HOUSTON NEUROLOGY ASSOCIATES

1. Please list the family members or other person, if any, whom we may inform about your general medical condition:

    ____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

    ____

3. Please list the address of where you would like your billing statements and/or correspondence from our office to be sent to if other than your home:

    ____

4. Please indicate if you want all correspondence from our office to be sent in a sealed envelope marked "CONFIDENTIAL". YES _____ NO _____

5. Please print the telephone number, if any, where you want to receive calls regarding your appointments, lab and x-ray results, or other health care information if other than your home number: (   ) _______-________

6. Can confidential messages be left on your home answering machine or voicemail? YES ____ NO ____

7. If you do not have a voicemail, can a confidential message be left at your place of employment? YES ____ NO ____ NA ____

PATIENT'S SIGNATURE: ____________________________________
(guardian if under 18)

PATIENT'S NAME (PRINTED) ________________________________

DATE ________________

HOUSTON NEUROLOGY ASSOCIATES
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Houston Neurology Associates to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (Houston Neurology Associates Notice of Privacy Practices provides a more complete description of such uses and disclosures)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Houston Neurology Associates reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Houston Neurology Associates at 7500 Beechnut, Suite 135, Houston, Texas 77074.

With this consent, Houston Neurology Associates may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Houston Neurology Associates may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

With this consent, Houston Neurology Associates may e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Houston Neurology Associates restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Houston Neurology Associates use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Houston Neurology Associates may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________________ ____________________
Patient's Name (printed) Date

HOUSTON NEUROLOGY ASSOCIATES
NOTICE OF PRIVACY PRACTICES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and protected health information to provide the highest quality medical care possible while protecting the confidentiality of the protected health information of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purpose of treatment, payment and healthcare operations. To that end, our practice and its physicians and staff will ---

Adhere to the standards set forth in the Notice of Privacy practices.

Collect, use and disclose protected health information only in conformance with state and federal laws and current patient covenants and or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose protected health information for uses outside of the practice's treatment, payment and healthcare operations, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

Use and disclose protected health information to remind patients of their appointments only with their consent.

Recognize that protected health information collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will ---

Implement reasonable measures to protect the integrity of all protected health information maintained about patients.

Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

Act as responsible information stewards and treat all protected health information as sensitive and confidential. Consequently, our practice and staff will:

Treat all protected health information data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.

Not disclose protected health information data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her protected health information. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will ---

Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patient's appeals.

Provide patients an opportunity to request the correction of inaccurate or incomplete protected health information in their medical records in accordance with the law and professional standards.

All physicians and staff of our practice will maintain a list of all disclosures of protected health information for purposes other than treatment, payment and healthcare operations for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

All physicians and staff of our practice will adhere to any restrictions concerning the use of disclosure of protected health information that patients have requested and have been approved by our practice.

All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of the policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.