

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Last 4 of SSN:** \_\_\_\_\_

**Current Mailing Address:** \_\_\_\_\_ # \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Secondary Mailing Address:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Home** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Work** ( ) \_\_\_\_\_ - \_\_\_\_\_ **Cell** ( ) \_\_\_\_\_ - \_\_\_\_\_

**Gender:**  Male  Female  Other **Relationship Status:**  Single  Married  Partnered  Divorced  Widowed

**Race:**  African American (Black)  American Indian/Alaska Native  Asian  Caucasian (White)

Hawaiian/Pacific Islander  Hispanic  Other \_\_\_\_\_

**Ethnicity:** Hispanic/Latino/Spanish origin  Yes  No

**Preferred Language:**  English  Spanish  Other (please specify) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

**\*Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_ - \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_ - \_\_\_\_\_

**PRIMARY INSURANCE:** *Complete the information below if you DO NOT HAVE a current insurance card at time of appointment.*

**Insurance Carrier:** \_\_\_\_\_ **Insurance Billing Address:** \_\_\_\_\_

**Group #:** \_\_\_\_\_ **Member ID:** \_\_\_\_\_

**Policy Holder (if not self):** \_\_\_\_\_ **Policy Holder DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECONDARY INSURANCE:**

**Insurance Carrier:** \_\_\_\_\_ **Insurance Billing Address:** \_\_\_\_\_

**Group #:** \_\_\_\_\_ **Member ID:** \_\_\_\_\_

**Policy Holder (if not self):** \_\_\_\_\_ **Policy Holder DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**PREVIOUS INSURANCE:**

Have you changed insurance plans within the last 12 months?  Y  N

If, yes provide previous insurance carrier name: \_\_\_\_\_

**Subscriber ID (if known):** \_\_\_\_\_ **Date of termination (if known):** \_\_\_\_\_

**WORKERS COMP?**  Y  N **Auto Accident:**  Y  N **Date of Injury:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**W/C Office:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_

**Adjuster's Name:** \_\_\_\_\_ **Adjusters Phone:** ( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

## Medical, Social, and Family History

Is there a possibility that you may be pregnant?  Yes  No

**Personal Medical History: Conditions - current or treated in the past. (Check all that apply)**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Obesity
<input type="checkbox"/> Anemia	<input type="checkbox"/> Dementia / Memory Loss
<input type="checkbox"/> Gout	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> COPD / Breathing Problems
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Leg / Foot Ulcers
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Coronary Artery Disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cataracts
<input type="checkbox"/> Heartburn / Gastric Reflux	<input type="checkbox"/> Obesity
<input type="checkbox"/> Benign Prostatic Hyperplasia	<input type="checkbox"/> Dementia / Memory Loss
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Diabetes
<input type="checkbox"/> HIV/Aids	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer (add comments below)	<input type="checkbox"/> Diverticulosis
<input type="checkbox"/> Hypertension/High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chronic Fatigue	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease/Hypothyroidism
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Erectile Dysfunction/Impotence
<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD / Breathing Problems	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Leg / Foot Ulcers	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> None
Other:	

Have you ever had COVID-19?

Yes  No If yes, please provide the approximate month(s) and year(s)  
 \_\_\_\_\_(mm/yyyy) \_\_\_\_\_(mm/yyyy) \_\_\_\_\_(mm/yyyy)

### Social History

#### Smoking/Tobacco Status

Do you or have you ever smoked:  Never Smoked  Ex-Smoker  Smoker  Occasionally\*

If you selected **Current** or **Ex-Smoker**, please think about your previous smoking habit and complete the below.

**Frequency:**  Light (1-9 Cigarettes per day)  Moderate (10-19 Cigarettes per day)  Heavy (20-39 Cigarettes per day)  Very Heavy (40+ Cigarettes per day)  Chain Smoker \*

**Type:**  Cigarettes  Vape  Marijuana  Cigar  Pipe  Chews Tobacco  Snuff User \*

#### Alcohol Use

Do you drink alcohol?  Yes  No

If you selected Yes, please complete the below

**Drinks Per Week:** \_\_\_\_\_

**Type:**  Beer  Wine  Liquor/Mixed Drinks

#### Marijuana Use

Do you use medical or recreational marijuana?  Yes  No

If you selected Yes, how do you consume/ingest marijuana:

Edibles/Gummies  Smoke  Vape  In Food

### Medication History

Medication Name <i>Example: Lisinopril</i>	Dosage/Strength <i>Example: 2MG</i>	Instruction <i>Example: 1 Tablets, Twice a day</i>

I do not take any medications

## Family Medical History

### Arthritis

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Asthma

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Cancer

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Diabetes

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Degenerative conditions such as Parkinson's or Alzheimer's Disease

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Heart Disease

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Hypertension/High Blood Pressure

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Stroke

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Thyroid Issues

Parent  Sibling  Grandparent  Multiple Family Members  None\*

### Other (Specify condition and family relationship to you)

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### Allergies (List any allergies or sensitivities)

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I do not have any allergies

## Sleep Related Symptoms

What is your WEEKDAY bedtime routine?

In bed time: \_\_\_\_\_ AM/PM      Out of bed time: \_\_\_\_\_ AM/PM

What is your WEEKEND bedtime routine?

In bed time: \_\_\_\_\_ AM/PM      Out of bed time: \_\_\_\_\_ AM/PM

### How many...

hours do you usually sleep at night? \_\_\_\_\_ hours

times per night do you wake up for more than three to five minutes? \_\_\_\_\_ times

times do you awaken to urinate at night? \_\_\_\_\_ times

naps do you take per day? \_\_\_\_\_ naps

### How often do you...

have problems with sleep?

Never    Rarely    Occasionally    Frequently    Almost Always\*

How Long (years):  Less Than 1    1-2    2-5    5-10    More Than 10

move when you sleep?

Never    Rarely    Occasionally    Frequently    Almost Always\*

dream when you sleep?

Never    Rarely    Occasionally    Frequently    Almost Always\*

have excessive daytime sleepiness?

Never    Rarely    Occasionally    Frequently    Almost Always\*

How Long (years):  Less Than 1    1-2    2-5    5-10    More Than 10

vary your bedtime routine from night to night?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

have difficulty going to sleep at night?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

have trouble staying asleep?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

use sleeping medications to help you sleep?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

make loud and disruptive noises (not snoring) when you breathe during sleep?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

sleep on your back?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

awaken with choking or the sensation of not breathing?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

awaken with heartburn?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

experience stomach acid in your throat during sleep?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

awaken with night sweats?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

awaken and experience heart palpitations or racing heart at night?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

awaken from sleep with a headache?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

use alcohol before bedtime to help you sleep?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

experience crawling or aching sensations in your legs while going to sleep or while sleeping?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

wake refreshed and ready to start the day?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

have difficulty doing your job because of sleepiness?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

How often is your breathing interrupted by long pauses?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

Does your partner report your breathing interrupted by long pauses?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

Do you snore loudly?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

Do you typically sleep

- in a Bed  on a Recliner or Sitting Up \*

If you sleep in a bed, how many pillows do you use? \_\_\_\_\_ pillows

Do you use stimulants to treat excessive sleepiness?

- Yes  No\*

IF YES, please complete the following:

Do symptoms improve?

- Never  Rarely  Occasionally  Frequently  Almost Always\*



Do you have difficulty concentrating during the day because of drowsiness?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

Compared to the past, your interest in sex is?

- Increased  Same  Lessened  Much Less  No Interest  Not Applicable\*

Are you more irritable than in the past?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

Do you experience depression?

- Never  Rarely  Occasionally  Frequently  Almost Always\*

## Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

<b>0</b> = would never doze
<b>1</b> = slight chance of dozing
<b>2</b> = moderate chance of dozing
<b>3</b> = high chance of dozing

Situation	Would Never Doze	Slight Chance	Moderate Chance	High Chance	Score
Sitting and Reading	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
Watching TV	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
Sitting, inactive, in a public place (e.g., a theater or during a meeting)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
As a passenger in a car for an hour without a break	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
Lying down to rest in the afternoon	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
Sitting and talking with someone	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
Sitting quietly after a lunch without alcohol	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
In a car, while stopped for a few minutes in traffic	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	
<b>Epworth Sleepiness Score</b>					

**In general scores can be interpreted as follows:**

- 0-5 > Lower Normal Daytime Sleepiness
- 6-10 > Higher Normal Daytime Sleepiness
- 11-12 > Mild Excessive Daytime Sleepiness
- 13-15 > Moderate Excessive Daytime Sleepiness
- 16-24 > Severe Excessive Daytime Sleepiness

## Review of Symptoms (*Please Check ALL That Apply*)

### Constitutional

- |  |                                  |  |
|--|----------------------------------|--|
| <input type="checkbox"/> Fevers              | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Unexplained Weight Gain |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Chills  | <input type="checkbox"/> Unexplained Weight Loss |

### Eyes

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Eye Pain |
|---|--|-----------------------------------|

### Ears/Nose/Throat/Neck

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Hearing Aids          | <input type="checkbox"/> Ear Pain                   | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Ringing in Ears (Tinnitus) |                                       |

### Respiratory

- |  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Shortness of Breath               | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Shortness of Breath with exertion |  |                                   |

### Cardiovascular

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Swelling in Feet                 |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Fainting     | <input type="checkbox"/> Shortness of Breath During Sleep |

### Gastrointestinal

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Diarrhea                            |
| <input type="checkbox"/> Constipation   | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Inability to Control Bowl Movements |

### Genitourinary/Nephrology

- Frequent Urination During the Night

### MUSCULOSKELETAL

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Joint Aches and Pains | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Aches and Pains |
|--|--|---|

### HEMATOLOGIC

- |  |                                 |
|--|---------------------------------|
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Anemia |
|--|---------------------------------|

### NEUROLOGICAL

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Difficulty with Speech | <input type="checkbox"/> Difficulty Using Hands | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Headache(s)            | <input type="checkbox"/> Memory Loss        |
| <input type="checkbox"/> Numbness               | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Tingling           |

### PSYCHIATRIC

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Feeling Anxious | <input type="checkbox"/> Depressed Mood | <input type="checkbox"/> Bipolar Disorder |
|--|---|---|

### ENDOCRINE

- |   |                                  |  |
|---|----------------------------------|--|
| <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Low Sex Drive |
| <input type="checkbox"/> Low Testosterone (Testicular Hypofunction) |                                  |  |

**INFECTIOUS**

- AIDS / HIV
- Hepatitis

- Scabies
- Tuberculosis
- Sexually Transmitted Disease(s)

List any other symptoms:

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## Sleep Consultation Consent

I have been referred to AMDx, LTD (dba, NeuroDiagnostic Laboratories) for a sleep consultation to determine if I am a candidate for sleep therapy. If it is determined that I am an eligible candidate for sleep therapy, related service(s) will be scheduled and rendered at a later date.

I understand that the provider will be asking me a series of questions regarding my current condition in order to complete an evaluation and recommend possible treatment options.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP CONSULTATION.

**Patient Name** (printed): \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**If applicable, please print the name of the patient's representative:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_



## **FINANCIAL POLICY**

As a courtesy, our facility will submit a claim to your insurance carrier on your behalf. However, practical benefits are not determined until a claim is received by your insurance company. When requested, we will provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party.

For patients without coverage by an insurance carrier, payment is due in full at the time of service. Patients may apply for CareCredit healthcare financing and arrange a payment plan if approved by CareCredit.

Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance with AMDx, Ltd. (dba: NeuroDiagnostic Laboratories, LLC).

A Non-sufficient Funds (NSF) Fee of \$25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

I understand that if my account is sent to an outside collection agency, I will be responsible for collection fees, which may be an additional 33% of the balance due.

A no call, no show (NCNS) fee of \$100 will be applied to the patient and/or responsible party if the patient fails to call to cancel their appointment or cancels their appointment less than 24-hours prior to scheduled appointment time. The NCNS fee for an in-lab sleep study is \$250 and the patient must cancel their appointment 72-hours prior to their scheduled appointment to avoid incurring the fee.

## **ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION**

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to AMDx, Ltd. / NDL, LLC and/or the affiliated entities or otherwise at its direction.

I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment(s) and coverage for services and/or supplies provided to me by AMDx, Ltd. / NDL, LLC.

NeuroDiagnostic Laboratories  
Corporate offices  
2423 W. Dunlap Avenue Suite 175  
Phone: (602) 424-4450 Fax: (602) 424-4451



**AUTHORIZATION TO APPEAL ON PATIENT'S BEHALF**

I further authorize AMDx Ltd., (dba. NeuroDiagnostic Laboratories) and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare if I am a Medicare beneficiary. I understand that in the event of an adverse decision made by my insurance carrier(s) as it relates to coverage, authorization or payment(s), AMDx Ltd., (dba. NeuroDiagnostic Laboratories) is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier.

I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUB-SECTIONS WITHIN.

**Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient Name (printed) :** \_\_\_\_\_ **Patient Signature:** \_\_\_\_\_

If applicable, please print the name of the Patient's Representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Representative Signature: \_\_\_\_\_

## **NOTICE OF PRIVACY PRACTICES**

### **THIS NOTICE IS INTENDED TO DESCRIBE HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION**

#### **\*\* PLEASE REVIEW THIS INFORMATION CAREFULLY \*\***

1) **PURPOSE:** American Medical Diagnostics, Ltd (AMDx, Ltd.), dba. NeuroDiagnostic Laboratories (NDL) and their employees follow the privacy practices described within this notice. NDL maintain your health information and confidential records, as required by law. NDL may use, disclose or share your health information as pertains to your treatment, payment of services and the general healthcare operations, necessary to provide you with quality health care.

2) **WHAT ARE TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS?** **Treatment** may include sharing information with the other health care providers who are involved in your care. For example, your health care provider may need to share information about your condition with a pharmacist in order for you to receive medications. **Payment** may include use of your health information as required by your insurance carrier to obtain prior authorization, when applicable, and payment for services rendered. **Health Care Operations** may include limited use of your health information to help improve the quality of your care and/or for educational purposes as it relates to the training of NDL employees and staff.

3) **HOW WILL NDL USE OR DISCLOSE MY HEALTH INFORMATION?** Your health information may be used for the following reasons or disclosed to the following individuals and entities. *Note: You may refuse any/all communications outlined below, when shown with an asterisk (\*).*

- Family members or close friends who are involved in your care or payment for treatment, or to family members, a personal representative or another person responsible for your or regarding your location, general condition or death. (\*)
- Disaster Relief Agency, if you are involved in a disaster relief effort (\*)
- Information provided to you, regarding alternative treatments or services related to your health (\*)
- Appointment Reminders
- Public Health Activities, such as; disease prevention, injury or disability, reporting of births/deaths, reporting adverse reactions to medications or product concerns, notification of recalls, infectious disease control, and notification to government agencies for suspected abuse, neglect or domestic violence
- Health Oversight Activities, such as; audits, inspections, investigation and licensure
- For Public Safety and Law Enforcement Activities, such as reporting crime in an emergency, a death that we suspect may have resulted from criminal conduct, to report a crime at one of our facilities, or to report information about a victim of a crime
- Marketing involving treatment, case management or care coordination, to direct or recommend alternative treatments, therapies, health care providers or settings, to describe a health related product or service included in a plan or benefits. NDL will obtain your authorization prior to using or disclosing your health information for purposes of marketing items or services to you if it is paid to make the communication. You may revoke your authorization by making a written request to NeuroDiagnostic Laboratories 2423 W. Dunlap Ave. Suite 175 Phoenix, AZ 85021
- To assist Coroners, Medical Examiners and Funeral Directors in carrying out their job duties
- Organ and Tissue Donation
- Certain Research Projects or for reviews preparatory to research
- Disclosures necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public
- If the disclosure is required by federal or state law, such as in the case of child neglect or abuse reporting
- Military Command Authorities, if you are a member of the armed forces or a member of a foreign military authority
- National security and intelligence activities to authorized person who use the disclose to conduct special investigations
- Worker's Compensation Payers, as it relates to any injury and/or illness reported to or by a worker's compensation office
- For judicial or administrative proceedings if ordered by a court or in response to a subpoena
- To a correctional institution or law enforcement official if you are in inmate of a correctional facility or are under the custody of a law enforcement official to provide you with health care or to protect your health and safety or the health and safety of others, including the correctional institution.
- Use or disclosure necessary to initiate and complete health care treatment, payment and operations or functions by business associates, such as; installation of a new computer software system

**Note: Information with Additional Protection:** Certain types of medical information have additional protection under Arizona law. In some circumstances, we will require your consent to disclose information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and mental health treatment.

4) **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:** Except where otherwise described, use and/or disclose of your medical information will not be released by NDL. If you would like us to release your medical information to a party/parties not otherwise mentioned, your request must be provided in writing and will only be effective as of the date you indicate. In addition, NDL require your written authorization to use or disclose your psychotherapy notes or to sell your health information. You may revoke any authorization to use or disclose your health information at any time by contacting [insert contact info], however, you understand that NDL may have already acted on your authorization to use or disclose your health information.

5) **WHAT ARE MY RIGHTS REGARDING MY HEALTH INFORMATION?** You have the following rights, when requested on the form(s) provided by NDL:

- **The Right to Request Restrictions:** You may request certain limitations on the usage or disclosure of your health information in relation to your health care, treatment, payment or operations. However, we are not required to comply with these types of requests, unless you request that we do not share your health information with your health insurer about a service for which you (or someone other than your insurer) has paid us in full and the disclosure is for the purpose of carrying out payment or health care operations and the disclosure is not otherwise required by law.
- **The Right to Confidential Communications:** You may request that communication regarding your health information be provided in a certain way or at a location, other than the personal address you provided. When submitting such a request, you must also provide a written method of contact for yourself; i.e., alternate phone number or address.
- **The Right to Inspect and Copy:** You may review and request a copy of your medical or health record(s). For certain requests, an administrative fee to cover the cost of the request may be applied. Under limited circumstances, your request may be denied. You then have the right to request review of the denial by another licensed health care professional, as selected by NDL. After the review is completed, NDL will comply with the outcome.
- **The Right to Request Amendment:** You may request an amendment to your medical or health record(s), if you believe that information maintained by NDL is incorrect or incomplete. However, we are not required to accept the amendment.
- **The Right to Accounting of Disclosures:** You may request a list of some of the disclosures made by AMDx Ltd./NDL of your health information. NDL may apply an administrative fee for any request received after the initial request.
- **The Right to a Copy of This Notice:** You may request a paper copy of this notice at any time, even if you have been provided with an electronic copy. To obtain an electronic copy of this notice, please refer to our website, at: [www.ndxlabs.com](http://www.ndxlabs.com).
- **To Be Notified in the Event of a Breach.** In the event AMDx. Ltd./NDL determine that the confidentiality of your health information has been breached, you have the right to be notified.

6) **WHAT REQUIREMENTS APPLY TO THIS NOTICE?** NDL is required by law to provide you with this notice and will continue to comply with the provisions outlined within, for as long as it is required by law. NDL reserves the right to change the terms outlined within this notice and any such changes will be effective for all information that may be in our health records for you, as well as for all future information we receive for or by you. All revisions to this notice will be available on our website, at [www.ndxlabs.com](http://www.ndxlabs.com). Revised paper copies will also be available, upon request. A copy of the notice may be provided to you, each time you register to receive services by NDL.

7) **WHAT IF I HAVE A COMPLAINT REGARDING PRIVACY PRACTICES?** If you believe your privacy rights have been violated, you may file a complaint with the NDL Privacy Officer or with the Secretary of the United State Department of Health and Human Services. All complaints must be submitted in writing and must describe the details / situation that caused the complaint. You will not be penalized or retaliated against for filing a complaint to NDL or to the Department of Health and Human Services.

NeuroDiagnostic Laboratories  
**ATTN: Privacy Officer**  
2423 W. Dunlap Ave | Suite 175  
Phoenix, AZ. 85021-5818  
(P) 602.424.4450 | (F) 602.424.4451

- A. An administrator shall ensure that:
1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
  2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
  3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
    - a. How and when a patient or the patient's representative is informed of patient rights in subsection (C); and
    - b. Where patient rights are posted as required in subsection (A)(1).
- B. An administrator shall ensure that:
1. A patient is treated with dignity, respect, and consideration;
  2. A patient is not subjected to:
    - a. Abuse;
    - b. Neglect;
    - c. Exploitation;
    - d. Coercion;
    - e. Manipulation;
    - f. Sexual abuse;
    - g. Sexual assault;
    - h. Except as allowed in R9-10-1012(B), restraint or seclusion;
    - i. Retaliation for submitting a complaint to the Department or another entity; or
    - j. Misappropriation of personal and private property by an outpatient treatment center's personnel member, employee, volunteer, or student; and
  3. A patient or the patient's representative:
    - a. Except in an emergency, either consents to or refuses treatment;
    - b. May refuse or withdraw consent for treatment before treatment is initiated;
    - c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
    - d. Is informed of the following:
      - i. The outpatient treatment center's policy on health care directives, and
      - ii. The patient complaint process;
    - e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
    - f. Except as otherwise permitted by law, provides written consent to the release of information in the patient's:
      - i. Medical record, or
      - ii. Financial records.
- C. A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
  2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
  3. To receive privacy in treatment and care for personal needs;
  4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
  5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
  6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
  7. To participate or refuse to participate in research or experimental treatment; and
  8. To receive assistance from a family member, the patient's representative, or other

**Submit Complaints in writing to: NeuroDiagnostic Labs**

**Attn: Erica Boehle  
2423 W. Dunlap Ave #175  
Phoenix, AZ 85021**



healthcurrent

## Notice of Health Information Practices

You are receiving this notice because your healthcare provider participates in a non-profit, non-governmental health information exchange (HIE) called Health Current. It will not cost you anything and can help your doctor, healthcare providers, and health plans better coordinate your care by securely sharing your health information. This Notice explains how the HIE works and will help you understand your rights regarding the HIE under state and federal law.

### How does Health Current help you to get better care?

In a paper-based record system, your health information is mailed or faxed to your doctor, but sometimes these records are lost or don't arrive in time for your appointment. If you allow your health information to be shared through the HIE, your doctors are able to access it electronically in a secure and timely manner.

### What health information is available through Health Current?

The following types of health information may be available:

- Hospital records
- Medical history
- Medications
- Allergies
- Lab test results
- Radiology reports
- Clinic and doctor visit information
- Health plan enrollment and eligibility
- Other information helpful for your treatment

### Who can view your health information through Health Current and when can it be shared?

People involved in your care will have access to your health information. This may include your doctors, nurses, other healthcare providers, health plan and any organization or person who is working on behalf of your healthcare providers and health plan. They may access your information for treatment, care coordination, care or case management, transition of care planning, payment for your treatment, conducting quality assessment and improvement activities, developing clinical guidelines and protocols, conducting patient safety activities, and population health services. Medical examiners, public health authorities, organ procurement organizations, and others may also access health information for certain approved purposes, such as conducting death investigations, public health investigations and organ, eye or tissue donation and transplantation, as permitted by applicable law.

Health Current may also use your health information as required by law and as necessary to perform services for healthcare providers, health plans and others participating with Health Current.

The Health Current Board of Directors can expand the reasons why healthcare providers and others may access your health information in the future as long as the access is permitted by law. That information is on the Health Current website at [healthcurrent.org/permitted-use](http://healthcurrent.org/permitted-use).

You also may permit others to access your health information by signing an authorization form. They may only access the health information described in the authorization form for the purposes stated on that form.

### **Does Health Current receive behavioral health information and if so, who can access it?**

Health Current does receive behavioral health information, including substance abuse treatment records. Federal law gives special confidentiality protection to substance abuse treatment records from some substance abuse treatment programs. Health Current keeps these protected substance abuse treatment records separate from the rest of your health information. Health Current will only share these protected substance abuse treatment records it receives from these programs in two cases. One, medical personnel may access this information in a medical emergency. Two, you may sign a consent form giving your healthcare provider or others access to this information.

### **How is your health information protected?**

Federal and state laws, such as HIPAA, protect the confidentiality of your health information. Your information is shared using secure transmission. Health Current has security measures in place to prevent someone who is not authorized from having access. Each person has a username and password, and the system records all access to your information.

### **Your Rights Regarding Secure Electronic Information Sharing**

You have the right to:

1. Ask for a copy of your health information that is available through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider.
2. Request to have any information in the HIE corrected. If any information in the HIE is incorrect, you can ask your healthcare provider to correct the information.
3. Ask for a list of people who have viewed your information through Health Current. To make this request, complete the Health Information Request Form and return it to your healthcare provider. Please let your healthcare provider know if you think someone has viewed your information who should not have.

**You have the right under article 27, section 2 of the Arizona Constitution and Arizona Revised Statutes title 36, section 3802 to keep your health information from being shared electronically through Health Current:**

1. Except as otherwise provided by state or federal law, you may “opt out” of having your information shared through Health Current. To opt out, ask your healthcare provider for the Opt Out Form. Your information will not be available for sharing through Health Current within 30 days of Health Current receiving your Opt Out Form from your healthcare provider.  
**Caution:** If you opt out, your health information will NOT be available to your healthcare providers—even in an emergency.
2. If you opt out today, you can change your mind at any time by completing an Opt Back In Form and returning it to your healthcare provider.
3. If you do nothing today and allow your health information to be shared through Health Current, you may opt out in the future.

**IF YOU DO NOTHING, YOUR INFORMATION MAY BE SECURELY SHARED THROUGH HEALTH CURRENT.**



**Acknowledgement of Receipt of Notice of Privacy Practice and Patient Rights Form**

This document provides acknowledgement of receipt of the American Medical Diagnostics Ltd (AMDx, Ltd.) / NeuroDiagnostic Laboratories (NDL) Notice of Privacy Practices and Patient Rights Form. AMDx maintains strict compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the guidelines set therein. I acknowledge that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona’s health information exchange (HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

Any questions you have regarding the information provided in the AMDx Notice of Privacy Practices or Patient Rights Forms should be directed to AMDx Administrative staff or the Privacy Officer indicated on the Privacy Practice.

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I understand that certain disclosures are required under federal law and may be released by AMDx, upon request from an authorized entity, as outlined below:

- Public health activities
  - Health oversight activities
  - Law enforcement
  - Coroners, medical examiners and funeral directors
  - Organ and tissue donation
  - Certain research projects
  - Disclosures necessary to prevent serious threats to health or safety
  - Military command authorities if you are a member of the armed forces or foreign military authority
  - National security and intelligence
  - Workers compensation payers
  - Disclosures necessary to initiate and complete health care treatment
  - Payment and operations or functions by business associates
- 

I further understand that the disclosures outlined below may be considered optional and that I may choose to ‘opt out’ of these types of disclosures by selecting ‘decline’ for any or all circumstances below.

- Family members or close friends who are involved in your care or payment for treatment  DECLINE
  - Disaster relief agencies, if you are involved in a disaster relief effort  DECLINE
  - Information provided to you regarding alternative treatments for your health care  DECLINE
  - Participation in Health Current, Arizona’s health information exchange (HIE)  DECLINE
- 

I have been given and have read and understand my rights under the Notice of Privacy Practices.

I have been given and have read and understand my rights under the Patient Rights.

I have been given and read and understand my rights under the Notice of Health Information Practices.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name** (printed): \_\_\_\_\_

If applicable, please print the name of the Patient’s Representative: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_ Representative Signature: \_\_\_\_\_