Phone: 205-803-2210 Fax: 205-803-2214

Patient Information

Please complete this entire packet

Name: _____DOB:_____Sex:_____

Marital Status:_____Social Security #:_____Email:_____

Home phone:_____Cell phone:_____Work phone:_____

Address:_____City_____State_____Zip_____

Employer:_____Phone:_____

Employer Address:_____City_____State_____Zip_____

Emergency Contact:_____Phone:_____Relationship:_____

Spouse's Name:_____DOB:_____Phone:_____

Spouse's Employer:_____Phone: _____

Employer Address:_____City_____State_____Zip_____

Primary Insurance:_____Insured Name:_____Insured DOB:_____

ID#:_____Group #:_____Effective date:_____

Insured Address:_____City_____State_____Zip_____

Secondary Insurance:_____Insured Name:_____Insured DOB:_____

ID#:_____Group #:_____Effective date:_____

Insured Address:_____City_____State_____Zip_____

Tertiary Insurance:_____Insured Name:_____Insured DOB:_____

ID#:_____Group #:_____Effective date:_____

Patient Name: _____ Date: _____ DOB: _____

Internist/Primary Care Physician: _____ Referring Physician: _____

Patient Medical History (Circle Yes or No)

Diabetes	Y	N
Hypertension	Y	N
Cancer	Y	N
Stroke	Y	N
Heart Trouble	Y	N
Arthritis	Y	N
Convulsions	Y	N
Bleeding Tendency	Y	N
Venereal Disease	Y	N
Hereditary Deficits	Y	N

Previous Hospitalizations,

Surgeries, Injuries?

What?	When?
_____	_____
_____	_____
_____	_____
_____	_____

Testing? What? When?

_____	_____
_____	_____
_____	_____

Patient Social History (Circle the Answer)

Marital Status: Single Married Separated Widowed Divorced

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Quit smoking Smoker- _____ packs per day

Family Medical History

	Age	Diseases	Deceased? Cause?
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
Grandparents	_____	_____	_____

Current Medications

Name	Strength	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

_____

_____

(Circle Yes or No to the below questions)

Musculoskeletal

Joint Pain	Y	N
Joint Stiffness/Swelling	Y	N
Weakness of muscle	Y	N
Muscle pain/cramps	Y	N
Back pain	Y	N
Cold extremities	Y	N
Difficulty Walking	Y	N

Gastrointestinal

Loss of appetite	Y	N
Nausea/vomiting	Y	N
Change in Bowels	Y	N
Frequent Diarrhea	Y	N
Abdominal Bleeding	Y	N
Ulcer	Y	N

Endocrine

Thyroid disease	Y	N
Diabetes	Y	N
Gland/Hormone problem	Y	N
Heat/Cold Intolerance	Y	N

Constitutional Symptoms

Recent weight change	Y	N
Fever	Y	N
Fatigue	Y	N
Headaches	Y	N

Neurological

Frequent Headaches	Y	N
Dizzy/Light Headed	Y	N
Convulsions/seizures	Y	N
Tremors	Y	N
Paralysis	Y	N
Stoke	Y	N
Head Injury	Y	N
Spinal Injury	Y	N

Genitourinary

Frequent Urination	Y	N
Burning/Painful urination	Y	N
Incontinence	Y	N
Male: Testicle Pain	Y	N
Female: pelvic pain	Y	N
Female: # pregnancies	_____	
# miscarriages	_____	

Eyes

Eye disease/injury	Y	N
Glasses/contacts	Y	N
Blurred/double vision	Y	N
Glaucoma	Y	N

Cardiovascular

Heart Trouble	Y	N
Chest pain	Y	N
Shortness of Breath	Y	N
Swelling hands/feet	Y	N

Psychiatric

Memory Loss/Confusion	Y	N
Depression	Y	N
Insomnia	Y	N
Nervous/anxious	Y	N

Hematological/Lymphatic

Anemia	Y	N
Bleeding/Bruising often	Y	N
Enlarged glands	Y	N
Past Blood Transfusion	Y	N

Integumentary (skin)

Rash/itching	Y	N
Changes in color of skin	Y	N

3105 Independence Drive, Suite 105, Birmingham, AL 35209

Phone: (205) 803-2210 Fax: (205) 803-2214

John B. Riser, MD

Emily S. Riser, MD

Release Information

Patient Name: _____DOB:_____

Medical Record Number:_____

I hereby authorized:

_____

Name of Physician/Clinic/Hospital

_____

Address

_____

City, State, Zip

To release any and all medical records to Dr. John Riser, Dr. Emily Riser and Alabama Neurology Associates, P.C. , Tanner Center, and NeuroRecovery relative to outpatient services and any hospitalization.

_____ _____

Signature Date

_____ _____

Witness Date

Alabama Neurology Associates

RECEIPT OF NOTICE OF PRIVACY PRACTICE

WRITTEN ACKNOWLEDGMENT FORM

I, _____ have received a copy of Alabama Neurology Associates, Tanner Center and NeuroRecovery Notice of Privacy Practices.

_____ _____

Signature Date

Alabama Neurology Associates

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I authorize Alabama Neurology Associates, P.C. to release my insurance company any medical information necessary for processing my claim. I understand the method of transmitting information may be done electronically, via fax or by US Mail and give my permission for necessary information to be sent to my insurance company by any method above.

I understand that Medicare, Blue Cross, and other Insurance companies may consider some services to be non-covered.

I agree to be responsible for all charges not reimbursed by my insurance company.

Patient's Signature: _____Date:_____

CONSENT TO ROUTINE DIAGNOSTIC PROCEDURES AND ROUTINE TREATMENT

This constitutes consent to such routine diagnostic procedures and routine treatment as ordered by the treating physician, his assistance or his designees. It is acknowledged that the practice of medicine is not an exact science and that no guarantees have been made as to the results of treatment or examination in this clinic.

Patient's Signature: _____Date:_____

IN ORDER TO COMPLY WITH NEW HIPPA REGULATIONS, PLEASE LIST THE NAME AND RELATIONSHIP OF ANYONE WE MAY SPEAK TO REGARDING YOUR TREATMENT, APPOINTMENT, OR ANY OTHER MATTER RELATING TO YOUR VISIT WITH US. (This includes spouses, children, parents, etc.)

_____

_____

_____

_____

_____

Financial Responsibility Agreement

- CO- PAYMENTS: Co- payments are required before services rendered.
- BALANCES: All balances must be paid in full before seeing the physician/therapist/receiving an infusion.
- MLA/ DISABILITY FORMS: Our office will be charging $25 fee for filling these forms out. This charge is not reimbursed by your insurance. Payment can either be made at the time forms are dropped off or picked up. These forms can not be mailed or faxed.
- NO SHOWS: Our office will be charging a $25 fee for appointments not kept. We require a 24 hour notice of cancellation for all appointments.
- LATE: If you are more than 15 minutes late to your appointment, our office will have to reschedule you to the next available appointment time.
- REFERRALS: If your insurance company requires for you to have a referral from a primary care physician, they must be obtained prior to seeing the physician; or receiving an infusion. If we have not received the referral, payment in full is required at the time of service or your appointment will need to be rescheduled.

Due to the increase cost of billing, patient's failure to fulfill their financial obligations, and other changes in healthcare regulations, it is necessary for our office to implement the above policies. If you have any questions or concerns regarding these policies, you may contact our practice administrator.

I fully understand my financial responsibility for services rendered at Alabama Neurology Associates, Tanner Center and NeuroRecovery. I understand that failure to comply with these policies will result in having to reschedule any appointments until I can fulfill my responsibility.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Date

Alabama Neurology Associates

*** THE REST OF THIS PACKET IS FOR THE PATIENT TO KEEP FOR HIS/HER RECORDS***

INSURANCE AND MISCELLANEOUS FORMS AND LETTERS

Due to the large number of request received weekly from insurance and other forms to be completed, we find it necessary to implement the following policies.

- Disability information requested by the sate of Alabama will be handled according to state guidelines.
- All other forms requested by either the patient or a third party will require a **$25** payment, due at the time the form is received in our office. Forms received without payment will be held until payment is received.
- A minimum of one week required for completion of all forms. Extensive requests may take longer. You will be notified in advance in order to complete forms, you must be an established patient who has been seen within the last 12 months. Generally, we will not be able to complete forms for a patient who has only one office visit.
- Short letters to employers and other entities are free of charge but do require a week to prepare.

PRESCRIPTION REFILLS

To abide by all State and Federal laws, the following policies will be strictly enforced. No exceptions will be made.

- Request for refills after 3:00pm Monday through Thursday will be responded to the next business day. All refill request received on Friday will not be handled until Monday. The doctor on call will not respond to request for medication refills.
- Prescriptions for **NARCOTICS CANNOT BE REFILLED EARLY.**
- Prescriptions for various narcotics cannot be called into a pharmacy. These prescriptions will have to be picked up by the patient during business hours.
- Patients who have not been seen in the last six months to one year (depending on condition) will have to make an appointment to see the doctor in order to get a refill on your medication.

TELEPHONE CALLS AND TEST RESULTS

- Office hours are 9am until 3:30pm Monday through Thursday and 9am until 12pm on Friday. Please make the receptionist aware if you are experiencing a true medical emergency.
- Test results will be given as soon as the doctor has reviewed them. MRI results will take at least three days (3) and lab results will take at least 7 days. You will be notified immediately of any urgent results.
- Messages left prior to 3pm will be returned that day. Calls are returned in the order of medical necessity.
- **NO PRESCRIPTIONS OR RESULTS WILL BE CALLED AFTER HOURS BY THE ON CALL PHYSICIAN.**

THIS DOCUMENT IS A TEMPLATE ONLY. IT DOES REFLECT THE REQUIREMENTS OF YOUR STATE'S LAWS. YOU SHOULD CONSULT WITH ADVISORS (YOUR STATE OR LOCAL MEDICAL OR SPECIALTY SOCIETY, ASSOCIATION OR LEGAL OR OTHER COUNSEL) FAMILIAR WITH YOUR STATE'S PRIVACY LAWS PRIOR TO USING THIS DOCUMENT.

NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), this notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.

Please review this notice carefully.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal law and state law, we must follow the terms of this notice of privacy practices that we have in effect at this time.
We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practices will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT:
Alabama Neurology Associates 205-803-2210

C. WE MAY USE AND DISCLOSE YOUR IIHI IN THE FOLLOWING WAYS:

The following categories describe the different ways in which we may use and disclose your IIHI:

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests). And we may use the results to help s reach a diagnosis. We might use your IIHI in order to write a prescription for you or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work in our practice, including but not limited to our doctors and nurses, may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We may use and disclose your IIHI to obtain payment from a third party that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
4. Optional:
5. Appointment reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
6. Treatment options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
7. Health Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
8. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold, in this example, the babysitter may have access to the child's medical information.
9. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your IIHI.

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease or condition
    - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
    - Reporting reactions to drugs or problems with products or devices
    - Notifying individuals if a product or devices they may be using has been recalled
    - Notifying appropriate government agencies and authorities regarding potential abuse or neglect of an adult patient (including domestic violence);however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
    - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. Health Oversight Activities. Our practice may disclose IIHI to a health oversight agency for activities authorized by law. Oversight activities can include for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. Lawsuits and Similar Proceedings. Our practice may use and disclose IIHI in response to a court or administrative order, if you are involved in a lawsuit or a similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party had requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:
    - Regarding a crime victim in certain situation, if we are unable to obtain the person's agreement
    - Concerning a death we believe had resulted from criminal conduct
    - Regarding criminal conduct at our offices.
    - In response to a warrant, summons, court order, subpoena or similar legal process
    - To identify/locate a suspect, material witness, fugitive or missing person
    - In an emergency to report a crime (including the location of victim(s) of the crime, or the description, identity or location of the perpetrator

Optional:

5. Deceased Patients. Our practice may release IIHI to medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
6. Organ and Tissue Donation. Our practice may release you IIHI to organizations that handle organ, eye, tissue procurement, or tissue donation and transplantation if you are an organ donor.
7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an institutional Review Board or privacy board has determined that the waiver of your authorization satisfies the following: 1) the use or disclosure involves no more than a minimal risk to your privacy based on the following: a)an adequate plan to protect the identifiers from improper use and disclosure b)an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and c) entity (except as required by law) for authorized oversight of the research study, or for other research for which the use of disclosure would otherwise be permitted; the research could not practicably be conducted without the waiver; and the research could not practicably be conducted without access to and use of the IIHI.
8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety or another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. Military. Our practice may disclose your IIHI if you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.
10. National Security. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if your are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary a) for the institution to provide healthcare services to you b)for the safety and security of the institution, and/or c) to protect your health and safety or the health of other individuals.
11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary a) for the institution to provide healthcare services to your b) for the safety and security of the institution, and/or c0 to protect your health and safety or the health of other individuals.
12. Worker's Compensation. Our practice may release your IIHI for worker's compensation or similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. In order to request a type of confidential communication, you must make a written request to our practice specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. Requesting Prescriptions. You have the right to request a restriction in our use or disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement; except when otherwise required by law such as emergency situations or when the information is needed to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our practice. Your request must describe in a clear and concise fashion: a) the information you wish restricted; b) whether you are requesting to limit our practice's use, disclosure, or both; c) to whom you want the limits to apply
3. Inspections and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our practice in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. Amendment. You may ask us to amend your IIHI if you believe it is incorrect or incomplete, and you request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our practice. You must provide us with a reason that supports your request for amendment. Our practice will deny you if you fail to submit your request and the reason supporting your request in writing. Also, we may deny your request if you ask us to amend information that is in our opinion; a)accurate and complete; b)not part of the IIHI kept by or for the practice; c)not part of the IIHI which you would be permitted to inspect and copy; or d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures". An accounting of disclosures is a list of certain none-routine disclosures our practice has made of your IIHI for non-treatment, non-payment, or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our practice. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years form the dates of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests and you may withdraw your request before you incur any costs.
6. Right to Paper Copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our practice.
7. Right to File a Complaint. If you believe our 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 our practice contact our office at (205) 803-2210. All complaints must be submitted in writing and you will not penalized for filing a complaint.
8. Rights to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to use regarding the use and disclosure of our IIHI may be revoked at any time **in writing.** After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our practice at (205) 803-2210