MS Center of Northeastern New York

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Empire Neurology, P.C.
1182 Troy Schenectady Road, Ste 203
Latham, NY 12110
(518) 785-1000
(518) 785 5000(Fax)
www.empireneuro.org

Lori L. Garten, M.D., Ph.D, Neurologist
Member, American Academy of Neurology
Member, International Society to Advance
Alzheimer's Research and Treatment (ISTAART)

**Accepting patients for Multiple Sclerosis and related diseases,
Alzheimer's disease and Chronic Migraine**

Date: _____

Dear _____:

Your appointment is scheduled for _____, at _____

with Dr. _____.

We ask that you please fill out completely and sign the enclosed forms and bring them with you to your appointment. This will enable us to expedite your visit.

Please arrive fifteen minutes early to register at the front desk.

NOTE: Dr. Edwards would like to make sure that he can provide you with the best medical care and to do so he must have prior medical information. It is the patient's responsibility to make sure that if you have an MRI or CT scan that the report and disc arrive at the office <u>prior</u> to your appointment.

PLEASE BRING WITH YOU AT THE TIME OF YOUR VISIT:

- INSURANCE IDENTIFICATION CARDS
- ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR A LIST OF ALL MEDICATIONS
- COMPLETED FORMS

Thank you for your cooperation in this matter.

Enclosures

Empire Neurology P.C.
Memory Center of Northeastern N.Y

Directions
(per Mapquest)

From the South (Poughkeepsie/Kingston)
- Take I-87 N/New York Thruway N via the ramp towards Albany (EXIT 22)
- Merge onto I-90 E/I-87 N towards Albany
- Merge onto I-87 N/ Adirondack Northway N via exit 1N toward Albany Intl Airport
- Take the NY-7W exit, EXIT 6, toward Schenectady, heading West
- In .3 miles, merge onto Troy-Schenectady Road
- We are located 3 miles up, on the left, just past Cumberland Farms (Behind Dunkin Donuts)

From the North (Saratoga/Glens Falls)
- Take I-87S/ Adirondack Northway S
- Merge onto Troy-Schenectady Road/NY-7 W via EXIT 6 towards Schenectady
- We are located 3 miles up, on the left, just past Cumberland Farms (Behind Dunkin Donuts)

From the East (Troy/Bennington)
- Take NY-7
- Take I-87 S EXIT on the left
- Merge onto Troy-Schenectady Road/NY-7 W via EXIT 6 towards Schenectady
- We are located 3 miles up, on the left, just past Cumberland Farms (Behind Dunkin Donuts)

From the West (Syracuse/Amsterdam)
- Take I-90E/ New York Thruway E toward Albany
- Merge onto I-890E via EXIT 26 towards Schenectady
- Merge onto NY-7 E via EXIT 7 towards Troy
- We are located 6 miles up on the right, behind Dunkin Donuts (past Berkshire Bank)

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The Memory Center of Northeastern New York
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Latham, NY 12110

PATIENT REGISTRATION

Pharmacy/ Ph # _____ Social Security #: _____ Date_____

Name_____ DOB ___/___/___ Martial Status: M S W O

Address: _____ City/State/Zip:_____

Phone (Home): _____ (Work):_____ (Cell): _____

Email Address: _____

Referring Physician: _____ PCP: _____

Spouse's Name: _____ DOB: ____/____/____ Phone #: _____

Emergency Contact: _____Relation: _____
(other than Spouse)
Address: _____Phone: _____

BILLING INFORMATION AND RESPONSIBLE PARTY

Billing Name (other than patient)	Relation to Patient
Billing Address	

Insurance Information **** Please Present Insurance Cards for photocopy upon Arrival****	
Primary Insurance Name	
Primary Insurance Address	
Primary Insurance Telephone	
Insurance ID #	Insurance Group #
Name of Insured (Self /Spouse/ Other)	DOB
Secondary Insurance Name	
Secondary Insurance Address	
Secondary Insurance Telephone	
Secondary Insurance ID#:	Secondary Group #
Name of Insured (Self /Spouse/ Other)	DOB

Consent to Use or Disclose (PHI) for (TPO):	**Receipt of Notice of Privacy Practices**
I consent to the use or disclosure of my protected Health Information by Empire Neurology for the purposes of providing Treatment, obtaining Payment or to conduct health care operations (as explained in the * Notice of Privacy Practices"). I may revoke this consent in writing except if actions rely on this consent. Signature: Date:	I have received a copy of EMPIRE NEUROLOGY's NOTICE OF PRIVACY PRACTICES'

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The Memory Center of Northeastern New York
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	Signature:	Date:

Payment Policy

TO ALL PATIENTS…
IF YOU HAVE AN INSURANCE that requires a CO-PAYMENT, the amount is due at the time of service or an additional fee of $10.00 will be charged to your account to cover billing expenses.
IF YOU DO NOT HAVE INSURANCE, you are responsible for payment of your bill, in total, at the time of your visit. We accept personal checks, cash, MC & Visa. A payment plan can be arranged.
SIMPLE AGREEMENT…
I request that payment of authorized benefits be made on my behalf directly to **EMPIRE NEUROLOGY** for service furnished me by any physician/provider employed. I understand and agree that I am responsible for the balance of my account for any professional services rendered. I certify that the information is true and correct to the best of my knowledge. I will notify this office of any changes in my insurance status.

Signature of Patient or Guardian: _____ **Date:** _____

Communication Authorization

I authorize my home phone number & the following as a designated contact where you may leave a detailed message of you, may openly discuss my treatment, payment or health care operations. i.e. scheduled appointments, test results, etc.

1) Name: _____
Phone: _____
Relationship: _____

2) Name: _____
Phone: _____
Relationship: _____

Signature of Patient or Guardian: _____ **Date:** _____

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THE FOLLOWING APPLIES TO MEDICARE:

Name of Beneficiary: _____

Health Insurance Claim Number: _____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to: **Empire Neurology, 1182 Troy-Schenectady Road, Ste 203, Latham, NY 12110** for any services furnished me by its physicians/health care providers. I authorize any holder of medical information about me to release to the **HEALTH CARE FINANCING ADMINISTRATION** and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary or Authorized Representative: _____

MEDIGAP (ONE-TIME) AUTHORIZATION FORM

Name of Beneficiary: _____

Health Insurance Claim Number:_____Group#_____
(Medigap Policy Number)
I request that payment of authorized Medigap benefits be made to either me or on my behalf to: **Empire Neurology, 1182 Troy-Schenectady Road, Ste 203, Latham, NY 12110** for any services furnished to me by its providers. I authorize any holder of medical information to release to : Name of Medigap Insurer_____
and information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary or Authorized Representative: _____

Patient History Questionnaire

NAME: _____ **DATE:** _____

Date of Birth: _____ **Marital Status:** **S M D W (please circle one)**

Reason for Today's Visit: _____

FAMILY HISTORY: IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING, PLEASE CIRCLE THE NUMBER AND INDICATE WHICH RELATIVE:
(for example Maternal Grandmother/Grandfather, Mother/Father, Sister/Brother, Child)

1) Epilepsy _____
2) Mental Illness _____ Type: _____
3) Asthma _____
4) Osteoporosis _____
5) Heart Disease _____
6) Hypertension _____
7) Cancer _____
Type: _____
8) Multiple Sclerosis _____
Year Diagnosed: _____
9) Migraine _____
10) Glaucoma _____
11) Bleeds Easily _____
12) Arthritis _____
13) Stroke _____
14) High Cholesterol _____
15) Dementia (Memory Loss) _____
Type: _____
16) Autoimmune Disease: _____
Type: _____

PLEASE LIST DISEASE RELATED DEATHS IF APPLICABLE: ☐ **N/A** ☐ **unknown/adopted**

Relationship	Age	Cause of Death if known
Mother		
Father		
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Brother		
Sister		
Child		

SOCIAL/ PERSONAL HISTORY

Whom do you live with?: _____

Number of Children: _____ **Number of Grandchildren (if applicable):** _____

Occupation: _____

□ Working □ Retired □ Disabled: Type _____ □ Other: _____

Highest Level of Education Completed _____ **Hand Dominance:** □ Left □ Right **Seatbelt Use:** □ Yes □ No

Tobacco Use: □ Never □ Former, Yr Quit____ □ Current Amount (day / week): ___ Type: □ cigarette □ other _____

Alcohol Use: □ Never □ Former, Yr Quit____ □ Current Amount per week: _____ Type: □ Liquor □ Beer □ Wine

Caffeine Use: (# cups per day) □ None ___ Coffee ___ Tea ___ Energy Drinks ___ Caffeinated Soda ___

(Social/ Personal History Continued)

Allergies: □ No Known Drug Allergies
□ Allergic to: _____

Type of Reaction: _____

Recreational Drug use: □ never □ Past □ Current Type: _____

Current Medications and Supplements:
LIST ALL MEDICATIONS YOU ARE NOW TAKING, INCLUDING THOSE YOU BUY WITH OR WITHOUT A PRESCRIPTION (Over the Counter and Nutritional Supplements):

Medication	*Dose*	*Frequency*	*Medication*	*Dose*	*Frequency*

(If additional Space is needed, please write on the back of this sheet)

ACCIDENTS-SURGERIES-HOSPITALIZATIONS (NOT INCLUDING PREGNANCIES)

Year	*Type*

Additional Information (if needed):

_____

_____

_____

_____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS:

Body System	Condition	Past/Stop Write Year (if known)	Current Write Start year (if known)
Ears, Eyes, Nose and Throat Do you have current symptoms? Y N	CHANGES IN VISION CHANGES IN HEARING SINUS TROUBLE		
Cardiac (Heart) Do you have current symptoms? Y N	CHEST PAIN PALPITATIONS SWELLING OF LEGS		
Endocrine Disorders (I.e. Diabetes/ Thyroid etc.) Do you have current symptoms? Y N	HEAT/COLD INTOLERANCE EXCESSIVE THIRST APPETITE LOSS		
Gastrointestinal (Stomach /Bowels) Do you have current symptoms? Y N	DIARRHEA BLOOD IN STOOLS VOMITING		
Nervous System (Brain/ Spinal Cord) Do you have current symptoms? Y N	HEADACHES SEIZURES PARALYSIS NUMBNESS/TINGLING		
Respiratory (Lungs/ Breathing) Do you have current symptoms? Y N	CHRONIC COUGH SHORTNESS OF BREATH COUGHING UP BLOOD		
Dermatology (Skin) Do you have current symptoms? Y N	RASH LUMPS SORES CHANGES IN HAIR/NAILS		
Renal (Kidney/Bladder) Do you have current symptoms? Y N	BLOOD IN URINE BURNING INCONTINENCE KIDNEY STONES		
Musculoskeletal (Joints) Do you have current symptoms? Y N	JOINT PAINS BACK PAIN NECK PAIN JOINT SWELLING		
Blood Disorders Do you have current symptoms? Y N	ANEMIA BLEEDING BRUISING		
Psychiatric Disorders (Depression, Bipolar, Etc.) Do you have current symptoms? Y N	NERVOUSNESS DEPRESSION ANXIETY HALLUCINATIONS		

Other: CIRCLE IF YOU CURRENTLY HAVE: FATIGUE NIGHT SWEATS FEVERS INSOMNIA

Empire Neurology, P.C.

New Office Policies and Procedures

Please Read Carefully

The goal of our practice is to give our patients the utmost of attention and care. Time for the physicians, clinicians, staff, and for you, the patient, is valuable. As of January 1, 2013, our office will be requiring advance notice of cancellation *prior to* a scheduled appointment, or a $60.00 charge may be applied.

Please alert us to any changes in your insurance, personal contact information, primary care physician, or emergency contact(s) throughout the course of your care at this practice. If you have a Health Care Proxy or Advanced Directive/Living Will on file, please let us know or bring a copy of it with you to be kept on file.

Letters and Forms Policy (e.g. FMLA, employment, insurance, disability forms, etc.):

For forms that need to be completed with medical information/documentation, there may be a charge of $25.00 to be paid at the time the paperwork is given to us. If paperwork arrives via mail or fax, we may contact you and charge for these services before the doctor or nurses complete the paperwork.

All requests must be pre-paid.

Second Opinions Policy:

If you wish to seek a second opinion with another neurology practice, please discuss it with your treating physician here (Dr. Edwards or Dr. Garten) and/or reception, and we will facilitate any referral. If you do not discuss a second opinion with us before seeing another neurologist, this will be considered a complete transfer of your care.

I confirm that I understand and agree to the policies stated above.

Print name: _____

Patient Signature: _____ **Date:** _____

Empire Neurology, P.C.

Prescription Policy

1. **Make sure that you obtain all of your prescriptions at your visit. Please make sure you have enough medication to last you until your next appointment. If you forget to ask for a prescription at your appointment and call in, please allow at least 24 hours for it to be filled.**
2. **If you need a prescription refill in between visits, please call your pharmacy. The pharmacy will need to send that information to our office.**
3. **If you have a formulary plan with your insurance company, please bring in a list of approved medications so that our physicians can prescribe the correct medication for you.**
4. **We will no longer be able to respond to "1-800" Pharmacy services in regard to your prescriptions.**
5. **Our physicians will not be responsible for another doctor's prescriptions.**
6. **We will no longer call or fax pharmacies with prescriptions; they MUST be obtained at office visit or sent to us from your pharmacy.**
7. **Prescriptions will not be renewed if you have not had a visit with the physician in over a year.**

Please note this practice does not prescribe narcotic medications.

I confirm that I understand and agree to the policies stated above.

Print name: _____

Patient Signature: _____ **Date:** _____

Empire Neurology, P.C.
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EMPIRE NEUROLOGY

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

MS. AMY BUTTON at (518) 785-1000

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take a child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. Disclosures Required By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for purposes such as:

- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition

- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain a court or administrative order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Amy Button, Medical Records Department**, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to **Amy Button, Medical Records Department.** Your request must describe in a clear and concise fashion:

(a) the information you wish restricted;
(b) whether you are requesting to limit our practice's use, disclosure or both; and
(c) to whom you want the limits to apply.

3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy and/or neuropsychological testing notes. You must submit your request in writing to **Amy Button, Medical Records Department** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews, unless the individual or entity that created the information is not available to amend the information.

4. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or no

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Empire Neurology P.C.
Memory Center of Northeastern N.Y

5. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Amy Button, Medical Records Department.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) *in writing*. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice n-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Amy Button, Medical Records Department.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Amy Button, Medical Records Department.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Amy Button. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the purposes described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Amy Button, Medical Records Department, 1182 Troy-Schenectady Road, Suite 203, Latham, NY 12110, (518) 785-1000**

Empire Neurology, P.C.

Memory Center of Northeastern N.Y

EMPIRE NEUROLOGY

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____ have received a copy of **EMPIRE NEUROLOGY'S Notice of Privacy Practices.**

_____ _____

Signature of Patient Date