Chandler Neurology & Sleep Disorders Associates PC
PATIENT DEMOGRAPHIC INFORMATION SHEET
(Please Print)

SS#: ____ - ____ - _____ PATIENT'S NAME: _____
Last Name, First Name Middle Initial

PERMANENT ADDRESS: _____ APT # _____

CITY: _____ STATE _____ ZIP _____

LOCAL ADDRESS: _____ APT # _____

CITY: _____ STATE _____ ZIP _____

DATE OF BIRTH: _____/_____/_____ SEX: (☐ / ☐) MARITAL STATUS : ☐/☐/☐/☐
Month day year

Phone #:(_____)_____-_____ Work Phone #:(_____)_____-_____

Other Phone #:(_____)_____-_____

PRIMARY CARE PHYSICIAN: _____ PCP Phone:(_____)_____-_____
Last Name First Name

PATIENT EMPLOYER: _____

Primary Insurance

Ins. Co. Name: _____

Policy #:_____ Group #: _____

Relation to Patient: _____

Insured's Name: _____

Insured's Date of Birth:_____ ☐/☐

Insured's Employer: _____

Insured's SS# _____

Secondary Insurance

Ins. Co. Name: _____

Policy #:_____ Group #: _____

Relation to Patient: _____

Insured's Name: _____

Insured's Date of Birth:_____ ☐☐

Insured's Employer: _____

Insured's SS# _____

Who may receive information regarding your Protected Health Information? (Check all that apply)

Spouse ☐ Name: _____ Date of Birth: ____/____/_____
Children ☐ Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Parent/Guardian ☐ Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____
Significant Other/Friend: ☐ Name: _____ Date of Birth: ____/____/_____
Name: _____ Date of Birth: ____/____/_____

May we leave messages regarding test results and appointments on your answering machine? ☐ Yes ☐ No

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.

Date:_____ **Signature** _____
Circle One (PATIENT/ PARENT /GUARDIAN)

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE YOU.

CHANDLER NEUROLOGY & SLEEP DISORDERS

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.

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 records including pharmacy records to Chandler Neurology & Sleep Disorders Associates, PC upon request.

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Chandler Neurology & Sleep Disorders, PC and its employee's permission to discuss, send and/or receive medical information to/with the following individuals:

Name_____ Relationship to the Patient_____

Name_____ Relationship to the Patient_____

Messages

Y____ N___ It is okay to leave a message on my home voice mail

Y____ N____ It is okay to leave a message on my work voice mail

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.

Patient Name _____ Date of Birth_____

Signature_____ Date_____

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH INFORMATION (PHI)

The office of Chandler Neurology & Sleep Disorders Associates PC is dedicated to protect your "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 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 from 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 record, 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 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 persons involved in your healthcare or entities who 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 record.

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

COMPLAINT/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 Officer of this practice at (480)722-0239.

THIS PRACTICE reserves the right to amend our privacy policy as dictated by 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.