



Tidewater Neurologists, Inc. & Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PATIENT REGISTRATION

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

Date: _____ Account # _____

Name: _____ SS# _____ Age: _____

Please write name EXACTLY as it appears on your insurance card.

DOB: _____ Sex: Male Female Marital Status: S M W D

Race: _____

(American Indian / Asian / Black / Hispanic / Latino / Native Hawaiian / White / Unreported or Refused to Give)

Ethnicity: _____

(Hispanic / Latino - Non-Hispanic/Latino - Unreported or Refused to Give)

Preferred Language: _____

(English / American Sign / Arabic / French / German / Hindi / Urdu / Japanese / Mandarin / Portuguese / Russian / Spanish)

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

Responsible Person for this Visit: _____

Please list name of SUBSCRIBER on your insurance card.

Relationship to Patient: _____

Patient or Guardians Employer: _____

Business Address: _____ Business Phone: _____

Emergency Contact

Person: _____ Phone #: _____

Do you have a living will? Yes No



Tidewater Neurologists, Inc. & Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PATIENT REGISTRATION

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

INSURANCE INFORMATION

Primary Insurance Co: _____

Subscriber Name: _____ SS# _____ DOB: _____

Sponsor Name: _____ SS# _____ DOB: _____

Secondary Insurance Co: _____

Subscriber Name: _____ SS# _____ DOB: _____

Sponsor Name: _____ SS# _____ DOB: _____

****PLEASE PRESENT INSURANCE CARDS AND PERSONAL ID WITH THIS REGISTRATION FORM****

Patient Name: _____ Date: _____

MEDICAL INFORMATION

Primary Care Physician: _____ Office #: _____

Address of PCP: _____

Referring Physician: _____ Office #: _____

Preferred Pharmacy: _____ Phone #: _____

Address/Location of Pharmacy: _____

Current List of Medications / Dose / And How Medication Is Taken



Thank you for selecting **Tidewater Neurologists, Inc. and Sleep Disorder Specialists** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your account is considered a part of your treatment.

All patients must complete our Patient Registration form and sign **all policies** before seeing the doctor. We also ask that you present your insurance card and a picture ID at each visit and notify us as soon as possible of any changes in your insurance coverage, address and/or telephone numbers. We would like to keep your patient information as current as possible.

- CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE
- WE ACCEPT CASH / CREDIT CARDS /OR PERSONAL CHECKS
(*NOTE: \$40.00 FEE IS CHARGED FOR RETURNED CHECKS.)

**IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN THE
PROPER INSURANCE REFERRALS FOR ALL VISITS**

- INSURANCE CLAIMS ARE FILED AS A COURTESY TO OUR PATIENTS

FILLING OUT FORMS:

The charge for filling out forms brought in by patients are (example: employment, disability, life insurance, DMV, etc.)

- \$10.00 - for one (1) page form
- \$25.00 - for up to three (3) pages
- \$40.00 - for four (4) or more pages

The charges for filling out forms is the patient's responsibility and fees are collected before the patient can pick up the forms.

MEDICAL RECORDS:

We have contracted **HEALTH PORT** to copy and send out all requested medical records. If you have any questions about your records any member of our staff can give you Health Port's toll free phone number. There is a charge generated by Health Port for their services.

For Dr. Hemang Shah and Dr. Eric Goldberg's patients access to their medical records is available thru the Patient Portal at <http://patientportal.trimedtech.com/tidewaterneurologists>.

PARTICIPATION (Insurance):

Tidewater Neurologists, Inc. participate with most health insurance plans including Medicare and Medicaid in the Tidewater area. Each plan has unique rules and regulations that must be followed by patients and physicians. **Please familiarize yourself with the particular benefits and rules of YOUR health care plan, since the contract is between the Patient and their Insurance Carrier.** Below you will find short summaries of how our practice addresses the particular requirement of each patient according to their health insurance coverage. If you have questions about which summary is applicable to you and your health insurance plan, please call our office Monday thru Friday at (757) 686-9300 between 9:00am and 4:00pm.

NOT PARTICIPATION (Insurance):

If your insurance plan is one with which we are not a participating provider, you will be responsible for payment for your visit(s). As a courtesy we will file your insurance claim and have the payment sent directly to you. In the event that your insurance carrier pays directly to our office, we will refund the payment to you as soon as possible.

INSURANCE REFERRALS:

Certain health insurance plans (HMO) require that you obtain a referral from your Primary Care Physician (PCP) before visiting a Specialist’s office. It is the patient’s responsibility to acquire this referral and keep track of the number of visits allowed and the start and end date of this referral. Alternative payment arrangements or rescheduling of your appointment may be necessary if proper authorization or referral is not obtained.

PRESCRIPTION REFILLS:

All refills require at least 7 days advance notice to be approved by your Doctor and sent into your pharmacy. **Do not wait until you run out of your medication to call in for a refill.**

WORKERS COMPENSATION:

We require approval/authorization by your employer and/or your worker’s compensation carrier and your Employer’s first report of injury prior to your initial visit. If our claim is denied, you will be responsible for payment in full for all visits.

PERSONAL INJURY:

If you are involved in a personal injury lawsuit or claim, we will bill your medical insurance carrier. In the absence of medical insurance, you will be responsible for payment of services on day of service(s). Tidewater Neurologists, Inc. does not participate in litigation cases.

SELF-PAY:

Payment in full is expected at time of service.

Thank you for understanding our financial policy. Please let us know should you have any questions or concerns.

(Please sign both places below:)

FINANCIAL AGREEMENT

I have read, understand and accept the above financial policy. In the event of non-payment by my insurance carrier for whatever reason, I understand I am responsible for the payment of the balance owed inclusive of any costs of collections, including collection agency fees and attorney fees of 33 1/3 percent of the amount past due and any court costs incurred to collect any amount that is past due.

Patient Signature

Date

ASSIGNMENT OF BENEFITS
AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of medical benefits directly to Tidewater Neurologists, Inc.

Patient Signature

Date

** This Financial Agreement is in effect as long as you are a patient in this practice.



Tidewater Neurologists, Inc. & Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PATIENT NO SHOW/ CANCELLATION POLICY

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

S. HABEEB RAHMAN, M.D.

*Diplomate of the American Board
of Neurology and Psychiatry*

ERIC GOLDBERG, M.D.

*Diplomate of the American Board
of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN*

HEMANG SHAH, M.D.

*Diplomate of the American Board
of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN
Diplomate of the American Board of Sleep Medicine*

Any Patient that fails to show up for a scheduled office appointment without calling the office to cancel the appointment or reschedule the appointment 24 hours in advance, or as soon as possible in an extreme emergency situation will be charted a **\$25.00** fee, billed directly to the patient after the “**second**” no show appointment. This charge will be used to help cover the expenses incurred in preparing the patients chart for the office visit. **Your insurance company will not be responsible for this charge.**

We make every effort to make an appointment reminder call to our patients the day prior to the appointment, *however*, there is no guarantee that we can reach all patients, so please keep up with your re-appointment cards. If we are able to reach our patients cancellations will be acceptable at that time.

The goal of our Physicians and Staff is to provide the most efficient care possible to meet the needs of **ALL** our patients. In order to do this we need to manage our Physicians time as wisely and productively as possible.

We ask the help of all patients in this endeavor and thank you in advance for your help and cooperation.

Sincerely,
Tidewater Neurologists, Inc. and Sleep Disorder Specialists

I have read and understand the Patient No Show / Cancellation Policy.

Patient Signature

Date



Tidewater Neurologists, Inc. & Sleep Disorder Specialists

PARTNERING FOR BEST SLEEP & BRAIN HEALTH

PRESCRIPTION MEDICATION POLICY

SLEEP DISORDER CENTERS

3235 Academy Avenue
Suite 305
Portsmouth, VA 23703
Tel. 757-686-9300
Fax 757-686-1514

300 Medical Parkway
Suite 108
Chesapeake, VA 23320
Tel. 757-549-8800
Fax 757-547-8180

2713 Magruder Blvd
Suite G3
Hampton, VA 23666
Tel. 757-262-0390
Fax 757-262-0391

4480 Holland Office Park
Bldg 2, Suite 225
Virginia Beach, VA 23452
Tel. 757-228-5801
Fax 757-228-5063

S. HABEEB RAHMAN, M.D.

Diplomate of the American Board of Neurology and Psychiatry

ERIC GOLDBERG, M.D.

*Diplomate of the American Board of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN*

HEMANG SHAH, M.D.

*Diplomate of the American Board of Neurology and Psychiatry
Board Certified Sleep Medicine, ABPN
Diplomate of the American Board of Sleep Medicine*

REFILLS:

- Patients are to call the office to request refills (when at least one week supply is left in the bottle). **Refills WILL NOT be called in the same day as the request.** _____
Patient Initial
- Refills will take 5 to 7 days for the office to process. **NO EXCEPTIONS.** _____
Patient Initial
- Any medication **SAMPLES** will be given to patients by the Doctor **ONLY** at the time of appointment.
- Any medication changes will be made at Patient's office visit **ONLY**. (i.e.: New medication **WILL NOT** be started from phone messages)
- Refills will not be called in for any patient who has not been seen in over **ONE YEAR.** _____
Patient Initial
- Refills will not be called in for **Controlled medications / pain medications** if patient has not been seen for more then **SIX MONTHS**.
- Patients taking controlled medications will be subject to random drug screenings at the patient's expense.

NARCOTIC / PAIN MEDICATIONS:

- Prescriptions for Narcotic medication are used for acute problems only. If long term use is necessary patients will be referred back to the Primary Care Physician or to a pain management specialist.

PRESCRIPTIONS MISUSE, ALTERATION OR FORGERY:

- Alteration of a prescription or use of a medication against medical advise **WILL NOT** be tolerated. It will result in termination of your care and prosecution as directed by state and federal law.

I have read and understand the Prescription Medication Policy.

Patient Signature

Date



HAMPTON LOCATION

2713 Magruder Blvd., Suite G1
Hampton, VA 23666
Ph. (757) 224-4200 • Fax (757) 788-8059

CHURCHLAND LOCATION

3235 Academy Avenue, #304
Portsmouth, VA 23703
Ph. (757) 686-8594 • Fax (757) 686-8596

CHESAPEAKE LOCATION

300 Medical Parkway, #108
Chesapeake, VA 23320
Ph. (757) 436-8304 • Fax (757) 436-8306

VIRGINIA BEACH LOCATION

4480 Holland Office Park, Bldg. 2, Ste. 225
Virginia Beach, VA 23452
Ph. (757) 456-0984 • Fax (757) 456-0986

HEMANG H. SHAH, M.D.

Diplomate, American Board of Sleep Medicine

SLEEP DISORDER SCREENING QUESTIONNAIRE

NAME (LAST, FIRST, MI)		SSN	
ADDRESS (STREET OR BOX NO.)			
CITY		STATE	ZIP
TELEPHONE (HOME)	TELEPHONE (WORK)	DATE OF BIRTH	AGE
		SEX (CIRCLE ONE) M F	
OCCUPATION		WORKING HOURS FROM _____ TO _____	
REFERRING PHYSICIAN			
REFERRING PHYSICIAN'S ADDRESS			

Height _____ Weight _____ Neck Size _____ Blood Pressure _____ Pulse _____

Any recent weight increase? Yes No How much _____ Over what time period _____

Any recent weight loss? Yes No How much _____ Over what time period _____

Reason for Sleep Study: Sleepiness Snoring Disturbed Sleep

SNORING:

- How many years have you been told you snore? _____
- Does your snoring disturb your bed partner? Yes No
- Has your snoring become progressively worse? Yes No Over what period of time? _____
- Have you been told you snore when sleeping? (*Circle all that apply*)
On your back On your side On your stomach In a sitting position
- On a scale of 1 to 5 (1 is minimal and 5 very loud), how loud is your snoring? _____
- Which pattern best describes your snoring? (*Circle one*)
a. Snoring is present almost continuously.
b. Snoring is noted only occasionally and is not continuous.
c. I snore loudly, then snoring and breathing stops, and then I snore loudly again.
- Have you ever awakened from sleep because you are snoring? Yes No

NAME: _____

EXCESSIVE DAYTIME SLEEPINESS: (*Epworth Sleepiness Scale*)

1. Do you usually feel tired during the day? Yes No
2. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? (This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.) Use the following scale to choose the most appropriate number for each situation:

- 0 = would never**
- 1 = slight chance of dozing**
- 2 = moderate chance of dozing**
- 3 = high chance of dozing**

SITUATION:

CHANCE OF DOZING

- | | |
|--|-------|
| a. Sitting and reading | _____ |
| b. Watching TV | _____ |
| c. Sitting, inactive in a public place (e.g., a theater) | _____ |
| d. As a passenger in a car for an hour without a break | _____ |
| e. Lying down to rest in the afternoon when time permits | _____ |
| f. Sitting and talking to someone | _____ |
| g. Sitting quietly after a lunch without alcohol | _____ |
| h. In a car, while stopped for a few minutes in traffic | _____ |

3. How many naps do you take per day? _____ Length _____

Do you feel refreshed after a nap? Yes No

4. Do you experience drowsiness or a tendency to fall asleep while driving? Yes No
5. Have you been in a car accident due to falling asleep at the wheel? Yes No Near miss
6. Please describe an incident when you fell asleep during the day when you were not expected to fall asleep.

APNEA:

1. Have you ever been observed to stop breathing during sleep? Yes No
2. Do you wake up with dry mouth? Yes No
3. How many times do you awake to go to the bathroom? _____
4. Have you ever awakened choking or gasping for breath? Yes No
5. Upon awakening, do you feel refreshed and rested? Yes No

NARCOLEPSY: (*Sleepiness with dreaming and spells of weakness*)

1. Do you have sudden attacks of sleepiness? Yes No
2. Have you recently noticed increased irritability or trouble thinking? Yes No
3. Has daytime sleepiness affected your job performance or your employment? Yes No
4. Do you have cataplexy? Yes No
(*Cataplexy is a brief (seconds or minutes) episode of muscle weakness; e.g., jaw drop, arm or leg weakness and/or paralysis. When the attack is over, the patient is completely normal. Laughter, anger, athletic activity, excitement are the usual factors that initiate an attack of cataplexy.*)
5. Do you have episodes of arm or leg paralysis (sleep paralysis) during sleep? Yes No
6. Do you hear or see something in the beginning or last part of sleep that is not real? (hallucinations) Yes No

NAME: _____

LEG PROBLEMS: (*Restless legs and compulsive leg moving at night*)

1. Do you have leg cramps at night? Yes No
2. Have you ever been told that your arms or legs move a lot at night? Yes No
3. Do you experience "creepy crawling" and/or aching feeling in your legs which make you want to move them? Yes No
4. Do you jerk your arms or legs during sleep? Yes No

SLEEP STATUS AND HABITS:

1. What do you usually do the hour before bed? _____
2. Do you often read in bed? Yes No
3. Do you often watch TV in bed? Yes No
4. Do you eat in bed? Yes No
5. During the night, do you often look at the clock? Yes No
6. On average, how long does it take you to fall asleep at night? _____ Min. _____ Hrs.
7. Do you have difficulty falling and/or staying asleep? Yes No
8. What time do you usually go to bed during the week? _____ Week-ends? _____
9. What time do you usually wake up during the week? _____ Week-ends? _____
10. How many times do you usually awaken during the night? 0-1 2-3 more than 3
11. How many times do you usually awaken to urinate? 0-1 2-3 more than 3
12. How long does it take to return to sleep? _____
13. Upon awakening, do you feel tired rested/refreshed other?
14. How many hours do you sleep at night? _____

MEDICAL HISTORY:

1. Do you have difficulty breathing through the nose? Yes No
2. Do you wear dentures? Yes No
3. Have you had any of the following:
 - a. Tonsillectomy and/or adenoidectomy? Yes No When: _____
 - b. Nasal or sinus surgery? Yes No When: _____
 - c. Vocal cord surgery (polyp, nodules, etc.)? Yes No When: _____
 - d. Any neck operations? Yes No When: _____
4. Have you been treated for sleep apnea? Yes No
When: _____ Where: _____
How: Tracheostomy UPP CPAP Drugs
Did treatment improve: Sleepiness Snoring Tiredness Quality of sleep
5. Do you have any of the following:
 - a. High blood pressure Yes No
 - b. Heart disease Yes No
 - c. Morning headaches Yes No
 - d. Memory loss Yes No
 - e. Sexual problems Yes No
 - f. Lung disease Yes No
 - g. Thyroid disease Yes No
 - h. Allergy Yes No
 - i. Swelling of your legs Yes No
 - j. Urinary or kidney problems Yes No
 - k. Stroke Yes No
 - l. Diabetes Yes No
 - m. Epilepsy Yes No
 - n. Elevated cholesterol Yes No
 - o. Any other neurologic disorder Yes No _____
 - p. Any psychiatric disorder Yes No _____
 - q. Any other problems Yes No _____

NAME: _____

6. Medications:

Allergies to Any Medications: _____

7. General health: _____

8. Do you smoke? Yes No If yes, how many packs per day? _____ or cigarettes per day? _____

9. Do you drink alcoholic beverages? Yes No If yes, how much per day? _____

10. Does alcohol affect your sleep? Yes No

If yes, please describe: _____

11. How many caffeinated drinks do you have in a day? Coffee _____ Tea _____ Soda _____

12. Do you use prescription or non-prescription sleeping pills? Yes No

FAMILY HISTORY:

1. Anybody in your family snore? Yes No

2. Anybody in your family is very sleepy? Yes No

3. Anybody in your family diagnosed with sleep disorder? Yes No If yes, what? _____

ANY FURTHER COMMENTS REGARDING YOUR CONDITION NOT COVERED IN THIS FORM?

Can we use the medical information provided in this form for publications or teaching (*without identifying the patient*)?

Yes No

NAME: _____ AGE: _____ SEX: _____

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement that best describes the way you have been feeling the past week, including today. If several statements within a group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. (0) I do not feel sad.
(1) I feel sad.
(2) I am sad all the time and I can't snap out of it.
(3) I am so sad or unhappy that I can't stand it.

2. (0) I am not particularly discouraged about the future.
(1) I feel discouraged about the future.
(2) I feel I have nothing to look forward to.
(3) I feel that the future is hopeless and that things cannot improve.

3. (0) I do not feel like a failure.
(1) I feel I have failed more than the average person.
(2) As I look back on my life, all I can see is a lot of failures.
(3) I feel I am a complete failure as a person.

4. (0) I get as much satisfaction out of things as I used to.
(1) I don't enjoy things the way I used to.
(2) I don't get real satisfaction out of anything anymore.
(3) I am dissatisfied or bored with everything.

5. (0) I don't feel particularly guilty.
(1) I feel guilty a good part of the time.
(2) I feel quite guilty most of the time.
(3) I feel guilty all of the time.

6. (0) I don't feel I am being punished.
(1) I feel I may be punished.
(2) I expect to be punished.
(3) I feel I am being punished.

7. (0) I don't feel disappointed in myself.
(1) I am disappointed in myself.
(2) I am disgusted in myself.
(3) I hate myself.

8. (0) I don't feel I am worse than anybody else.
(1) I am critical of myself all the time for my faults.
(2) I blame myself all the time for my faults.
(3) I blame myself for everything bad that happens.

NAME: _____

9. (0) I don't have any thoughts of killing myself.
(1) I have thoughts of killing myself, but I would not carry them out.
(2) I would like to kill myself.
(3) I would kill myself if I had a chance.
10. (0) I don't cry anymore than usual.
(1) I cry more now than I used to.
(2) I cry all the time now.
(3) I used to be able to cry, but now I can't cry even though I want to.
11. (0) I am no more irritated now than I ever am.
(1) I get annoyed or irritated more easily than I used to.
(2) I feel irritated all the time now.
(3) I don't get irritated at all by the things that used to irritate me.
12. (0) I have not lost interest in other people.
(1) I am less interested in other people than I used to be.
(2) I have lost most of my interest in other people.
(3) I have lost all of my interest in other people.
13. (0) I make decisions about as well as I ever could.
(1) I put off making decisions more than I used to.
(2) I have greater difficulty in making decisions than before.
(3) I can't make decisions at all anymore.
14. (0) I don't feel I look any worse than I used to.
(1) I am worried that I am looking old or unattractive.
(2) I feel that there are permanent changes in my appearance that make me look unattractive.
(3) I believe that I look ugly.
15. (0) I can work about as well as before.
(1) It takes an extra effort to get started at doing something.
(2) I have to push myself very hard to do anything.
(3) I can't do any work at all.
16. (0) I can sleep as well as usual.
(1) I don't sleep as well as I used to.
(2) I wake up 1-2 hours earlier than usual and it is hard to go back to sleep.
(3) I wake up several hours earlier than I used to and cannot get back to sleep.
17. (0) I don't get more tired than usual.
(1) I get tired more easily than I used to.
(2) I get tired from doing almost anything.
(3) I am too tired to do anything.

NAME: _____

18. (0) My appetite is no worse than usual.
(1) My appetite is not as good as it used to be.
(2) My appetite is much worse now.
(3) I have no appetite at all anymore.

19. (0) I haven't lost much weight, if any, lately.
(1) I have lost more than 5 pounds.
(2) I have lost more than 10 pounds.
(3) I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes No

20. (0) I am no more worried about my health than usual.
(1) I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
(2) I am very worried about physical problems and its hard to think of much else.
(3) I am so worried about my physical problems that I cannot think about anything else.

21. (0) I have not noticed any recent change in my interest in sex.
(1) I am less interested in sex than I used to be.
(2) I am much less interested in sex now.
(3) I have lost interest in sex completely.

TOTAL SCORE _____



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice 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 out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the Patient's signature in acknowledgement of this ***Notice of Privacy Practices***, but was unable to do so as documented below:

Date: _____ Initial: _____ Reason: _____.

****This HIPPA Privacy Form will be in effect as long as you are a patient in this practice.**