CHANDLER NEUROLOGY & SLEEP DISORDERS

Patient Demographic Information Sheet

SS#: ______-______-_______ Patient Name: ____
Last Name, First Name Middle Initial

Date of Birth: ________/________/________ Sex: (**Male / Female**) Marital Status: (**S / M / W / D**)
Month Day Year

Address: ____ Apt #: ____________

City: ______________________________ State: ____________________ Zip: ____________________

Secondary Address: ____ Apt #: ____________

City: ______________________________ State: ____________________ Zip: ____________________

Home Phone#: (________)________-________ Cell Phone#: (________)________-________

E-mail Address: ______________________________ Employer: ______________________________

Race: ____________________ Ethnicity: ______________________ Language: __________________

Primary Care Physician: ____________________________________Phone#: (______)________-________

Referred By (if other than PCP): ________________________________Phone#: (______)________-________

Pharmacy Information

Name: ____ Pharmacy Type: (**Mail Order** / **Regular**)

Cross Streets & City: ______________________________________ Phone#: ____________________

Insurance Information

Primary Insurance: ________________________
ID#: ____________________________________
Group#: ________________________________
Card Holder Name: ________________________
Card Holder SS#: __________________________
I gave a copy of my Insurance card: (**Y / N**)

Secondary Insurance: ______________________
ID#: ____________________________________
Group#: ________________________________
Card Holder Name: ________________________
Card Holder SS#: __________________________
I gave a copy of my Insurance card: (**Y / N**)

Who, on behalf of you, may receive information regarding your Protected Health Information?

Name: ______________________________ DOB: ____________________ Relation: __________________
Name: ______________________________ DOB: ____________________ Relation: __________________
Name: ______________________________ DOB: ____________________ Relation: __________________
Name: ______________________________ DOB: ____________________ Relation: __________________

Personal Representatives I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider: **INITIAL** ________

I give my consent to obtain any and all records pertaining to my prescription history: **INITIAL** _______

Today's Date: ______________ **Signature:** ____

Circle One: *(Patient / Parent / Guardian)*

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HIPPA PRIVACY NOTICE

I have received the HIPPA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records. **(Page 3)**

I hereby authorize Chandler Neurology & Sleep Disorders, PC 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 record including pharmacy records to Chandler Neurology and Sleep Disorders Associates, PC upon request.

If I have provided a list of personal representatives (family member, spouse, attorney, etc), I hereby authorize Chandler Neurology and Sleep Disorders, PC and its employee's permission to discuss, send and/or receive medical information to/with the individuals listed. **(Page 1)**

Faxes

When expedient, I authorize the transmittal of my records by fax. I understand that transmission by fax, by its very nature is not confidential.

Messages

May we leave a voice message regarding test results & appointments on your home number? **(Y / N)**
May we leave a voice message regarding test result & appointments on your cell phone? **(Y / N)**

Disability Paperwork

Paperwork can be done in this office for disabilities related to your neurological condition; ***an appointment is required, paperwork may take up to 10 business days to be completed and you may be charged up to $25.00 for the paperwork***. I understand that it is my responsibility to ensure all needed paperwork is received by the office in a timely manner if there may be a deadline to submit my paperwork.

Insurance

I understand that I am responsible for ensuring this office has my insurance information up-to-date at every office visit. Tests done in this office may or may not require prior authorization through my insurance. If a test does not require prior authorizations or if it is approved by my insurance, this is not a guarantee that my insurance will pay for this test. Please contact your insurance if you have any questions about specific test done in this office: **INITIAL ______**

Patient Name: ____ DOB: _____/_____/_____

Signature: ____ Today's Date: ___________

Circle One: *(Patient / Parent / Guardian)*

CHANDLER NEUROLOGY & SLEEP DISORDERS

Notice of Privacy Policy for Protected Health Information (PHI)

The office of Chandler Neurology & Sleep Disorders Associates, PC is dedicated to protect you "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:
Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came in to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:
We collect this information so that we can treat your medical condition and obtain payment for you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:
To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:
Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical records, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.
Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and the Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but the persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS:
You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your records.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlines in this notice.

COMPLAINTS / COMMENTS:
If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Office of this practice at (480) 722-0239.

THIS PRACTICE reserves the right to amend out privacy policy as dictated by the law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of June 1, 2008.