Associated Neurologists, P.C.

69 Sand Pit Road, Suite 300 · Danbury, Connecticut 06810 · Tel: (203) 748-2551 · Fax: (203) 790-6375
1389 W. Main Street, Suite 212 · Waterbury, Connecticut 06708 · Tel: (203) 755-7367 · Fax: (203) 755-1947

Adult Neurology

Jan Mashman, M.D.
Martin Kremenitzer, M.D.
Diane Wirz, M.D.
Samuel Markind, M.D.
Neil Culligan, M.D.
Anna Alshansky, M.D.
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Beth Capron, MPT
Karen Nell, PTA
Nicole Saviano, PTA
Diane Yandow, P.T.

Administration

Arlene Barra
Wendy White

PLEASE CHECK WITH YOUR INSURANCE COMPANY TO SEE IF A REFERRAL IS REQUIRED PRIOR TO YOUR SCHEDULED APPOINTMENT.

THANK YOU

Directions to Associated Neurologists Danbury Office

69 Sand Pit Road, Suite 300
Danbury, CT 06810
203-748-2551

Route 84 (East or West) to EXIT 7
Take the next EXIT (Exit 11, Federal Rd)
Make right at light (White Turkey Extn) Take this to the end (Approx 1 mile)
Make left at light (This is Federal Rd)
Go to 2nd light make right (just past the rte 84 overpass - sign points right to Germantown)

From Hartford - 84 Heading West

1. Take exit 7 (Brookfield, New Milford, North) and stay in the right lane.
2. Take the first exit onto Federal Road.
3. At the end of the ramp, turn right. Follow this connector road to the end.
4. Turn left at the light onto Federal Road and stay in the right lane.
5. You will pass a Harley Davidson dealership on the left.
6. At the 2nd light, turn right onto Starr Road (just beyond the underpass).
7. At the traffic light, turn right onto Sand Pit Road.
8. You will pass the AT&T garage on the right.
9. Look for the sign "Medical Center of Western Connecticut" on the left.
10. Turn left into that driveway and drive straight ahead to building 69 (the brick building with the green roof).

From New York State - 84 Heading East

1. Take exit 7 (Brookfield, New Milford, North). This will be a left lane exit.
2. Take the first exit onto Federal Road.
3. At the end of the ramp, turn right. Follow this connector road to the end.
4. Turn left at the light onto Federal Road and stay in the right lane.
5. You will pass a Harley Davidson dealership on the left.
6. At the 2nd light, turn right onto Starr Road (just beyond the underpass).
7. At the traffic light, turn right onto Sand Pit Road.
8. You will pass the AT&T garage on the right.
9. Look for the sign "Medical Center of Western Connecticut" on the left.
10. Turn left into that driveway and drive straight ahead to building 69 (the brick building with the green roof).

Route 7 North - From Ridgefield and South

1. Travel north on Route 7 and merge onto 84 towards Hartford. Stay in left lane. Follow directions as if from New York State – 84 Heading East.

Route 7 South - From New Milford and North

1. Travel south on Route 7 and take left onto Route 7 spur.
2. Take the second exit onto Federal Road.
3. At the end of the ramp, turn left. Follow this connector road to the end.
4. Turn left at the light onto Federal Road and stay in the right lane.
5. You will pass a Harley Davidson dealership on the left.
6. At the 2nd light, turn right onto Starr Road (just beyond the underpass).
7. At the traffic light, turn right onto Sand Pit Road.
8. You will pass the AT&T garage on the right.
9. Look for the sign "Medical Center of Western Connecticut" on the left.
10. Turn left into that driveway and drive straight ahead to building 69 (the brick building with the green roof).

Directions to Associated Neurologists Waterbury Office
1389 W. Main Street Suite 212
Waterbury, CT 06708
203-755-7367

Traveling West on 84 from Hartford/Waterbury:

- Take I-84 to exit 18 – Chase Parkway
- Bear left
- Turn left at the light at the end of the ramp
- 1389 W. Main Street is the large white medical building on the left (Waterbury Medical Center)
- We are in Tower 1, Suite 212 (look for "Associated Neurologists" on the directory by the elevator)

Traveling East from New York/Danbury/Newtown:

- Take I-84 to exit 18 – Chase Parkway
- At the end of the ramp, turn right
- Turn right at the light
- Turn right at the next light onto W. Main Street
- 1389 West Main Street is the large white building (Waterbury Medical Center)
- We are in Tower 1, Suite 212 (look for "Associated Neurologists" on the directory by the elevator)

Patient Name________________________________ Date____/____/____

DOB____/_____/______

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Robert Bonwetsch, M.D.
Stephen Peters, Psy.D.
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Anna Alshansky, M.D.
David Greco, M.D.
Loralee Richter, PA-C

Referring Physician: ____

Primary Physician: ____ Your Age: ______________

Chief Complaint (Why were you referred to Associated Neurologists)? ________________________________

HPI (History of Present Illness)

❑ Location	
❑ Quality	
❑ Severity	
❑ Duration	
❑ Timing	
❑ Context	
❑ Modifying Factors	
❑ Assoc. Signs/ Symptoms	

PMH (Past Medical History)

Document Prior:	
❑ Major Illnesses	
❑ Operations	
❑ Hospitaliza-tions	

Medications (List all medications you are currently taking)	Drug	Dose (mg)	Frequency

Medication Allergies:_______________________________________ Please state "none" if no allergies to medications

Please see other side

Patient Name______________________________ Date____/____/____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) **Alcohol:** ☐ No ☐ Yes Amount: ___________

Education: ______________________________ **Tobacco:** ☐ No ☐ Yes Amount: ___________

Occupation: ______________________________

Other Information: ____

Family History:

	Age (Currently or at death)	State of Health (Indicate if deceased)	Significant Disease or Illnesses (If deceased, indicate cause of death)
Mother			
Father			
Brothers			
Sisters			
Children			

REVIEW OF SYSTEMS

Please check all that apply

1. Constitutional ☐ Negative
- ☐ Feeling tired or poorly
- ☐ Fever
- ☐ Recent change in weight

2. Eyes ☐ Negative
- ☐ Loss of part of field of vision
- ☐ White/light spots in field of vision
- ☐ Seeing double images
- ☐ Blurry vision

3. Ears, Nose, Mouth Throat ☐ Negative
- ☐ Loss of hearing
- ☐ Earache
- ☐ Discharge from the ears
- ☐ Nosebleeds
- ☐ Choking

4. Cardiovascular ☐ Negative
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Difficulty breathing
- ☐ Shortness of breath

5. Respiratory ☐ Negative
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty swallowing

6. Gastrointestinal ☐ Negative
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in the stool
- ☐ Diarrhea
- ☐ Constipation

7. Genitourinary ☐ Negative
- ☐ Burning sensation during urination
- ☐ Urinary loss of control
- ☐ Urinary frequency
- ☐ Blood in urine

8. Musculoskeletal ☐ Negative
- ☐ Joint pains
- ☐ Bone pain
- ☐ Lower back pain
- ☐ Neck pain

9. Integumentary (Skin) ☐ Negative
- ☐ Itching
- ☐ Unusual growth on skin

10. Neurological ☐ Negative
- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Difficulty walking

11. Psychiatric ☐ Negative
- ☐ Depression
- ☐ Anxiety
- ☐ Unreasonable or irrational fears

12. Endocrine ☐ Negative
- ☐ Excessive thirst/fluid intake
- ☐ Temperature intolerance to heat
- ☐ Temperature intolerance to cold

13. Hematological / Lymph ☐ Negative
- ☐ Easy bruising
- ☐ Easy bleeding

Please print clearly and complete all items

Associated Neurologists, P.C. 69 Sand Pit Road Danbury, CT 06810 (203) 748-2551

Appt. Confirmation Phone Number__________________

Pharmacy _______________ Location:_______________

E-mail address______________________________

Patient First Name: ______________________MI____

Patient Last Name: ______________________

Street Address: ______________________

City: ______________________

State, Zip Code: ______________________

Marital Status (please circle) (child) S M D W

Primary Care Physician ______________________

Primary Care Physician phone # ______________________

Maiden Name (if applicable) ______________________

Employer Name: ______________________

Employer Address: ______________________

Spouse Name: ______________________

Emergency Contact: ______________________

Patient's Home Phone # ( ) ______________________

Patient's Work Phone # ( ) ______________________

Patient Date of Birth: ______________________

Patient Sex: _____Male _____Female

Patient Social Security Number ______________________

Dominant Hand: _____Left _____Right _____Both

Referring Physician: ______________________

Referring Physician Phone #: ______________________

Occupation: ______________________

Employer Phone # ______________________

Is this MVA? If so Date of Accident ______________________

Is this Work Comp.? If so Date of Injury ______________________

Reason you are here: ______________________

Insurance Information

Primary Insurance Information:

relationship to patient: __________

Insurance Company Name and Address:____

Policy ID #:______________________

Policy Holder Name: ______________________

Policy Holder Address: ______________________

Policy Holder Employer: ______________________

Group Number: ______________________

Policy Holder Social Security # :______________________

Policy Holder Date of Birth: ______________________

Employer Phone Number: ______________________

Secondary Insurance Information:

relationship to patient: __________

Insurance Company Name and Address:____

Policy ID #:______________________

Policy Holder Name: ______________________

Policy Holder Address: ______________________

Policy Holder Employer: ______________________

Group Number: ______________________

Policy Holder Social Security # ______________________

Policy Holder Date of Birth: ______________________

Employer Phone Number: ______________________

Financial and Privacy Policy and Permission to Treat (Please read carefully)

Charges for medical services are due and payable by the patient / guardian at the time services are rendered. Co-payments, deductibles, and coinsurance are due at the time of service for Medicare and other Health Care Plans that are accepted by this office. Obtaining proper referrals to this practice is the patient / guardian's responsibility and if proper referrals are not obtained, the patient / guardian is responsible for payment in full for professional services rendered. Charges for patients with insurance plans we do not participate with are due and payable in full at time of service. The patient / guardian is responsible for all fees, regardless of insurance coverage. Motor Vehicle and Liability claims are the patient / guardian's responsibility. If the patient misses an appointment, a missed appointment fee of $50.00 will be charged. Finance charges will accrue on balances that are over thirty days. The patient / guardian is liable for all collection costs (collection agency fees, legal feel, and court cost) in addition to professional fees charged by this practice. Checks returned by the bank will incur an additional $25.00 service fee. I have read the above and request that all payments by my insurance carrier, including Medicare, to be paid directly to Associated Neurologists, P.C. I also authorize the release of any medical or other information to my insurance carrier necessary to process my claims. **The signature below acknowledges that I have received a copy of Associated Neurologist's Privacy Policy. I have read and understand its contents and agree to abide by the terms and conditions therein.**

Signature of patient / guardian______________________________________ Date:__________________

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Wendy White

Financial Policy

We are dedicated to providing you with the best possible care and service. It is essential that you have a clear understanding of your financial responsibilities. Unless you or your health insurance carriers have made other arrangements in advance, full payment is due at the time of service. For your convenience, we accept MasterCard, Visa, and Discover.

Your Appointment:
If you are late for your appointment, please be aware that you may be asked to reschedule that appointment in an effort to prevent delaying other patients who have arrived on time.

Insurance Coverage:
We have agreements with many insurance plans (including Medicare) to accept their fee schedules. We will submit claims on your behalf to the insurance carriers with whom we participate. Please make sure you check with your insurance carrier to see if we are on your insurance plan as a participating provider. You are required to pay the co-pay on the same day you receive our services. It is your responsibility to know your individual benefits and the limits on your health insurance plan. In the event your health plan determines that a service is "not covered," you will be responsible for the entire charge, and payment is due upon receipt of our billing statement. If we do not participate with your insurance plan, you are responsible for payment in full on the day the service is rendered. You are also responsible for notifying our office whenever your insurance plan changes.

Motor Vehicle, Workers' Compensation, and Liability Services:
As a courtesy, we will bill your motor (MVA) or liability insurance carrier. Should your policy exhaust (meaning your coverage has been fully used), you are responsible for any balance due, which is payable upon receipt of our billing statement. Accidents involving litigation do not absolve you from your financial responsibility to Associated Neurologists, P.C. You are responsible for full payment for our services - due upon receipt of our billing statement. You are to collect any settlement monies from your attorney. We will bill your Workers' Compensation carrier as required by law; however, any Workers' Compensation case that is contested by your employer and subsequently denied is your financial responsibility.

Referrals:

It is your responsibility to make sure that all referrals from your primary care physician are in place prior to your scheduled visit. Failure to have proper referrals will result in your being responsible for full payment of services on the day of your appointment; otherwise, your appointment will be cancelled.

Missed Appointments:

We reserve the right to charge you a missed appointment fee of $50.00 when appointments are not cancelled at least 24 hours in advance. This charge is not billable to your insurance carrier and is your responsibility. When you do not keep your appointment, you hold a valuable spot for another patient who requires medical care. **Your consideration by arriving on time for your scheduled appointment is essential to all patient care.**

Minor Patients:

A parent or custodial guardian must accompany any patient under the age of 18 years, and any payment due is the responsibility of that parent or guardian on the day of service.

Returned Checks:

If you pay us with a personal check and your bank returns that check to us, you will be charged a $25.00 service fee. You are then required to remit all monies due by either a money order or a certified bank check.

Delinquent Accounts:

Payment is due upon receipt of our billing statement. Accounts that are past due will accumulate finance charges equal to 1.5% per month (with a minimum of $1.00/month). Accounts that are over 90 days past due may be sent to a collection agency, small-claims court, or our attorney. Patients / guardians who are sent to a collection agency or court will be responsible for collection agency fees, court costs, and legal fees in addition to the original outstanding balance due.

Insurance Authorization and Financial Policy Agreement:

I hereby authorize Associated Neurologists, P.C. to furnish information to my insurance carrier concerning my illness and treatment necessary to process my claims. I acknowledge that I have received a copy of Associated Neurologists' Financial and Privacy Policy.

I have read and understand the financial policy of this practice, and I agree to be bound by its terms and conditions therein. I also understand and agree that such terms may be amended from time to time by the Practice.

___________________________________ _______________
Signature of patient or parent / legal guardian Date

____
Please print the name of the person signing

_________________________________ ____________________
Please print the name of the patient Account # (completed by staff)

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Administration

Arlene Barra
Wendy White

Please return completed forms sent to you plus copies of any school reports obtained in order for the doctor to review them <u>prior</u> to the scheduled appointment.

Thank you.

Notice of Privacy Practices

ASSOCIATED NEUROLOGISTS, P.C.

(203-748-2551)

Effective Date: April 11, 2003

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.

We understand the importance of privacy, and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide, and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information

A. How this Medical Practice May Use or Disclose Your Health Information

The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We may use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. We may also share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

2. Payment. We may use and disclose medical information about you to obtain payment for the services we provide. For example, we may give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. We may also use and disclose this information to request that your health plan authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your information with other health care providers, a health care clearinghouse or health plans that have a relationship with you when they request this information, to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of compliance, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

4. Business Associates. We may share your medical information with our "business associates". We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information.

5. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information with the person answering the phone or on your answering machine. We may also mail you post cards reminding you of future appointments.

6. Sign in sheet. We may ask you to sign in when you arrive at our office. We may also call out your name when we are ready to see you.

7. Notification and communication with family. We may disclose your health information to a family member or a close friend or other person you identify where relevant to that person's involvement in your care or payment for your care. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communicating with your family and others.

8. Marketing. We may contact you to give you information about product or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and

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services that may be of interest to you or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use of disclose your medical information for marketing purposes without your written authorization.

9. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings.

12. Judicial and administrative proceedings We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. To avert a serious threat to health or safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

18. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record may be transferred the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

20. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time, except to the extent that we have already taken action in reliance on the authorization.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by submitting a written request specifying what information you want to limit and

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what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision. Please ask for a form at the front desk.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Connecticut law. We may deny your request under limited circumstances.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 7 (notification and communication with family) and 17 (certain government functions) of Section A of this Notice of Privacy Practices or disclosures of data which exclude direct patient identifiers for purposes of research or public health or disclosures which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities and certain other disclosures.

6. Right to Receive a Notice of Privacy Practices. You have a right to receive a paper copy of this Notice of Privacy Practices. .

D. Special Rules Regarding Disclosure of Psychiatric, Substance Abuse and HIV-Related Information

Under Connecticut or federal law, additional restrictions may apply to disclosures of health information that relates to care for psychiatric conditions, substance abuse or HIV-related testing and treatment. This information may not be disclosed without your specific written permission, except as may be specifically required or permitted by Connecticut or federal law. The following are examples of disclosures that may be made without your specific written permission:

- Psychiatric information. We may disclose psychiatric information to a mental health program if needed for your diagnosis or treatment. We may also disclose very limited psychiatric information for payment purposes.
- HIV-related information. We may disclose HIV-related information for purposes of treatment or payment.
- Substance abuse treatment. We may disclose information obtained from a substance abuse program in an emergency.

E. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and provide you with a copy upon request.

F. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

You may also submit a complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

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Acknowledgement of Receipt of Notice of Privacy Practices

Associated Neurologists, P.C.

69 Sand Pit Road, Suite 300

Danbury, CT 06810

203-748-2551

Name of Patient: ____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

I give permission for my medical condition and/or records to be discussed with the following person (one contact, please):

Name: ______________________ Relationship: ______________ Phone: (____)___________

My instructions expire on: _______________________ **OR** there is no expiration: ____________

Signed: ____________________________________ Date: ___________________________

Print Name: ________________________________ Phone: (_____)____________________

If not signed by the patient, please indicate your relationship to the patient: __________________

____

This Section for Office Use Only:

- Signed form received by: ______________________________
- Acknowledgment refused:

Efforts to obtain:

____

____

Reasons for refusal:

____

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Revised 02-01-2008

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