ROSENFELD
NEUROLOGY and SLEEP

Patient Registration

Name: _____ Date of Birth: _____ SSN: _____

Please circle all that apply:

Marital Status:	**Race:**	**Ethnicity:**	**Sex:**	**Sexual Orientation**
Married	American Indian/Alaska Native	Hispanic/Latino	Male	Straight/Heterosexual
Single	Asian	Not Hispanic/Latino	Female	Lesbian/Gay/Homosexual
Divorced	Black/African American	Declined		Bisexual
Separated	Native Hawaiian/Pacific Islander			Don't Know
Widowed	White			Choose Not To Disclose
Declined	Other: _____			
	Declined			

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Please circle: Home Cell

Alternate Phone: _____ Please circle: Home Cell Work

Email: _____

Referring MD (if applicable): _____ Primary Care MD: _____

Preferred Pharmacy: _____ Preferred Lab: _____

If patient is a minor or dependent, please complete the following:

Responsible Party/Legal Guardian: _____ Relationship to Patient: _____

Primary Phone: _____ Alternate Phone: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Primary Phone: _____ Alternate Phone: _____

Patient Acknowledgement

I consent to treatment necessary for the care of the named patient.

I authorize the release of all medical records to the referring and primary physicians and to my insurance company, if applicable.

I allow fax and/or electronic transmission of my medical records, if necessary.

I acknowledge the receipt of the Notice of Privacy Policy.

I acknowledge full financial responsibility for services rendered by Rosenfeld Neurology & Sleep, LLC.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I agree to pay all attorney fees and collection costs in the event of default of payment to Rosenfeld Neurology & Sleep should they elect to receive such payment.

I understand that I may withdraw this authorization to release medical information at any time, communicated to the practice either in writing or verbally, followed by written withdrawal.

Patient or Responsible Party Signature: _____ Date: _____

Insurance and Injury Questionnaire | Rosenfeld Neurology & Sleep

Please note, all patients are required to answer the following questions. We file insurance as a courtesy to our patients, however, the following information must be completed in order to process your claim.

Patient Name: _____ Date of Birth: _____

- Are you receiving Black Lung Benefits? YES NO
- Are you receiving Workers Compensation Benefits? YES NO
- Are you receiving treatment for an injury or illness which another party could be held liable, or could be covered under no-fault or auto insurance? YES NO
- Will this claim be filed with any other insurance such as homeowners or business liability, etc.…? YES NO

Signature of Patient or Responsible Party: _____ Date: _____

If you answered YES to any of the above questions, please complete the following section.

Name of Insurance Company where benefits are held: _____

Claim/Policy Number: _____ Date of Injury: _____

Adjustor Name: _____ Adjustor Phone & Ext: _____

Adjustor Fax: _____ Adjustor Email: _____

Financial and Treatment Policy | Rosenfeld Neurology & Sleep

Thank you for choosing Rosenfeld Neurology and Sleep, LLC to care for your medical needs. In order to keep your cost as low as possible, we have the following financial policy in place. All patients are required to read and sign this document prior to their first visit.

- Before your appointment, please verify that we are a participating provider with your insurance plan and obtain any necessary authorizations. You are responsible to maintain any required authorizations for your continued care.
- Our contracts with insurance plans require that we collect any co-payment, co-insurance, or deductible due before you are seen for your appointment, unless other arrangements have been made prior to your visit. *Failure to pay a fee due prior to your appointment may result in the rescheduling of your appointment.*
- You will be financially responsible for any services provided that are not covered by your insurance.
- Patients without insurance coverage will be charged for all professional services rendered and are due at the time of service unless prior financial arrangements are made.

Insurance Carriers typically do not cover all medical costs. Some pay fixed allowances for each office visit and procedure, while others pay only a percentage of the costs. Some outpatient procedures may have a higher co-payment or apply to the annual deductible. *It is the patient's responsibility to understand their insurance coverage and to notify us of any changes in insurance coverage.*

When you receive a statement from Rosenfeld Neurology and Sleep, you are required to pay the balance due upon receipt of the statement. Accounts not paid in full within 90 days with no acceptable payment arrangement will be referred to an outside collection agency. Accounts turned over to an outside collection agency are subject to an administrative fee of 25% of the account balance.

Acceptable forms of payment are cash, check, and all major credit cards. Please note: if you pay with a check and it is returned unpaid from your bank, your account will be charged a service fee of $50. We will bill you for the returned check plus the service fee according to the policy stated above.

At the discretion of Rosenfeld Neurology & Sleep, If you do not show up or if you do not cancel your appointment more than 24 hours prior to your scheduled appointment, you will be charged a $50 fee in order to reschedule an appointment.

If the patient is a minor or legal dependent, the accompanying parent or legal guardian of the patient is responsible for full payment.

I have read and understand the financial policy of the practice and agree to be bound by its terms and conditions. I also understand and agree that such terms may be amended occasionally by the practice. I authorize the release of any medical information necessary to process any insurance claim.

_____

Patient Name (PRINT)

_____ _____

Signature of Patient or Responsible Party Date

Notice of Privacy Policy | Rosenfeld Neurology & Sleep

This notice describes how information about you may be used and disclosed and how you can access this information. Please review it carefully.

Introduction
At Rosenfeld Neurology and Sleep, LLC, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective March 1, 2020 and applies to all protected health information as defined by the federal government.

Understanding Your Health Record
Each time you visit Rosenfeld Neurology and Sleep, LLC, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and outcomes we achieve

Understanding what is in your health record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Rosenfeld Neurology and Sleep, LLC, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record
- Request that your health record be amended
- Obtain an accounting of disclosures of your health information: To do this, please contact Rosenfeld Neurology and Sleep, LLC's Privacy Officer. This information will be provided to you within 30 days.
- Request a restriction on certain uses and disclosures of your information
- Revoke your authorization to use or disclose your health information
- You may request that we not submit your information to your health insurance carrier if you have paid for the service
- You may request an electronic copy of your health record

Our Responsibilities
Rosenfeld Neurology and Sleep, LLC is required to:

- Maintain the privacy of your health information.
- Provide you with this notice about our privacy practices
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.
- We must notify you of a breech of unsecured health information.

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please send your written request to Rosenfeld Neurology and Sleep, LLC.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer at 912.298.6646.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, US Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building
Washington, DC, 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For Example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your heath care team. Members of your heath care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physicians or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your heath information for payment.

For Example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.

For Example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in effort to continually improve the quality and effectiveness of the heath care and service we provide.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health Professionals, using their best judgement, 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 payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives of other health-related benefits and services that may interest you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing and controlling disease, injury or disability.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your heath information to be released to an appropriate heath oversight agency, public heath authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

HIPAA Disclosure and Authorization | Rosenfeld Neurology & Sleep

I hereby authorize Rosenfeld Neurology and Sleep to release the following information from the health record of:

Patient Name: _____ Date of Birth: _____

To be released to:

Name:	Relationship:	Date of Birth:	Phone:
Name:	Relationship:	Date of Birth:	Phone:
Name:	Relationship:	Date of Birth:	Phone:
Name:	Relationship:	Date of Birth:	Phone:

Information to be Released:

☐ Entire Record ☐ Patient Registration ☐ Lab/Testing Results ☐ Medication Records

☐ Office Notes ☐ Insurance/Billing Information

For the Purpose of:

☐ On behalf of the patient ☐ Scheduling Appointments ☐ Picking up Prescriptions/Forms/Medication

☐ Speaking to RNS staff regarding my PHI ☐ Billing Purposes ☐ Other: _____

I understand that Rosenfeld Neurology & Sleep will refuse to discuss my information with anyone not listed above, except in the event of an emergency. I understand I can revoke this authorization by providing written notice to Rosenfeld Neurology & Sleep at 7001 Hodgson Memorial Dr., Suite 1, Savannah, GA 31406. I understand that if information has been released by relying on this authorization, that revocation will not be valid. I place no limitations on history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse or dependency, psychiatric or psychological illness, mental illness or retardation and acquired immune deficiency (AIDS) syndrome. I understand that I am waiving my rights to privacy by releasing my medical information to the above listed parties and this information may be re-disclosed by the receiving party. I hereby authorize the entity listed above to release said information as described. I understand that this consent does not apply to medical providers participating in the treatment of my health care.
In addition to granting permission to the above named individuals, I have received a copy of Rosenfeld Neurology & Sleep "Notice of Privacy Practice" which details how my personal health information may be used and disclosed as permitted under Federal and State law. I have read and understood the contents of the notice. ***This form can be amended at any time if the patient/responsible party completes and signs a new form.***

☐ I do not wish to give anyone access to my health record, other than what is described above as "emergency" or my Healthcare Providers.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient or Legally Responsible Party Staff Witness