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NEUROCARE CENTER

Section I: PATIENT HIPAA ACKNOWLEDGMENT & CONSENT FORM

The pamphlet entitled "Notice of Privacy Practices" provides information about how NeuroCare Center LLC may use and disclose protected health information about you, and is compliant with the requirements of the most recent Health Insurance Portability and Accountability Act (HIPAA). Our Notice of Privacy Practices states that we reserve the right to change terms described. Should this happen we will display the new policy and effective date at our office locations. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions; but if we do, we are bound by our agreement with you. By signing below, you acknowledge that you have had the opportunity to review our Notice of Privacy Practices.

Section II (Optional): PERSONAL REPRESENTATIVE, FAMILY OR OTHER ENTITIES AUTHORIZED ACCESS TO PROTECTED HEALTH INFORMATION TO BE USED AND/OR DISCLOSED

Name or specifically identify these persons and/or other entities you are authorizing to make use of and/or to disclose your protected health information regarding treatment, payment and other healthcare operations;

Name of Authorized Person: _____ Tel. _____

Relationship: _____ Email: _____

Section III: AUTHORIZATION FOR USE OF ANSWERING MACHINE AND/OR VOICE MAIL AND/OR EMAIL (*Please initial, then sign below*)

NeuroCare Center is sometimes unable to contact patients directly during normal business hours. On these occasions our office leaves messages on communication devices provided by our patients. Information that we may possibly disclose on your home, work, or cell phone would include some or all of the following information*: test/lab results, prescription/pharmacy information, appointment instructions for visits and procedures, insurance issues, and appointment scheduling information.*

__ **(Initial)** Yes, I agree to allow NeuroCare Center, LLC to leave messages that include the above information on the telephone numbers and email indicated on the Patient Registration form completed and signed by me or my representative. **OR**

__ **(Initial)** No, I do not agree to allow NeuroCare Center, LLC to leave messages that include the information above on my telephone answering machine or voice mail.

__ **(Initial)** No, I do not agree to allow NeuroCare Center, LLC to email me messages that include the information above.

Section IV: PATIENT ACKNOWLEDGMENT OF OFFICE POLICIES

- While we strive to honor all appointments (and are usually on time), medically urgent situations take priority.
- Prescription refill requests are to be made by your pharmacy, either electronically or by fax to our office.
- Please allow 3-5 business days for authorization of refill requests and other routine requests.
- Forms requiring review and signature by your doctor require 5-7 business days' notice.
- Records requests must be submitted in writing and require 5-7 business days' notice.
- Patients are responsible for providing us with any changes to their health insurance and/or to their contact information.
- Patients are responsible for providing any referrals required by their health insurance companies.

Patient Signature: _____ *Date: _____*
(or authorized representative)

Print Name: _____