Madhureeta Achari, MD
Neurology/Neuroimaging/Neurophysiology
Nutritional Neurology

Diplomate, American Board of Psychiatry & Neurology
Diplomate, United Council of Neurological Specialties

NEW PATIENT FORMS

Please use our secure patient portal, Passport, to upload a copy of your Photo ID, insurance cards and COVID Vaccination record. If you would prefer to **send your IDs by FAX,** the number is **832-793-7540**. Please provide these forms and **all requested documentation to hold and confirm your appointment date.**

NAME: _____

ADDRESS: _____
(Street)

_____
(City) (State) (Zip)

DATE OF BIRTH _____ AGE _____ SEX ____ MARITAL STATUS:_____

HOME PH _____ CELL PH_____WORK PH _____

EMAIL _____ CONTACT PREFERENCE: ☐ Email ☐ Text ☐ Call

SOCIAL SECURITY# _____

EMPLOYER: _____ PHONE: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT

NAME: _____PH: _____

RELATIONSHIP: ☐ SPOUSE ☐ PARTNER ☐ PARENT ☐ FRIEND ☐ CO-WORKER

☐ SIBLING ☐ CHILD

POINT OF CONTACT

If needed, please identify ONE family member or caregiver as a point of contact for communications about prescriptions, appointments or other concerns.

NAME: _____ Ph: _____

e-mail: _____

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VIRTUAL VISIT CONSENT FORM & INSTRUCTIONS

Patient Name: **Date:**

Patient D.O.B

☑ I hereby authorize **Madhureeta Achari, MD** and **Integrated Neurology, PA** to use the **Virtual Visit** (Facetime, Skype WhatsApp or Zoom) platform(s) for evaluating, testing and diagnosing my medical condition.

☑ I understand that technical difficulties may occur before or during the **Virtual Visit** and that my appointment may not begin at the appointed time.

☑ I accept that **Dr. Achari** can conduct interactive sessions using the above formats; however, if Internet speed, or other technical issues arise, **Dr. Achari** may call to conduct a phone visit (for established patients only).

☑ I acknowledge that my **Virtual Visit** is private, and that it is not recorded in any way other than written notes by **Dr. Achari** within my patient chart.

Signature of Patient:

FOR CAREGIVERS:

I consent to the terms listed above and agree to be present during the Virtual

Visit between (Patient): and Dr. Achari.

Signature of Caregiver:

(Cont.) Patient Instructions for a Successful Virtual Visit

CHECKLIST

Dr. Madhureeta Achari wants to insure the same high-quality care that you would get by coming in for a visit. By taking a few minutes to prepare, you can set yourself up for a successful Virtual Visit. Here is a quick checklist to make sure are prepared for your Virtual Visit.

TECHNICAL

1. **Use the best camera you can find on your chosen device:** Virtual Visits work best when your doctor can see you clearly. If your device has an external camera, you can try a practice video call with a friend or family member to be sure of the quality.
2. **Place your device's camera at eye level:** Sit eye-level with your camera so you can make eye contact with Dr. Achari.
3. **Test the sound on your device:** Most devices have a built-in microphone and speaker system. Try a test video call with a family member or friend, making sure the other person can hear you and that you can hear them.
4. **Plug in your device for power and check your Internet connection**

ENVIRONMENT

Choose a quiet space that is well-lit: Find a quiet space with room to stand up and move around, where you will not be interrupted. It is important that you feel comfortable and have privacy to discuss your health concerns, so you are less likely to be distracted during the visit. Before you begin your visit, check the lighting. Try turning on overhead lights or closing blinds and drapes to reduce background light.

Also, please wear pants. ;)

CONTENT OF YOUR VISIT: Take a minute or two before starting the visit to write down any questions you may have for your doctor.

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REFERRING PHYSICIAN:

Name:_____

Address:_____

Phone: _____

PRIMARY CARE PHYSICIAN:

Name: _____

Address: _____

Phone:_____

REASON FOR YOUR VISIT WITH DR. ACHARI:

_____

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_____

_____

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HEALTH QUESTIONNAIRE

PATIENT NAME: _____
(Last) (First) (Middle Initial)

DATE OF BIRTH: _____

Patient height_____weight_____

FAMILY MEDICAL HISTORY: PLEASE CHECK BOX FOR ILLNESS & INDICATE RELATIONSHIP TO FAMILY MEMBER.

Illness	Family/Relation	Illness	Family/Relation	Illness	Family/Relation
☐ Epilepsy		☐ Asthma		☐ High Blood Pressure	
☐ Migraine		☐ Anemia		☐ High Cholesterol	
☐ Mental Illness		☐ Bleeds Easily		☐ Alcoholism	
☐ Glaucoma		☐ Osteoporosis		☐ Hepatitis	
☐ Diabetes		☐ Arthritis		☐ Cancer	
☐ Thyroid		☐ Heart Disease		☐ Other	
☐ Hay-Fever		☐ Stroke			

HOSPITAL ADMISSIONS:

YEAR ILLNESS OR OPERATION

_____
_____
_____
_____
_____

VACCINE	YEAR	TEST/EXAM	YEAR
☐ Tetanus/Td		☐ Cholesterol	
☐ Flu		☐ Eye exam	
☐ Pneumonia		☐ TB test	
☐ Hepatitis		☐ Hepatitis	
☐			

ALLERGIES-(TO MEDICATIONS OR FOODS)

_____
_____
_____
_____
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_____

YOUR MEDICAL HISTORY: PLEASE INDICATE CURRENT OR PAST SYMPTOMS OR DISEASES:

HEARING:
☐ Decreased Hearing
☐ Ringing In Ear
☐ Ear Infections ☐ Frequent
☐ Dizziness
☐ Fainting

EYES:
☐ Failing Vision
☐ Eye Pain
☐ Double or Blurred Vision

NOSE/THROAT/LUNGS:
☐ Nose Bleeds ☐ Recurrent
☐ Sinus Trouble
☐ Sore Throat ☐ Frequent
☐ Hoarseness ☐ Prolonged
☐ Hay-Fever/Allergies
☐ Pneumonia/Pleurisy
☐ Bronchitis/Chronic Cough
☐ Asthma/Wheezing
☐ Shortness Of Breath:
☐ On Exertion ☐ Lying Flat

HEART & VASCULAR:
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Swollen Ankles
☐ Irregular Pulse
☐ Palpitations
☐ Leg Pain ☐ When Walking
☐ Varicose Veins/Phlebitis
☐ Cold, Numb Feet

GASTROINTENSTINAL:
☐ Loss Of Appetite ☐ Recent
☐ Difficulty Swallowing
☐ Heartburn
☐ Peptic Ulcer
☐ Nausea/Vomiting
☐ Abdominal Pain
☐ Gallbladder
☐ Jaundice/Hepatitis
☐ Diarrhea

- ☐ Constipation
- ☐ Diverticulosis
- ☐ Crohn's/Colitis
- ☐ Inflammatory Bowel Syndrome
- ☐ Bloody Or Tarry Stools
- ☐ Hemorrhoids
- ☐ Hernia

URINATION:

- ☐ Overactive Bladder
- ☐ Overnight
- ☐ More Than Twice
- ☐ More Than 8 Times/24hrs
- ☐ Urgency To Urinate
  - ☐ With Leakage
  - ☐ Decrease In Force/Flow
  - ☐ Painful
  - ☐ Stress Incontinence

- ☐ Urine Leakage w/
  - ☐ w/Exercise/Movement
  - ☐ Blood In Urine
  - ☐ Kidney Stones
  - ☐ Urine Infections
  - ☐ Frequent Bed Wetting

- ☐ Weight Loss ☐ Gain
- ☐ Height Loss
- ☐ Loss Of Appetite
- ☐ Anemia
- ☐ Bruise Easily
- ☐ Blood Transfusions
- ☐ Easily Fatigued
- ☐ Decreased Energy/Endurance
- ☐ Seizures
- ☐ Tremor/Hands Shaking
- ☐ Headaches
- ☐ Numbness ☐ Tingling

BONE & JOINT:

- ☐ Arthritis/Rheumatism
- ☐ Bone Fracture/Joint Injury
- ☐ Osteoporosis
- ☐ Foot Pain

KIDNEY/LIVER:

- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Gout

CANCER:

Type of Cancer

_____

- ☐ In Treatment
- ☐ Completed Treatment

BRAIN/MENTAL:

- ☐ Concentration Problems
- ☐ Depression
- ☐ Nervousness
- ☐ Memory Loss
- ☐ Suicidal Thoughts
- ☐ Feelings Of Worthlessness
- ☐ Phobias
- ☐ Mental Illness

SLEEP:

- ☐ Sleep Problems:
  - ☐ How Long
  - ☐ How Frequent
- ☐ Waking Refreshed

CHECK IF YOU HAVE HAD THE FOLLOWING DISEASES:

- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Chickenpox
- ☐ Polio
- ☐ Mumps
- ☐ Measles
- ☐ German Measles
- ☐ Tuberculosis
- ☐ Herpes
- ☐ Aids/HIV
- ☐ STD

INTERPERSONAL:

- ☐ Sexual Issues/Enjoyment
- ☐ Decreased Life Enjoyment
- ☐ Decreased Work Performance

LIFESTYLE:

- ☐ Alcohol
  - _____ Drinks Per Week
- ☐ Coffee/Tea
  - _____ Cups Per Day
- ☐ Other Tobacco
  - _____ Times Per Day
- ☐ Cigarettes
  - _____ Per Day
  - _____# Of Years Smoking
  - _____ Year Quit
- ☐ Street Drugs
- ☐ Exercise _____ Per Week

HAIR/SKIN:

- ☐ Unwanted Facial Hair
- ☐ Hair Loss:
  - ☐ Progressive ☐ Recent
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema

MEN ONLY:

- ☐ Prostate Problems

WOMEN ONLY:

Menstrual Flow:

- ☐ Regular ☐ Irregular
- ☐ Pain/Cramps
- ☐ Days Of Flow_____
  - Length Of Cycle_____

1st Day Of Recent Cycle: _____

- ☐ Pain/Bleeding During Or After Sex

Number Of:

- ☐ Pregnancies
- ☐ Abortions
- ☐ Miscarriages
- ☐ Live Births

- ☐ **Birth Control Method:** _____

Birth Control Pill Name:

_____

- ☐ Peri-menopause
- ☐ Menopause ☐ Hot flashes
- ☐ Currently Taking Hormones

Date of Last Pap Test _____

- ☐ Normal ☐ Abnormal

Date Of Last Mammogram _____

- ☐ Normal ☐ Abnormal

OTHER:

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Nutritional Neurology
Ph: 832-793-7530 Fx: 832-793-7540
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integrated neurology

List All Medications / Prescription & Refill Policy

For your safety, it is YOUR RESPONSIBILITY to inform us of ALL medications you are currently using.

This includes:

- Prescription medications
- Over the counter medications
- Vitamin and mineral supplements
- Herbal supplements- natural and synthetic supplements
- Energy drinks and related products
- Exercise and weight gain products
- Weight loss products
- Nicotine products (sachets or vape)
- Caffeine and other natural stimulants
- CBD and THC products
- Recreational Substances

Patient Name: _____D.O.B. _____

List All Medications: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

- **For your safety and to avoid medication errors, our office does not authorize medication refills by phone.**
- Please make sure you have an adequate supply of medication to last until your next appointment.
- **Patients should initiate refills with their pharmacy. Please do not request refills through email.**
- There will be a charge for Prescriptions that have to be replaced.
- **Refill authorizations requested after 4pm on Thursdays will be processed the following Monday.**

☑ I have read and understand the preceding policy.

_____

Signature of Patient Date

Integrated Neurology, PA
Madhureeta Achari, MD
Neurology/Neuroimaging/Neurophysiology
Nutritional Neurology
1411 Heights Blvd. Houston, Tx 77008

ADDITIONAL DISCLOSURES: Governing Law, Prohibition of Recording & Lab Results

1. AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agrees:

A. That **all health care rendered shall be governed exclusively and only by Texas law**, and in no event shall the law of any other state apply to any health care rendered to patient; and;

B. in the event of a dispute, any lawsuit, action, or cause of which in any way related to the health care provided to the patient shall be brought only to a Texas court in the county/district where all or substm1tially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and not permissive.

2. PROHIBITION OF RECORDING BY PATIENTS AND VISITORS

To ensure confidentiality and privacy, **I acknowledge any type of photographic, video, audio, electronic, and/or digital recordings is strictly prohibited** at any location within this office and/or during patient care, regardless of location, unless otherwise specified and specifically acknowledged by the physician at that time.

3. LAB RESULTS

I acknowledge that if I do not receive my lab/test results in a timely fashion, it is my responsibility to notify the practice and follow up and confirm that I receive them. I will not assume the results are normal just because I have not received them and/or been notified of them. **Additionally, it is my responsibility to provide the practice with updated contact information.**

Signature of Patient (or Legal Guardian, if minor or Legal Guardianship) Date of Birth

Printed Name of Patient (or Legal Guardian, if minor or Legal Guardianship) Relationship to Minor

PHARMACY INFORMATION

PHARMACY 1

NAME/ADDRESS: _____

PHONE: _____ FAX: _____

ADDRESS: _____

PHARMACY 2

NAME/ADDRESS: _____

PHONE: _____ FAX: _____

ADDRESS: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

PHONE: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

RELATION TO PATIENT: _____

POLICY/ID# _____ GROUP# _____

EMPLOYER/ GROUP NAME: _____

SECONDARY INSURANCE: _____

PHONE: _____

POLICY HOLDER NAME: _____

POLICY HOLDER DOB: _____

IS YOUR CONDITION THE RESULT OF AN ACCIDENT? Y ☐ N ☐

RELATION TO PATIENT: _____

POLICY/ID# _____ GROUP# _____

EMPLOYER/ GROUP NAME: _____

PRIVACY AND YOUR MEDICAL INFORMATION

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 (the "Notice") tells you about the ways we may use and disclose your protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Madhureeta Achari, M.D. P.A. including its providers and employees (the "Practice").

1. **OUR OBLIGATIONS:**

   We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you; Notify affected individuals following a breach of unsecured medical information under federal law and;
- Follow the terms of the version of this Notice that is currently in effect.

2. **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:**

   The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment.
   We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.
B. For Payment.
   We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

(PRIVACY CONT)

C. For Health Care Operations.
We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance.
We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review.
We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review.
We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives.
We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services.
We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you. We may use and disclose medical information, in order to contact you via email correspondence to provide appointment reminders and other information.

I. Business Associates.
There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care.
We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law.
We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety.
We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

(PRIVACY CONT)

M. Organ and Tissue Donation.
If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

1. Research.
We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

N. Military and Veterans.
If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

O. Workers' Compensation.
We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

P. Public Health Risks.
We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

Q. Health Oversight Activities.
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, Licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

R. Legal Matters.
If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

S. Law Enforcement, National Security and Intelligence Activities.
In certain circumstances, we may disclose your medical information. If we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary, to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

T. Coroners, Medical Examiners and Funeral Home Directors.
We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

U. Inmates.
If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

V. Electronic Disclosures of Medical Information.
Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations.
There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information.
Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

(PRIVACY CONT)

C. Right to Revoke Authorization.
If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law. If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information that we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing. 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 (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

(PRIVACY CONT)

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures. If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIP AA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations. To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below. Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. 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 also have the right to request a restriction or limitation 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.
Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply. As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

(PRIVACY CONT)

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below. We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. 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. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. 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, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Integrated Neurology, P.A.
Attn: HIPAA Officer
1411 Heights Blvd. Houston, TX 77008
Phone: 832-793-7530

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

(Patient Name PLEASE PRINT)

Patient Date of Birth: _____

SIGNATURES:

_____

(Patient/Legal Representative) (Date)

_____

(If Legal Representative, Relationship To Patient) (Date)

_____

(Witness-OPTIONAL) (Date)

NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I run entitled to receive a copy of this document.

_____

(Signature) (Date)

PAYMENT

Payment is expected when services are rendered. If prior arrangements have been made, our office will file with your insurance company as a courtesy to you. However, it is your responsibility to assure that your account is paid in a timely manner. It is your responsibility to have current referrals from your PCP, and to make sure that Dr. Madhureeta Achari is a participating provider with your insurance company. If claims are not paid within 45 days from the date of service, the account becomes your responsibility and payment will be expected from you. If your insurance has a co-payment, it may be paid by CASH, CHECK, MASTERCARD, AMERICAN EXPRESS, DISCOVER, OR VISA. In consideration of services rendered, I hereby transfer and assign to Dr. Madhureeta Achari any payment due for services. I authorize the release of Medical information to my Insurance Company for the completion on my Insurance Claim to the Insurance Carrier.

(Signature) (Date)

FINANCIAL POLICY

We are committed to providing you with quality medical care. Our professional fees have been determined through careful consideration. We believe these fees are reasonable and reflect other area physician charges. It is your responsibility to verify that the physician you will see is a contracted provider under your insurance plan. This office does not provide insurance verification services. Please obtain the necessary referrals required by your insurance plan for office services, as well as additional testing which may be necessary. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service. A current copy of your insurance card is required at the time of service. It is not our responsibility to locate the information for you. All information must be provided (group number, policy number, phone number and Insured's full information).

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance without further notice. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, co-pays, coordination of benefits, pre-existing conditions and "reasonable and customary" charges, other than to supply relevant information when necessary.

You are responsible for the timely payment of your account. You are responsible for supplying us with accurate and current insurance information in a timely fashion. If you fail to provide us with a change of insurance at the time of your visit you may be responsible for payment for that date of service, as we have a limited amount of time to file your claim.

Any accounts with outstanding balances must be paid prior to any additional services are rendered. Accounts are also subject to review for collections after three consecutive statements have been sent.

☑ I have read and understand the above terms and conditions.

_____

(Signature) (Date)

LATE CANCELLATION/NO-SHOW FEES

We require 2 business days notice when canceling an appointment. **A $50 administrative fee for late cancellations, no-call and no-shows will be charged. For procedures such as EEG, EMG and Botox injections, we charge a $100 procedure fee for late cancellations, no-call and no-shows.**

PRIOR AUTHORIZATION/PRE-CERTIFICATION FEE

Please be advised that your insurance company may require a prior authorization for certain medications or pre certification for certain tests.

This process involves calling and obtaining forms from your insurance company, the physician providing documentation of your medical history to your insurance company and Madhureeta Achari, MD calling and justifying to an insurance company employed doctor why a test or medication is needed for you. On average this process takes 1-2 hours or more of physician and staff time per authorization.

Due to the time and effort involved in this process, it is necessary to charge a $75.00 fee per authorization performed on your behalf.

I have read and understand the above terms and conditions.

_____

(Signature) (Date)