Premier Neurology & Pain Specialists

15750 Northline Rd
Southgate, MI 48195

WWW.PNPSPECIALISTS.COM
T: 734-357-0505 F: 734-357-0506

New Patient Intake Forms

In an effort to serve you in a timely fashion please make sure this packet is fully completed prior to attending your appointment

Type of Visit: Choose one

[X] Neurology Consultation

[ ] Pain management Consultation

[ ] Diagnostic study (EMG, EEG, other)

[ ] Pain Injections/Treatments

To better serve you:

- **Please bring all of your imaging (X-ray, MRI, CT) on a CD to review at the time of your visit.**
- **Please bring a list of your current medications**

Every effort will be made to honor your appointment time and prevent extended wait times in our lobby or exam rooms

Due to the nature of our specialty there maybe delays at times, thus we apologize in advance and promise to provide you the exceptional care that you deserve at the time of your visit

How did you find us?

[ ] Referred by Doctor [ ] Family [ ] Friend [ ] online search [ ] other_____

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Patient Information

Full Name (Print)_____[ ] M [ ] F Date of birth_____

Home Adresss_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Email_____

Driver License Number_____Social Security number_____

Emergency Contact_____Phone Number_____

Employment

Current status [ ] Working [ ] Not working Employer_____

address:_____City_____State_____Zip_____phone_____

Insurance

Primary Insurance_____Contract#_____Group#_____

Subscribers name_____DOB of subscriber_____

Secondary Insurance_____ _Contract#_____Group #_____

Subscriber name_____DOB of subscriber_____

Automobile/motor cycle insurance coverage

Is this Injury covered by an automobile accident insurance? [ ] Yes [ ] No [ ]Not applicable (skip below)

Date of accident_____Claim #_____

Insurance Carrier_____Carrier Address_____

Name of Insured_____Adjustor_____Adjustor Phone_____

Workers Compensation

Is this injury covered by Workers Compensation? [ ] Yes [ ] No [ ] Not Applicable (skip below)

Insurance Carrier_____Carrier Address_____

Adjustor_____Adjustor phone_____

Do you have an attorney for this injury/claim? [ ] Yes [ ] No

Attorney Name_____Address_____

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Full Name_____**Age**_____**DOB**_____

Height _____**Weight**_____**Handed [ ] Right [ ] Left**

Referring Physicain_____**Physician Phone #**_____

Primary Care Physician_____**Physician Phone #**_____

What is your current problem/chief complaint?_____

_____

PAST MEDICAL HISTORY: Select all that apply, unchecked box indicates negative

Anesthesia:	**Cardiovascular:**	**Pulmonary:**	**Neurological:**
[ ] Difficult Intubation	[ ] Angina	[ ] Asthma	[ ] Anxiety
[ ] Malignant Hyperthermia	[ ] CHF	[ ] COPD	[ ] Bipolar Disorder
Hepatic/Renal:	[ ] Coronary Artery Disease	[ ] Pulmonary Fibrosis	[ ] Depression
[ ] Cholelithiasis	[ ] Dysrhythmia	[ ] Tuberculosis	[ ] Neuropathy
[ ] Cirrhosis	[ ] Heart Murmur	**Endocrine:**	[ ] Schizoaffective Disorder
[ ] Jaundice	[ ] Hyperlipidemia	[ ] Diabetes Type 1	[ ] Seizures
[ ] Kidney Disease	[ ] Hypertension	[ ] Diabetes Type 2	[ ] Stroke
[ ] Kidney Stones	[ ] Myocardial Infarction	[ ] Hyperthyroidism	[ ] TIA
[ ] Liver Disease	**Gastrointestinal:**	[ ] Hypothyroidism	**Hematologic:**
[ ] Pancreatitis	[ ] Colon Cancer	Other:	[ ] Anemia
[ ] Renal Insufficiency	[ ] Esophageal Cancer	_____	[ ] Blood Transfusion Reaction
[ ] Viral Hepatitis	[ ] GI Ulcer	_____	[ ] Clotting Disorder
	[ ] Hiatal Hernia	_____	
	[ ] Inflammatory Bowel Disease	_____	

FAMILY MEDICAL HISTORY: Select all that apply to your **F**ather, **M**other, **B**rother, **S**ister, so**N** or **D**aughter. Unchecked box indicates negative.

F M B S N D	F M B S N D	F M B S N D	F M B S N D
[ ][ ][ ][ ][ ][ ] Alcohol abuse	[ ][ ][ ][ ][ ][ ] Depression	[ ][ ][ ][ ][ ][ ] High Cholesterol	[ ][ ][ ][ ][ ][ ]Stroke
[ ][ ][ ][ ][ ][ ] Arthritis	[ ][ ][ ][ ][ ][ ] Diabetes	[ ][ ][ ][ ][ ][ ] High Blood Pressure	[ ][ ][ ][ ][ ][ ] Vision Loss
[ ][ ][ ][ ][ ][ ] Asthma	[ ][ ][ ][ ][ ][ ] Drug Abuse	[ ][ ][ ][ ][ ][ ] Kidney Disease	[ ][ ][ ][ ][ ][ ] Heart Attack
[ ][ ][ ][ ][ ][ ] Birth Defects	[ ][ ][ ][ ][ ][ ] Early Death	[ ][ ][ ][ ][ ][ ] Mental Illness	[ ][ ][ ][ ][ ][ ] _____
[ ][ ][ ][ ][ ][ ] Cancer_____	[ ][ ][ ][ ][ ][ ] Hearing Loss	[ ][ ][ ][ ][ ][ ] Mental Retardation	[ ][ ][ ][ ][ ][ ] _____
[ ][ ][ ][ ][ ][ ] COPD	[ ][ ][ ][ ][ ][ ] Heart Disease	[ ][ ][ ][ ][ ][ ] Miscarriage	[ ][ ][ ][ ][ ][ ] _____

SURGICAL HISTORY: List all and please be specific (i.e right shoulder rotator cuff) and include dates

1.	4.
2.	5.
3.	6.

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CURRENT MEDICATIONS: Please list all of your medications

Name of Medication	Dose	Regimen
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

MEDICATION ALLERGY: Please list name and reaction

MEDICATION NAME	DESCRIPTION OF ALLERGIC REACTION
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

NON-MEDICATION ALLERGY (i.e contrast): Please list name of item and reaction

ITEM	DESCRIPTION OF ALLERGIC REACTION
1.	1.
2.	2.
3.	3.
4.	4.

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SOCIAL HISTORY

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Other_____

Could you be pregnant? [ ] Yes [ ] No [ ] Maybe [ ] NA How many weeks?_____ Due date_____

How many children do you have?_____ **Education Level:** [ ] High School [ ] Graduated college [ ] Other____

Do you use tobacco? [ ] Yes [ ] No How many packs per day_____

Do you drink alcohol? [ ] Yes [ ] No How much do you drink per day_____

Do you currently use any of the following? [ ] Yes [ ] No [ ] Marijuana [ ] cocaine [ ] Heroin [ ] Other_____

Have you ever used any of the following? [ ] Yes [ ] No [ ] Marijuana [ ] cocaine [ ] Heroin [ ] Other_____

Are you currently working? [ ] No [ ] Retired [ ] Short or long term disability [ ] Unemployed

[ ] Yes Occupation_____Employer_____

Duties at work: [ ] Lifting [ ] Bending [ ] Standing [ ] Reaching [ ] Other_____

REVIEW OF SYSTEMS: Circle all that apply

Constitutional Symptoms:
Activity change
Appetite change
Chills
Diaphoresis
Fatigue
Fever
Unexpected weight change

HENT:
Congestion
Dental problem
Drooling
Ear discharge
Ear pain
Facial swelling
Hearing loss
Mouth sores
Nosebleeds
Postnasal drip
Rhinorrhea
Sinus pressure
Sneezing
Sore throat
Tinnitus
Trouble swallowing
Voice change

Skin:
Color change
Pallor
Rash
Wound

Eyes:
Eye discharge
Eye itching
Eye pain
Eye redness
Photophobia
Visual disturbance

Respiratory:
Apnea
Chest tightness
Choking
Cough
Shortness of breath
Stridor
Wheezing

Cardiovascular:
Chest pain
Leg swelling
Palpitations

GI:
Abdominal distention
Abdominal pain
Anal bleeding
Blood in stool
Constipation
Diarrhea
Nausea
Rectal pain
Vomiting

Endocrine:
Cold intolerance
Heat intolerance
Polydipsia
Polyphagia
Polyuria

Genitourinary:
Difficulty Urination
Dyspareunia
Dysuria
Enuresis
Flank pain
Frequency
Genital sore
Hematuria
Menstrual problem
Pelvic pain
Urgency
Urine decreased
Vaginal bleeding
Vaginal discharge
Vaginal pain

Musc:
Arthralgias
Back pain
Gait problem
Joint swelling
Myalgias
Neck pain
Neck stiffness

Allerg/Immuno:
Environnemental allergies
Food allergies
Immunocompromised

Neurological:
Dizziness
Facial asymmetry
Headaches
Light-headedness
Numbness
Seizures
Speech difficulty
Syncope
Tremors
Weakness

Hematologic:
Adenopathy
Bruises/Bleeds easily

Psychiatric:
Agitation
Behavior problem
Confusion
Decreased concentration
Dysphonic mood
Hallucinations
Hyperactive
Nervous/Anxious
Self-injury
Sleep disturbance
Suicidal idease

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CONSENT FOR TREATMENT

I do hereby consent to treatment of my condition by the staff of Premier Neurology and Pain Specialists.

I also certify that no guarantees or assurances have been made to me as to the results that may be obtained as a result of procedures, treatment and/or techniques used by a Premier Neurology and Pain Specialist.

Furthermore, I understand that while I am being assessed and/or treated at Premier Neurology and Pain Specialists will not be held responsible for any injury sustained outside of its immediate physical premises.

_____

Patient Name (PRINT)

_____ _____

Patient Signature Date

_____ _____ _____

Alternate Signature (if patient cannot Sign) Relationship to patient Date

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ELECTRONIC PRESCRIPTION PROGRAM

Premier Neurology and Pain Specialists will offer Electronic Prescription Prescribing (EPP). EP allows us to send your medication refills electronically to your pharmacy. This means no more waiting for your prescription to be filled.

Please fill in the blanks below with your Pharmacy information.

Pharmacy Name_____

Pharmacy Location_____

Pharmacy Phone Number_____

Patient Name (PRINT)_____

Patient Signature_____Date_____

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BILLING/ASSIGNMENT OF BENEFITS AGREEMENT

Thank you for choosing to be treated at Premier Neurology and Pain Specialists. Our office is happy to participate in your insurance plan and provide care for your medical condition. Our billing service will provide regular statements with updated account status.

Patients may have an outstanding balance with Premier Neurology and Pain Specialists for any of the following reasons:

1. Insurance payment is pending
2. Checks for payment were sent directly to patient
3. Insurance plan does NOT cover charges in full (i.e Co-pays, reductions)
4. Deductible has not been previously met

BY LAW, we MUST BILL all patients for any balance remaining after insurance has paid its share. Please do not hesitate to call our office if you have any questions.

We ask for your cooperation in promptly paying any unpaid balances and in forwarding any insurance checks that is meant to pay for our service to our office.

I have read the above billing policy and procedures of Premier Neurology and Pain Specialists and fully understand the aforementioned.

Your signature at the conclusion of this agreement confirms that you have read fully and understand the right of confidentiality and the limits to that right, as well as our fee policy.

I, the undersigned patient, have and do assign all rights and benefits of insurance of any and all applicable personal injury protection, medical payments and/or insurance to Premier Neurology and Pain Specialists for services and/or supplies to the undersigned patient and covered by Personal Injury Protection (P.I.P) Coverage, Worker's Compensation or other insurance coverage under my policy, I have read the information herein and it is true to the best of my knowledge and belief.

This Assignment includes, but is not limited to, all right to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits, including legal suit. If for any reason the insurance company fails to make payments of benefits to which I am due.

I understand That if my insurance or any other payer fails to pay for the services rendered at Premier Neurology and Pain Specialists, it is subsidiaries or affiliates that I personally guarantee payment. If collection action regarding my outstanding balance occurs I agree to reimburse Premier Neurology and Pain Specialists for attorney's fees and costs, court costs and prejudgment and any applicable interest.

I hereby instruct the insurance carrier that in the event the subject's medical benefits are disputed for any reason, including medical relatedness, reasonableness and/or necessary, that the amount of benefits claimed by Premier Neurology and Pain Specialists is to be set aside and not disbursed until the dispute is resolved. I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she/it may exercise their legal rights. I have read the information herein and it is true to the best of my knowledge and belief.

I understand that anesthesia services provided at PNPS are administered and billed separately by providers of **Conquest Pain Management, LLC**. I understand that if my insurance or any other payer fails to pay for the services rendered by **Conquest Pain Management, LLC**, I personally guarantee payment. If collection action regarding my outstanding balance occurs I agree to reimburse **Conquest Pain Management, LLC** for attorney's fees and costs, court costs and prejudgment and any applicable interest.

Patient Signature_____ Date_____

Witness_____ Date_____

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HIPAA Privacy Authorization Form

If there is anyone, such as family members or caregivers, that you wish to authorize to discuss your health information such as history or appointments with our office, please indicate this information below.

I, _____, authorize my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name:	*Relationship:*
1. _____	_____
2. _____	_____
3. _____	_____

Health Information to be disclosed upon the request of the person named above
(Check either A or B)

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, appointments, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following:

_____

_____

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods. **OR**
- ☐ From _____ to _____.

Unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers in writing.)

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Date

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Acknowledgement of Cancellation and No-show Policy

- I understand that Premier Neurology and Pain Specialists have a no show and cancellation policy. PNP reserves the right to charge for my appointment if I cancel or miss my appointment with less than a 24-hour notice.
- Cancellations are only expected in the setting of an emergency and expect a 24-hour notice from the patient to our office staff.
- Any patient appearing 15 or more minutes to schedule appointment, we reserve the right to cancel the appointment and reserve the right to discharge the patient from our care for repeated occurrences of late arrivals.
- I understand that PNP does not overbook appointment slots, thus we reserve the right to charge a fee $50.00 for each cancelled appointment with less than a 24-hour notice and for no-shows.
- I understand that Premier Neurology and Pain Specialists reserve the right to discharge me from their care if I was to miss three or more appointments or cancel an appointment with less than a 24-hour notice in a 6-month period.
- I understand that I will not be seen by a physician until all outstanding cancellation/no-show fees have been paid in full and that any self-pay fees are non-refundable.

Please Print Name:_____

Patient Signature:_____Date:_____

Provider Signature:_____Date:_____

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Patient Rights, Responsibilities and Advance Directive

Patient rights

- The patient has the right to be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided ion a safe environment with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Knowledge of who is the treating physician and has right to request a change in provider.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Be informed of the facility policy and state regulations regarding advance directives and provided advance directive forms if requested.
- Receive a copy of a clear and understandable itemized bill and receive explanation regardless of source of payment.
- Have all patient right apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decision regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discretely. The patient has the right to be advised as to the reason for presence of any individual involved in his/her health care.
- Receive information in a manner that he/she understands.
- Access information contained in his/her medical record per federal law.
- Be advised of the facility's grievance process should the patient wish to communicate a concern regarding the quality of care received.
- Be advised if facility or personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse in such research or withdraw after enrolling. The decision not to participate or withdraw will not affect the patient's right to access care, treatment or services.
- Be informed by his/her physician or a delegate of thereof of the continuing healthcare requirement following their discharge from th facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care providers or heal care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

Patient Responsibilities

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illness, hospitalizations, medications (including over the counter products and dietary supplements, herbal medications or prescriptions), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointment and informing the facility if wishes to re-schedule.

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- The patient is responsible in asking all questions to their care in situations that are not clear to him or her.
- The patient is responsible for following the treatment plan established by his or her physician, including instructions of nurses and other health professionals as they carry out the physician orders.
- The patient is responsible for reporting to the health care provider any unexpected changes in his/her conditions.
- It is the patient responsibility to have a responsible adult to transport hi/her home from the facility and remain with him/her for at least 24 hours.
- The patient is responsible for his or her actions should he or she refuse treatment or not follow exact physician orders.
- The patient is responsible to ensure that all of his or her financial obligations are fulfilled prior to surgery or other services.
- The patient is responsible for being aware and follows all facility policies and procedures.
- The patient is responsible to inform the facility of his or her advance directive.
- The patient is responsible for being considerate and respectful of the rights of other patients and facility personnel.

Advance Directive Notification:

- In the state of Michigan all patient's have the right to participate in their own health care decisions and make an Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. We respect these decisions.
- Most of the performed procedures in our facility are considered of "minimal" risk however not without risk, **thus it is our policy regardless of what the Advance Directive, Power of Attorney or instruction from health care surrogate or attorney-in-fact wishes are, in the setting of unexpected adverse event that may occur at our facility, the patient will be resuscitated or stabilized than transferred to an acute care facility.** At the accepting facility further treatment or withdrawal of treatment will be pursued in accordance with your wishes.
- If you agree with our facilities policies we will be pleased to assist you in scheduling you for treatment or diagnostic procedures.
- Your agreement with our policy will not revoke or invalidate any health care directive or health care power of attorney.
- To obtain advance directive form you can visit:

  http://www.michigan.gov/documents/miseniors/Advance_Directives_230752_7.pdf

Patient Complaint or Grievance

- If you have any problems or concerns regarding your care please speak to our receptionist or health care provider. We will address all your concerns promptly.
- Patient complaints or grievances may also be filed through the State of Michigan Department of Licensing and Regulatory Affairs at 517-373-9196.

By signing below you agree and understand the your rights, responsibilities, our advance directive policy in a setting of an emergency and ability to have your complaints heard

_____ _____

Patient/Patient Representative Signature Date

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NOTICE OF PRIVACY POLICY

Premier Neurology and Pain Specialists (Fadi Delly, MD, PC) is required by federal law to provide a notice of Privacy Practices that describe how health information that we maintain for your care about you may be used or disclosed. The notice describes each use and disclosure that we are permitted to make, and provides a description of your rights and responsibilities along with our obligations under federal and state privacy laws.

We are required to Safeguard your protected health information (PHI). We are committed to this mission. PHI is information that can be used to identify you that we have created or received about your past, present or future health conditions, the provision of health care to you or payment for health care provided to you.

We are required to provide you with this notice to explain our privacy policy practices and how, when and why we use and disclose your PHI. Generally, we will not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure, although there are some exceptions.

We are legally required to follow the privacy practices described in this notice.

Uses and disclosures

We are permitted to use and disclose your health information under variety of circumstances. Sometimes we must obtain your authorization before we use or disclose that information, but in other circumstances we may use your information without your authorization and without informing you of use or disclose. Some of the reasons that we may use or disclose your information include:

A. Use and disclosure related to treatment, payment or health care operations do not require your consent.
   a. **For treatment:** we can you use and disclose your PHI to physicians, nurses, medical assistance, physician assistants, nurse practioners, medical students and all other employees of PNP who are involved in your care
   b. **To obtain payment**: we may use and disclose your PHI to bill and collect payment for the health care services provided to you.
   c. **For health care/office operations:** we may use and disclose your PHI to operate our practice, clinics and other health care facilities. For example, we may use your PHI to review the care provided to you or to evaluate the performance of the health care professionals and processes involved in your care. We may also provide your PHI to our business associates that are involved in our business operations such as attorneys and consultants and other companies.

B. Certain other uses and disclosures that do not require your consent to use your PHI.
   a. **When disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement.** For example we make disclosures when a law requires that we report information to government agencies about victims of abuse, neglect or domestic violence, when dealing with gunshot or other wounds or when ordered in a judicial or administrative proceeding.
   b. For public health activities. For example, we must report to government officials in charge of collecting specific information related to births, deaths, and certain disease and infections. Also we provide coroners, medical examiners and funeral directors necessary information related to individuals deaths.

i. By law we are required to report certain disease conditions to Central disease control.
ii. PHI may also be disclosed to certain people exposed to communicable diseases and to employers in connection with occupational health and safety or worker's compensation matters.
iii. We may also disclose PHI to manufacturers of drugs, biologics, devices and other products regulated by the federal food and drug administration (FDA) when information is related to quality, safety or effectiveness.

c. For health care oversight activities to government agencies or other officials.
d. For organ donation if applicable.
e. For Research purposes: In event that one of your physicians or health care providers is involved in research projects. This research is generally subject to oversight by an institutional review board. Usually the PHI is used to prepare a research project or to contact you and ask you weather you would be interested in participating in a study, thus it will not be disclosed further for research without your authorization. PHI maybe used or disclosed for research in a "limited or de-identified data set" which does not include your name, address or other direct identifier that are unique to you.
f. To avoid harm and keep people safe of certain individuals or the general public. We will provide PHI to law enforcement personnel in an event that would lesson a specific harm.
g. For specific government function such as protecting the national security of our country or elected officials.
h. For worker's compensation purposes. We may provide PHI to comply with worker's compensation laws.
i. To provide appointment reminders and health-related benefits or services. Such as treatment alternatives or other health care services or benefit that we offer.

C. Uses and disclosures in which you may have an opportunity to object:

a. Disclosure to family, friends and others. This will be to individuals that are involved in your care or responsible for the payment for your healthcare unless you object in whole or in part.
b. Health information exchange: we may make your PHI available electronically throught health information exchanges (HIEs) to other health care providers, health plans, and health care clearninghouses. Participation in HIE also lets us see their information about you which helps us provide care to you. You may have the right to opt out of participating in such efforts by noting this request.
c. Applicable to Michigan law. Our use and disclosure of PHI must comply not only with federal privacy regulations but also with Michigan regulations. There are additional restrictions placed on PHI disclosure of individuals with mental health, substance abuse, HIV/AIDS conditions, and certain genetic information. In some situations, your specific authorization maybe required.
d. In other instances, not mentioned here, we will ask for your written authorization before using or disclosing your PHI. Your authorization can be revoked in writing at any time to stop any future uses and disclosures this will not apply to prior authorization made.

D. Your rights regarding your PHI

a. The right to request restriction on uses and disclosures of PHI. You have the right to limit how we use and disclose your PHI for treatment, payment or care operations. This request must be made to our practice in writing. We are NOT required to always agree to your restriction requests. If we are to agree, we will honor our agreement except in cases of an emergency or in cases where you are legally required or allowed to make a use or disclosure.
    i. You may also request us to limit PHI disclosure to family members, other relatives or close friends involved your care or payment.
b. Right to confidential communication involving your PHI. In writing, you can ask to send information to you via certain way or location. For example, you can request we mail PHI to a post office box rather than your home. We must agree to your request so long as we can easily provide it in the format you requested.
c. Right to receive copies of your PHI. In most cases you have the right to receive copies of your PHI, such as health or billing records, used by us to make decisions about you. This request must be made in writing.

We will respond within 30 days after receiving the written request, and we may charge a reasonable fee for this service. In certain situations, we may deny your request, but will do so in writing, and we will provide our reasons for the denial and explain your right to have the denial reviewed.

d. The right to list of the disclosures we have made of your PHI. You have the right to get list of instances in which we have disclosed your PHI. This is called accounting of disclosures.
    i. This does not apply to certain disclosures such as those made for purposes of treatment, payment or health care operations, disclosures made to you or to others involved in your care, disclosures made with your authorization, or disclosures made for national security or intelligence purposes or to correctional institutions or law enforcement purposes.
    ii. Your request for accounting of disclosure must be made in writing. We will respond within 60 days of receiving your request by providing a list of disclosures made within the past three years from the receipt date your request, unless a shorter time period is requested. If more than one request is made within one calendar year than we may charge a fee for this service.

e. Right to amend or update your PHI. If you believe your PHI is incorrect or incomplete, you have the right to request us to amend the existing information or add information. Your request must be done in writing and must include reasons for your request. We will respond within 60 days of recieivng your request.
    i. We may deny this request in writing if the PHI is correct, was not created by us, not allowed to be disclosed or is not part of our records. This denial will include reasons and explain your right to file a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your amendment request and our denial be attached to your PHI.
    ii. If your amendment request is approved, we will make the change to your PHI and let you know that it has been completed. An amendment may take several forms, such as an explanatory statement added to your recored.

f. The right to a copy of this notice. You have the right to request a paper copy of this notice be mailed to you or given to you in person.

E. Contact information for our Notice of Privacy practices

a. If you have questions about this notice of privacy or have complaints about our privacy practices. You can contact our manager at 734-357-0505.
b. You will not be penalized for filing your complaint.
c. Written complaints must be submitted to:

Premier Neurology & Pain specialists

15750 Northline Rd.

Southgate, Michigan 48195

F. We may amend our Notice of Privacy Practices from time to time. All amendments apply retroactively. The amendments will be available in your office and at our website.

Premier Neurology & Pain Specialists

15750 Northline Rd
Southgate, MI 48195

WWW.PNPSPECIALISTS.COM
T: 734-357-0505 F: 734-357-0506

ACKNOWLDEGMENT of RECIEPT of NOTICE of PRIVACY PRACTICES

Notice to patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice of Privacy Practice. You can also refuse to sign this acknowledgment if you wish.

Print name_____

Signature_____Date_____

Office use only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it was not obtained because:

[ ] Patient refused to sign

[ ] Due to an emergency situation and acknowledgement was not obtained

[ ] Unable o communicate with patient or care giver (please provide specific details)

[ ] Other reason not to sign (give details)

Employee Signature:_____Date_____

This form does not constitute legal advice