

**NEURODIAGNOSTIC CONSULTANTS, LLC.**  
1247 Milwaukee Avenue, Suite 100  
Glenview, IL 60025

**PATIENT REGISTRATION FORM**

**Section I. PATIENT INFORMATION**

Legal Name (First, Middle, Last):		
Social Security Number:	Date of Birth (month, day, year):	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:		
Home Phone Number:	Work Phone Number:	Cell Phone Number:
Occupation:	Allergies or Medical Alerts:	Pharmacy Phone Number:
Preferred Phone for Contact: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Messages may be left at: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Messages <b>MAY NOT</b> be left at ANY phone if initialed here _____

**Section II. REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION**

Referring Physician Name:	Referring Physician Phone:
Referring Physician Address:	
Primary Care Physician Name:	Primary Care Physician Phone:
Primary Care Physician Address:	

**Section III. PATIENT MEDICAL INSURANCE INFORMATION**

PRIMARY Medical Insurance Carrier:	Plan No.
	Group No.
Primary Medical Insurance Subscriber Name: <input type="checkbox"/> Same as Patient <input type="checkbox"/> Patient is a Dependent of _____	
Primary Medical Insurance Carrier Address and Telephone Number:	
SECONDARY Medical Insurance Carrier:	Plan No.
	Group No.
Secondary Medical Insurance Subscriber Name: <input type="checkbox"/> Same as Patient <input type="checkbox"/> Patient is a Dependent of _____	
Secondary Medical Insurance Carrier Address and Telephone Number:	

**Section IV. EMERGENCY CONTACT**

Legal Name (First, Middle, Last):
Home Address and Phone Number:
Relation To Patient:

\_\_\_\_\_  
Patient's (or Patient Guardian's) Signature

\_\_\_\_\_  
Date signed

**NEURODIAGNOSTIC CONSULTANTS, LLC.**  
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**CONSENT TO MEDICAL CARE**

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

I hereby voluntarily request, consent to and authorize all medical care, including, but not limited to, collecting my medical, social and family history, conducting physical examination(s), prescribing laboratory tests and medication(s), reviewing my medical records produced by other health care providers.

Neurodiagnostic Consultants, LLC. and its physicians may release my medical information (including information pertaining to psychological, psychiatric, drug abuse, alcoholism or HIV/AIDS) pursuant to conditions stipulated in the Notice of Privacy of Health Information, which I have read and signed. Should I wish to request that my health information be released from Neurodiagnostic Consultants, LLC. in other circumstances, I shall request and authorize such release in writing by completing and signing an Authorization For Release Of Health Information form.

I acknowledge that I am fully responsible for reimbursement for medical care services provided by Neurodiagnostic Consultants, LLC. and its physicians, whether or not I am a covered member of a health insurance plan. If I am entitled to Medicare Benefits, I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct.

I hereby assign, transfer, set over to Neurodiagnostic Consultants, LLC. and its Physicians sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care and authorize the submission of claims for reimbursement for services, tests and/or treatments rendered to myself or my dependent by Neurodiagnostic Consultants, LLC and its physicians.

I shall be responsible for verification of benefits under the provisions of my medical insurance plans, including, but not limited to verification of in-network or out-of-network status of my physician; the extent of coverage (or lack thereof) for the services rendered to me by my physicians; the amount of co-insurance and/or deductible I shall be responsible for; the need for pre-approved referrals, and/or pre-certifications and/or authorizations that may be required by my insurance company. I understand that if I fail to obtain any such pre-approved referrals, and/or pre-certifications and/or authorizations, my medical insurance company may decline coverage for services provided to me and that I may be fully responsible for reimbursing Neurodiagnostic Consultants, LLC. and its physicians for the services rendered to me.

I will be charged \$50 (fifty dollars) for missed appointments, unless I cancel or re-schedule with at least 24-hour notice prior to the appointment time. It is my responsibility to be aware of my appointment dates and times.

I shall be responsible for any and all additional fees incurred in attempts to collect reimbursement for medical care services provided by Neurodiagnostic Consultants, LLC. and its physicians.

\_\_\_\_\_  
Patient's (or Patient Guardian's) Signature

\_\_\_\_\_  
Date signed

**NEURODIAGNOSTIC CONSULTANTS, LLC.**  
**1247 Milwaukee Avenue, Suite 100**  
**Glenview, IL 60025**

## **NOTICE OF PRIVACY OF HEALTH INFORMATION**

Effective Date: November 1, 2006

**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.**

**WHO MUST FOLLOW THIS NOTICE:** This notice describes the privacy practices of Neurodiagnostic Consultants, LLC.

**OUR OBLIGATIONS.** We are required by law to:

- Maintain the privacy of protected health information;
- Give you this notice of our legal duties and privacy practices regarding health information about you; and
- Follow the terms of our notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION.**

The following categories describe ways that we may use and disclose health information that identifies you ("Health Information"). Some of the categories include examples, but every type of use or disclosure of Health Information in a category is not listed. Except for the purposes described below, we will use and disclose Health Information only with your written permission. If you give us permission to use or disclose Health Information for a purpose not discussed in this notice, you may revoke that permission, in writing, at any time by contacting Neurodiagnostic Consultants, LLC.

▶ **For Treatment.** We may use Health Information to treat you or provide you with health care services. We may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our facility who may be involved in your medical care. For example, we may tell your primary physician about the care we provided you or give Health Information to a specialist to provide you with additional services.

▶ **For Payment.** We may use and disclose Health Information so that we or others may bill or receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about your treatment so that they will pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

▶ **For Health Care Operations.** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use Health Information to review the treatment and services we provide to ensure that the care you receive is of the highest quality.

▶ **Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services.** We may use and disclose Health Information to contact you as a reminder that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment options or alternatives or health-related benefits and services that may be of interest to you.

▶ **Individuals Involved in Your Care or Payment for Your Care.** We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as your legal guardian, a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

▶ **Research.** Under certain circumstances, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication or treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, though, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, so long as they do not remove or take a copy of any Health Information.

## **SPECIAL CIRCUMSTANCES**

- ▶ **As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.
- ▶ **To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.
- ▶ **Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- ▶ **Organ and Tissue Donation.** If you are an organ donor, we may release Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.
- ▶ **Military and Veterans.** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- ▶ **Workers' Compensation.** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- ▶ **Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of the hospital in certain limited circumstances concerning workplace illness or injury. We also may release Health Information to an appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence; however, we will only release this information if you agree or when we are required or authorized by law.
- ▶ **Health Oversight Activities.** We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- ▶ **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- ▶ **Law Enforcement.** We may release Health Information if asked by a law enforcement official for the following reasons: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- ▶ **Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.
- ▶ **National Security and Intelligence Activities.** We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

▶ **Protective Services for the President and Others.** We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

▶ **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**YOUR RIGHTS. YOU HAVE THE FOLLOWING RIGHTS REGARDING HEALTH INFORMATION WE MAINTAIN ABOUT YOU.**

▶ **Right to Inspect and Copy.** You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. To inspect and copy this Health Information, you must make your request, in writing, to Neurodiagnostic Consultants, LLC.

▶ **Right to Amend.** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. To request an amendment, you must make your request, in writing, to the University Privacy Official.

▶ **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures of Health Information we made. To request an accounting of disclosures, you must make your request, in writing, to Neurodiagnostic Consultants, LLC.

▶ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. In addition, you have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about your surgery with your spouse. To request a restriction, you must make your request, in writing, to Neurodiagnostic Consultants, LLC. We are not required to agree to your request. If we agree, we will comply with your request unless we need to use the information in certain emergency treatment situations.

▶ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communications, you must make your request, in writing, to Neurodiagnostic Consultants, LLC. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

▶ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for Health Information we already have as well as any information we receive in the future. We will make available a copy of the current notice at all Neurodiagnostic Consultants, LLC offices. The notice will contain the effective date on the first page, in the top left-hand corner.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or the Office for Civil Rights (OCR) of the Department of Health and Human Services. To file a complaint with us, contact a Neurodiagnostic Consultants, LLC official. All complaints must be made in writing. You will not be penalized for filing a complaint.

Patient Signature: \_\_\_\_\_ Patient SSN: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Legal Guardian Name: \_\_\_\_\_

Relation to Patient: \_\_\_\_\_