your dependent's PHI.

*As required by an agency of the government*. In general, Arizona Institute of Neurology and Polysomnography does not need you to sign a valid authorization to release your PHI if required by law or for public health and safety purposes. Arizona Institute of Neurology and Polysomnography is allowed to use and disclose your PHI without your authorization under the following circumstances:

- When required by law
- When permitted for purposes of public health activities
- When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exist you may be a victim of such abuse.
- When required for judicial or administrative proceedings (e.g. subpoena or discovery request)
- When required for law enforcement purposes
- When required to be given to a coroner or medical examiner
- For research, subject to certain conditions
- To comply with workers' compensation or other similar programs established by law

*For treatment, payment, or health care operations*. Arizona Institute of Neurology and Polysomnography and its business associates will use PHI, without a signed valid authorization or your opportunity to restrict or object, when carrying out treatment, payment or health care operations.

*Implicit authorization to release PHI and process for restriction*. In addition to disclosures mandated by law, and disclosures to individuals or entities you have specifically authorized, Arizona Institute of Neurology and Polysomnography will assume your authorization for release of PHI to the following:

- Your spouse, if you do not restrict or object
- Your legal representative with valid power of attorney, your court-ordered (approved) guardian, or your conservator, if you do not restrict or object.
- Your designated personal representative, if you have not revoked your personal representative.
- Either parent of a minor child, if you do not restrict or object.

You may specifically restrict authorization by submitting a signed written request for restrictions to the Privacy Officer noted on page one.

# Arizona Institute of Neurology HIPAA Privacy Notice

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

## Your Individual Privacy Rights

Although your health record is the physical property of Arizona Institute of Neurology and Polysomnography, the information in your record does belong to you, and therefore, you have rights related to its uses and disclosures. Except as otherwise indicated in this Notice, uses and disclosures of your PHI will be made only with your signed valid authorization, subject to your right to revoke your authorization.

## In addition, you have the following rights:

You may inspect and receive a copy of your PHI.
You have the right to amend your PHI.
You have the right to receive an accounting of PHI disclosures:

At your request Arizona Institute of Neurology and Polysomnography will provide you with an accounting of disclosures made by Arizona Institute of Neurology and Polysomnography. The accounting will not include disclosures made before April 14, 2003.

You have the right to receive a paper copy of this Notice upon request.
Your personal representative:

You may exercise your rights to your PHI by designating a personal representative. You must designate your personal representative before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed and signed letter designating your personal representative.

- Arizona Institute of Neurology and Polysomnography will automatically consider a parent or guardian as the personal representative of unemancipated minor (a child generally under age 18) unless applicable law requires otherwise, or you restrict such disclosure.
- Personal representative designations may be revoked at any time by submitting a written statement of revocation. This statement must be received by the Privacy Officer prior to a revocation becoming effective.

You have the right to file a complaint if you believe your privacy rights have been violated.

To exercise one or more of these rights you should submit a signed, written statement detailing your request to the Privacy Officer listed on page one of this Notice. Arizona Institute of Neurology and Polysomnography is not required to agree to your request if the Privacy Officer determines it to be unreasonable, for example, when a custodial parent is seeking treatment for your minor child or when it would interfere with Arizona Institute of Neurology and Polysomnography's ability to file a claim.

## Responsibilities of Arizona Institute of Neurology and Polysomnography

Arizona Institute of Neurology and Polysomnography is responsible for the following items:

Maintain privacy of your health information. Arizona Institute of Neurology and Polysomnography is required by law to maintain the privacy of your PHI.

Notice Distribution. Arizona Institute of Neurology and Polysomnography is required to provide you with notice of its legal duties and privacy practices. This Notice is effective beginning on April 14, 2003. However, Arizona Institute of Neurology and Polysomnography reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by Arizona Institute of Neurology and Polysomnography. If a privacy practice is changed, a revised version of this Notice will be provided to patients.

Disclosing only the minimum necessary PHI. When using or disclosing PHI, Arizona Institute of Neurology and Polysomnography will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment
- Uses or disclosures made to you
- Disclosures made to the DHHS
- Uses or disclosures required y law (e.g. Public Health Agencies)
- Uses or disclosures required for compliance with legal regulations (e.g. subpoenas)

Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

### Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer as follows:

Arizona Institute of Neurology and Polysomnography
Attn: HIPAA Privacy Officer
1653 E McMurray Blvd. Suite 139
Casa Grande, AZ 85122
Tel: (520) 423-2046

There will be no retaliation for filing a complaint. You may also file a complaint (within 180days of the date you know or should have known about an act or omission) with the DHHS.

## If you need more information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact Arizona Institute of Neurology and Polysomnography's Privacy Officer.

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

# HIPAA Omnibus Notice of Privacy Practices

Revised 2013
Effective as of 9/23/2013

**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 of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your right 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 of future physical or mental health condition and related healthcare services.

## Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Arizona Institute of Neurology and Polysomnography. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medial information. We are required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give you this notice of our legal duties and privacy practices concerning medical information about you; and
3. Follow the terms of the notice that is currently in effect.

## How We May Use or Disclose Medical Information About You

When you obtain services from Arizona Institute of Neurology and Polysomnography, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. The following categories describe ways that Arizona Institute of Neurology and Polysomnography uses or discloses your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

**Your health information will be used for treatment:** For example: Disclosures of medical information about you maybe may be made to doctors, nurses, technicians, or others who are involved in taking care of you at Arizona Institute of Neurology and Polysomnography. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Any physician that our office refers you to see for continued care. Information may be shared with pharmacies, laboratories, or radiology centers for the coordination of different treatments.

**Your health information will be used for payment:** For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

**Your health information will be used for health care operations:** For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

**Business Associates:** there are some services that we provide through contracts with third party business associates. Examples include external laboratories, transcription agencies and copying services. To protect your health information, Arizona Institute of Neurology and Polysomnography requires these business associates to appropriately protect your information.

**Required By Law:** We may use or disclose your protected health information (PHI) to the extent that law requires the use or disclosure. 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.

**Legal Proceedings:** We may disclose protected health information (PHI) 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 (PHI), 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.

**Notice of Privacy Practices will not be disclosed without your authorization.**

## Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

## HIPAA Omnibus Notice of Privacy Practices (Continued)

**Right to Inspect and Copy:** You have the right to insect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by Arizona Institute of Neurology and Polysomnography will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

**Right to Amend:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to include additional information in our medical record. You have the right to request and amend for as long as all of the information, both old and new, is kept by or for Arizona Institute of Neurology and Polysomnography. To request an amendment, you request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason that supports your request. In addition, we may deny your request if you ask us to amend information that: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the medical information kept by or for our Practice; Is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, excluding disclosures for the purpose of treatment, payment and health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Administrator. Your request must state a time period, which may not be longer than six years and may not include dates before July 13, 2009. Your request should indicate in what form you want the list (for example, on paper, electronically).

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for your treatment, payment or health care operations. You have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communication:** 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.

**Right to Restrict Release of Information for Certain Services:** You have the right to restrict the disclosure of information regarding services for which you have paid in full or on an out of pocket basis. The information can be released only upon your written authorization.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any of our office staff or our Privacy officer or you may write to our Practice at Arizona Institute of Neurology and Polysomnography, 1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122.

**Right to Breach Notification:** You have the right to be notified of any breach of your unsecured healthcare information.

### Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, the effective date. In addition, each time you are seen for treatment or health care services at our office, we will offer you a copy of the current notice in effect.

### Complaints

If you believe our privacy rights have been violated, you may file a complaint with our Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with Arizona Institute of Neurology and Polysomnography, please write to the Privacy Officer at Arizona Institute of Neurology and Polysomnography, 1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

### Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

**Acknowledgement of HIPAA Omnibus Privacy Practice Notice is included in the privacy notice new patient paperwork for your signature.**

# Arizona Institute of Neurology Privacy Notice

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

I have received the HIPAA Privacy Notice and HIPAA Omnibus Notice regarding the uses and disclosures of my Protected Health Information, and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Arizona Institute of Neurology and Polysomnography to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Arizona Institute of Neurology and Polysomnography upon request.

**FAXES:** When expedient, I authorize the transmittal of my records by FAX to doctors, pharmacies, insurance companies, or upon my request. In understand that transmission by FAX, by its very nature, is not confidential.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

**PERSONAL REPRESENTATIVES** (family members, attorneys, etc.): I hereby authorize Arizona Institute of Neurology and Polysomnography and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

**MESSAGES:**

☐ Yes ☐ No It is ok to leave a message on my home voice mail #: _____

☐ Yes ☐ No It is ok to leave a message on my work voice mail #: _____

Arizona Institute of Neurology Cancellation Notice

1653 E McMurray Blvd. Suite 139, Casa Grande, AZ 85122 Tel: (520) 423-2046 Fax: (520) 423-0208

# CANCELLATION POLICY

At Arizona Institute of Neurology and Polysomnography, our goal is to provide quality care in a timely manner. We have implemented an Appointment/Cancellation Policy which enables us to better utilize available appointments for our patients in need of care.

A “no show” is someone who missed an appointment without canceling it 24 hours in advance. No-shows inconvenience those individuals who need access to neurological care in a timely manner. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to a provider.

Without a 24-hour notice before your scheduled appointment, you will be charged for the missed appointment. The charge will occur for any reason even those outside of your control, (e.g. car troubles, illness, or transportation issues, etc.)

I AGREE TO PAY $75 FEE IF I DO NOT CANCEL MY APPOINTMENT BY 12:00 PM THE BUSINESS DAY PRIOR TO MY APPOINTMENT.

Your signature indicates that you understand the above and accept the financial responsibility for any appointment missed without prior notification.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date