neurocare Centers of America | Pittsburgh Neurocare Center

Pittsburgh Neurocare Center
Phone: (412) 891-1500
Fax: (412) 891-1505
pittsburghneurocare.com

PITTSBURGH
1340 Old Freeport Rd, Ste 2B
Fox Chapel, PA 15238

Please confirm your treatment location above

How'd you find out about us? Please select one option from the list below.

Physician Friend, family, colleague Insurance company

Google Ad Google, Yahoo, Bing, Ask.com or other Internet search

Social Media (Facebook, Instagram, X/Twitter, YouTube, LinkedIn, etc.)

Patient Information:

Last Name: _____ First: _____ MI: _____

Prefers to be called (if different from legal name): _____

Preferred Pronouns: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone: _____ Cell Phone: _____
* Please indicate if you do not want us to leave voice mail on phone numbers listed.

Date of Birth: ____________ Age: _____ Sex: Male Female

Social Security #: _____

Personal Information:

Spouse's Name: _____ Phone: _____

Patient Employer/Occupation: _____ Phone: _____

Emergency Contact: _____ Phone: _____

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Please share with us a list of your current and past medications, along with any supplements you're taking.
Please list your current and past medications, dosage, start date (Month/Year), stope date if applicable (Month/Year), reason for stopping the medication (Specific Side Effect or Ineffective). This will help us in completing any prior authorization as needed.

Psychiatric Therapy History
Please include history along with all provider names, dates, inpatient/outpatient status.

Medical History
Please list any current or past medical conditions and/or surgeries with the corresponding year.

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AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD
(Also known as Protected Health Information)

Patient Name: _____ Date of Birth: ____________

Address (Mailing): _____

City: _____ State: _____ Zip Code: _____

Phone: _____

_____

I authorize the release of my protected health information:

To/From: Pittsburgh Neurocare Center

To/From: _____

Phone: _____

Information to be released: Intake/Psych eval, Medical records, Diagnoses, Medications w/ doses and durations

Purpose of disclosure: Coordination of Care

This form, when properly completed, permits the release of confidential information about a person receiving services. Any information to be released under this form shall be released in accordance with HIPAA. The records released through this authorization are protected by HIPAA. Further disclosure of this information to parties other than those designated on this form is prohibited without the written consent of the person to whom the information pertains.

1. I understand that information used or disclosed pursuant to this authorization carries with it the potential for an unauthorized re-disclosure which may not be protected by Federal Privacy regulations.
2. I understand that signing this Authorization is voluntary and refusing to will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.
3. I understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has already been taken in reliance upon it, and that the revocation does not affect any information that was released before the revocation. Even if I do not revoke this Authorization, the Authorization expires automatically one (1) year from the date of signature.

Signature: _____ Date: _____

Signature of Parent or Guardian: _____

Notice of Privacy Practices (Medical)
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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
This notice is effective as of January I, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing and complaint.
Please contact us for more information.

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W. Washington, D. C. 20201 (202) 619-0257
Toll Free: 1-877-696-6775

HIPPA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I, _____, (patient's name) understand that this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness: _____

Printed Name of Individual or Legal Representative: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Others (please specify)

_____

Electronic Mail (EMAIL) Policy:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face- to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 48 hours.

*I have read and agree to the terms of the email policy

Signature: _____

Medication Refill policy:

Medication refill requests require a 7-day notice. Patient is to contact the Pittsburgh Neurocare Center office for prescription/refills requests. If you need to call for a refill you can do so during posted business hours. Refills will be communicated to your pharmacy within 48 hours during regular business hours. After hours and weekend requests may not be called in until the next business day. Please call with your prescription information and dosage as well as your pharmacy name, location and phone number. We will need this information to complete your refill request.

Insurance Policy:

Pittsburgh Neurocare Center / Neurocare Centers of America is contracted with Aetna, Cigna, Highmark BCBS, UPMC Health Plan, and Medicare. We will file your insurance for you and you will be responsible for any deductible or copay as determined by your insurance company.

For all other insurance companies that Pittsburgh Neurocare Center is out-of-network with we are happy to file your insurance claims for you, however, arrangements for payment in full will need to be made at the time of service, except if your insurance is through Cigna.

Consent to Treatment and Patient/Guarantor Responsibility:

If I choose to have my insurance filed for me, I hereby authorize payment by my insurance company directly to **Pittsburgh Neurocare Center**.

I hereby authorize **Pittsburgh Neurocare Center** to release any information my insurance company may require concerning patient care in regard to billing or prescription needs.

Patient's Signature: _____

Date: _____

Appointment Charges / Cancellation Policy:

We do not overbook appointments therefore all slots are reserved specifically for the patient. If you need to change or reschedule an appointment, please call our office as soon as you can so we can accommodate other patients who wish to be seen.

We require a 24-hour cancellation notice. Patients will be charged $50.00 if they cancel an appointment within the 24-hour time frame or if they fail to keep their appointment on the day it is scheduled.

Payment Policy:

Payment is required in full at the time of service. We accept credit/debit/checks/cash (please note we do not keep change in the office for cash payments but are happy to put a credit on your account if you do not have exact cash). For your convenience we can keep a credit card on file to charge your deductible, copay or out-of-network payment at your appointments.

Credit/Debit Card Payment for missed or canceled appointments:

I authorize Pittsburgh Neurocare Center to charge the below credit/debit card when I do not give advance notice for a late-cancellation or no-show, as per the policies below. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

___Visa ___ MasterCard ___ Discover ___ American Express

Name on Card: _____ Security Code: _____

Billing Zip Code: _____ Card #: _____

Exp. Date: _____

Termination of Treatment:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your doctor.

Emergencies:

To reach your doctor after office hours call the main office at (412) 891-1500 and leave a voicemail, your doctor will be contacted and return your call within 24 hours. If you are experiencing an emergency and cannot wait, please call 911.

Patient's Signature: _____

Date: _____

ELECTRONIC SIGNATURE ACKNOWLEDGEMENT AND CONSENT FORM:

I, _____, agree and understand that by signing the Electronic Signature Acknowledgment and Consent Form, that all electronic signatures are the legal equivalent of my manual/handwritten signature and I consent to be legally bound to this agreement. I further agree my signature on this document is as valid as if I signed the document in writing. This is to be used in conjunction with the use of electronic signatures on all forms regarding any and all future documentation with a signature requirement, should I elect to have signed electronically. Under penalty of perjury, I herewith affirm that my electronic signature, and all future electronic signatures, were signed by myself with full knowledge and consent and am legally bound to these terms and conditions.

Patient's Signature: _____

Date: _____

COMMUNICATION CONSENT FORM:

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Pittsburgh Neurocare Center respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. **We will only be using email, text and voicemail to leave you messages confirming your appointment, schedule an appointment, regarding insurance or billing and medical record request.** Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Pittsburgh Neurocare Center will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

Please indicate below what types of correspondence you consent to receive by email or text:

_____ I do not consent to any voicemail, email or texting communication.

_____ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means **(check all that you consent to):**

___ Email ___ Text ___ Voicemail

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to communicate through: _____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature: _____ Date_____