Foothills Neurology New Patient Registration

4530 E. Muirwood Drive Suite 111, Phoenix, AZ 85048 (480) 961-2365 Fax (480) 961-2382

Name: _____ Date of Birth: _____

Address: _____

Gender: M F

Home phone: (_____)_____

❑ Home phone is same as cell phone number

Mobile phone: (_____)_____ ❑ None

Can we send you text reminders? Y N

Work phone: (_____)_____

Email: _____ ❑ No e-mail

What is your preferred way for us to contact you?

- ❑ Home phone ____ok to leave a message
- ❑ Work phone ____ok to leave a message
- ❑ Cell phone ____ok to leave a message
- ❑ Mail
- ❑ Patient Portal On-line

The U. S Government would like the following information:

Marital Status: ____**Single** ____**Married** ____**Divorced** ____**Widowed** ____**Other**

Primary Language: _____ ❑ **Decline**

Race: _____ ❑ **Decline**

Ethnicity: _____ ❑ **Decline**

Which Pharmacy would you like us to send your prescriptions to?

_____ _____

Pharmacy Number — Cross Streets or Address or Phone

Which laboratory would you like to go to if we send you for blood work?

_____ _____

Lab — Cross Streets or Address or Phone Number

Family Doctor: _____ Which Office?_____

Referring Doctor: _____ Which Office?_____

Emergency Contact: _____ Relation: _____

Emergency Contact Phone: (_____)_____

Primary Insurance: _____

Secondary Insurance: _____

Please bring your insurance card for us to copy

If the patient is not the primary policy holder...

Name of primary_____ DOB_____ Gender: M F

The patient is the primary policy holder's ____spouse ____child ____other

Patient Signature_____Date_____

Financial Responsibility

4530 E. Muirwood, Suite 111, Phoenix, AZ 85048 (480) 961-2365 Fax (480) 961-2382

I understand I am financially responsible for any copayments, deductibles, coinsurance and all charges, which are not covered by my insurance. I understand that verification of coverage is not a guarantee of payment of benefits. Your insurance company determines insurance benefit payments. I understand I will be responsible for the portion not covered by my insurance.

I understand that Foothills Neurology *does not* accept liens, worker's compensation or MVA/auto claims and I am responsible for any insurance claims denied for such. If my medical insurance denies or takes back any monies provided, I understand I am responsible to pay all claims in full in a timely manner.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid after 60 days of the billing date. In the event my account is turned over for collection, I will pay all reasonable collection, court and attorney costs at the time the account is considered delinquent.

Patients are responsible for making sure that Dr. Stuart Hetrick is *in network* with your insurance provider. We verify insurance eligibility, *but we do not verify* that we are in each individual network.

Due to the large amount of insurance plans and policies, it is the patient's responsibility to be aware of the services that are covered by your plan. Please call your insurance company for an explanation of your benefits.

This is what you need to know:

- **You have to pay for services that your insurance company says are your responsibility.**
- **If your insurance is not active on the day of your appointment, you will have to pay the whole bill.**
- **Your co-pay must be paid before each visit.**
- **We will charge you $50 if you miss your appointment unless 24-hour notice is given.**
- **There is a $25 charge for a Non-Sufficient Funds (NSF) check.**

I hereby authorize the release of information that may be necessary in the processing of any insurance claims.

I hereby authorize my insurance company to make payment directly to: Foothills Neurology, P.C.

Signature of patient (or parent / guardian)_____

Print Name _____

Date _____

Foothills Neurology, P.C.

Stuart Hetrick, DO 4530 E. Muirwood Drive, Suite 111, Phoenix, AZ 85048

Name: _____ **Date of appointment:** _____

What is the main problem you are having? _____

Is this due to an accident? ___Y ___N ___Don't know **Is a legal case pending?** ___Y ___N ___Maybe

Age _____ **DOB** _____

PLEASE LEAVE THIS BOX BLANK

Have you had any Tests done already? (e.g., MRI, Cat scan, EMG, X-rays, Ultrasound, etc...)

Test / X-Ray	Approximate Date Done	Result

***ALLERGIES*: Do you have any allergies to any medicine?** _____

What *MEDICINE* or *DRUG STORE PRODUCTS* are you taking?

Name of Medicine	Dosage	Times per Day	For What	Approx. Date Started
•				
•				
•				
•				
•				
•				

Have you stopped any medicine recently or used other medicine in the past for this problem?

Do you take birth control pills, patch or implant? Y N What?_____

Medication History

Name: _____ **DOB:** _____

Please check those medications that you have **tried in the past:**

ANTI-INFLAMMATORIES	Date	Effectiveness
__aspirin (Bayer, ecotrin)		
__ibuprofen (Motrin/Advil/Nuprin)		
__naproxyn (Naprosyn/Aleve/Anaprox)		
__celecoxib (Celebrex)		
__diclofenac (Voltaren, Cambia)		
__indomethacin (Indocin) pills or Suppos.		
__ketorolac (Toradol) pills or injection		
__steroids (prednisone)		
__Other:_____		

MIXED ANALGESICS (MILD PAIN)	Date	Effectiveness
__butalbital (Fioricet/Esgic Plus)		
__Excedrine (any form)		
__tramadol (Ultram/Ultracet)		
__Other:_____		

NARCOTIC PAIN MEDICINE	Date	Effectiveness
__codeine		
__hydrocodone (Vicodin/Lortab/Norco)		
__oxycodone (Percocet/Endocet/Roxicet)		
__meperidine (Demerol) pills or shots		
__Other:_____		

LONG ACTING NARCOTICS	Date	Effectiveness
__methadone (Dolphine, Methadose)		
__OxyContin		
__MS Contin (Avinza/Kadian/MSIR)		
__Fentanyl Patch (Duragesic Patch)		
__hydromorphone (Exalgo, Dilaudid)		
__Other:_____		

MUSCLE RELAXANTS	Date	Effectiveness
__baclofen (Lioresal)		
__cyclobenzaprine (Flexeril, Amrix)		
__tizanidine (Zanaflex)		
__Other:_____		

ALTERNATIVE TREATMENTS	Date	Effectiveness
__botulinum toxin (Botox)		
__lidocaine 5% (Lidoderm Patch)		
__IV therapy for migraine		
__acupuncture		
__trigger point injections		
__nerve blocks(occipital/neck/back)		
__physical therapy		
__massage		
__oxygen		
__vitamins/minerals (B, D, Magnesium)		
__biofeedback __meditation		
__Ice/Heat		
__Other: _____		
__Other: _____		
__Other: _____		

MIGRAINE MEDICINES	Date	Effectiveness
__sumatriptan (Imitrex/Treximet) (pills/shot/nasal spray)		
__rizatriptan (Maxalt)		
__eletriptan (Relpax)		
__frovatriptan (Frova)		
__zolmitriptan (Zomig)		
__naratriptan (Amerge)		
__almotriptan (Axert)		
__dihydroergotamine (DHE/Migranal)		

ANTICONVULSANTS	Date	Duration Tx	Effectiveness
__valproic acid (Depakote)			
__zonisamide (Zonagran)			
__gabapentin (Neurontin)			
__oxcarbazepine (Trileptal)			
__lamotrigene (Lamictal)			
__levetiracetam (Keppra)			
__topiramate (Topamax)			
__pregabalin (Lyrica)			
__tiagabine (Gabitril)			
__lacosamide (Vimpat)			
__Other:_____			

TRICYLIC ANTIDEPR	Date	Duration Tx	Effectiveness
__amitriptyline (Elavil)			
__nortriptyline (Pamelor)			
__doxepin (Sinequan)			
__trazodone (Desyrel)			
__Other:_____			

SRI/DOPA INHIBITORS	Date	Duration Tx	Effectiveness
__bupropion (Wellbutrin)			
__venlafaxine (Effexor)			
__milnacipran (Savella)			
__duloxetine (Cymbalta)			
__Other:_____			

BETA BLOCKERS	Date	Duration Tx	Effectiveness
__propranolol (Inderal)			
__atenolol (Tenormin)			
__nadolol (Corgard)			
__metoprolol (Lopressor)			
__Other:_____			

CALCIUM BLOCKERS	Date	Duration Tx	Effectiveness
__verapamil (Calan,Veralan)			
__nicardipine(Cardene)			
__Other:_____			

ALLERGIES: Medication & Reaction

_____

_____

_____

_____

PAST MEDICAL HISTORY **Do you have any other medical problems such as:**

Yes	No		Yes	No		Yes	No	
___	___	diabetes	___	___	ulcers	___	___	heart problem
___	___	kidney problem	___	___	hepatitis	___	___	stroke
___	___	thyroid problem	___	___	cancer	___	___	arthritis
___	___	fibromyalgia	___	___	seizures	___	___	asthma/emphysema
___	___	TMJ	___	___	depression	___	___	anxiety
___	___	lung disease	___	___	high cholesterol	___	___	headache
___	___	eye disease	___	___	osteoporosis	___	___	chronic pain in:
___	___	anemia	___	___	high blood pressure			___back ___neck ___other

Have you had any other surgeries, hospitalizations or other medical problems? If so list them:

Do you have any other problems for which you have been seeing a *doctor* or *chiropractor* on a regular basis?

FAMILY HISTORY

Do you have any family members with similar problems as you? Y N

Do you have any family members with?

brain tumor	**N**	**Y**	**who?**	stroke	**N**	**Y**	**who?**
seizures	**N**	**Y**	**who?**	heart attack	**N**	**Y**	**who?**
headaches	**N**	**Y**	**who?**	aneurysm	**N**	**Y**	**who?**

SOCIAL HISTORY:

Do you use tobacco? Y N How much? _____

Do you drink alcohol? Y N How much? _____

What is your occupation or major daytime activity? _____

Have you been unable to work or carry out your usual daytime activities due to this problem?

___able to work ___have trouble working ___have missed some work

___less productive ___can not work ___have not worked since_____

In the **past 3 months**:

how much work or school have you missed because of this problem?_____

how many visits to the ER, Urgent Care treatment?_____

How many cups/drinks per day of: coffee_____ colas_____ tea_____ alcohol_____

Do you drink diet drinks or use Nutrasweet/Equal (aspartame) or other artificial sweeteners? **Y N**

Have you ever abused drugs or alcohol? **Y N** if yes explain:

If you are pregnant or thinking of getting pregnant please check here: ☐

(ROS) Do you have any other symptoms that you feel are important but have not already mentioned?

___fever/chills	___blurred vision	___double vision	___jaw pain with chewing
___chest pain	___eye pain	___trouble urinating	___difficulty swallowing
___palpitations	___constipation	___diarrhea	___shortness of breath
___joint pain	___stomach pain	___trouble sleeping	___ excessive sweating
___numbness/tingling	___dizziness	___swollen glands	___**other (please explain)**

Headache

If headaches are one of your big problems, please answer the following questions:

When did the headaches first start? _____ Is the headache due to an injury? **Y** **N**

Are your headaches getting worse? **Y** **N**
When did this change occur? _____
Do you know why? _____

How often do your headaches come?	**mild to moderate**	**moderate to severe**
daily or almost daily	_____	_____
4-5 days per week	_____	_____
2-3 days per week	_____	_____
2-3 days per month	_____	_____
other:	_____	_____

How long do the headaches typically last?
mild to moderate headaches: ___hours ___all day ___several days ___weeks ___constant
mod. to severe headaches: ___hours ___all day ___several days ___weeks ___constant

Where in your head do these headaches occur?
mild to mod. ___one side ___both sides ___top ___back of head ___neck ___front ___eye
mod to severe ___one side ___both sides ___top ___back of head ___neck ___front ___eye

The pain is usually:
mild to mod. HA ___throbbing or pulsating ___constant pressing like a tight band ___other:
mod to severe HA ___throbbing or pulsating ___constant pressing like a tight band ___other:

Along with the bad headaches do you have:
___upset stomach ___sensitivity to light ___droopy eye lid ___eye tearing
___vomiting ___sensitivity to noise ___red eye ___stuffy nose

Does routine physical activity like walking make the headache worse? **Y** **N**

Do you experience any other symptoms **with the headache?**
___blind spots ___blurred vision ___numbness/tingling ___weakness
___flashing lights ___zigzag lines ___trouble talking ___**other:**

Are your headaches affected by your menstrual cycle? **Y** **N** How?_____

What other treatments have you received for your headaches?
___chiropractor ___herbal therapy ___biofeedback
___acupuncture ___trigger-point injections ___stress management
___physical therapy ___nerve blocks ___**other:**

Muscle/Joint Pain

If you have diffuse muscle or joint pain, please answer the following questions:

Where is your pain? ___left side of body ___right side of body
___above waist ___below waist
___neck, back or spine

Do you have tender points? Where? (11/18)

Fatigue

If you have chronic fatigue please answer the following questions:

Is the fatigue: ___persistent ___relapsing

When did it start?_____

Do you feel better if you get rest? Y N

Does the fatigue interfere with your desired daily activities? Y N

Have you had any of the following lasting off and on or constant for over 6 months? (4/8)

___memory loss or trouble concentrating, "brain fog"
___chronic sore throat
___tender lymph nodes in neck or armpits
___diffuse muscle achiness
___multiple joint pains
___new or worsened headache
___unrefreshing sleep
___post-exercise fatigue lasting more than 24hours if you try to exercise

Name_____ **Date of Birth** _____

Constitutional:

___vital signs – BP, pulse, weight, respirations
___well appearing, pleasant & cooperative

Cardiovascular:

___ extremities – norm pulses, no edema, good cap refill
___heart RRR
___ carotid arteries without bruits _____

MSE
___orientation normal
___recent & remote memory intact
___attention & concentration normal
___speech fluent without aphasia
___fund of knowledge appears normal

Cranial Nerves

___ **Eyes: ophthalmoscopic examination exam**: discs normal without papilledema or pallor
___ confrontations normal (CN II) ___visual acuity normal ___pupils equal & react normally
___eye movements full (CN III, IX, VI) ___saccades accurate
___face sensation symmetric (CN V) ___corneal reflexes normal
___face movement symmetric (CN VII)
___hearing appears normal (CN VIII) ___Weber midline ___René' normal
___palate raises symmetrically (CN IX, X)
___shoulder shrug symmetric (CN XI) ___SCM muscles symmetric
___tongue midline (CN XII)

Musculoskeletal

___strength in UE & LE normal ___pronator drift negative ___no fasciculations noted
___tone in UE & LE normal w/o rigidity or spasticity ___rapid fine movements norm ___no abnormal movements
___gait & station normal ___tremor absent ___C-spine full ROM

Sensory Exam

___sensation to LT norm ___vibratory norm ___pin prick norm ___position sense norm ___Rhomberg neg

Reflexes

___DTRs in UE & LE norm ___plantar reflexes flexor ___finger flexor reflexes norm ___Homan sign neg

Coordination

___FTN normal ___HTS normal ___RAM normal ___tandem gait normal

Impression: **prob. focused = 1+** **expanded = 6+** **detailed = 12+** **comprehensive = all**

Recommendations:

-
-
-
-

Follow-up: _____**wk / mon**
Consider at next visit: _____

Examiner's Signature ☐ **Dictated**

More than _____ **minutes was spent face to face with the patient, over half of which was spent discussing:**

FOOTHILLS NEUROLOGY, P.C.
HIPAA PRIVACY NOTICE

Purpose of this Notice
At Foothills Neurology, P.C. we are committed to treating and using protected health information about you responsibly. We are also required by federal law to take reasonable steps to ensure the privacy of your health information.

The use and disclosure of Protected Health Information (PHI) is regulated by the federal law, the Health Insurance Portability and Accountability Act (HIPAA). You may find these rules in 45 Code of *Federal Regulations* Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulation will supersede this Notice if there is any discrepancy between the information in this Notice and the regulation.

Effective Date
The effective date of this Notice is April 14, 2003.

Privacy Officer
Foothills Neurology, P.C. has designated a Privacy Officer to oversee the administration of privacy at this office and to receive complaints. The Privacy Officer may be contacted as follows:

Foothills Neurology, P.C.
Attn: HIPAA Privacy Officer
4530 E. Muirwood Drive, Suite 111
Phoenix, AZ 85048
(480) 961-2365

Your Protected Health Information
Each time you visit Foothills Neurology, P.C. 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 serves as the basis for planning your care and treatment. It is also a means for communicating among the many health professionals who contribute to your care, is a legal document describing the care you received, and is the means by which you or a third-party payer can verify that services billed were actually provided.

The term "Protected Health Information" (PHI) includes all information related to your past, present, or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by Foothills Neurology, P.C. in spoken, written, electronic, or any other form.

When Foothills Neurology can disclose your PHI
Under the law, Foothills Neurology, P.C. may disclose your PHI, without authorization, in the following cases:

At your request. If you request it, Foothills Neurology, P.C. is required to give you access to your or your dependent's PHI.

As required by an agency of the government. In general, Foothills Neurology, P.C. does not need you to sign a valid authorization to release your PHI if required by law or for public health and safety purposes. Foothills Neurology, P.C. is allowed to use and disclose your PHI without your authorization under the following circumstances:

- When required by law
- When permitted for purposes of public health activities
- When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if a reasonable belief exists that you may be a victim of such abuse.
- When required for judicial or administrative proceedings (e.g. subpoena or discovery request)
- When required for law enforcement purposes
- When required to be given to a coroner or medical examiner
- For research, subject to certain conditions
- To comply with workers' compensation or other similar programs established by law

For treatment, payment or health care operations. Foothills Neurology, P.C. and its business associates will use PHI, without a signed valid authorization or your opportunity to restrict or object, when carrying out treatment, payment or health care operations.

Implicit authorization to release PHI and process for restriction. In addition to disclosures mandated by law, and disclosures to individuals or entities you have specifically authorized, Foothills Neurology, P.C. will assume your authorization for release of PHI to the following:

- Your spouse, if you do not restrict or object
- Your legal representative with a valid power of attorney, your court-ordered (approved) guardian, or your conservator, if you do not restrict or object.
- Your designated personal representative, if you have not revoked your personal representative
- Either parent of a minor child, if you do not restrict or object

You may specifically restrict authorization by submitting a signed, written request for restrictions to the Privacy Officer noted on page one.

Your Individual Privacy Rights
Although your health record is the physical property of Foothills Neurology, P.C., the information in your record does belong to you and, therefore, you have rights related to its uses and disclosures. *Except as otherwise indicated in this Notice, uses and disclosures of your PHI will be made only with your signed valid authorization, subject to your right to revoke your authorization.*

In addition, you have the following rights:

You may inspect and receive a copy of your PHI.
You have the right to amend your PHI.
You have the right to receive an accounting of PHI disclosures:
At your request, Foothills Neurology, P.C. will provide you with an accounting of disclosures made by Foothills Neurology, P.C. The accounting will not include disclosures made before April 14, 2003.

You have the right to receive a paper copy of this Notice upon request.
Your personal representative:
You may exercise your rights to your PHI by designating a personal representative. You must designate your personal representative **before** the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed and signed letter designating your personal representative.

- Foothills Neurology, P.C. will automatically consider a parent or guardian as the personal representative of an unemancipated minor (a child generally under age 18) unless applicable law requires otherwise or you restrict such disclosure.
- Personal representative designations may be revoked at any time by submitting a written statement of revocation. This statement must be received by the Privacy Officer prior to a revocation becoming effective.

You have the right to file a complaint if you believe your privacy rights have been violated.

To exercise one or more of these rights, you should submit a signed, written statement detailing your request to the Privacy Officer listed on page one of this Notice. Foothills Neurology, P.C. is not required to agree to your request if the Privacy Officer determines it to be unreasonable, for example, when a custodial parent is seeking treatment for your minor child or when it would interfere with Foothills Neurology, P.C.'s ability to file a claim.

Responsibilities of Foothills Neurology, P.C.
Foothills Neurology, P.C. is responsible for the following items:
Maintain privacy of your health information. Foothills Neurology, P.C. is required by law to maintain the privacy of your PHI.

Notice Distribution: Foothills Neurology, P.C. is required to provide you with notice of its legal duties and privacy practices. This Notice is effective beginning on April 14, 2003. However, Foothills Neurology, P.C. reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by Foothills Neurology, P.C. If a privacy practice is changed, a revised version of this Notice will be provided to patients.

Disclosing only the minimum necessary PHI: When using or disclosing PHI, Foothills Neurology, P.C. will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment
- Uses or disclosures made to you
- Disclosures made to the DHHS
- Uses or disclosures required by law (e.g. Public Health Agencies)
- Uses or disclosures required for compliance with legal regulations (e.g. subpoenas)

Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer as follows:

Foothills Neurology, P.C.
Attn: HIPAA Privacy Officer
4530 E. Muirwood Drive, Suite 111
Phoenix, AZ 85048
(480) 961-2365

There will be no retaliation for filing a complaint. You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the DHHS.

If you need more information
If you have any questions regarding this Notice or the subjects addressed in it, you may contact Foothills Neurology, P.C.'s Privacy Officer.

HIPAA Omnibus Notice of Privacy Practices

Revised 2013
Effective as of 09/23/2013

Foothills Neurology
4530 E. Muirwood Drive, Suite 111 Phoenix, AZ 85048
480-961-2365

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Foothills Neurology. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our Practice. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give you this notice of our legal duties and privacy practices concerning medical information about you; and
3. Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

When you obtain services from Foothills Neurology, certain uses and disclosures of your health information are necessary and permitted by law in order to treat you, to process payments for your treatment and to support the operations of the entity and other involved providers. The following categories describe ways that Foothills Neurology uses or discloses your information, and some representative examples are provided in each category. All of the ways your health information is used or disclosed should fall within one of these categories.

Your health information will be used for treatment: For example: Disclosures of medical information about you maybe made to doctors, nurses, technicians, or others who are involved in taking care of you at Foothills Neurology. This information may be disclosed to other physicians who are treating you or to other healthcare facilities involved in your care. Any physician that our office refers you to see for continued care. Information maybe shared with pharmacies, laboratories or radiology centers for the coordination of different treatments.

Your health information will be used for payment: For example: Health information about you may be disclosed so that services provided to you may be billed to an insurance company or third party. Information may be provided to your health plan about treatment you are going to receive in order to obtain prior approval or to determine if your health plan will cover the treatment.

Your health information will be used for health care operations: For example: The information in your health record may be used to evaluate and improve the quality of the care and services we provide.

Business Associates: There are some services that we provide through contracts with third party business associates. Examples include external laboratories, transcription agencies and copying services. To protect your health information, Foothills Neurology requires these business associates to appropriately protect your information.

Required By Law: We may use or disclose your protected health information (PHI) to the extent that law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Legal Proceedings: We may disclose protected health information (PHI) in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information (PHI), so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Notice of Privacy Practices will not be disclosed without your authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

HIPAA Omnibus Notice of Privacy Practices

Revised 2013

Effective as of 08/23/2013

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. If you request a copy of the Information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request, in writing, that the denial be reviewed. Another licensed health care professional chosen by Foothills Neurology will review your request and the denial. The person conducting the review will not be the person who previously denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to include additional information in your medical record. You have the right to request an amendment for as long as all of the information, both old and new, is kept by or for Foothills Neurology. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the medical information kept by or for our Practice; Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, excluding disclosures for the purpose of treatment, payment and healthcare operations. To request this list or accounting of disclosures, you must submit your request in writing to the Administrator. Your request must state a time period, which may not be longer than six years and may not include dates before July 13, 2009. Your request should indicate in what form you want the list (for example, on paper, electronically).

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You have the right to request a limit on the medical 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. **We are not required to agree to your request**. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.

Right To Restrict Release of Information For Certain Services: You have the right to restrict the disclosure of information regarding services for which you have paid in full or on an out of pocket basis. This information can be released only upon your written authorization.

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, ask any of our office staff or our Privacy Officer or you may write to our Practice at Foothills Neurology, 4530 E. Muirwood Drive, Suite 111, Phoenix, AZ 85048

Right To Breach Notification: You have the right to be notified of any breach of your unsecured healthcare information.

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 medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, the effective date. In addition, each time you are seen for treatment or health care services at our office, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with Foothills Neurology, please write to the Privacy Officer at Foothills Neurology, 4530 E. Muirwood Drive, Suite 111, Phoenix, AZ 85048. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of HIPPA Omnibus Privacy Practice Notice is included in the privacy notice new patient paperwork for your signature.

Foothills Neurology, P.C. Privacy Notice

4530 E. Muirwood Drive Ste. 111, Phoenix, Arizona 85048 (480) 961-2365

I have received the HIPAA Privacy Notice and HIPAA Omnibus Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.

I hereby authorize Foothills Neurology to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical records including pharmacy records to Foothills Neurology upon request.

FAXES: When expedient, I authorize the transmittal of my records by FAX to doctors, pharmacies, insurance companies, or upon my request. I understand that transmission by FAX, by its very nature, is not confidential.

_____ _____

Patient Name Date of Birth

_____ _____

Patient Signature Date

PERSONAL REPRESENTATIVES (family members, attorneys, etc): I hereby authorize Foothills Neurology and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient

MESSAGES:

Y ____N_____ It is ok to leave a message on my home voice mail #: _____

Y ____N _____ It is ok to leave a message on my work voice mail #: _____

Foothills Neurology, P.C.

4530 East Muirwood Drive ▪ Suite 111 ▪ Phoenix, Arizona ▪ 85048 Phone (480) 961-2365 Fax (480) 961-2382

CANCELLATION POLICY

At Foothills Neurology, our goal is to provide quality care in a timely manner. We have implemented an Appointment/Cancellation Policy which enables us to better utilize available appointments for our patients in need of care.

A "no show" is someone who missed an appointment without canceling it by 12:00 p.m. (1) one working day in advance. No-shows inconvenience those individuals who need access to neurological care in a timely manner. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to a provider.

Without notification by 12p.m. (1) one business day before your scheduled appointment, you will be charged for the missed appointment. The charge will occur for any reason even those outside of your control, ie: car troubles, illness, or transportation issues, etc.

I AGREE TO PAY A $50 FEE IF I DO NOT CANCEL MY APPOINTMENT BY 12 P.M. THE BUSINESS DAY PRIOR TO MY APPOINTMENT

Your signature indicates that you understand the above and accept the financial responsibility for any appointment missed without prior notification.

Signature: _____ Date: _____

Print Name :_____ DOB: _____

Stuart J. Hetrick, DO Scot Fechtel, MD Padma Mahant, MD Timothy Visser, ND Susan G. Hawrylkiw, NP
Leigh Gressley, NP Amber McLouth, PA-C Robin Adamson, PA-C Melinda Preston, Psy NP Mary Diedrich, PT