NeuroDiagnostic Laboratories

Patient Name: ________________________________ **Date of Birth**: ____ /____ / ____ **Last 4 of SSN**: __________

Current Mailing Address: ____ # _____________

City: ____________________________ **State**: __________ **Zip Code**: ___________________

Email Address: ____

Home ( ) ________ - ________ **Work** ( ) ________ - _________ **Cell** ( ) _______ - __________

Gender: ☐ Male ☐ Female ☐ Other **Relationship Status**: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widowed

Race: ☐ African American (Black) ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian (White)

☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ Other ____________________________________

Ethnicity: Hispanic/Latino/Spanish origin ☐ Yes ☐ No

Preferred Language: ☐ English ☐ Spanish ☐ Other (please specify) ____________________________

EMERGENCY CONTACT INFORMATION

*__Name__: ________________________ **Relationship**: ____________________ **Phone:** ( ) ________ - _________

Primary Care Physician: ____________________________________ **Phone:** ( ) ________ - _________

PRIMARY INSURANCE: ***Complete the information below if you DO NOT HAVE a current insurance card at time of appointment.***

Insurance Carrier: ____________________________ Insurance Billing Address: ______________________________

Group #: ____________________________________ Member ID: ____

Policy Holder (if not self): ______________________________ Policy Holder DOB: _______ / ______ / ________

SECONDARY INSURANCE:

Insurance Carrier: ____________________________ Insurance Billing Address: _____________________________

Group #: ____________________________________ Member ID: _______________________________________

Policy Holder (if not self): ______________________________ Policy Holder DOB: _______ / ______ / ________

PREVIOUS INSURANCE:

Have you changed insurance plans within the last 12 months? ☐ Y ☐ N

If, yes provide previous insurance carrier name: _________________________________

Subscriber ID (if known): _________________ Date of termination (if known): __________________________

WORKERS COMP? ☐ Y ☐ N **Auto Accident:** ☐ Y ☐ N **Date of Injury:** _____ / ______ / ______

W/C Office: ________________________________ **Claim #:** ______________________________________

Adjuster's Name: ____________________________ **Adjusters Phone:** ( ) ________ - _________ ext. _________

Neuro Diagnostic Sleep Centers

Appointment Date
_______/_________/_______

MEDICAL HISTORY

Is there a possibility that you may be pregnant? ☐ Yes ☐ No
Are you currently receiving palliative care? ☐ Yes ☐ No
**Palliative care is specialized medical care that focuses on providing patients relief from pain and other symptoms of a serious or life-threatening illness, no matter the diagnosis or stage of disease.*

Have you been vaccinated for either of the following?
Influenza ☐ Yes ☐ No If yes, date of vaccination ____ /____ / ____
Pneumococcal ☐ Yes ☐ No If yes, date of vaccination ____ /____ / ____

FAMILY HISTORY

For each family member below, please indicate below if any of your immediate family members have any of the following: diabetes, obesity, heart problems, hypertension, degenerative conditions such as Parkinson's Disease or Alzheimer's, cancer, other.

Mother____ Father_______________________________________
Brother____ Sister____
Paternal grandmother______________________________ Paternal grandfather__________________________

Family History of Sleep Disorders?
Disorder/Diagnosis_______________________ Relation_______________________
Disorder/Diagnosis_______________________ Relation_______________________

PAST MEDICAL HISTORY

Do you currently have or have you ever had any of the following (choose all that apply):

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) ___________________
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Other______________________
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Impotence/Erectile Dysf.

Have you ever been hospitalized? ☐ Yes ☐ No
If so, what were the circumstances of your hospitalization? __________________________________
Have you been diagnosed with COVID-19? ☐ Yes ☐ No
If so, when did you experience the last COVID-19 symptom? ______________________________
Did you have a subsequent negative test? ____
Have you ever been diagnosed with any of the following: ☐ Insomnia ☐ Narcolepsy ☐ Deviated Septum
Are you currently taking or have you ever taken medication to help you sleep? ☐ Yes ☐ No
If yes, which please list the medication(s): ____
How long did you take these medications? ____

Neuro Diagnostic Sleep Centers

Appointment Date
_______/_________/_______

SOCIAL HISTORY

Smoking Status: ☐ Smoker ☐ Occasional Cigarette Smoker ☐ Ex-Smoker ☐ Non-Smoker

Frequency: ☐ Light (1-9 Cigarettes/day) ☐ Moderate (10-19 Cigarettes/day)
☐ Heavy (20-39 Cigarettes/day) ☐ Very Heavy (40+ Cigarettes/day) ☐ Chain Smoker

Other Tobacco Use: ☐ Chews Tobacco ☐ Cigar Smoker ☐ Pipe Smoker ☐ Cigar Smoker ☐ Snuff User

Do you drink alcohol? ☐ NO ☐ YES If yes, ☐ Beer ☐ Wine ☐ Liquor/Mixed Drinks
_____ times per day/week/month/year (please circle)

Do you use medical or recreational marijuana? ☐ NO ☐ YES If yes, _____times per day/week/month/year (please circle)

CURRENT MEDICATIONS

☐ ***No current medications***

Please include all medications including over the counter medications and supplements

Name of Medication	***Strength/Dosage***	***Frequency***	***Method (Oral, topical, nasal, intravenous, intramuscular, inhalation, sublingual, etc.)***

ALLERGIES

☐ ***NO KNOWN ALLERGIES***

______________________________ ______________________________ ______________________________

Neuro Diagnostic
Sleep Centers

Appointment Date

______/________/______

Patient Name: ______________________________________ DOB: _____/_____/_____

Symptoms	X
Loud snoring	
Breathing or snoring stops in my sleep	
Awaken gasping for breath	
Become sleepy during the day	
Difficulty falling asleep	
Difficulty remaining asleep	
Awaken too early	
My mind races with many thoughts when I try to fall asleep	
I often worry whether or not I will be able to fall asleep	
Fatigue	
Awaken with a dry mouth	
Vivid or lifelike visions (people in room, etc.) as you fall asleep or wake up	
Irritability/ Depression	
Memory impairment or Inability to concentrate	
Sinus trouble, nasal congestion or post-nasal drip interfering with sleep	
Heartburn, sour belches, regurgitation, or indigestion which disrupts sleep	
Pain which delays, prevents, or awakens me from sleep	
Inability to move as you are trying to go to sleep or wake up	
Morning headaches	
Sudden weakness or feel your body go limp when you are angry or excited	
Irresistible urge to move legs or arms	
Creeping or crawling sensation in your legs before falling asleep	
Legs or arms jerking during sleep	
Frequent urination disrupting sleep	
Sleep talking or Sleep walking	
Restless sleep	
Hyperactivity	
Daytime inattention	
Frequent awakenings	
Learning problems	
Bedwetting	
Night-time fears	

Sleep Habits:

At what time do you usually get in bed on workdays? ______________________
At what time do you usually get in bed on weekends? ______________________
You usually wake up from sleep at what time on workdays? ______________________
You usually wake up from sleep at what time on weekends? ______________________
How many times do you awaken each night? ____________________
After waking up, how much time do you spend in bed?____________________
Total amount of time you spend awake in bed?____________________
Total amount of time asleep in bed? ______________________

Neuro Diagnostic Sleep Centers

Appointment Date
______/________/______

If you do rotating shift work, or have other work schedule changes and need more space to describe? ____

Describe any sleep issue(s) you are experiencing: ____
____

Sleeping Arrangements:

Do you share a room and/or bed with: ☐ another person(s), ☐ with pets, ☐ N/A

Do you sleep in a: ☐ bed ☐ sitting up in a chair/recliner ☐ couch/futon?

If you sleep in a bed, how many pillows do you use? _______________

Do watch TV while falling asleep? ☐ Yes ☐ No

Do you use mobile devices (phone/tablet/laptop) right before falling asleep? ☐ Yes ☐ No

Sleep Treatment History:

Have you ever had a sleep study conducted? ☐ Yes ☐ No

If yes, please answer the following questions:

- What year was your sleep study conducted? _____________
- Were you diagnosed with sleep apnea? ☐ Yes ☐ No
- Have you ever been treated with positive airway pressure (PAP) therapy? ☐ Yes ☐ No
- If yes, please bring your SD card or PAP therapy machine into the office for download or review.
- Do you have a durable medical equipment (DME) company that you have used or currently use? ☐ Yes ☐ No
- If yes, please list the name of the company ___________________________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the **most appropriate number** for each situation. 0 = would never doze; 1 = slight chance of dozing; 2 = moderate chance of dozing; 3 = high chance of dozing

Situation	Score
Sitting and reading	
Watching TV	
Sitting, inactive, in a public place(e.g., a theater or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking with someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
Total*	

*Greater than 10 indicates sleepiness

NeuroDiagnostic Sleep Centers

Appointment Date

______/________/______

Review of Symptoms

Please Check ALL That Apply

CARDIAC	Chest Pain		Murmur(s)		Palpitation(s)	
CONSTITUTIONAL	Fatigue		Fever		Sleep Disorders	
	Weight Gain		Weight Loss			
EARS,NOSE,THROAT	Difficulty Swallowing		Hearing Aids		Ringing In Ears	
	Ear Pain		Hearing Loss			
ENDOCRINE	Diabetes		Thyroid			
EYES	Blurred Vision		Double Vision		Eye Pain	
GASTROINTESTINAL	Abdominal Pain		Constipation		Heartburn/Reflux	
	Bowel Incontinence		Diarrhea		Vomiting	
HEMATOLOGIC	Anemia		Easy Bruising			
INFECTIOUS	AIDS / HIV		Scabies		Tuberculosis	
	Hepatitis		Sexually Transmitted Disease(s)			
MUSCULOSKELETAL	Joint Pain		Muscle Pain		Other	
NEUROLOGICAL	Difficulty with Speech		Fainting/Black Out		Numbness	
	Difficulty Using Hands		Headache(s)		Seizures	
	Difficulty Walking		Memory Loss		Tingling	
	Dizziness		Muscle Weakness		Tremors	
PSYCHIATRIC	Anxiety		Bi-Polar Disorder		Depression	
RESPIRATORY	Asthma		Chronic Cough		Shortness of Breathe	
UROLOGIC	Kidney Stones		Painful Urination			
	Prostate Disorder		Urinary Hesitation		Impotence/Erectile Dysfunction	

Sleep Consultation Consent

I have been referred to AMDx, LTD (dba, NeuroDiagnostic Laboratories) for a sleep consultation to determine if I am a candidate for sleep therapy. If it is determined that I am an eligible candidate for sleep therapy, related service(s) will be scheduled and rendered at a later date.

I understand that the provider will be asking me a series of questions regarding my current condition in order to complete an evaluation and recommend possible treatment options.

I HAVE BEEN ADVISED OF AND UNDERSTAND THE DEFINITIONS AND PROCEDURES DESCRIBED WITHIN THIS DOCUMENT AND AGREE TO PROCEED WITH THE SLEEP CONSULTATION.

Patient Name (printed): ________________________

Patient Signature:_____________________________ Date: ____/____/____

If applicable, please print the name of the patient's representative:___________________________________

Relationship to Patient: __________________________________

Representative Signature: __________________________________

FINANCIAL POLICY

As a courtesy, our facility will submit a claim to your insurance carrier on your behalf. However, practical benefits are not determined until a claim is received by your insurance company. When requested, we will provide an estimate of your cost share, as determined by your insurance carrier. Therefore, as the patient and/or responsible party, you are responsible for providing us with the most current and complete information regarding your insurance coverage. This includes but is not limited to; Health Plan Name, Policy ID and Group ID (when applicable), Cardholder Name (if different than the patient) and providing a copy of your insurance card at the time of service. It is also your responsibility to pay any amounts determined to be patient responsibility by your insurance carrier, at the time service is rendered. Any service(s) denied by your insurance for reasons that cannot be appealed by our medical group, will become the financial responsibility of the patient and/or responsible party.

For patients without coverage by an insurance carrier, payment is due in full at the time of service. Patients may apply for CareCredit healthcare financing and arrange a payment plan if approved by CareCredit.

Failure to make payment, within the agreed time(s) allotted will result in collection activity. The patient and/or responsible party will assume all financial costs assigned by the collection agency, attorney and/or court, in addition to the original patient balance with AMDx, Ltd. (dba: NeuroDiagnostic Laboratories, LLC).

A Non-sufficient Funds (NSF) Fee of $25.00 will be applied to the patient and/or responsible party balance for any returned check(s). At that point, any/all future payments must be made in cash, money order or credit/debit transactions.

I understand that if my account is sent to an outside collection agency, I will be responsible for collection fees, which may be an additional 33% of the balance due.

A no call, no show (NCNS) fee of $100 will be applied to the patient and/or responsible party if the patient fails to call to cancel their appointment or cancels their appointment less than 24-hours prior to scheduled appointment time. The NCNS fee for an in-lab sleep study is $250 and the patient must cancel their appointment 72-hours prior to their scheduled appointment to avoid incurring the fee.

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I authorize direct remittance of insurance benefit payment(s) including Medicare (when applicable) to AMDx, Ltd. / NDL, LLC and/or the affiliated entities or otherwise at its direction.

I further authorize the release of any information pertaining to the Health Care Financing Administration, My Insurance Carrier(s) and/or other entities necessary in the determination of benefit payment(s) and coverage for services and/or supplies provided to me by AMDx, Ltd. / NDL, LLC.

AUTHORIZATION TO APPEAL ON PATIENT'S BEHALF

I further authorize AMDx Ltd., (dba. NeuroDiagnostic Laboratories) and/or the affiliated entities to submit appeals on my behalf, including submissions to Medicare if I am a Medicare beneficiary. I understand that in the event of an adverse decision made by my insurance carrier(s) as it relates to coverage, authorization or payment(s), AMDx Ltd., (dba. NeuroDiagnostic Laboratories) is not obligated to file an appeal on my behalf and that by signing this authorization I am not released from any financial obligation resulting from the determination(s) made by my insurance carrier.

I HAVE BEEN ADVISED OF, UNDERSTAND AND AGREE TO THE FINANCIAL POLICY AND SUB-SECTIONS WITHIN.

Date: ______ / ______ / _______

Patient Name (printed) : ____________________________ **Patient Signature**: _______________________________

If applicable, please print the name of the Patient's Representative: ____

Relationship to the patient: ________________________ Representative Signature: _______________________________

NeuroDiagnostic Laboratories
Corporate offices
2423 W. Dunlap Avenue Suite 175
Phone: (602) 424-4450 Fax: (602) 424-4451

NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS INTENDED TO DESCRIBE HOW YOUR HEALTH INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION

**** PLEASE REVIEW THIS INFORMATION CAREFULLY ****

1) **PURPOSE:** American Medical Diagnostics, Ltd (AMDx, Ltd.), dba. NeuroDiagnostic Laboratories (NDL) and their employees follow the privacy practices described within this notice. NDL maintain your health information and confidential records, as required by law. NDL may use, disclose or share your health information as pertains to your treatment, payment of services and the general healthcare operations, necessary to provide you with quality health care.

2) **WHAT ARE TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS? Treatment** may include sharing information with the other health care providers who are involved in your care. For example, your health care provider may need to share information about your condition with a pharmacist in order for you to receive medications. **Payment** may include use of your health information as required by your insurance carrier to obtain prior authorization, when applicable, and payment for services rendered. **Health Care Operations** may include limited use of your health information to help improve the quality of your care and/or for educational purposes as it relates to the training of NDL employees and staff.

3) **HOW WILL NDL USE OR DISCLOSE MY HEALTH INFORMATION?** Your health information may be used for the following reasons or disclosed to the following individuals and entities. *Note: You may refuse any/all communications outlined below, when shown with an asterisk (*)*.

- Family members or close friends who are involved in your care or payment for treatment, or to family members, a personal representative or another person responsible for your or regarding your location, general condition or death. (*)
- Disaster Relief Agency, if you are involved in a disaster relief effort (*)
- Information provided to you, regarding alternative treatments or services related to your health (*)
- Appointment Reminders
- Public Health Activities, such as; disease prevention, injury or disability, reporting of births/deaths, reporting adverse reactions to medications or product concerns, notification of recalls, infectious disease control, and notification to government agencies for suspected abuse, neglect or domestic violence
- Health Oversight Activities, such as; audits, inspections, investigation and licensure
- For Public Safety and Law Enforcement Activities, such as reporting crime in an emergency, a death that we suspect may have resulted from criminal conduct, to report a crime at one of our facilities, or to report information about a victim of a crime
- Marketing involving treatment, case management or care coordination, to direct or recommend alternative treatments, therapies, health care providers or settings, to describe a health related product or service included in a plan or benefits. NDL will obtain your authorization prior to using or disclosing your health information for purposes of marketing items or services to you if it is paid to make the communication. You may revoke your authorization by making a written request to NeuroDiagnostic Laboratories 2423 W. Dunlap Ave. Suite 175 Phoenix, AZ 85021
- To assist Coroners, Medical Examiners and Funeral Directors in carrying out their job duties
- Organ and Tissue Donation
- Certain Research Projects or for reviews preparatory to research
- Disclosures necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public
- If the disclosure is required by federal or state law, such as in the case of child neglect or abuse reporting
- Military Command Authorities, if you are a member of the armed forces or a member of a foreign military authority
- National security and intelligence activities to authorized person who use the disclose to conduct special investigations
- Worker's Compensation Payers, as it relates to any injury and/or illness reported to or by a worker's compensation office
- For judicial or administrative proceedings if ordered by a court or in response to a subpoena
- To a correctional institution or law enforcement official if you are in inmate of a correctional facility or are under the custody of a law enforcement official to provide you with health care or to protect your health and safety or the health and safety of others, including the correctional institution.
- Use or disclosure necessary to initiate and complete health care treatment, payment and operations or functions by business associates, such as; installation of a new computer software system

Note**: Information with Additional Protection:** Certain types of medical information have additional protection under Arizona law. In some circumstances, we will require your consent to disclose information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and mental health treatment.

4) **YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES:** Except where otherwise described, use and/or disclose of your medical information will be not be released by NDL. If you would like us to release your medical information to a party/parties not otherwise mentioned, your request must be provided in writing and will only be effective as of the date you indicate. In addition, NDL require your written authorization to use or disclose your psychotherapy notes or to sell your health information. You may revoke any authorization to use or disclose your health information at any time by contacting [**insert contact info**], however, you understand that NDL may have already acted on your authorization to use or disclose your health information.

5) **WHAT ARE MY RIGHTS REGARDING MY HEALTH INFORMATION?** You have the following rights, when requested on the form(s) provided by NDL:

- **The Right to Request Restrictions:** You may request certain limitations on the usage or disclosure of your health information in relation to your health care, treatment, payment or operations. However, we are not required to comply with these types of requests, unless you request that we do not share your health information with your health insurer about a service for which you (or someone other than your insurer) has paid us in full and the disclosure is for the purpose of carrying out payment or health care operations and the disclosure is not otherwise required by law.
- **The Right to Confidential Communications:** You may request that communication regarding your health information be provided in a certain way or at a location, other than the personal address you provided. When submitting such a request, you must also provide a written method of contact for yourself; i.e., alternate phone number or address.
- **The Right to Inspect and Copy:** You may review and request a copy of your medical or health record(s). For certain requests, an administrative fee to cover the cost of the request may be applied. Under limited circumstances, your request may be denied. You then have the right to request review of the denial by another licensed health care professional, as selected by NDL. After the review is completed, NDL will comply with the outcome.
- **The Right to Request Amendment:** You may request an amendment to your medical or health record(s), if you believe that information maintained by NDL is incorrect or incomplete. However, we are not required to accept the amendment.
- **The Right to Accounting of Disclosures:** You may request a list of some of the disclosures made by AMDx Ltd./NDL of your health information. NDL may apply an administrative fee for any request received after the initial request.
- **The Right to a Copy of This Notice:** You may request a paper copy of this notice at any time, even if you have been provided with an electronic copy. To obtain an electronic copy of this notice, please refer to our website, at: www.ndxlabs.com.
- **To Be Notified in the Event of a Breach**. In the event AMDx. Ltd./NDL determine that the confidentiality of your health information has been breached, you have the right to be notified.

6) **WHAT REQUIREMENTS APPLY TO THIS NOTICE?** NDL is required by law to provide you with this notice and will continue to comply with the provisions outlined within, for as long as it is required by law. NDL reserves the right to change the terms outlined within this notice and any such changes will be effective for all information that may be in our health records for you, as well as for all future information we receive for or by you. All revisions to this notice will be available on our website, at www.ndxlabs.com. Revised paper copies will also be available, upon request. A copy of the notice may be provided to you, each time you register to receive services by NDL.

7) **WHAT IF I HAVE A COMPLAINT REGARDING PRIVACY PRACTICES?** If you believe your privacy rights have been violated, you may file a complaint with the NDL Privacy Officer or with the Secretary of the United State Department of Health and Human Services. All complaints must be submitted in writing and must describe the details / situation that caused the complaint. You will not be penalized or retaliated against for filing a complaint to NDL or to the Department of Health and Human Services.

NeuroDiagnostic Laboratories
ATTN: Privacy Officer
2423 W. Dunlap Ave | Suite 175
Phoenix, AZ. 85021-5818
(P) 602.424.4450 | (F) 602.424.4451

A. An administrator shall ensure that:
   1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
   2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
   3. Policies and procedures are established, documented, and implemented to protect the health and safety of a patient that include:
      a. How and when a patient or the patient’s representative is informed of patient rights in subsection (C); and
      b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:
   1. A patient is treated with dignity, respect, and consideration;
   2. A patient as not subjected to:
      a. Abuse;
      b. Neglect;
      c. Exploitation;
      d. Coercion;
      e. Manipulation;
      f. Sexual abuse;
      g. Sexual assault;
      h. Except as allowed in R9-10-1012(B), restraint or seclusion;
      i. Retaliation for submitting a complaint to the Department or another entity; or
      j. Misappropriation of personal and private property by an outpatient treatment center’s personnel member, employee, volunteer, or student; and
   3. A patient or the patient's representative:
      a. Except in an emergency, either consents to or refuses treatment;
      b. May refuse or withdraw consent for treatment before treatment is initiated;
      c. Except in an emergency, is informed of alternatives to a proposed psychotropic medication or surgical procedure and associated risks and possible complications of a proposed psychotropic medication or surgical procedure;
      d. Is informed of the following:
      i. The outpatient treatment center’s policy on health care directives, and
      ii. The patient complaint process;
      e. Consents to photographs of the patient before a patient is photographed, except that a patient may be photographed when admitted to an outpatient treatment center for identification and administrative purposes; and
      f. Except as otherwise permitted by law, provides written consent to the release of information in the patient’s:
      i. Medical record, or
      ii. Financial records.

C. A patient has the following rights:
   1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
   2. To receive treatment that supports and respects the patient’s individuality, choices, Strengths, and abilities;
   3. To receive privacy in treatment and care for personal needs;
   4. To review, upon written request, the patient’s own medical record according to A.R.S.§§ 12-2293, 12-2294, and 12-2294.01;
   5. To receive a referral to another health care institution if the outpatient treatment center is not authorized or not able to provide physical health services or behavioral health services needed by the patient;
   6. To participate or have the patient's representative participate in the development of, or decisions concerning, treatment;
   7. To participate or refuse to participate in research or experimental treatment; and
   8. To receive assistance from a family member, the patient’s representative, or other

Submit Complaints in writing to: NeuroDiagnostic Labs
Attn: Erica Boehle
2423 W. Dunlap Ave #175
Phoenix, AZ 85021

Acknowledgement of Receipt of Notice of Privacy Practice And Patient Rights Form

This document provides acknowledgement of receipt of the American Medical Diagnostics Ltd (AMDx, Ltd.) / NeuroDiagnostic Laboratories, LLC (AMDx) Notice of Privacy Practices and Patient Rights Form. AMDx maintains strict compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the guidelines set therein.

Any questions you have regarding the information provided in the AMDx Notice of Privacy Practices or Patient Rights Forms should be directed to AMDx Administrative staff or the Privacy Officer indicated on the Privacy Practice.

I understand that certain disclosures are required under federal law and may be released by AMDx, upon request from an authorized entity, as outlined below:

- Public Health Activities
- Health Oversight Activities
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Organ and Tissue Donation
- Certain research projects
- Disclosures necessary to prevent serious threats to health or safety
- Military Command Authorities; if you are a member of the armed forces or foreign military authority
- National Security and Intelligence
- Worker's Compensation Payers; and
- Disclosures necessary to initiate and complete health care treatment
- Payment and operations or functions by business associates

I further understand that the disclosures outlined below may be considered optional and that I may choose to 'opt out' of these types of disclosures by selecting '*decline*' for any or all circumstances below.

- Family members or close friends who are involved in your care or payment for treatment ☐ DECLINE
- Disaster Relief Agencies; if you are involved in a disaster relief effort; and ☐ DECLINE
- Information provided to you regarding alternative treatments for your health care ☐ DECLINE

I have been given, and have read and understand my rights under the Notice of Privacy Practices.
I have been given, and have read and understand my rights under the Patient Rights Form.

Patient Name (printed): ______________________________

Patient Signature: ____ **Date**: _____/_____/_____

If applicable, please print the name of the Patient's Representative: ____

Relationship to the patient: _______________________ Representative Signature: ______________________________