MERCY CLINIC CHILD NEUROLOGY

(please print)

Patient's Name _____ Birth Date_____Sex_____

Patient's Address _____

Street City State Zip

Patient's Phone Number (_____) _____

PHARMACY: _____

Mother	**Father**
Name _____	**Name _____**
Birth Date _____	**Birth Date _____**
Address _____	**Address _____**
Home Phone (_____)_____	**Home Phone (_____)_____**
Employer _____	**Employer _____**
" Address _____	**" Address _____**
" Phone _____	**" Phone _____**
Soc Sec. No _____	**Soc Sec No _____**

Patient's Primary Physician _____

Address _____ Phone (_____) _____

Referring Physician (if different from primary) _____

Address _____ Phone (_____) _____

INSURANCE INFORMATION

Name of Plan _____

Subscriber _____

Contact phone number _____

Group Number _____ Policy Number _____

Please list other insurance coverage in back

It is the policy of our office that the parent requesting treatment for the child is responsible for all fees for services rendered. CO-PAYMENTS ARE REQUIRED AT THE TIME OF SERVICE.

I hereby authorize the Physician to release information related to this claim

Mother _____ Father _____

Mercy Clinic Child Neurology Page 1

Please complete these forms and bring with you at the time of your appointment. This will assist us in the evaluation of your child.

Child's Name:_____ Age:_____
First Last

Date of Birth:_____ Date of this visit:_____

Parents' Names:_____

Phone Numbers: Home:_____ Work:_____

Primary Care MD:_____ Who referred you?_____

Other physicians currently providing care for your child:_____

CURRENT PROBLEMS:
Please describe the patient's neurological problem and your current concerns. Indicate when the problem began, how it has progressed and how it is interfering with the child's ability to function. Include information on prior testing for this problem (CT or MRI scans, etc.)

_____

_____

_____

_____

CURRENT MEDICATIONS & DOSES:

_____

_____

MEDICATION ALLERGIES:_____

PAST MEDICAL HISTORY:
Is child adopted or a foster child?_____ Birth Weight:_____

If premature, gestational age at birth:_____

Did mother or child have any problems during the pregnancy or labor?_____

Complications of pregnancy, labor or delivery:_____

_____

Neonatal complications:_____

Child illnesses, hospitalizations and ER visits_____

_____

_____

Surgeries or serious injuries:_____

_____

Allergies to medications, foods, or other substances _____

Are immunizations up to date?_____

Developmental History: (For children under age 10 years)

Approximate age child did the following:

Rolled over:	_____	Used gestures/pointing:	_____
Held toy:	_____	Said first words:	_____
Sat alone:	_____	Used sentences:	_____
Crawled:	_____	Removed clothing:	_____
Walked:	_____	Toilet trained:	_____

Describe any feeding/eating problems:_____

_____

Describe child's sleeping habits:_____

_____

Describe your child's temperament by using at least five adjectives (i.e. quiet, restless, active, affectionate, withdrawn, whining, etc.):_____

_____

Does your child have any concerning behaviors such as rocking, head banging, breath holding, hair twirling, hand-flapping, etc.? Please describe:_____

_____

FAMILY HISTORY:

How old is mother?_____ Father?_____ Brothers?_____ Sisters?_____

How many times has mother been pregnant?_____ Any miscarriages?_____

Do you have a child with a serious illness or neurological disorder?_____

_____

Circle and describe issues below occurring in biological family:

Seizures/epilepsy:_____	Behavior disorders:_____
Mental retardation:_____	Psychiatric disorders_____
Learning problems:_____	Diabetes:_____
Birth defects:_____	Strokes:_____
Headaches:_____	High blood pressure:_____
Vision/hearing problems:_____	Heart disease:_____
Muscle problems:_____	Other family diseases:_____

NAME:_____ D.O.B:_____ DATE:_____

SOCIAL HISTORY: Please describe family and living situation, child's school and grade, and any issues regarding parental custody, etc.:_____

_____

REVIEW OF SYSTEMS IF YES PLEASE EXPLAIN

CATEGORY	PROBLEM		IF YES EXPLAIN
General	Weight gain or loss, fatigue, fever, excess sweating, exercise intolerance, sleeping problems	☐Yes ☐No	
Ears, nose, mouth, throat	Dental work, infections, hearing change, other	☐Yes ☐No	
Eyes	Vision changes, infection, other	☐Yes ☐No	
Skin	Acne, birthmarks, other	☐Yes ☐No	
Respiratory	Shortness of breath, asthma, cough, other	☐Yes ☐No	
Cardiovascular	Irregular heart rate, heart murmur, chest pain, other	☐Yes ☐No	
Gastrointestinal	Nausea, vomiting, diarrhea, constipation, abdominal pain, other	☐Yes ☐No	
Neurological	Headache, seizures, weakness, fainting, unsteady walking, dizziness, other	☐Yes ☐No	
Genitourinary	Increased or decreased urine output, urinary tract infections, menstrual problems, other	☐Yes ☐No	
Musculoskeletal	Pain, arthritis, muscle aches, stiffness, scoliosis, other	☐Yes ☐No	
Psychiatric	Major stress, irritability, anxiety, depression, other	☐Yes ☐No	
Endocrine	Thyroid, growth problems, puberty problems, other	☐Yes ☐No	
Hematologic Lymphatic	Anemia, bleeding problems, lymph nodes, other	☐Yes ☐No	

HIPAA COMPLIANCE

THIS NOTICE DESCRIBES HOW HEALTH INFORMTAION 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 that we maintain in our practice concerning you 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 of 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 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:

Stephanie Vazquez (314) 251-5866

C. WE MAY USE AND DISCLOSE YOUR (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 test (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 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. **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.
5. **Appointment Reminders:** Our practice may use your IIHI to remind you of an appointment.

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 IIHI:

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
    - Reporting child abuse/neglect
    - Preventing or controlling disease, injury or disability

- Notifying a person regarding potential exposure to a communicable disease or condition
- Reporting reactions to drugs or problems with a products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency (ies) and authory (ies) regarding the potential abuse or 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 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 tight 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 protecting the information the party has requested.
4. **Law Enforcement:** We may release IIHI if asked to 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 office
    - 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 am emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)
5. **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.

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 Stephanie Vazquez 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 on 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 Stephanie Vazquez. 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 decision about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Stephanie Vazquez 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.
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 an amendment, your request must be made in writing and submitted to Stephanie Vazquez. 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 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 or 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 Stephanie Vazquez. All requests for an "accounting of disclosures" must state a time period, which may not be longer than (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 charges, 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 request, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of the Notice:** You are entitled to receive a paper copy of our notice of privacy practices. You my ask us to give you a copy of this notice at any time. To obtain a copy contact Stephanie Vazquez (314) 251-5866.
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 Stephanie Vazquez (314) 251-5866. 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 reason describes 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 Stephanie Vazquez
(314) 251-5866.

Effective Date of This Notice: 4/14/2003

ST. LOUIS CHILD
NEUROLOGY SERVICES, P.C.
John F. Mantovani, M.D.
Denis I. Altman, M.D.
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)

621 South New Ballas Road, 5009

St. Louis, MO 63141
(314) 251-5866

Please Print and Sign HIPAA Form Below

JOHN F. MANTOVANI, M.D.	DENIS I. ALTMAN, M.D.

ST. LOUIS

CHILD NEUROLOGY SERVICES, PC
621 S. New Ballas Rd., Suite 5009B, St. Louis MO 63141
(314) 251-5866 Fax: (314) 251-5867

RELEASE OF INFORMATION, ASSIGNMENT OF BENEFITS, AND FINANCIAL RESPONSIBILITY

PATIENT'S NAME: _____

INSURED'S NAME: _____

PHYSICIAN'S NAME: _____

RELEASE OF INFORMATION: I authorize the release of medical and financial information for the purpose of collection of my account. I also authorize my insurance benefits to be paid directly to my doctor and acknowledge that I am financially responsible for any unpaid balance. I agree to pay this balance in full, and if unable to pay in full, will make other arrangements with the billing department.

INSURED AGREEMENT: I am aware that my insurance carrier may require me to use participating providers, and to follow plan requirements, including primary care referral and pre-certification, and that failure to comply could result in my sole responsibility to pay any charges for services rendered.

SELF-PAY AGREEMENT: If I do not have any insurance coverage, or if my insurance carrier does not cover this service, I agree to be responsible for the full balance. If I am unable to pay the balance in full, I agree to make other arrangements with the billing department.

_____ _____

Signature of Parent/ Guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I have received a copy of St. Louis Child Neurology Services, P.C's Notice of Privacy Practices dated 4/14/03.

_____ _____

Signature of Parent/ Guardian Date