Neurology Medical Center

M. Mike Kreidie, M.D.
Fellow of The American Academy of Neurology
Diplomat of the American Board
of Psychiatry and Neurology

26932 Oso Parkway
Suite 240
Mission Viejo, California 92692

(949) 348-8880
FAX (949) 348-8881
www.neuromedcenter.com

PATIENT REGISTRATION FORM

Please print all information

Patient Name _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip _____

Telephone ( ) _____

Cell Phone ( ) _____

Social Security # _____ Driver's License _____

Name of Spouse _____

Occupation _____

Employer's Name _____

Work Number ( ) _____

Work Address _____

City _____ State _____ Zip _____

Referred By _____

Neurology Medical Center

PATIENT REGISTRATION FORM **Please print all information**

If there are any questions regarding the bill, the person who is registering today will be responsible for payment. If the patient is a minor, the person registering the patient will be responsible.

RELEASE STATEMENT

1. I authorize NEUROLOGY MEDICAL CENTER and THEIR STAFF to perform diagnostic tests and provide treatment necessary for medical evaluation and health care to the above registered patient.

2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above registered patient.

3. I understand that ongoing primary medical care is the responsibility of the patient, and it is not the responsibility of NEUROLOGY MEDICAL CENTER.

4. NEUROLOGY MEDICAL CENTER will bill your insurance carrier. However, the balance owed will be the sole responsibility of the above registered patient.

Print Name _____

Signature _____ Date _____

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HIPAA MEDICAL RECORDS DISCLOSURE FORM
(EFFECTIVE April 14, 2003)

Printed Name _____

Date	Type of Medical Information Disclosed	Location Sent
_____	Dictation of Medical Exams	_____
_____	Patient Billing Information	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
Printed Name of Patient

_____ _____
Patient Signature Date

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AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

I hereby authorize:

Provider Name: _____ Organization: _____

Address: _____

Telephone #: _____ Fax #: _____

To disclose the following information from the health records of:

Patient Name (Last, First, Middle): _____

Previous Name (Last, First, Middle): _____

Address: _____

Telephone #: _____ S.S. #: _____

D.O.B.: _____

To be disclosed to:

Provider Name: _____ Organization: _____

Address: _____

Telephone #: _____ Fax #: _____

Information to be disclosed:

- o All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- o All of my health information described above except for the following: _____

  _____

  Only the following records or types of health information: (Insert dates of treatment, types of treatment and/or other designation): _____

For the purpose of: _____

I understand that I am entitled to a copy of this authorization upon my request.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions

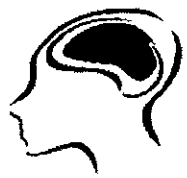
I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization or as specifically required or permitted by law.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.
The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Expiration date or event: _____

Patient Signature: _____ Date: _____ (or)

Legal Representative & Relationship: _____ Date: _____



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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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I understand that, under the Health Insurance Portability & Accounting Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple heath care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I have received, read and understood the "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that Neurology Medical Center has the right to change its "Notices of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry our treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name: _____

Patient Representative: _____

Signature: _____

I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices", but was unable to do so, as documented below.

Date	Initials	Reason
_____	_____	_____

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

Our commitment to your privacy

- Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Neurology Medical Center. If you have questions, please contact the Office Manager at 949-348-8880.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Neurology Medical Center. If you have questions, contact the Office Manager at 949-348-8880. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. Right to file a complaint. If you believe your 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 our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at 949-348-8880.