Nashville Neurocare Therapy

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Phone: (615) 465-4875
Fax: (615) 472-9479
www.nashvilleneurocare.com

COOL SPRINGS	GREEN HILLS	MIDTOWN	MURFREESBORO
2001 Mallory Lane, Ste 304 Franklin, TN 37067	30 Burton Hills Blvd Nashville, TN 37215	1900 Church St, Ste 305 Nashville, TN 37203	1725 Medical Center Pkwy, Ste 215 Murfreesboro, TN 37219
☐	☐	☐	☐

Please check preferred treatment location above

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

__ Physician ___ Friend, family, colleague __ Insurance company __ NeuroStar

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

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

Patient Information:

Last Name:__________________________First:____________________________MI: ________

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

Address: ____

City:____________________________State:____________________Zip code: ______________

Email: ____

Home Phone:______________________________Cell Phone: __________________________

* Please indicate if you do not want us to leave voice mail on the phone numbers listed.

Date of Birth:_______________Age:________Sex:◯Male◯Female

Social Security # ____

Personal Information:

Spouse's Name:___________________________________Phone:_______________________

Patient Employer/Occupation:__________________________________Phone: ______________

Emergency Contact:__________________________________Phone: _____________________

Privacy Practices Acknowledgment Form

I understand that, under the Health Insurance Portability & Accountability Act of1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- obtain payment from third party payer.
- conduct normal healthcare operations such as quality assessments andphysician certifications.

I have been informed by you of your notice of privacy practices containing a morecomplete description of the uses and disclosures of my health information. I have been given the right to review such notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of privacy practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

______________________________ ______________________________

Patient Name Signature Date

______________________________ ______________________________

Relationship to Patient Date

neurocare Centers of America

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			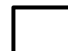

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

Patient Name____Date of Birth ____________________
Address(Mailing)____Phone______________________
____

I authorize the release of my protected health information:

To/From: W. Scott West, MD

To/From:____
Phone____Fax___________________________
Information to be released: Intake/Psych eval, Medical records, Diagnoses, Medications w/ doses and durations ____
Purpose of disclosure: TMS Evaluation

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

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

Signature____Date ________________

Signature of Parent or Legal Guardian ____

Notice of Privacy Practices(Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

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

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

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

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

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

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

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extentthat we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

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

We are required by law to maintain the privacy of your protected health information and to provide youwith notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January l, 2011 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of PrivacyPractices and to make the new notice provisions effective for all protected health information that wemaintain. We will post and you may request a written copy of a revised Notice of Privacy Practices fromthis office.

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

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services Office ofCivil Rights
200 Independence Avenue, S.W. Washington, D. C. 20201 (202) 619-0257
Toll Free: 1-877-696-6775

Termination of Treatment:

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

Consent to Treatment and Patient/Guarantor Responsibility:

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

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

Patient's Signature (Parent or Guardian, if minor): ________________________________

Date: ________________________________

Insurance Policy:

Nashville Neurocare Therapy/neurocare Centers of America is contracted with Medicare, BCBS TN, Humana, Beacon, Aetna, TRICARE, and United Behavioral Health/Optum. We will file your insurance for you and you will be responsible for any deductible or copay as determined by yourinsurance company.

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

Payment Policy:

Payment for TMS treatment is due in full at the beginning of treatment.

Emergencies:
To reach your doctor after office hours call the main office at 615-465-4875 and leave a voicemail, your doctor will be contacted and return your call within 24 hours. If you are experiencing an emergency and cannot wait, please call 911.