



Penrose Pavilion  
2312 N. Nevada Ave.  
Suite 100  
Colorado Springs, CO 80907

719-473-3272 PH  
719-389-1188 FX  
www.csneuro.com

## FINANCIAL POLICY

Welcome to our practice. We are committed to giving you the best medical care. In return, we expect that you have the same commitment to your medical care and your financial responsibility associated with this care.

As a courtesy, CSNA will file your insurance claim, however, it is your responsibility to know your insurance company's requirements. Please verify with your insurance company that the doctor you are scheduled to see is participating with your insurance. We accept cash, checks, credit cards (Visa, MasterCard and Discover) and CareCredit. A \$28.00 service charge is assessed for all returned checks. Any accounts not paid in full within 60 days of your first statement may be considered for collections and subject to applicable fees.

**AUTO** We will bill your auto insurance for you, however, your auto insurance may not pay us directly. If direct payment is not received you are responsible for payment.

**CONTRACTED HMOs and PPOs** You are responsible for any applicable deductibles or co-insurance amounts. Co-payments are due at the time of service. Services not covered by your plan will be billed to you. Referrals are your responsibility. If a referral is not in place, your appointment will be rescheduled.

**INSURANCE WE DO NOT PARTICIPATE WITH** As a courtesy we will file your insurance for you. If your insurance has not paid within 60 days, you will be expected to pay your account in full.

**MEDICAID** A referral from your primary care physician and a copy of your current card are required before services can be provided. If either or both are missing, your appointment will be rescheduled.

**SELF PAY** You are required to pay for each visit in full at the time of services. If you have any questions, contact our financial office at 719-389-1137.

**WORKERS COMPENSATION** If your injury is work related, we need the carrier name, address and case number prior to your visit. If you do not provide us with this information, you will be responsible for the charges incurred at the time of service. If this is a Federal workers compensation claim, please provide us with the Letter of Acceptance at the time of your appointment.

**ANCILLARY SERVICES** With the numerous managed care plans and the ever-changing participating providers for radiology, laboratory, surgery centers, physical therapy and hospitals, it will be your responsibility to know which facility you are required to use. If you are unsure call your insurance company.

**RELEASE OF INFORMATION** I hereby authorize the release of medical records and/or statement of account to my insurance company in order to determine benefits for services rendered.

**ASSIGNMENTS OF BENEFITS** I hereby authorize direct payment for medical and/or surgical services to CSNA. This authorization will remain in effect until revised by me in writing. A copy of this authorization will be considered as valid as the original. I understand I am financially responsible for all charges, surcharges, and attorney's fee, whether or not they are paid by my insurance. I hereby authorize the above listed provider to release all information necessary to secure payment.

I have read and I understand the above financial policy. I accept responsibility for all professional fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## COMMUNICATION WITH FAMILY AND OTHERS INVOLVED IN YOUR HEALTHCARE

**PATIENT IDENTIFICATION**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_

Please list any family member or other who may be involved in coordinating your care or payment for care. Also, indicate what information may be shared with each individual.

Name	Phone Number	Relationship to Patient	TYPE OF INFORMATION		
			All	Scheduling/ Appointments	Medical
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specific Instructions or Limitations: \_\_\_\_\_

Password: \_\_\_\_\_ Please provide this password to any individual who may be involved in coordinating your care or payment for care. They will be asked this password before information will be released over the phone. Password Hint: \_\_\_\_\_

**We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify our office if you wish to alter the designations above.**

Signature of Patient/  
 Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_

To revoke this authorization, please send a written request with a copy of this form to the address below:

Colorado Springs Neurological Associates, PC  
 Medical Records – Release of Information  
 2312 N. Nevada Avenue, Suite 100  
 Colorado Springs, CO 80907

If you have any questions, please call CSNA – Medical Records Dept at 719-473-3272.



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Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M F

Referring MD: \_\_\_\_\_ Primary MD: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Right / Left Handed

Please list conditions/diseases, which you wish to have checked at this examination: \_\_\_\_\_

MEDICATIONS: (Please list medications and dosages)	

ANY BLOOD THINNERS: Coumadin Plavix Aspirin Others: \_\_\_\_\_

ALLERGIES: (Please list any allergies to medications) \_\_\_\_\_

CONDITIONS: (Please mark any conditions you have or had in the past)

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV           | <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Liver Disease    | <input type="checkbox"/> Rheumatoid Arthritis         |
| <input type="checkbox"/> Alcohol problems   | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Low back pain    | <input type="checkbox"/> Sciatica                     |
| <input type="checkbox"/> Appendicitis       | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Gout                | <input type="checkbox"/> Neck pain        | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arm pain           | <input type="checkbox"/> Chemical Dependency    | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Neuropathy       | <input type="checkbox"/> Stroke/TIA                   |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Depression             | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Osteoporosis     | <input type="checkbox"/> Suicide attempt              |
| <input type="checkbox"/> Bipolar Disorder   | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Thyroid problems             |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Eating Disorder        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Breast Lump        | <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers                       |

MAJOR ILLNESSES, SURGERIES, or HOSPITALIZATIONS: (Please provide approximate year of illness or surgery)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

OCCUPATIONAL CONCERNS:  
 Have you filed a Work Injury report with your employer?  
 Yes No

Date of injury: \_\_\_\_\_

Is there a lawsuit planned relating to the current medical problem?  
 Yes No

Your Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Health Habits: Tobacco Yes No packs/day? \_\_\_\_\_  
 Alcohol Yes No how much? \_\_\_\_\_  
 Recreational Drugs Yes No

**FAMILY HISTORY**

Father: Age \_\_\_\_\_ Condition of health \_\_\_\_\_ Deceased at age \_\_\_\_\_ Cause of death \_\_\_\_\_  
 Mother: Age \_\_\_\_\_ Condition of health \_\_\_\_\_ Deceased at age \_\_\_\_\_ Cause of death \_\_\_\_\_

Any significant illnesses in the family: \_\_\_\_\_

**Constitutional Symptoms: (mark any symptoms that you may have)**

**GENERAL**

- Fever
- Fatigue
- Loss of appetite
- Significant weight loss

**DERMATOLOGY**

- Itching
- Redness
- Lumps
- Rash
- Skin cancer

**ENDOCRINOLOGY**

- Excessive sweating
- Excessive thirst
- Temperature intolerance
- Lactation

**NEUROLOGY**

- Headache
- Memory problems
- Tremors
- Balance difficulty
- Numbness
- Weakness
- Speech problems
- Dizziness
- Seizures

**OPHTHALMOLOGY**

- Vision loss
- Blurring of vision
- Double vision

**HEMATOLOGY**

- History of transfusion
- Easy bruising

**ENT / RESPIRATORY**

- Hearing loss
- Ringing in ears
- Shortness of breath
- Sleep apnea
- Cold and cough
- Change in voice
- Difficulty swallowing

**CARDIOLOGY**

- Chest pain
- Palpitations / irregular heartbeat
- Leg swelling
- History of heart attack
- Atrial fibrillation

**GASTROENTEROLOGY**

- Abdominal pain
- Heartburn
- Nausea
- Vomiting
- Blood in stool

**MUSCULOSKELETAL**

- Joint pain
- Joint swelling
- Joint stiffness
- Muscle aches

**PSYCHOLOGY**

- Anxiety
- Depression
- Sleep disturbances
- Hyperactivity
- Attention deficit

**GENITOURINARY**

- Difficulty urinating
- Urinary urgency
- Increased urinary frequency
- Urinary incontinence

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the physicians to whom you would like for us to send a report:  
• \_\_\_\_\_ • \_\_\_\_\_  
• \_\_\_\_\_ • \_\_\_\_\_

Patient Signature \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES

**Effective Date: September 23, 2013**

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.

*We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.*

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## NOTICE OF PRIVACY PRACTICES

This medical practice collects health information about you and stores it in an electronic health record/personal health record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your medical information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. *[Participants in organized health care arrangements only should add: We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations.*

OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders: We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
5. Sign In Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication with Family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing: Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, recommend that you participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information: We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
9. Required by Law: As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
10. Public Health :We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
11. Health Oversight Activities: We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
12. Judicial and Administrative Proceedings: We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
13. Law Enforcement: We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
14. Coroners: We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
15. Organ or Tissue Donation: We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.



16. Public Safety: We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
17. Proof of Immunization: We will disclose proof of immunization to a school that is required to have it before admitting a student if you have agreed to the disclosure on behalf of yourself or your dependent.
18. Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
19. Worker's Compensation: We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
20. Change of Ownership: In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
21. Breach Notification: In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate. [Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]
22. Psychotherapy Notes: We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) your treatment, 2) for training our staff, students and other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your psychotherapist, 6) to avert a serious threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
23. Research: We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

## **B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your Health Information Rights**

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, we will provide your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal [and state] law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

### **C. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and posted on our website. A copy will be available at each appointment.

### **E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer.

Tracie Broome, Practice Manager

2312 N. Nevada Avenue, Suite 100

Colorado Springs, CO 80907

(719) 473-3272

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

U.S. Department of Health and Human Services by email at: [OCRMail@hhs.gov](mailto:OCRMail@hhs.gov)

The complaint form may be found at: [www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf](http://www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf). You will not be penalized in any way for filing a complaint.

## Acknowledgement of Receipt of Notice of Privacy Practices

Colorado Springs Neurological Associates

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

I  I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

\_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and Address of Patient: \_\_\_\_\_

## Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

***For Office Use Only:***

Date received:	Processed by:
Practice Follow-up: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Practice Follow-up:

*Complete the following only if the Patient refuses to sign the Acknowledgment:*

Efforts to obtain:

\_\_\_\_\_  
\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_  
\_\_\_\_\_