ATTENTION ALL PATIENTS

Our goal is to provide quality health care to all our patients in a timely manner. No-shows, late arrivals, and cancellations inconvenience not only our provider, but our other patients as well. Please be aware of our policy regarding confirming & missed appointments.

Confirming appointments

All appointments MUST be confirmed 24hrs in advance via email/text or call the office. If they are not confirmed your appointment will automatically be cancelled.

Appointment Cancellation

When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment.

If cancellation is necessary, we require that you call at least 24hrs in advance. Appointments are in high demand, and your advanced notice will allow another patient access to that appointment time.

How to Cancel Your Appointment

If you need to cancel your appointment, please call us at 973-974-9946 between the hours of Monday-Thursday 9am-5pm and Friday 9am-2pm. If necessary, you may leave a detailed voicemail message. We will return your call as soon as possible or the next business day if left after hours.

Late Cancellations/No-Shows

A cancellation is considered late when the appointment is cancelled less than 24hrs before the appointed time. A no-show is when a patient misses an appointment without cancelling. In either case, we will charge the patient $50.00 for a NO SHOW follow up appointment and $250.00 for a NO SHOW EMG or EEG appointment. These fees must be paid before rescheduling a new appointment.

For NEW PATIENTS' first appointments, a no show or late cancellation will result in a FULL CHARGE of the new patient fee of $600.00.

SIGNATURE______________________________________

DATE___________________

THE NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY

DR. GUHA K. VENKATRAMAN M.D., F.A.A.N.

340 East Northfield Rd., Suite 1B, Livingston NJ 07039

Phone: 973-974-9946 Fax: 973-500-4411

FEE SCHEDULE

__________	1/2 PAGE LETTER, SHORT FORM	$15
__________	1 TO 2 PAGE FORM	$25
__________	2 OR MORE PAGE FORM	$50
__________	MISSED APPOINTMENTS	$50
__________	MISSED EEG + EMG	$250
__________	MEDICATION REFILLS AFTER HOURS	$35
	MISSED NEW PATIENT APPOINTMENT	$600

SIGNATURE OF RESPONSIBLE PARTY__________________________

PRINT NAME OF PATIENT__________________________

NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY

340 East Northfield Road, Suite 1B Livingston, NJ 07039
Phone: (973) 974-9946 | Fax: (973) 500-4411

PATIENT INFORMATION

DATE:________________

Name:______________________________
Address:____________________________
City:_______________________________
State:__________ Zip:______________
Home Phone:(______) ______-________
Cell Phone:(______) ______-________
Age:________ Date of Birth:____________
Emergency Contact:___________________
Emergency Phone:____________________
Male (__) Female (__)
Is the patient the insured party? (__) Y (__) N

Social Security #:_____________________
Referring M.D:________________________
Primary M.D:__________________________
Employer Name:_______________________
City:________________________________
State:____________ Zip:_______________
Business Phone: (_____) _____-_____

Does the patient have any disability that may require special accommodation? (__) Yes (__) No
If Yes, please check one: (__) Wheelchair User
(__) Deaf or Hard of Hearing (__) Blind (__) Other

EMAIL ADDRESS______________________________________

PREFERRED PHARMACY INFORMATION

Preferred Pharmacy Name:____
Address:____
Phone Number:______________________________
Fax Number:________________________________

INSURANCE INFORMATION

Primary Insurance Company:______________________________

Subscriber Name:______________________ ID:______________________

Secondary Insurance Company:______________________________

Subscriber Name:______________________ ID:______________________

GURANTOR INFORMATION

(List Person or Insured Name responsible for bill. Use full Legal Name and No Nick Name)

Relationship of Guarantor to Patient: Self_______ Spouse _______ Parent _______ Other _______

Last Name:__________________ First Name__________________ Middle Initial_______

Address:______________________________

City__________________ State:__________________ Zip:______________

Preferred Phone#:______________________ DOB:______________________

Sex: Female______________________ Male:______________________

Employer Name:______________________________

Employer Address:______________________________

Work Phone#:______________________________

Financial Responsibilities : I hereby authorize and assign all claims for payment of any insurance or third parties directly to NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY for the services I received. I understand I am responsible for payment in full. I acknowledge I am responsible for any co-payments, deductibles, co-insurance, and non-covered services. I understand its NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY choice to appeal any denied claims or seek payment from me. I authorize NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY or any of its affiliated designee to contact me regarding my financial responsibilities in various methods such as email, text messages, the use of an automated dialing service or pre-recorded message. I understand it's my responsibility to update any changes to my contact information to NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY change of insurance, employer, home address, home number, cellular number, and email address.

____

Authorized Signature:______________________________ Date:______________

Neurological Institute of Northern New Jersey, LLC

340 East Northfield Road, Suite 1B

Livingston, NJ 07039

PATIENT MEDICAL QUESTIONAIRE

Name:_________________________________ Date: _____________
Address: ____
City: ________________ State:______________________ Zip: _____________
Home Phone: ______________ Cell phone: ______________

Sex: _____ Age: ____ Date of Birth: __________Email: _________________________

Physician's Name: __________________________ Phone: ____________________
Address: ____
Were you referred by your physician? Yes/No If not, how were you referred?
______________________ shall we send a report to your physician? Yes/No

Years of school: 7 8 9 10 11 12 13 14 15 16 17 18 19 20

Marital Status: Single Married Remarried Divorced Widowed Separated
How many years? _____ Number of children: _____ Ages: __________
Primary Occupation: ________________ Years: _____________
Previous/other occupations, hobbies: ____________________________________
Spouse's Occupation: ____
Last worked: __________________Are you disabled from work: Yes _____ No ________
Reason: ____

Exposure to hazardous materials: Yes _____ No ____ Type _________________________

What is the chief problems that brings you here: _________________________________
How long have you had the problem? ____
What do you think might be causing it? ______________________________________

PAST MEDICAL HISTORY:

Year	Illness/operations	Place of hospitalization	Do not write here
_____	________________	__________________	
_____	________________	__________________	
_____	________________	__________________	
_____	________________	__________________	

Family History: List parents and all siblings. If deceased, please list age of death and cause.

Living?	Age:	Any known medical conditions or cause of death
Spouse:		
Children:		
Mother:		
Father:		
Sisters:		
Brothers:		

Is there a family history of any of the following in a blood relative, including parents, siblings, aunts, uncles, grandparents, etc.

Stroke	Tuberculosis	Breast Cancer	Kidney disease
Heart surgery	Glaucoma	Colon Polyps	Alcoholism
Aneurysm	Nervous breakdown	Arthritis	Thyroid disease
Liver problems	Kidney stones	Epilepsy	Colon cancer
Diabetes	Kidney failure	Migraine headaches	Asthma/emphysema
High blood pressure	High cholesterol / Triglyceride	Other cancer	Heart attack/angioplasty

Other problems________________

MEDICINES: List all medicines that you have been taking recently. Include all vitamins and non-prescription medicines. Please bring all on day of visit.

Name:	Dose(mg's & times per day)	Date started	Date stopped	Name:	Dose (mg's & times per day)	Date started	Date stopped
1.				5.			
2.				6.			
3.				7.			
4.				8.			

Have you used and "recreational" drugs? ___Yes ___No Kind: ________________

ALLERGIES or reactions to medicines or other substances. List all medications and substances.

Name of Medication:	Type of Reaction:	Date:

IMMUNIZATION/VACCINES and Date:

Pneumonia (pneumovax)________________

Measles ________________

Tetanus ________________

Other ________________

Hepatitis ________________

BCG ________________

Flu ________________

PREVIOUS STUDIES/DATE (Bring copies of recent test and x-ray results)

Chest X-ray ________________ Cat Scan Head ________________ Bronchoscopy ________________

Kidney/IVP________________ Cat scan Other ________________ Echocardiogram________________

Stomach/UGI________________ Colon/ Barium Enema ________________MRI ________________

Ultrasound of________________ Stress test ________________ Protoscopy________________

PERSONAL HABITS:

Tobacco: ____Yes ______ No Have you ever smoked? ____ Yes ______ No

Type and amount ______________________ Years _________ If stopped, When? _________

Have you tried to stop? ______ Yes ______ No Do you wish to stop? ____Yes ____No

Alcohol: Amount (including beer, wine, and liquor) ______________________

Have you felt the need to cut down on alcohol? ______ Yes ______ No

Do you feel guilty about the amount used? ______ Yes ______ No

Have you had a problem with alcohol? ______ Yes ______ No

Have you had a drink in the last 24 hours? ______ Yes ______ No

Coffee, Tea and Cola Beverages: (amount per day): ______________________

Travel: (Where and when in the last 2 years): ______________________

Diet: Any special diets or change in eating habits? ______________________

Exercise: Any exercise? ____Walking ____ Athletic ____Other ______________________

Is the purpose of this examination to determine disability status for the government or an insurance company? ______ Yes ______ No

Have you had an injury for which there is now a lawsuit pending? ______ Yes ______ No

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Do you have any of the following:

Recent weight gain? (amount) ______________ ______ Yes ______ No

Recent weight loss? (amount) ______________ ______ Yes ______ No

Fever or soaking sweats at nights? ______ Yes ______ No

Fatigue? ______ Yes ______ No

Weakness, numbness, tingling, cramps at night of arms or legs? ______ Yes ______ No

New, frequent or severe headaches? ______ Yes ______ No

Falls, imbalance or difficulty walking? ______ Yes ______ No

Loss of consciousness, fainting or convulsions? ______ Yes ______ No

Loss of memory or confusion? ______ Yes ______ No

Problem with vision or eyes? ______ Yes ______ No

Date of last eye exam? ______________

Do you wear glasses or contact lenses? ______ Yes ______ No

Change in hearing? ______ Yes ______ No

Do you use a hearing aid? ______ Yes ______ No

Change in speech or voice? ______ Yes ______ No

Dizziness? (__ Spinning __ Lightheadedness) ______ Yes ______ No

Frequent or severe nosebleeds? ______ Yes ______ No

Trouble chewing or swallowing? ______ Yes ______ No

Sore tongue or mouth or dental problems? ______ Yes ______ No

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Daily cough or cough with bloody phlegm? ______ Yes ______ No

Short of breath after walking up two flights of stairs or hurrying? ______ Yes ______ No

Short of breath when just sitting or reclining? ______ Yes ______ No

Discomfort or pain in chest? ______ Yes ______ No

Swelling of the ankles every day? ______ Yes ______ No

Do you have any of the following:

Abdominal pain?	___ Yes	___ No
Frequent heartburn or indigestion?	___ Yes	___ No
Change in bowel habits?	___ Yes	___ No
Black or bloody bowel movements?	___ Yes	___ No
Difficulty urinating?	___ Yes	___ No
Do you lose control of urine at times?	___ Yes	___ No
Awaken at night more than once to urinate?	___ Yes	___ No
Sexual problems or change in sex drive?	___ Yes	___ No
Do you have any discharge?	___ Yes	___ No

Any changes in skin, moles, rash?	___ Yes	___ No
Persistent painful stiff or swollen joints?	___ Yes	___ No
Back pain or discomfort?	___ Yes	___ No

Do you enjoy your work?	___ Yes	___ No
How many people in your household?	___ Yes	___ No
Any stress or frequent conflict at home?	___ Yes	___ No
Do you feel anxious or depressed?	___ Yes	___ No
Have you seriously considered suicide?	___ Yes	___ No
Difficulty in sleeping?	___ Yes	___ No
History of hospitalization for an emotional problem?	___ Yes	___ No

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Women only:

Are menstrual periods normal?	___ Yes	___ No
Date of last menstrual period?	___ Yes	___ No
Bleeding between periods or after menopause?	___ Yes	___ No
Any "hot flashes?"	___ Yes	___ No
Any pain or dryness with intercourse?	___ Yes	___ No
Any breast discharge?	___ Yes	___ No

Pregnancies____ Deliveries______

Miscarriages______ Abortions______

Approximate date of last PAP smear? ________________

Have you used hormones? ___ Yes ___ No

Have you ever had?

___ Asthma
___ AIDS or HIV Testing
___ Skin Cancer
___ Diabetes -Years________
___ Gonorrhea
___ Heart Murmur
___ Heart Attack -Year________
___ Hepatitis
___ Herpes
___ Kidney Stones
___ Bladder Infection
___ Kidney Infection
___ Radiation or Chemotherapy
___ Phlebitis or Blood Clots
___ Pneumonia
___ Polio
___ Rheumatic Fever
___ Stroke
___ Syphilis
___ Cancer
___ Thyroid Trouble
___ Ulcer
___ Tuberculosis
___ Colon Polyps
___ Sexually Transmitted Disease
___ Migraine/Head Pain

Have we left anything out that you are concerned about or feel is important about your health?

____

____

NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY

340 East Northfield Road, Suite 1B Livingston, NJ 07039

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO NEUROLOGICAL INSTITUTE OF NORTHERN NJ

PATIENT NAME:______________________________ D.O.B.:______________________

S.S.#:______________________________

I hereby authorize______________________________ to disclose my health information to:

NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY

340 East Northfield Road, Suite 1B Livingston, NJ 07039

The above named patient is currently being treated at NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY and this information is needed as soon as possible for continuing medical care. Please fax the requested information to the following :

Fax#: 973-500-4411

The information to be disclosed to and used by the above is for the following purpose:______________________________

This authorization is limited to the following dates of treatment: FROM______________________ TO______________________

Information to be disclosed:

~ EMERGENCY ROOM RECORD
~ HISTORY & PHYSICAL EXAM
~ OPERATIVE REPTS & PATHOLOGY
~ ADMISSION ASSESSMENT
~ CONSULTATIONS
~ PROGRESS NOTES
~ LAB, X-RAYS & TESTS
~ MEDICATIONS
~ DISCHARGE SUMMARY
~ COMPLETE RECORD
~ ABSTRACT
~ OTHER

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, AIDS and HIV, SEXUALLY TRANSMITTED, TUBERCULOSIS AND other INFECTIOUS DISEASE information, as applicable.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if 1 revoke this authorization, 1 must do so in writing and present my written revocation to NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY. 1 understand the revocation will not apply to the extent that NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY has already taken action in reliance on this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition:______________ .

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY at 973-974-9946.

PATIENT SIGNATURE:______________________________ DATE:______________________

If legal representative, sign below, state relationship and authority to do so **and** attach the document of authority.

LEGAL REPRESENTATIVE:______________________________ DATE:______________________

RELATIONSHIP:______________________________

WITNESS:______________________________ DATE:______________________

(Two signatures required for Verbal Consent)

ORIGINAL - RECORD COPY - PATIENT

NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY

340 East Northfield Road, Suite 1B Livingston, NJ 07039

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME:______________________________ D.O.B.:______________

ADDRESS:____

TELEPHONE:____

I hereby authorize NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY to disclose my health information to:

____

____

____

The information to be disclosed to and used by the above is for the following purpose:______________

____

This authorization is limited to the following dates of treatment:

FROM______________________ TO______________________

Information to be disclosed:

~ EMERGENCY ROOM RECORD
~ HISTORY & PHYSICAL EXAM
~ OPERATIVE REPTS & PATHOLOGY
~ DISCHARGE SUMMARY

~ CONSULTATIONS
~ PROGRESS NOTES
~ TESTS
~ NURSES` NOTES

~ COMPLETE RECORD
~ ABSTRACT
~ BILLING INFORMATION
~ OTHER______________

I understand that the information to be disclosed includes my identity, diagnosis and treatment including ALCOHOL, DRUGS, GENETIC TESTING, BEHAVIORAL OR MENTAL HEALTH SERVICES, REPRODUCTIVE RIGHTS, SEXUALLY TRANSMITTED & INFECTIOUS DISEASES, AIDS and HIV information, as applicable.

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PATIENT SIGNATURE:______________________________ DATE:______________

If legal representative, sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE:______________________________ DATE:______________

RELATIONSHIP:______________________________

WITNESS:______________________________ DATE:______________

ORIGINAL - RECORD COPY - PATIENT

NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY
340 East Northfield Road, Suite 1B
Livingston, NJ 07039
Phone (973) 974-9946
Fax (973) 500-4411

Guha Venkatraman MD, FAAN

PHYSICIAN PRACTICE'S NOTICE OF PRIVACY PRACTICES

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information," or "PHI" for short, it includes information that can be used to identify you and that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Whenever we make an important change to our policies, we will promptly change this notice and post a new notice on our website. You can also request a copy of this notice from the front desk staff at any time and can view a copy of this notice on our website at www.NINNJ.com.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFO RM ATI ON.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disc l os ure s.

A.Uses and Disclosures Which Do Not Require Your Authorization
.
We may use and disclose your PHI without your authorization for the following reasons:

1. For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services, except where the PHI is related to HIV/AIDS, genetic testing, or federally funded drug or alcohol abuse treatment facilities, or where otherwise prohibited pursuant to State or Federal law. For example, we may disclose PHI to a pharmacy to fill a prescription, or to a laboratory to order a blood test.

2. To obtain payment for treatment. We may use and disclose your
PHI in order to bill and collect payment for the treatment and sen/ices provided to you. For example, we may provide portions of your PHI to our billing staff and your health plan to get paid for the health care services we provided to you. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. For example we may disclose your demographic information to anesthesia care providers for payment of their services.

3 . For health care operations. We may disclose your PHI, as necessary, to operate this facility and provide quality care. For example, we may use your PHI in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we're complying with the laws that affect us.

4 .
When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.

5 . For public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.

6 . For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits; civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.

7 . To coroners, funeral directors, and for organ donation. We may
disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.

8 . For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.

9 . To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10 . For specific government functions. We may disclose PHI of military personnel and veterans in certain situations. We may also disclose PHI for national security and intelligence activities.

11 . For workers' compensation purposes. We may provide PHI in
order to comply with workers' compensation laws.

12 . Appointment reminders and health-related benefits or services. We may use PHI to provide appointment reminders or give you information about treatment alternatives, or other health care services or benefits we offer. Please let us know if you do not wish to have us contact you for these purposes, or if

you would rather we contact you at a different telephone number or addre ss.

B. Uses and Disclosures Where You to Have the Opportunity to Object :

1. Disclosures to family, friends, or others. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part.

C. All Other Uses and Disclosures Require Your Prior Written Autho rizatio n. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon the authorization.

D. Incidental Uses and Disclosures. Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure. However, such incidental uses or disclosure are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient within the office that might be overheard by persons not involved in your care would be permitted.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. Under certain circumstances, we may terminate our agreement to a restriction.

B. The Right to Choose How We Send PHI to You. You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, via e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the manner you requested.

C. The Right to See and Get Copies of your PHI. In most cases, you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request a copy of your information, we may charge you a reasonable fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, those made pursuant to your written authorization, or those made directly to you or your family. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14, 2003.

We will respond within 60 days of receiving your written request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide one (1) list during any 12-month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

E. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request in writing. We may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to have your request and our denial attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. The Right to Get This Notice by E-Mail. You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W.; Room 615F; Washington, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THISNOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: Office Manager, 973-974-9946.

VII. EFFECTIVE DATE OF THIS NOTICE

This notice is effective April 14, 2003.

I acknowledge receipt of NEUROLOGICAL INSTITUTE OF NORTHERN NEW JERSEY.

Print Name____

Signature: ____ Date :______________________