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

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

PATIENT 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 Care credit. **A $20.00 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 & PPOs You are responsible for any applicable deductibles or coinsurance 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.

WORKERS COMPENSATION If your injury is work-related, we need the carrier's 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 to determine benefits for services rendered.

ASSIGNMENT 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 that I am financially responsible for all charges, surcharges, and attorney fees, regardless if they are paid by my insurance. I hereby authorize the above listed provider to release all information necessary to secure payment.

Co-pays are due at time of service.

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

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

NO SHOW/LATE CANCELLATION We understand that there are times when you must miss an appointment due to an emergency or a last-minute obligation to work or family. However, when you do not call to a cancel an appointment, you may be preventing another patient from getting needed treatment. We will confirm your appointment 3 days and 1 day in advance. If your schedule changes, please call our office 48 hours prior to your appointment time to cancel.

MEDICAID & VETERANS ADMIN

Patients with Medicaid or VA as their primary insurance are granted two no-show/late cancellation appointments. Missed appointments with any CSNA practice provider thereafter will result in a discharge from the entire practice, and a letter of your discharge and/or noncompliance will be sent to both your referring provider and your insurance plan. Your future benefits could be impacted but will be determined by your insurer.

ALL OTHER INSURERS

If your appointment is not canceled at least 48 hours in advance or if you fail to show up for your scheduled appointment; you will be charged a fee, the amount depending on the department specialty and visit type.

Office Visit:	**Neurology - $75.00**
	Neurosurgery - $75.00
	Neuropsychology - $250.00
Procedures:	**EEG - $150.00**
	EMG - $150.00
	Botox - $150.00
	Surgery - $250.00

These fees will ***NOT*** *be covered by your insurance company* and will be required to be paid before you can schedule your next visit. Please be aware two no-show appointments with any CSNA practice provider within a rolling twelve-month period may result in a dismissal from our entire practice for one year from the date of the last no-show.

You may leave a voice message at any time, send a message through MyChart, or send us an email at www.csneuro.com that you need to cancel or reschedule your appointment.

I have read and understand the above Patient Financial Policy and No Show/Late Cancellation Policy. I agree to all stipulations and accept responsibility for all applicable fees mentioned within.

Printed name: ______________________________

Signature: ______________________________ Date: ____/____/_____

CSNA
Comprehensive Neurosciences

Release of Information (Contact List)

Please list individuals that you authorize your health care information to be released to in coordinating your care or payment for care. Indicate what information may be shared with each individual.

Name	Phone Number	Relationship to Patient	All	Scheduling/Appointments	Medical
______________________	__________	__________	☐	☐	☐
______________________	__________	__________	☐	☐	☐
______________________	__________	__________	☐	☐	☐

[ ] Information is not to be released to anyone.

Message Preferences

Please call [ ] my home [ ] my work [ ] my cell number

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Printed Name:____ DOB:______________

Signature:____ Date:______________

This **Release of Information** will remain in effect until terminated in writing.

To revoke this authorization, please send a written request to:

Colorado Springs Neurological Associates

Medical Records

2312 N. Nevada Avenue, Suite 100

Colorado Springs, CO 80907

If you have any questions, please call CSNA 719-473-3272

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

719-473-3272 PH
719-389-1191 FX
www.csneuro.com

Date: ___/___/___
Name: ______________________________ Age: ______ Date of Birth: ___/___/___ Sex: M / F
Referring MD: ______________ Primary MD: ______________ Height: ____ Weight: ____ Right / Left Handed
How did you hear about us? ☐ Online ☐Physician Referral ☐ Friend/relative ☐ Other: __________
Please list conditions / diseases you wish to have checked at this examination:

____

____

MEDICATIONS: (Please list medications & dosages)	

ANY BLOOD THINNERS: Coumadin Plavix Aspirin Other:________________
ALLERGIES: (Please list any allergies to medications) ____

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

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

MAJOR ILLNESSES, SURGERIES, or HOSPITALIZATIONS:

____ Year: ______
____ Year: ______
____ Year: ______
____ Year: ______
____ Year: ______
____ Year: ______

OCCUPATIONAL CONCERNS:
Have you filed a Work Injury report with your employer?
YES / NO
Date of injury: ___/___/___

Is there a lawsuit planned that relates to the current medical problem?
YES / NO

Your occupation: __________________ Marital Status: ______________

HEALTH HABITS

Tobacco	Yes / No	Packs per day: ______
Alcohol	Yes / No	Drinks per day: ______
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: (Please mark any symptoms that you may have)

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

OPHTHALMOLOGY
- ☐ Vision loss
- ☐ Blurring of vision
- ☐ Double vision

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

DERMATOLOGY
- ☐ Itching
- ☐ Redness
- ☐ Lumps
- ☐ Rash
- ☐ Skin cancer

HEMATOLOGY
- ☐ History of transfusion
- ☐ Easy bruising

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle aches

ENDOCRINOLOGY
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Temperature intolerance
- ☐ Lactation

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

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

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

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

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: ____

CSNA
Comprehensive Neurosciences

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

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

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.

Table of Contents

A. How This Medical Practice May Use or Disclose Your Health Information.
B. When This Medical Practice May Not Use or Disclose Your Health Information 6
C. Your Health Information Rights 6
1. Right to Request Special Privacy Protections 6
2. Right to Request Confidential Communications 6
3. Right to Inspect and Copy 6
4. Right to Amend 7
5. Right to an Accounting of Disclosures 7
6. Right to a Paper or Electronic Copy of this Notice 7

D. Changes to this Notice of Privacy Practices 8
E. Complaints 8

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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 of 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.

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

D. Complaints

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

Andre Beach, CEO

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**

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

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

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.

ïï 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: ____

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved

Notice of Privacy Practices Acknowledgments Tracking Information

Name of Patient: ______________________________

Address: ______________________________

____

For Office Use Only:

Date received:	Processed by:
Practice Follow-up: Yes No	Date of Practice Follow-up:

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

Efforts to obtain:

____

____

Reasons for refusal:

____

____

© 2002-2013 by PrivaPlan® Associates, Inc. Patent Pending. All Rights Reserved