Nemechek Autonomic Medicine

PATIENT INFORMATION

Name: _____ Birth Date: _____/_____/_____
(First) (M.I.) (Last)

Address: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____

Social Security #: _____ - _____ - _____

Emergency Contact: Name: _____ Phone: (_____) _____

Dr. Nemechek has opted out of Medicare. Both Dr. Nemechek and the patient (or their legal representative) are prohibited from submitting claims to Medicare any service furnished by Dr. Nemechek.

____ I **DO** have Medicare insurance or a Medicare Advantage plan.

____ I **DO NOT** have Medicare insurance or a Medicare Advantage plan.

Insurance:
(We do not accept any form of health insurance but use this information to assist you with any potential prior authorizations for prescriptions or other services. This information will not be used for any billing purposes by this office.)

Primary Insurance Company: _____ Telephone #: _____

ID: _____ Group Number: _____

Group Plan Name: _____ Effective Date: _____

Policy Holders Name: _____ Policy Holder DOB _____

Policy Holder's SS#: _____ - _____ - _____ Relationship to patient: _____

INFORMED CONSENT, PROPRIETARY INFORMATION, ELECTRONIC RECORDS, CANCELLATION /RESCHEDULE/NO-SHOW POLICY

YOU ARE ASKED TO READ THE FOLLOWING MATERIAL TO ENSURE THAT YOU ARE INFORMED OF THE NATURE OF YOUR TREATMENT BY DR. NEMECHEK THROUGH THE "HELLO HEALTH PORTAL" (Electronic Records) AND OF DR. NEMECHEK'S CANCELLATION, RESCHEDULE, and NO-SHOW POLICY. SIGNING THIS FORM WILL INDICATE THAT YOU HAVE BEEN SO INFORMED AND THAT YOU HAVE GIVEN YOUR CONSENT TO BOTH.

MEDICAL TREATMENT

Dr. Patrick Nemechek, D.O. provides only consultative medical care for his patients. He does not provide primary care services. You should be aware that every treatment has associated risks, benefits and alternatives. You are welcome to ask all the questions you need in order to decide for yourself to go through with any proposed procedure or treatment.

The use of vagus nerve stimulation in some circumstances is considered experimental and has not been proven effective in large scale randomized trials. Information from your care may be used anonymously as a source of research data for presentation at research conferences or publication in medical journals.

ELECTRONIC RECORDS SYSTEM

Dr. Patrick Nemechek, D.O. uses telephone, fax, e-mail, text, and electronically (currently the "Hello Health Electronic Portal") to communicate with tie and you hereby consent to be contacted in that manner.

TERMINATION OF TREATMENT

You have the right to refuse any treatment recommended to you by Dr. Nemechek, and you can withdraw as a patient at any time. Should you choose to be cared for by another health care provider, we would like to know of your decision, so we may provide you with an exit copy of your medical records.

CANCELLATION, RESCHEDULE, and NO-SHOW POLICY

Due to the high level of service and amount of time spent with each patient by Dr. Nemechek any changes to an appointment, or the failure to appear at any appointment, affects us greatly and thus our cancellation/reschedule/no-show policy is strictly enforced. **All cancellations or appointment changes to another day must be done no later than 7 days before an initial visit and no later than 48 hours before the time of any other appointment** by calling Nemechek Autonomic Medicine, by telephone at 623-208-4226.

Failure to notify us by telephone within those advanced time frames, or failure to show at any appointment time (this includes failure to be available for a scheduled telephone conference call), shall result in an immediate and non-refundable charge equal to the amount of the full, scheduled visit.

VOLUNTARY CONSENT

I do hereby certify that I have read the preceding, or that it had been read to me, and that I understand its contents.

_____	_____	_____
Patient Name	Patient (Guardian) Signature	Date

Nemechek Autonomic Medicine

INTELLECTUAL PROPERTY

The Nemechek Protocol ®, all materials, and all related treatment programs are the intellectual property of Dr. Patrick M. Nemechek and Jean R. Nemechek and/or their respective businesses including Autonomic Recovery, LLC, Nemechek Consultative Medicine, Inc., and Nemechek Technologies, LLC and are protected by copyright, trademark, and/or patent.

You are authorized to use these materials and the program in connection with the consultative medical care services provided to you for your personal healthcare purposes only.

No other permission, authorization, or license is granted to you with respect to these materials or in the intellectual property protecting these materials to disclose, use, copy, reproduce, prepare derivative works, distribute, record, publicly display or perform any of the proprietary materials provided to you during or after the course of the services, whether such use is for commercial or non-commercial purposes.

___ I am a healthcare professional ___ I am **not** a healthcare professional

Occupation: _____

Employer: _____

Address: _____

_____

Phone: _____

Website: _____

Name and relationship to you of other persons who will be attending your appointment, if any:

_____

_____

_____ _____ _____

Patient Name Patient (Guardian) Signature Date

Nemechek Autonomic Medicine

AGREEMENT AND AUTHORIZATION
REGARDING PAYMENT AND INSURANCE

All patients must read and sign this agreement (and any necessary insurance forms) before seeing the doctor. By signing this agreement, I am confirming that I have read and understand the agreement, and agree to be bound by its terms. If there is any part I do not understand, I will discuss it with the doctor or other staff member before signing.

Full payment for services (including co-payments and deductibles) is due at the time services are provided to me by Nemechek Autonomic Medicine (NAM). Payment may be made with cash, a check, or a credit card. Outstanding balances are subject to monthly finance charges as allowed by law. If NAM participates in my health insurance plan, I may assign my insurance benefits to NAM. However, my insurance plan might not pay the entire amount of my charges, and I am responsible for all amounts not paid by insurance. NAM is committed to providing me with the best care possible, and is not obligated to accept the amount my insurance company pays based on its rates for "usual and customary" charges. Any amount not paid by my insurance company within sixty (60) days of the date services are provided will automatically be transferred to my personal account.

By signing this agreement, and in consideration of the services to be provided me by NAM, I am assigning to NAM all my rights, claims, and causes of action against my health insurance company and any other entity or person responsible for payment of my account at NAM, to the extent of my account balance plus all costs of collection including, but not limited to, attorney fees, expenses, and court costs. However, it is understood and agreed I am not personally responsible for any such costs of collection. I am also agreeing to cooperate with and assist NAM in its efforts to collect all amount due NAM based on services provided me.

As part of such cooperation, I agree that my file information (including Protected Health Information), to the extent necessary, may be released to third parties (including, but not limited to, attorneys, government agencies, and insurance companies) by NAM in furtherance of its efforts to collect amounts owed to it for services rendered to me until such time as I withdraw this authorization (which may only be done prospectively). NAM may also retain an attorney or other party on my behalf, at its sole expense, to further any such collection efforts. However, nothing herein shall obligate NAM to retain attorneys or other parties, either on its behalf or mine or to prosecute any legal action.

All pricing is subject to change without notice. All visit times are approximate and may include time spent in other communications with Dr. Nemechek or his office. Patients are charged a flat fee for the length of time of the visit on the schedule, whether or not the full time is used. There is no additional charge if extra time is required to finish a clinical visit.

This agreement shall be binding on and inure to the benefit of me, NAM, and both our successors, assigns, heirs, representatives, and estates, and will be interpreted according to Arizona law.

_____ Date: _____

Patient signature

_____

Patient Name Printed

Nemechek Autonomic Medicine

RECEIPT OF NOTICE OF PRICACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM
AND
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices of Nemechek Autonomic Medicine.

I hereby give my consent for Nemechek Autonomic Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Nemechek Autonomic Medicine) 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. Nemechek Autonomic Medicine, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Nemechek Autonomic Medicine. Privacy Officer: Patrick M. Nemechek, D.O., Nemechek Autonomic Medicine, 4252 N. Verrado Way, Suite 103, Buckeye, Arizona, 85396.

With this consent, Nemechek Autonomic Medicine, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Nemechek Autonomic Medicine, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Nemechek Autonomic Medicine, may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Nemechek Autonomic Medicine, restrict how it uses or discloses my PHI to carry out TPO.

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 Nemechek Autonomic Medicine's use and disclosure of my PHI to carry out TPO.

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, Nemechek Autonomic Medicine, may decline to provide treatment to me.

Patient Name Printed: _____

Guardian Name Printed (if applicable): _____

Patient or Guardian Signature: _____

Date: _____

Nemechek Autonomic Medicine

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

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 INDENTIFIABLE 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 or 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 OUR PRIVACY OFFICER: Patrick M. Nemechek, D.O., Nemechek Autonomic Medicine, 4252 N. Verrado Way, Suite 103, Buckeye, AZ 85396. Telephone (623) 208-4226.

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 your. 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.

1. 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.

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

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

4. 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.

5. Release of Information to Family/Friends. Our practice may release your IIHI to a friend, family member or guardian that is involved in your care, or who assists in taking care of you.

6. 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 the purpose of:

- Maintaining vital records, such as births and deaths.
- Reporting child abuse or child 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 an 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 out 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 Institutional 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 the 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 at work. In order to request a type of confidential communication, you must make a **written request** to our **Office Manager**, 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.

For more information, please call our Office Manager at (623) 208-4226.

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 our **Office Manager**. 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 notes. You must submit you request **in writing** to our **Office Manager** in order to inspect and/or obtain a copy of your IIHI. Our practice may change 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 in certain limited circumstances; however, you may request review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. 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 and amendment, your request must be made **in writing** and submitted to our **Office Manager**. 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, unless the individual or entity that created the information is not available to amend the information.

5. 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 non-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 our **Office Manager**. All requests for an "accounting of disclosures" must state a time period, which may 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 will be provided free of charge. 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 our **Receptionist**.

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, it must be **in writing** and submitted to our **Privacy Officer**. **You will not be penalized for filing a complaint.**

8. Right to Provide and 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 reasons 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 our **Privacy Officer.**