PATIENT INFORMATION

Date: ☐ New ☐ Update

Patient's LEGAL Name (Last, First, MI)		DOB (mm/dd/yyyy)	Gender ☐ Male ☐ Female
Address		Preferred Name/Nickname	
City / State / Zip Code		Driver's License Number	
Primary Phone Number	☐ Day ☐ Evening ☐ Home ☐ Mobile ☐ Work	Social Security Number	
Secondary Phone Number	☐ Day ☐ Evening ☐ Home ☐ Mobile ☐ Work	Preferred Contact Method: ☐ Home ☐ Cell ☐ Email	
Email Address			
Emergency Contact 1	Relationship	Phone Number	
Emergency Contact 2	Relationship	Phone Number	
Spouse Name / Parent Name	Relationship	Phone Number	
Address (If different from patient's)			
Work Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student			
Employer / School		Occupation	
Address		Phone Number	
City / State / Zip Code		Fax Number	

Language		Ethnicity	Pharmacy Name
☐ Arabic	☐ Hindi	☐ American Indian	
☐ Armenian	☐ Italian	☐ Asian	
☐ Chinese	☐ Japanese	☐ Pacific Islander	Pharmacy Phone Number
☐ English	☐ Korean	☐ Caucasian	
☐ Farsi	☐ Polish	☐ Hispanic	
☐ French	☐ Portuguese	☐ Other Race	Pharmacy Fax Number
☐ German	☐ Russian	☐ Unknown	
☐ Haitian	☐ Spanish		
☐ Hebrew	☐ Other		

PATIENT AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Neuroscience Institute (NSI) is authorized to release protected health information (PHI) about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with patient's instructions.

ENTITY TO RECEIVE INFORMATION (check each person/entity that you approve to receive information)	**DESCRIPTION OF INFORMATION TO BE RELEASED** (check each that can be given to the person/entity on the left in the same section)
☐ Voice Mail (☐ Home ☐ Work ☐ Cell)	☐ Results of X-rays/Labs, Referrals, Appointment Reminder ☐ Other:
☐ Employer ☐ School	☐ Appointment Information ☐ Other:
Family Members/Other Persons	
☐ Name (Relationship):	☐ Financial ☐ Medical as follows:
☐ Name (Relationship):	☐ Financial ☐ Medical as follows:
☐ Name (Relationship):	☐ Financial ☐ Medical as follows:

Rights of the Patient:
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to NSI. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may not longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Patient's or Legal Representative's Signature	Legal Representative's Name + Relationship to Patient
Patient's Name (Last, First MI)	Patient's DOB (mm/dd/yyyy)
Witness / Translated By: ☐ N/A	Date:

9170 Haven Ave. #108 Rancho Cucamonga, CA 91730 (909) 948-8754 Fax: (909) 948-8960
401 E. Highland Ave. #553 San Bernardino, CA 92404 (909) 881-6713 Fax: (909) 883-7235

MEDICAL PROVIDERS

Date:

Patient's Name (Last, First, MI)	DOB (mm/dd/yyyy)
Primary Care Physician	
Name (Last, First)	Specialty
Address	Phone Number
City / State / Zip Code	Fax Number
Referring Physician	
Name (Last, First)	Specialty
Address	Phone Number
City / State / Zip Code	Fax Number
Other Physician	
Name (Last, First)	Specialty
Address	Phone Number
City / State / Zip Code	Fax Number
Other Physician	
Name (Last, First)	Specialty
Address	Phone Number
City / State / Zip Code	Fax Number
Other Physician	
Name (Last, First)	Specialty
Address	Phone Number
City / State / Zip Code	Fax Number

Neuroscience Institute

OFFICE POLICIES

1. MISSED/LATE CANCELLATION APPOINTMENT POLICY:

   If you are unable to make your previous scheduled appointment, you must contact the office at: (909) 948-8754 (Rancho Cucamonga Office) or (909) 881-6713 (San Bernardino Office) to cancel said appointment with at least 24 (twenty-four) hours advance notice. Those patients who do not contact the office with at least 24 hours notice will be charged a missed appointment fee of $50 (fifty dollars). Please be advised that insurance companies DO NOT pay for missed appointments.

   Our staff will continue to make every effort to call patients a day or two in advance to confirm advance, but it remains YOUR responsibility to cancel or reschedule if you are unable to make the schedule appointment.

2. FORMS COMPLETION AND PROCESSING FEES:

   There will be a $20 (twenty dollars) charge per form requiring doctors' signatures.

   Payment can be rendered in cash, check, or credit card. If you would like for us to forward all forms via mail or fax, payment is due upon drop-off and authorization for release of forms must be signed. Forms can be paid for after completion only if you are going to expedite your own forms.

   Please allow 1-2 weeks for forms to be completed.

I have read and understood these policies.

Patient's Signature:	Date:

MEDICARE

Name of Beneficiary: _____Claim #: _____

I request that payment of authorized benefits be made either to me or on my behalf to Neuroscience Institute (NSI) for any services furnished to me by my physician. I authorize any holders of medical information about me to release to the health care financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act. A copy of this authorization is valid as an original.

Patient's Signature:	Date:

COMMERCIAL INSURANCE

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the doctor, or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this authorization is valid as an original.

Patient's Signature:	Date:

PATIENT MEDICAL HISTORY

Date:

Patient's LEGAL Name (Last, First MI)	DOB (mm/dd/yyyy)

1. PLEASE CHECK THE CONDITIONS WHICH YOU HAVE BEEN DIAGNOSED AS HAVING. ☐ NONE

☐ Anemia	☐ Heart Disease / Coronary	☐ Parkinson's Disease
☐ Anxiety	☐ Heart Murmur	☐ Peptic (Stomach) Ulcers
☐ Arthritis	☐ Heart Palpitations	☐ Peripheral Vascular Disease
☐ Asthma	☐ Heart Valve Disease	☐ Pneumonia
☐ Atrial Fibrillation	☐ Hemorrhoids	☐ Polio
☐ Back Problems	☐ Hepatitis A / B / C	☐ Prostate Enlargement
☐ Bladder Infections	☐ High Blood Pressure	☐ Pulmonary Embolism
☐ Bleeding Disorder	☐ High Cholesterol	☐ Rheumatic Fever
☐ Blood Clots / DVT	☐ HIV / AIDS	☐ Rheumatoid Arthritis
☐ Blood Transfusions	☐ Hyperthyroid	☐ Scarlet Fever
☐ Bronchitis	☐ Hypothyroid	☐ Seasonal Allergies
☐ Cancer:	☐ Infectious Mononucleosis	☐ Sexually Transmitted Disease
☐ Cataracts	☐ Insomnia / Sleep Disorder	☐ Shingles
☐ Chicken Pox	☐ Irregular Heart Beat	☐ Sleep Apnea
☐ Congenital Deformities	☐ Irritable Bowel Syndrome	☐ Smallpox
☐ Congestive Heart Failure	☐ Kidney Disease / Dialysis	☐ Stroke / TIA
☐ COPD / Emphysema	☐ Kidney Stones	☐ Tuberculosis
☐ Crohn's / Ulcerative Colitis	☐ Liver Disease / Cirrhosis	☐ Urinary Incontinence
☐ Dementia	☐ Low Blood Pressure	☐ Vertigo
☐ Depression	☐ Lupus	☐ Whooping Cough
☐ Diabetes:	☐ Malaria	☐ Carpal Tunnel Syndrome
☐ Diphtheria	☐ Measles	☐ Chronic Low Back Pain
☐ Diverticulosis	☐ Migraines / Headaches	☐ Chronic Neck Pain
☐ Eczema	☐ Mitral Valve Prolapse	☐ Chronic Joint Pain
☐ Epilepsy / Seizures	☐ Mumps	☐ Joint Injury
☐ Fibromyalgia	☐ Neurological Disease	☐ Vertebral Compression Fracture
☐ GERD / Heartburn	☐ Neuropathy	☐ Varicose Veins
☐ Glaucoma	☐ Osteoporosis	☐
☐ Gout	☐ Pacemaker	☐
☐ Heart Attack	☐ Pancreatitis	☐

2. PLEASE CHECK/LIST ALL SURGERIES YOU HAVE HAD. ☐ NONE

☐ Appendix	☐ Cardiac Catheterization	☐ R / L - Hip
☐ Cataract	☐ Pacemaker/Defibrillator	☐ R / L - Shoulder
☐ Gall Bladder	☐ Colonoscopy	☐ R / L - Elbow
☐ Hernia Repair	☐ Prostate	☐ R / L - Wrist
☐ Tonsils / Adenoids	☐ Bladder Suspension	☐ R / L - Hand / Finger
☐ Wisdom Teeth	☐ Gastric Bypass	☐
☐ Cesarean Section	☐ Cosmetic	☐
☐ Hysterectomy	☐ Neck / Cervical Spine	☐
☐ Tubal Ligation	☐ Back / Lumbar Spine	☐
☐ Cardiac Stents / Angioplasty	☐ R / L - Ankle / Foot	☐
☐ Cardiac Bypass	☐ R / L - Knee	☐

3. FAMILY HISTORY		
☐ I have no significant family medical history.	☐ I am adopted ☐ No medical history available	
	Age	Conditions/Disease (If Deceased, Cause of Death)
Father		
Mother		
Sibling		
Sibling		

☐ Arthritis	☐ Heart Disease	☐ Liver Problems
☐ Cancer	☐ High Blood Pressure	☐ Osteoporosis
☐ Diabetes	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Headaches	☐ Kidney Problems	☐ Stroke
Other Medical Problems:		

4. SOCIAL HISTORY			
Marital Status	☐ Single	☐ Married	☐ Domestic Partner
	☐ Separated	☐ Divorced	☐ Widowed
Education Level	☐ Grade School	☐ High School	☐ College
	☐ Post-Graduate		
Living Situation	☐ With Family	☐ With Friends	☐ Alone
	☐ Assisted Living	☐	☐
Alcohol Use	☐ Never	☐ Drink Socially	☐ Daily Limited Use
	☐ Current Alcoholism	☐ History of Alcoholism	
Tobacco Use	☐ Never	☐ Former Smoker	Quit:
	☐ Current Smoker	Packs/Day:	Years Smoking:
Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No			

5. Work Status	☐ Employed	☐ Full Time	☐ Part Time
	☐ Disability	☐ Retired	☐ Student
	☐ Unemployed	☐ Regular Duty	☐ Modified Duty
Employer:		Title/Position:	
Physical Demand	☐ No Physical Demand	☐ Heavy Lifting	☐ Repetitive Motion

Additional Notes About Medical History:

REVIEW OF SYSTEMS

Patient Name (DOB):

Constitutional		Skin		Hemilymphatic/Endocrine	
Altered Taste/Smell	☐ Y ☐ N	Birth Marks	☐ Y ☐ N	Anemia	☐ Y ☐ N
Cancer	☐ Y ☐ N	Psoriasis	☐ Y ☐ N	Blood Disorder	☐ Y ☐ N
Change in Appetite	☐ Y ☐ N	Skin Rashes	☐ Y ☐ N	Circulatory Problems	☐ Y ☐ N
Excessive Sleepiness	☐ Y ☐ N	Melanoma	☐ Y ☐ N	Diabetes	☐ Y ☐ N
Fatigue	☐ Y ☐ N	Easy Bruising	☐ Y ☐ N	Dry Eyes/Mouth	☐ Y ☐ N
Fever	☐ Y ☐ N	Change in Hair/Nails	☐ Y ☐ N	Endocrine Disorder	☐ Y ☐ N
Depression	☐ Y ☐ N	Tattoos/Piercings	☐ Y ☐ N	Excessive Thirst	☐ Y ☐ N
Anxiety	☐ Y ☐ N	**Respiratory**		Low Blood Sugar	☐ Y ☐ N
Recent Sore Throat	☐ Y ☐ N	Asthma	☐ Y ☐ N	Lymph Node Swelling	☐ Y ☐ N
Sleep Apnea	☐ Y ☐ N	Bronchitis	☐ Y ☐ N	Hepatitis	☐ Y ☐ N
Weight Loss/Gain	☐ Y ☐ N	Chronic Cough	☐ Y ☐ N	HIV/AIDS	☐ Y ☐ N
Sleep Disturbance	☐ Y ☐ N	COPD	☐ Y ☐ N	Pituitary Disorder	☐ Y ☐ N
Insomnia	☐ Y ☐ N	Emphysema	☐ Y ☐ N	Sickle Cell Disease	☐ Y ☐ N
		Pneumonia	☐ Y ☐ N	Thyroid Disease	☐ Y ☐ N
Cardiovascular		Shortness of Breath	☐ Y ☐ N	Night Sweats	☐ Y ☐ N
Chest Pain/Pressure	☐ Y ☐ N	Trouble Breathing	☐ Y ☐ N	Hot/Cold Intolerance	☐ Y ☐ N
Fainting	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N	**Neurological**	
Heart Attack	☐ Y ☐ N	Wheezing	☐ Y ☐ N	Balance Difficulty	☐ Y ☐ N
Heart Defect	☐ Y ☐ N	**Musculoskeletal**		Choking	☐ Y ☐ N
Heart Murmur	☐ Y ☐ N	Connective Tissue d/o	☐ Y ☐ N	Clumsiness	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Low Back Pain	☐ Y ☐ N	Concussion	☐ Y ☐ N
Low Blood Pressure	☐ Y ☐ N	Neck Pain	☐ Y ☐ N	Confusion	☐ Y ☐ N
Leg Swelling	☐ Y ☐ N	Joint Pain	☐ Y ☐ N	Difficult Concentration	☐ Y ☐ N
Varicose Veins	☐ Y ☐ N	Joint Replacement	☐ Y ☐ N		
Ears, Nose, & Throat		Joint Swelling	☐ Y ☐ N	Dizziness	☐ Y ☐ N
Hearing Loss	☐ Y ☐ N			Drooling	☐ Y ☐ N
Mouth Sores	☐ Y ☐ N	**Genitourinary**		Falls	☐ Y ☐ N
Ringing in Ears	☐ Y ☐ N	Blood in Urine	☐ Y ☐ N	Hallucinations	☐ Y ☐ N
Sinus Disease	☐ Y ☐ N	Change in Habits	☐ Y ☐ N	Headache	☐ Y ☐ N
Trouble Swallowing	☐ Y ☐ N	Urinary Infections	☐ Y ☐ N	Loss of Consciousness	☐ Y ☐ N
Eyes		Kidney Disease	☐ Y ☐ N	Memory Problems	☐ Y ☐ N
Blurred Vision	☐ Y ☐ N	Kidney Stones	☐ Y ☐ N	Muscle Twitching	☐ Y ☐ N
Cataracts	☐ Y ☐ N	Loss of Control	☐ Y ☐ N	Nausea	☐ Y ☐ N
Double Vision	☐ Y ☐ N	Painful Urination	☐ Y ☐ N	Numbness	☐ Y ☐ N
Glaucoma	☐ Y ☐ N	Urinary Urgency	☐ Y ☐ N	Personality Change	☐ Y ☐ N
Macular Degeneration	☐ Y ☐ N	Vaginal Bleeding	☐ Y ☐ N	Seizure	☐ Y ☐ N
Peripheral Vision Issue	☐ Y ☐ N	Sexual Dysfunction	☐ Y ☐ N	Shooting Pains	☐ Y ☐ N
Visual Impairment	☐ Y ☐ N			Smelling Difficulty	☐ Y ☐ N
Glasses/Contact	☐ Y ☐ N			Stroke	☐ Y ☐ N
Gastrointestinal				Tasting Difficulty	☐ Y ☐ N
Black/Blood in Stool	☐ Y ☐ N			Tingling Sensation	☐ Y ☐ N
Constipation	☐ Y ☐ N			Vertigo	☐ Y ☐ N
Diarrhea	☐ Y ☐ N			Walking Difficulty	☐ Y ☐ N
Gall Bladder Problem	☐ Y ☐ N				
Ulcers	☐ Y ☐ N				
Vomiting	☐ Y ☐ N				
Abdominal Pain	☐ Y ☐ N				
Hernia	☐ Y ☐ N				

(PROVIDERS ONLY) All other ROS Negative: ☐ Initials:

NOTICE OF PRIVACY PRACTICES

Effective Date: August 20, 2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact our Privacy Officer.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. Our practice is dedicated to maintain the privacy of your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Our practice will post a copy of our current notice in a visible location at all time. Upon your request, we will provide you with any revised Notice of Privacy Practice by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

WHO WILL FOLLOW THIS NOTICE:

This Notice describes the **Neuroscience Institute (NSI)** privacy practices and that of all employees, staff, and other personnel, including non-employees who have a need to use your medical information to perform their job, including physicians and allied health professionals while they are caring for you. All these entities, sites and locations will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment and/or its own limited and Medical Office operation purposes described in this notice.

**This Notice does not cover other physician offices or medical facilities.

REQUIREMENTS:

The following categories describe the different way in which we may use and disclose your PHI.

1. **Treatment:** Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy we order a prescription for you. Many of the people who work for our practice, including but not limited to, our doctors, nurses, and medical assistants, may use or disclose your PHI in order to treatment you or to assist others in your treatment. Under certain circumstances we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if you insurer will cover, or pay for, you treatment, we may also use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

Health Care Operations: Our practice may use and disclose your PHI as needed to operate our business. These activities include but are not limited to quality assessment activities, training of medical students, licensing and conducting or arranging for other business activites. We may call you by name in the waiting room when your physician and/or health care provider is ready to see you. We

3. may share your PHI with third party "business associates" that perform various activities for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.
4. **Appointment Reminders:** Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. **Treatment Options:** Our practices may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. **Release of Information to Family/Friends:** Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a stepparent may take a child to the doctor's office for treatment of an injury. In this example, the stepparent may have access to this child's medical information.
7. **Disclosure Required By Law:** Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN/SPECIAL CIRCUMSTANCES:

The following categories describe unique scenarios in which we may use or disclose your PHI.

1. **Public Health Risks:** our practice may disclose your PHI to public health authorities that are authorized by law to collect information for purposes such as:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading or contract a disease or condition
- Reporting reaction to drugs or problems with products or devices
- Notifying individual is a product or device they may be using has been recalled
- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information agrees or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight:** We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
3. **Legal Proceedings:** We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
4. **Law Enforcement:** We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our office
- In response to a warrant, summons, court order, subpoena, or similar legal process
- To identify/locate a suspect, material witness, fugitive, or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity, or location of the perpetrator)

5. **Coroners, Funeral Directors, and Organ Donation:** We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, to permit the funeral director to carry out his/her duties. We may disclose such information in reasonable anticipation of death. PHI may be used and disclosed for cadaveric organ, eye or tissue donation purpose.
6. **Research:** PLEASE SEE CONSENT FOR RESEARCH.

Serious Threats to Health and Safety: Consistent with applicable federal and state laws, we may disclose PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious and

7. imminent threat to the health or safety of a person or the public. We may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
8. **Military and National Security:** Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) if required by the appropriate authorities. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. WE may also disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
9. **Inmates:** Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you; (b) for the safety and security of the institution; and/or (c) to protect your health and safety or the health and safety of other individuals.
10. **Worker's Compensation:** We may disclose your PHI as authorized to comply with worker's compensation laws and other similar legally established programs.

Your Rights Regarding your PHI:

You have the following rights regarding the PHI that we maintain about you.

1. **Confidential Communications:** You have the right to request that we communicate your PHI to you by a certain means or at a certain location. For example, you might request that we only contact by mail or at work. WE are not required to agree to request for confidential communications that are unreasonable. To make a request for confidential communications, you must submit a written request to our Privacy officer/coordinator. The request must tell us how or where you want to be contacted. In addition if another individual or entity is responsible for payment, the request must explain how payment will be handled.
2. **Requesting Restrictions:** You have the right to request a restriction of your PHI. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If you physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment.
3. **Inspection and Copies:** You have the right to inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you but does not include psychotherapy notes. You must submit your request in writing to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the cost of copying, mailing, labor, and supplies associated with your request as allowed by law.
4. **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information if kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also we may deny your request to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) nor part of the PHI which you be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures:** All patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for no-treatment of operations purposes. Use of your PHI as a part of routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to the Privacy Officer. All request for an "accounting of disclosures" must state the period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice:** You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice you must contact the Privacy Officer.
7. **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 Privacy Officer. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*
8. **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. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked in writing at ANY TIME. After you revoke your authorization, we will not longer use or disclose your PHI for the purposes described in the authorization. Please not that we are required to retain records of your care.

If you have any questions regarding this notice or our Notice of Privacy Practices during normal business hours, please contact the Privacy Officer at **Neuroscience Institute - 160 E. Artesia St. Suite 220, Pomona, CA 91767 c/o Terri King (Manager) (909) 865-1020.**

PATIENT ACKNOWLEDGEMENT:

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

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

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may cause this organization at any time at the address below 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.

I understand that I may revoke this acknowledgement in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

atients Legal Representative Signature:	tPatients legal rep. relationship to Patient: ☐ N/A
?atients legal name:	Legal Representative's Name: ☐ N/A
ranslated by By: ☐ N/A	Patients Signature:

_____ I have received a copy of this document (Patient's Initials).

Neuroscience Institute

CONSENT TO TREATMENT AND OTHER ACKNOWLEDGEMENTS

Note to Patient: The following consent describes information regarding your treatment and policies at the Neuroscience Institute (NSI). It is important that you carefully read this document and that any questions regarding the information have been answered to your satisfaction before signing this consent form.

By reading and signing this document, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by my attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. NSI assumes no responsibility for, and I hereby release NSI from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.

2. I hereby expressly authorize NSI and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to NSI and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to NSI and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

3. In return for services to be provided by NSI, I promise to pay for services rendered by NSI to me or for my benefit. If the services I receive from NSI are covered by a third party payor, NSI may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third party payor determines are my responsibility. In the case of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.

4. I authorize and release NSI and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. All personal health information (PHI) is to be kept in an anonymous and confidential manner (your identity will not be disclosed) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

5. I consent to the use of medical records, radiological scans, history, physical and survey forms as instruments for the study of outcomes that may be included in publications, presentations, case studies and/or educational purposes. I understand that they in no way affect my care. All personal health information (PHI) is to be kept in an anonymous and confidential manner (your identity will not be disclosed) in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

6. I acknowledge and accept that the physicians (surgeons) and health care providers at NSI are involved in the confidential collection of outcomes data including radiographic and clinical outcomes to advance and develop new medical technologies. I allow my data regarding outcome and radiographs to be shared or published with the understanding that my personal data (name, birth date, address, or other identifying data) will be kept strictly confidential.

7. I understand that the physicians (surgeons) and other health care providers at NSI are involved in various sponsored research studies and that a separate consent process needs to be completed before being enrolled in any or such study(s). I further understand that such a study is approved and overlooked by the appropriate Institutional Review Board (IRB) of the affiliated hospital(s). These research studies are for the furthering of educational purposes only.

8. I understand and authorize the presence of qualified medical personnel (associates, assistants, and other health care providers) during the course of my care and treatment, including but not limited to: physicians' assistants, nurses, medical assistants, medical students, medical representatives, research coordinators.

9. NSI physicians and healthcare professionals cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release NSI, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of NSI or its employees.

10. I authorize NSI to release my protected health information (medical records) to my referring physician, primary care physician, and any physician(s) I may be referred to. I also understand and accept that NSI will not release my protected health information to any other party without express consent.

11. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

12. I hereby consent and request diagnostic procedures including X-rays, blood tests, medical treatment, including immunizations and treatment deemed advisable by the professional staff of Neuroscience Institute and/or Chaparral Medical Group.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). I have had an opportunity to discuss it, and any questions I had have been answered to my complete satisfaction.

Legal Representative's Signature	Representative's Name + Relationship to Patient
Patient's Name (Last, First MI)	Patient's DOB (mm/dd/yyyy)
Witness / Translated By: ☐ N/A	

Neuroscience Institute

PATIENT MEDICATION LIST

Date:

Patient's Name (Last, First, MI)	DOB (mm/dd/yyyy)

Source of Medication Information:

☐ Patient ☐ Family ☐ Old Chart ☐ Pharmacy ☐ PCP ☐ Sending Facility ☐ Other:

Medication Allergies/Adverse Reactions

☐ No Known Allergies

Drugs/Food/Latex/Contrast/Other	Reaction
1.	
2.	
3.	
4.	
5.	

Blood Thinners:

☐ Aspirin ☐ Warfarin/Coumadin ☐ Pradaxa ☐ Lovenox ☐ Plavix ☐

Vitamins/Herbal Supplements/Nutritional Supplements:

Medication	Dose/Route/Frequency	Reason for Taking Medication
1.		
2.		
3.		
4.		
5.		
6.		
7.		

8.			
9.			
10.			
11.			
12.			
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14.			
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19.			