PATIENT FOCUSED
NEUROLOGY

"Patient Care is our FOCUS."

PATIENT PHARMACY INFORMATION

Pharmacy Name _____ Phone _____

Pharmacy Address _____

Pharmacy two major cross streets (if applies) _____

Mail Order Pharmacy _____ Phone _____

Pharmacy Address _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HIPAA PRIVACY POLICIES

I certify that I have received a copy of Notice of HIPAA Privacy Policies and I have been provided an opportunity to review it. The Notice of HIPAA Privacy Policies describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of **Patient Focused Neurology's** health care operations. The Notice of HIPAA Privacy Policies also describes my rights and **Patient Focused Neurology's** duties with respect to my protected health information. The Notice of HIPAA Privacy Policies is available in the reception area. **Patient Focused Neurology** reserves the right to change the privacy policies that are described in the Notice of HIPAA Privacy Policies. I may obtain a revised Notice of HIPAA Privacy Policies by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment, or through e-mail.

Name _____ Signature X_____ Date _____

In the event this request is made by the individual's personal representative:

Representative Name _____ Representative Signature _____ Date _____

PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

Statement to Permit Payment of Health Insurances Benefit to supplier, physician, or patient

Beneficiary Signature Regulations in effect April 1, 1982, allow physicians to obtain from the patient a signature authorization for the physician to submit assigned or unassigned claims to the insurance company on the patient's behalf. The signature will be retained in our file for any future claims for the patient.

The patient must sign a brief statement substantially as follows:

"I, _____ *(patient name)* request that payment of authorized medical insurance benefits be made on my behalf to **Patient Focused Neurology** for any services by the physician(s). I authorize my medical information to be released to my insurance company and its agents needed to determine these benefits or the benefits payable for related services"

Patient Name _____ Signature X_____ Date _____