

**HARTFORD NEUROLOGY, LLC  
EMG/NCS REGISTRATION**

Name \_\_\_\_\_ Home Telephone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security # \_\_\_\_\_ Cell #(\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Spouse/Guardian/Other \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_

**Work Related Injury?** Yes \_\_\_\_\_ No \_\_\_\_\_ **Auto Accident Injury?** Yes \_\_\_\_\_ No \_\_\_\_\_

**\*If answered yes, is there an existing claim?** \_\_\_\_\_ Yes \_\_\_\_\_ No

**INSURANCE/BILLING INFORMATION**

(Please note: if a referral is required; it is your responsibility to make sure you have a referral in place before the appointment)

**Primary Insurance Company** \_\_\_\_\_

Name of Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ Insured SS# \_\_\_\_\_

Relationship to \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_ Co pay \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_

Name of Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ Insured SS# \_\_\_\_\_

Relationship to \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_ Co pay \_\_\_\_\_

**Tertiary Insurance Company** \_\_\_\_\_

Name of Insured \_\_\_\_\_ D.O.B. \_\_\_\_\_ Insured SS# \_\_\_\_\_

Relationship to \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_ Co pay \_\_\_\_\_

**MEDICAL INFORMATION**

**Referring Physician** \_\_\_\_\_ Referring Dr. Phone Number \_\_\_\_\_

Address \_\_\_\_\_

**Primary Care Physician (PCP)** \_\_\_\_\_ PCP Phone Number \_\_\_\_\_  
(If different from above)

Address \_\_\_\_\_

Do you have allergies: \_\_\_\_\_

I hereby authorize the release of medical information and/or payment directly to Hartford Neurology, LLC.

**Signature** \_\_\_\_\_ Today's Date \_\_\_\_\_

**HARTFORD NEUROLOGY, LLC      DOB:**  
**PRIVACY NOTICE**

As a patient of Hartford Neurology, LLC, we want to provide you with the best possible care. We want you to feel free to make full disclosure of information to the physician(s) so that effective treatment can be provided. As required by the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Hartford Neurology, LLC is providing you, the patient or the patient's legal representative, with a copy of our Privacy Notice. HIPAA regulations require us to provide this information to you and to obtain your signature or the signature of your legal representative as proof that you have received our Privacy Notice.

The policy of Hartford Neurology, LLC is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use of such information. This policy applies to both current and former patients.

Protected Health Information (PHI) is individually identifiable health and personal information and includes any information obtained by Hartford Neurology, LLC in connection with providing healthcare treatment, obtaining payment and related healthcare operations. This relates to past, present or future information that Hartford Neurology, LLC receives from you as our patient.

We will use this information to provide caring and quality medical care to you. Examples of PHI include diagnosis, treatment, and communications, both oral and written and including answering machines, voice mail and e-mail, used for follow-up, appointment scheduling, reminders, and test results reporting. As part of our standard healthcare operations, we may share information with a facility such as a hospital, laboratory, diagnostic service or healthcare provider to coordinate your treatment plan in the most efficient manner. For insurance carriers, your information will be used for claims submission and to obtain payment for services provided. We will exchange data with your insurance carrier for activities such as confirming your eligibility with the plan, benefit and coverage determinations, and pre-certification/authorization and utilization review.

Your information is maintained in our office in our practice management information system. We also maintain information about you in your medical chart. Hartford Neurology, LLC limits access to your PHI to those employees and business associates who need to know this information and we restrict the types and amount of information provided to that which is "minimally necessary" in order to carry out their work.

We do not disclose PHI to third parties for purposes other than treatment, payment or health care operations unless the following exceptions occur:

- We receive a signed authorization from you to release your individually identifiable information. Hartford Neurology, LLC will provide you with an Authorization Form that will need to be signed by you, the patient, or in the case of a minor, his/her guardian. This authorization will be for a defined period of time and may be cancelled by you, the patient, or in the case of a minor, by his/her guardian, at any time.
- Federal, state or other applicable law requires us to share PHI.
- Workers' Compensation purposes.

You have the right to request a review of your PHI, to amend your records, and request restrictions on how your PHI is used. You may request an accounting of how your PHI has been disclosed. Any requests for amendments or restrictions to the use of your PHI must be in writing. You have a right to request a copy of your medical record. Hartford Neurology, LLC will make every effort to provide you with your record within a reasonable amount of time and subject to normal copying charges.

I acknowledge that I have received the above Hartford Neurology, LLC Privacy Notice.

\_\_\_\_\_  
✓ **Patient Name**

\_\_\_\_\_  
✓ **Date**

**CONSENT FOR TREATMENT AND RELEASE INFORMATION**

I AUTHORIZE to HARTFORD NEUROLOGY, LLC’S use & disclosure of all individual identifiable personal, health, financial, & demographic information (known as Protected Health Information or PHI) for the purpose of:

- Providing medical treatment
- Obtaining payment & reimbursement
- Obtaining authorizations from my insurance for test (where required)
- Requesting healthcare services from other providers
- Cooperating with other providers in my medical care
- Fulfilling requests for information when specifically authorized by me
- In addition, doing all other things directly related to providing healthcare to me

The above purpose & all other uses are known collectively as Treatment, Payment, & Other healthcare options or TPO.

I AUTHORIZE any physician or healthcare facility to provide upon request any PHI to HARTFORD NEUROLOGY, LLC, when needed for the purpose of TPO.

**I CONSENT to HARTFORD NEUROLOGY, LLC discussing any or all of my medical care including my evaluation, treatment, diagnosis even if related to psychiatric or psychosocial impairments, substance abuse, acquired immunodeficiency virus (HIV), HIV-related opportunistic infections, or pregnancy with the following person(s).**

1. \_\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Relationship: \_\_\_\_\_
4. \_\_\_\_\_ Relationship: \_\_\_\_\_

**I CONSENT to HARTFORD NEUROLOGY, LLC leaving messages on my answering machine.**

**I have been given the opportunity to review HARTFORD NEUROLOGY, LLC’s, Privacy Notice.**

I understand my rights to restrict the use & discloser of PHI & to revoke this consent at any time in writing.

I understand that should I choose not to consent to the terms & conditions of HARTFORD NEUROLOGY, LLC’s Privacy Notice, the practice has the right to & will withhold treatment except where required by law.

**PATIENT NAME:** \_\_\_\_\_

**PATIENT’S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**INSURED OR GUARDIAN’S SIGNATURE** \_\_\_\_\_ **DATE:** \_\_\_\_\_

The Health Insurance Portability and Accountability Act of 1996 prohibits the use and discloser of protective health information for treatments, payments, & other healthcare operations without a signed consent & prohibits the use and discloser of protective health information for non healthcare related activities without specific & explicit authorization.