



5860 N La Cholla Blvd, Suite 100
Tucson, AZ 85741
(520) 742-7890 fax (520) 742-7894

Neurological Surgery

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Neurology

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Please complete the enclosed paperwork for your scheduled appointment. It is important to bring with you these forms as well as your insurance card(s) and a valid photo ID.

If applicable, please bring the following items listed below.

- Written order and/or Referral from your referring physician
- Radiology images and reports
- Medical records including office notes and tests performed
- Medication list

When you arrive, please note our entrance is on the south side of the building.

If you are unable to keep your appointment, kindly give a 24 hour notice. If you have any questions or concerns, please feel free to contact our office at (520) 742-7890 or (800) 637-4576

Thank you.

Northwest NeuroSpecialists
MEDICAL HISTORY FORM

PATIENT'S NAME: _____ DATE: _____

Medical Reason for visit today: _____ Height: _____ Weight: _____

1. Do you have any one of the following? Please check (✓) if the answer is yes.
- | | | | |
|-------------------------|-------|---|-------|
| a. Heart disease | _____ | g. Thyroid disease | _____ |
| b. High blood pressure | _____ | h. Reflux | _____ |
| c. Elevated cholesterol | _____ | i. Other medical problems (Please list) | _____ |
| d. Cancer | _____ | | _____ |
| e. Depression | _____ | | _____ |
| f. Diabetes | _____ | | _____ |

Other Medical Information: _____

2. Do you have a living will? Yes _____ No _____ Do you have Advanced Directives? Yes _____ No _____

3. Please list all your medications. Please include vitamins and any herbal substances.

	<u>Name</u>	<u>Dose</u>	<u>Frequency</u>
a.	_____		
b.	_____		
c.	_____		
d.	_____		
e.	_____		
f.	_____		

4. Are you allergic to any medications? Please list below with the reaction that happened.

5. What surgeries have you had?

6. Do you smoke? No _____ Yes _____ Amount _____ Did you ever smoke? _____

7. Do you drink alcohol? No _____ Yes _____ Amount _____

8. What is your occupation? _____

9. How many children do you have? _____ Do they have any medical problems? _____

10. Are your parents alive? _____ What medical problem do (did) they have? _____

Northwest NeuroSpecialists PLLC

5860 N La Cholla Blvd

Tucson, AZ 85741-3537

(520) 742-7890

PATIENT INFORMATION

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE		EMAIL ADDRESS			CITY, STATE ZIP
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)		
ADDRESS				ADDRESS		
CITY, STATE ZIP				CITY, STATE ZIP		
WORK PHONE				WORK PHONE		

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE		EMAIL ADDRESS			CITY, STATE ZIP
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#			
NAME OF INSURED			GROUP#			
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$			
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$			
RELATIONSHIP TO PATIENT			EFFECTIVE DATE		EXPIRATION DATE	

AUTHORIZATION OF INSURANCE BENEFITS: I authorize payment of benefits to be paid to NORTHWEST NEUROSPECIALISTS, PLLC. I understand that I am financially responsible for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits when coverage is subject to coordination of benefits. In the event I am delinquent in payment, I understand that there will be a \$15.00 charge posted to my account for each month I am past due. Should it be necessary to place the account with a collection agency, I understand that I will be responsible for eighteen percent (18%) simple interest on the unpaid balance. Should legal action become necessary to collect the balance due, I understand I am responsible for attorney's fees, interest and court costs.

SIGNATURE OF PATIENT/GUARDIAN

DATE

**NORTHWEST NEUROSPECIALISTS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Please Print

Patient's Full Name: _____

Date of Birth: _____ Social Security Number: _____

Patient's Address: _____
Street City State Zip Code

THIS AUTHORIZES: _____
Physician Name

Address City State Zip Code

TO RELEASE INFORMATION SPECIFIED TO: _____
(Name of receiving party)

Address City State Zip Code

PHOTOCOPIES OF INFORMATION TO BE RELEASED:

Initials Medical Records of the past two (2) years of treatment

Initials Other Medical Information (please specify) _____

I also authorize release of records pertaining to:

Initials All HIV-Related information and Communicable Disease-Related Information

Initials Conditions related to psychiatric/psychological treatment

In accordance with Federal Regulations 42 CFR Part 2, I hereby consent to the release of records pertaining to the treatment/diagnosis of the following:

Initials Conditions relating to substance and/or alcohol/drug abuse

I consent to the release of the specified information or medical records about my condition and the treatment and services I received to those persons or agencies listed. I further release Northwest NeuroSpecialists and any of its staff, employees and agents from any liability arising from the release of this information or records to such designated persons or agencies. I understand that I may revoke this consent at any time and upon fulfillment of the above stated purpose(s), this consent will automatically expire one (1) year following date of signature.

Signature of patient/parent/guardian*/authorized representative* Date

*Copies of legal documents supporting legal representation of the patient MUST accompany this release form.
01/03



**NORTHWEST NEURO SPECIALISTS, PLLC
NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

This practice is required by a federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This practice will not use or disclose your health information except as described in this Notice.

This practice is **permitted** by federal privacy law to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information (PHI) is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record maintained on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

Examples of Uses of your Health Information for Treatment Purposes:

1. A staff member obtains treatment information about you and records it in the health record.
2. During the course of your treatment, the physician or physician assistant determines he/she will need to consult with another physician(s). He/she will share the information with such physician(s) and obtain his/her input.

Examples of Use of your Health Information for Payment Purposes:

1. We submit requests for payment to your health insurance company. The health insurance company (or other business associate helping us to obtain payment) requests health information from us regarding medical care given. We will provide information to them about you and the care given, which may include copies or excerpts of your medical record which are necessary for payment of your account. For example, bills sent to your health insurance company may include information that identifies your diagnosis, and the procedures and supplies used.

Examples of Use of your Health Information for Health Care Operations:

1. We obtain services from our insurers and other business associates (an individual or entity under contract with us to perform or assist us in a function or activity that necessitates the use or disclosure of health information) such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical transcription, medical review, legal services and insurance. We will share health information about you with our insurers or other business associates as necessary to obtain these services. We require our insurers and other business associates to protect the confidentiality of your health information.

Your Health Information Rights:

The health and billing records we maintain are the physical property of this practice. The information in it, however, belongs to you. You have the right to:

1. Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request that is granted.
2. Request not to disclose certain PHI to health plan if the information solely concerns a health care item or service that the patient has paid for in full out-of-pocket (i.e. patient pays in full for a service upon delivery of that service and requests that his/her physician not submit the bill to his/her commercial health plan).
3. Obtain a paper copy of the Notice of Privacy Practice for Protected Health Information ("Notice") by making a request at our office.
4. Request that you be allowed to inspect and review your medical records and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
5. Appeal a denial of access to your protected health information except in certain circumstances.
6. Request that your medical record be amended to correct incomplete or incorrect information by delivering a written request, including a reason to support the change, to our office using the form we provide to you upon request. (We are not required to make such amendments).
7. File a statement of disagreement if your amendment request is denied and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
8. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. An accounting will include uses and disclosures of information as of January 1, 2011 for treatment, payment and health care operations made to you or made at your request; it may or may not include uses and disclosures made pursuant to an authorization signed by you; or to family members or friends or uses relevant to that person's involvement in your care or in payment for such care; or uses or disclosures to notify family or others responsible for your care or your location, condition or your death. We may charge a cost-based fee for more than one accounting in a 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 cost.

Effective Date of this Notice: March 1, 2011

9. Request that confidential communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request.
10. Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact in writing or in person:

Privacy Officer
Northwest NeuroSpecialists PLLC
5860 N. La Cholla Blvd, Suite 100
Tucson AZ 85741

Telephone 520-742-7890 or 800-637-4576
Fax: 520-742-7894

Our office will provide assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the acknowledgement authorizing use and disclosure of your protected health information for treatment, payment and health care operations purposes.

Our Responsibilities:

The practice is required to:

1. Maintain the privacy of your health information as required by law.
2. Provide you with a Notice as to our duties and privacy practices as to the information we collect and maintain about you.
3. Abide by the terms of this Notice.
4. Notify you if we can not accommodate a requested restriction or request.
5. Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change or eliminate provisions in our privacy practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our Notice or by visiting the office and picking up a copy. Our current Notice will also be posted on our website www.nwneuro.com.

To Request Information or File a Complaint

If you have questions, would like additional information, want to report a problem regarding the handling of your information, or if you believe your privacy rights have been violated and wish to file a written complaint with our office, please contact:

Privacy Officer
Northwest NeuroSpecialists PLLC
5860 N. La Cholla Blvd, Suite 100
Tucson AZ 85741

You may also file a complaint by mailing it or emailing it to the Secretary of Health & Human Services.

1. We cannot, and will not, require you to waive your rights under the Privacy Rule including the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
2. We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses We Can Make Without Your Written Authorization

Notification of Family/Friends

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition or your death.

Communication with Family/Friends

Using our best judgment, we may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your health information to assist in disaster relief efforts.

Employers

We may release health information about you to your employer as we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work related illness or injury. Our practice may release your health information for workers' compensation and similar programs. Any other disclosures to your employer will be made only if you execute an authorization for the release of that information to your employer.

Deceased Persons

We may disclose your health information to funeral directors, medical examiners or coroners consistent with applicable law to allow them to carry out their duties. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Organ Procurement Organizations

Consistent with applicable law, we may disclose your health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

Appointment Reminders, Treatment Alternatives and Sign In Sheets

We may contact you and remind you of an appointment, test or treatment. We may also contact you to provide information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you. We will not disclose your health

Effective Date of this Notice: March 1, 2011

information without your written authorization for any outside marketing. We may use and disclose your health information by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Any limitation that you might request for the use of protected health information is to be provided in writing to NNS.

Food and Drug Administration (FDA)

We may disclose to the FDA your health information relating to adverse events with respect to food supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacements.

Workers' Compensation

If you are seeking compensation through Workers' Compensation, we may disclose your health information to the extent necessary to comply with laws relating to Workers' Compensation.

Public Health

As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is a risk for contracting or spreading a disease or condition.

Abuse, Neglect & Domestic Violence

We may disclose your health information to public authorities as allowed by law to report abuse, neglect or domestic violence.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement officer, we may disclose to the institution or law enforcement official health information necessary for your health and safety of other individuals.

Law Enforcement

We may disclose your health information for law enforcement purposes as required by law, such as when required by a court order; for identification of a victim of a crime if certain protective requirements are met; to report a crime on our premises; to report crime in emergencies; and other appropriate situations permitted by law.

Health Oversight

We may disclose your health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

We may disclose your health information in the course of any judicial or administrative proceedings as allowed or required by law or as directed by a proper court order or in response to a subpoena, with your authorization, discovery request or other lawful process if certain specific requirements are met.

Serious Threat

To avert a serious threat to health or safety, we may disclose your health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

We may disclose your health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other Uses

Other uses and disclosures of your health information besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization. You may revoke the written authorization as previously provided in this Notice. We will not sell your health information without specific written authorization from the patient and no disclosure can occur until written authorization is received.

Website

We will post the most recent Notice on the website; www.nwneuro.com

Research

We may use and disclose your health information for research purposes in certain limited circumstances, to include contacting you regarding clinical research trials being conducted at our practice. We will obtain your written authorization to use and disclose your health information for outside research purposes except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the health information will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the health information.

Original Effective Date: April 14, 2003
Revised Effective Date: January 1, 2010
Effective Date of Last Revision: March 1, 2011



NORTHWEST NEUROSPECIALISTS PLLC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a
Patient's Name – please print

copy of Northwest NeuroSpecialists' Notice of Privacy Practices.

Please Note:

As required by current law, you may select one or both of the following options. Currently NNS does not conduct any fundraising activities and does not offer secure email communications.

- I would like to receive fundraising solicitations.
- I would like to receive communications via secure email to the address of:

Signature of Patient

Date

Printed name if signed on behalf of the patient

Date