NeuroDiagnostic Laboratories

Appointment Date
_____/_____/_____

Patient Name:_____**DOB**:_____/_____/_____ **AGE**: _____

WHEN was the FIRST time you ever experienced "dizziness"? _____
**Dizziness can be described as a sensation or illusion of movement (such as spinning, rotating, tilting or rocking), unsteadiness, disequilibrium, lightheadedness, etc.*

WHAT were the circumstances? _____

WHEN was the LAST time you experienced dizziness? _____

WHAT were the circumstances? _____

CURRENT SYMPTOMS: PLEASE CHECK THE BOX THAT BEST DESCRIBES YOUR SYMPTOMS

My dizziness mostly consists of… *(check ALL that apply)*

- ☐ Spinning sensation
- ☐ Off-balance sensation
- ☐ Light-headed or near faint sensation
- ☐ *Other;* please describe: _____

Currently, my dizziness… ☐ is constant ☐ is always there, but changes intensity ☐ *comes and goes

If your symptoms *come and go…

How long does it typically last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

How often does it typically occur?_____times per: ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year

Between episodes I feel… *(check ONE)*

- ☐ Normal
- ☐ Dizzy or off-balance all the time
- ☐ *Other;* please describe: _____

My episodes occur… (*check ALL that apply*)

- ☐ Spontaneously; symptoms can occur at any time, no matter what
- ☐ When standing or walking
- ☐ In relation to any head motion
- ☐ Only in relation to certain head positions. Please describe: _____

When I roll over in bed… *(Check ONE)*

☐ Nothing unusual happens ☐ The room spins sometimes ☐ The room spins every time

Is there anything you can do to make your dizziness go away? (stand still, sit down, lie down, close eyes, etc.)
If YES, please describe_____

_____

NeuroDiagnostic Laboratories

Appointment Date
_____/_____/_____

Do you feel nauseous with your symptoms?	☐ NO	☐ YES	☐ Sometimes	
Do you have headaches with your symptoms?	☐ NO	☐ YES	☐ Sometimes	
Do you have blurred or double vision with your symptoms?	☐ NO	☐ YES	☐ Sometimes	
Do you have any visual impairments?	☐ NO	☐ YES	☐ What type?	_____
Do you have any cardiovascular conditions?	☐ NO	☐ YES	☐ What type?	_____
Do you have diabetes?	☐ NO	☐ YES	☐ What type?	_____
What is your blood pressure?	☐ Low	☐ Normal	☐ High	

EARS & SINUS: PLEASE CHECK ALL THAT APPLY. BE SURE TO INDICATE **WHEN** AND **HOW LONG** EACH LASTED

☐ Sinus Infection ☐ Sinus Pressure ☐ Ear Infection ☐ Head Congestion

_____ _____ _____ _____

Do you hear "noises" in your ears?	☐ NO	☐ YES	☐ BOTH		
If BOTH, which ear is greater?	☐ Left	☐ Right			
Do you feel pressure or a full sensation in your ears?	☐ NO	☐ YES	☐ BOTH		
If BOTH, which ear is greater?	☐ Left	☐ Right			
Do you feel pain in your ears?	☐ NO	☐ YES	☐ BOTH		
If BOTH, which ear is greater?	☐ Left	☐ Right			
Do you have drainage in your ears?	☐ NO	☐ YES	☐ BOTH		
If BOTH, which ear is greater?	☐ Left	☐ Right			
Do you have sudden or fluctuating loss of hearing?	☐ NO	☐ YES	☐ BOTH		
If BOTH, which ear is greater?	☐ Left	☐ Right			
Do you have a history of ear surgery?	☐ NO	☐ YES	☐ BOTH	☐ Left	☐ Right
If YES, what type of surgery?	_____				

HEAD: PLEASE CHECK ALL THAT APPLY. IF "YES" BE SURE TO DESCRIBE EACH.

Do you have a history of migraines or other headache disorders? ☐ NO ☐ YES

Have you ever had a head trauma? ☐ NO ☐ YES

If YES, please describe _____

Have you ever had a stroke or TIA (mini-stroke)? ☐ NO ☐ YES

If YES, please describe _____

Please provide any additional information regarding your current symptoms in the space below.

_____

_____

NeuroDiagnostic Laboratories

Appointment Date
_____/_____/_____

MEDICAL HISTORY

Is there a possibility that you may be pregnant? ☐ Yes ☐ No
Are you currently receiving palliative care? ☐ Yes ☐ No
**Palliative care is specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious or life-threatening illness, no matter the diagnosis or stage of disease.*

Have you been vaccinated for either of the following?
Influenza ☐ Yes ☐ No If yes, date of vaccination _____/_____/_____
Pneumococcal ☐ Yes ☐ No If yes, date of vaccination _____/_____/_____

SOCIAL HISTORY

Smoking Status: ☐ Smoker ☐ Occasional Cigarette Smoker ☐ Ex-Smoker ☐ Non-Smoker

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

Other Tobacco Use: ☐ Chews Tobacco ☐ Cigar Smoker ☐ Pipe Smoker ☐ Cigar Smoker ☐ Snuff User

Do you drink alcohol? ☐ NO ☐ YES If yes, ☐ Beer ☐ Wine ☐ Liquor/Mixed Drinks
_____ Times per day/week/month/year (please circle)

CURRENT MEDICATIONS

☐ ***No current medications***

Please include all medications including over the counter medications and supplements

Name of Medication	***Strength/Dosage***	***Frequency***	***Method (Oral, topical, nasal, intravenous, intramuscular, inhalation, sublingual, etc.)***

ALLERGIES

☐ ***NO KNOWN ALLERGIES***

NeuroDiagnostic Laboratories

VIDEONYSTAGMOGRAPHY (VNG) TESTING CONSENT

Videonystagmography (VNG) has become the standard for consistently testing deficiencies, defects, disorders and diseases of the inner ear and central vestibular functions. These conditions can lead to general unsteadiness and balance disturbances. The VNG test is the most accurate method of testing used today to determine the presence and location of a vestibular abnormality.

A VNG measures eye movements using a pair of special goggles and infrared cameras. You will be asked to follow moving lights, look from one point to another, and make rapid changes in your posture. Additionally, you will experience the sensation of cool and warm air being placed in the ear canal to stimulate the balance mechanism of the inner ear. VNG testing is non-invasive, with minimal to no discomfort.

While the test is being performed you may become dizzy, nauseated and/or feel weak. You will be monitored by an audiologist and/or technologist, at all times, to ensure your safety during this process. The level or severity of these symptoms may vary depending on the reason for your test and the level of symptoms you are already experiencing. These symptoms are temporary and are typically only experienced for a few moments. There are no lasting side effects due to, or as a result of, VNG testing. There are no clear substitutes for this particular method of testing.

There are no guarantees regarding the results of VNG testing. The alternative to a VNG test is to refuse testing, in which case any information regarding potential vestibular abnormality will not be obtained.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE PROCEDURES AND THE DEFINITIONS FOR VNG TESTING, AS OUTLINED WITHIN THIS DOCUMENT.

Patient Name (printed): _____

Patient Signature: _____ **Date**: _____

If applicable, please print the name of the patient's representative: _____

Relationship to the patient: _____ Representative Signature: _____

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

NeuroDiagnostic Laboratories

Patient Name: _____ **Date of Birth**: ____ /____ / ____ **Last 4 of SSN**: _____

Current Mailing Address: _____ # _____

City: _____ **State**: _____ **Zip Code**: _____

Secondary 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. _____

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).

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 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.

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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: _____

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

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 be 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.
- **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. 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

NeuroDiagnostic Laboratories

Patient Rights

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 as 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.

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.

NeuroDiagnostic LABORATORIES

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.

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: _____

Clinic Discharge Agreement

I, _____, understand that at the conclusion of my scheduled appointment today I am being released from the care of NeuroDiagnostic Laboratories and all results from my testing and/or recommendations from a consultation/visit today will be sent to my referring physician's office. It is my responsibility to follow-up with my physician to review these results and discuss any further healthcare needs.

Patient Name (printed): _____

Patient Signature: _____ Date: ___ / ___ / ___

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

Relationship to the patient: _____ Representative Signature: _____

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