Michigan Advanced Neurology Center
Debasish Mridha, M.D.
4705 Towne Centre, Ste. 201•Saginaw, MI 48604
Telephone (989) 799-2770•Fax (989) 799-2737

Dear Patients,

Please fill out the enclosed forms and bring them with you to your scheduled appointment.

Please bring along a **current medication list, insurance card(s), and driver's license**. If your insurance requires a referral, please be sure to contact your primary care physician at least two weeks prior to your appointment so we have it in our office before your appointment. In addition, please arrive 5-10 minutes early so we can get all the paperwork completed.

If you are a self-referral, we require any medical records from previous specialists and family physicians. Please bring them with you to your appointment.

Any copays and balances will be collected at the time of visit. We accept cash, checks, and credit cards.

Thank you,

M.A.N.C.

NOTE: Michigan Advanced Neurology is **NOT** currently taking any Workman's Comp, Disability, or Auto related patients.

Patient Signature Date

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PATIENT REGISTRATION

(PLEASE PRINT)

Patient Name_____ Todays Date _____

Street Address_____ Apt. _____ Phone (____) _____

City _____ State _____ Zip_____

Sex: _____ Male_____ Female Birthday _____/_____/_____ Age _____

Social Security_____ Race / Ethnicity_____

Patient Pharmacy _____ Email _____

Circle One: Single Married Separated Divorced Widowed Significant Other
With whom do you live with: _____

Patient Employed: □ Full Time □ Part Time □ Retired □ Student □ Unemployed □ Disabled

Patient Employer _____Phone_____

Responsible Party (if minor) _____

If pt is a minor: Mother's DOB _____Father's DOB_____

Primary Insurance _____

Contract or ID# _____ Group _____

Subscriber _____ Subscriber's DOB _____

Secondary Insurance_____

Contract # _____ Group_____

Subscriber _____Subscriber's DOB_____

Is this a work or auto claim? Yes_____ No _____

Primary Care Physician _____ **Phone: (____)** _____

Referring Physician_____ **Phone: (____)** _____

Emergency Contact (not living with you) _____

Phone: (_____) _____ Work/ Cell Phone: (_____) _____

ASSIGNMENT OF RELEASE:
I authorize any holder of medical or other information about me to release to all carriers any information needed for this or any other related medical insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. I understand I am financially responsible for all charges whether or not paid by insurance.

Signature of Insured/Guardian Date

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STATEMENT OF DISCLOSURE

Patient Name: _____ Birthdate: _____

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I hereby authorize Debasish Mridha, M.D. and staff to provide my medical records, mental health therapy or treatment/counseling records, alcohol treatment records, and/or substance abuse records, make a full oral or written report to:

- ❑ Authorization of any and all family members
- ❑ Do not disclose medical information to anyone but myself
- ❑ Disclose medical information only to the following people:
  (Please include any physicians that you would like a copy of reports sent to)

Name: _____
Relationship: _____ Telephone Number: _____

Name: _____
Relationship: _____ Telephone Number: _____

Name: _____
Relationship: _____ Telephone Number: _____

This authorization will expire: _____at the end of treatment_____
(Expiration Date or Defined Event)

I further request that you permit such records be copied or Photostat or otherwise. A photo static copy of this authorization shall be considered as effective and valid as the original.

_____
Patient Signature Date

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Name_____ **Todays Date**_____

Birthdate _____ **Age** ____ □ M □ F **Social Security:** _____

Email: _____

Primary Care Physician:_____

Pharmacy: _____

HISTORY OF PAST ILLNESS (please specify):

- □ Parkinson's disease (G20)
- □ Seizure (R569)
- □ Heart disease (I519)
- □ Alzheimer's disease (G309)
- □ Stroke (I6340)
- □ Multiple Sclerosis (G358
- □ Mental Illness _____
- □ Cancer (R971)_____
- □ Other _____

SURGICAL HISTORY & DATES:

_____
_____
_____
_____

ALLERGIES:

_____
_____
_____

FAMILY HISTORY:

Family Member	Health/ Medical problems	Age @ Death	Cause of Death
Father			
Mother			
Sibling(s) (M/F)			
Children (M/F)			
Grandparents			
Other			

SOCIAL HISTORY:

Tobacco: □ Never smoked □ Quit _____ years ago
□ Cigarettes □ Cigars □ Pipe
□ Chews Tobacco □ Dipping Tobacco

Smoked # years _____ Packs per day _____

Alcohol: □Beer □ Wine □Hard Liquor
□ Never □ <1 a week □ 1-5 a week
□ Drinks heavily □ Drinks occasionally

How many per day: Coffee _____ regular/decaf

Tea _____ reg/decaf Carbonated Drinks _____ reg/diet

Energy Drinks ____ Chocolate ____ Caffeine pills ____

Highest Education Completed:

□ Grade school □ High School

□ Some college □ College graduate

□ Higher level (specify): _____

Recreational Drug Use? □ No □ Yes

If Yes, What Kinds? _____
_____

How long have you used drugs? _____

If you quit, how long ago?_____

Obstetrics:
How many pregnancies? _____
How many childbirth's? _____
Complications (please specify):
_____
_____
_____
_____

CONTINUE ON BACK→→

PROBLEM LIST

GENERAL:
____ Headache (R51)
____ Migraine (G43119)
____ Lethargy/Weakness (M6281)
____ Night Sweats (R61)
____ Fainting/LOC (R55)
____ Dizziness (R42)
____ Recent Weight Loss (R634)
____ Recent Weight Gain (R635)

EYES:
____ Blurred Vision (H5319)
____ Double Vision (H532)
____ Eye Pain (H5713)

EAR/NOSE/THROAT:
____ Deafness (H9190)
____ Noise in ears (H833X9)
____ Sinus/Congestion (J329)
____ Nose Bleeds (R040)
____ Sore Throat (J029)
____ Hoarse Voice (R499)

HEART:
____ Chest Pain (R079)
____ Heart Murmur (R011)
____ Palpitations (R002)
____ High Blood Pressure (I10)
____ Edema (M7989)
Location _____

LUNG:
____ Pneumonia (J129)
____ Shortness of Breath (R0602)

STOMACH:
____ Constipation (K5900)
____ Diarrhea (R197)
____ Liver Disease (K769)
____ Irritable Bowel Syndrome (K588)

KIDNEY/BLADDER/PROSTATE:
____ Frequent Urination (R350)
____ Urinary Incontinence (N3942)
____ Difficulty starting urine (R3911)
____ Dribbling (N3943)
____ Sex Difficulties (F529)
____ Prostate Disease (N4289)

INFECTIONS:
____ Meningitis (A879) (please specify):
□ Viral □ Bacterial

BREAST/MENSTRUAL:
____ Menstrual Irregularity (N926)
____ Endometriosis (N809)

SKIN:
____ Rash (R21)
____ Dry Skin (L110)
____ Bruise Easily (T1490)

MUSCULOSKELETAL:
____ Back Pain (M545)
____ Neck Pain (M542)
____ Difficulty Walking (R262)
____ Arthritis (M069)
____ Fibromyalgia (M797)
____ Muscle Spasm (M6240)

NEUROLOGY:
____ Memory Problems (R4181)
____ Confusion (F4489)
____ Forgetfulness (R413)
____ Numbness/Tingling (R209)
____ Balance Problem (R269)
____ Tremor (G250)

PSYCHIATRY:
____ Depressed (F328)
____ Considered Suicide (R45851)
____ Anxiety/Tension (F411)
____ Fatigue (R5382)
____ Panic Attack (F410)

ENDOCRINE:
____ Thirsty (T731XXA)
____ Diabetes I (E109)
____ Diabetes II (E119)

SLEEP:
____ Snore (R0683)
____ Sleep Apnea (G4733)
____ Restless Sleep (G4709)
____ Insomnia (G4700)
____ Sleep walk/talk (F514)
____ Restless Leg Syndrome (G2581)

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HIPPA NOTICE OF PRIVACY PRACTICES FOR DEBASISH MRIDHA, M.D., P.L.L.C.

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction:

This Notice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective since April 14, 2003.

Understanding Your Health Record/Information:

Your medical information is personal. We are committed to protecting your medical information. Each time you visit DEBASISH MRIDHA, M.D., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- **Basis for planning your care and treatment:** We will use medical information about you to provide you medical treatment and services. We may disclose your medical information to doctors, nurses, technicians and other personnel who are involved in providing you medical treatment.

- **For payment:** We may use and disclose your medical information so that the treatment and services you receive at this office may be billed to or payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about your treatment to your insurance company so that your health plan may pay us for treatment you received. Sometimes, we may need to send your health information to prior approval or to determine whether your plan will cover the treatment.

- **For health care operation:** We may use and disclose medical information about you for office operations. These disclosures are necessary to run the office and make sure that all of our patients receive quality care. We may disclose your medical information when we contact with you as a reminder that you have an appointment for treatment or medical care at this office.

- **For research:** Under certain circumstances, we may use and disclose medical information for research purposes.

- **As required by law:** We will use and disclose your medical information when required to do so by Federal, State or Local Law. For example, disclosure may be required by Worker's Compensation statutes and various public health statutes in connection with reporting required reporting of certain disease, child abuse and neglect, domestic violence, adverse drug reaction, etc.

- **For legal issue:** We may disclose medical information about you to respond to a court order.

- **Health oversight activities:** We may disclose your medical information to Government or other oversight agency or organization for activities by Law. For example, disclosure of your medical information may be needed for audits, investigations, inspections, etc.

- **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

- **Communication with family:** Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

- **Funeral directors:** We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of DEBASISH MRIDHA, M.D. the information belongs to you. You have the right to:

- **Obtain a paper copy of this notice** of information practices upon request.

- **Inspect and copy your health record.** You must request in written form to DEBASISH MRIDHA, M.D. We may charge a fee for the cost of copying, mailing or other supplies associated with our request.

- **Amend your health record.** If you feel that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information in writing and you must prove the reason that supports your request. We may deny it if it is not in writing or does not include the reason. We may also deny it if you ask us to amend information that: was not created by us, is not part of the medical information kept by this office, is not part of the information which you were permitted to inspect and copy or is accurate and complete.

- **Obtain an accounting of disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures this office has made of your medical information. To request this disclosure, you must submit your request in writing to DEBASISH MRIDHA, M.D. Your request must state a time period, which may not be longer than six years and may not include dates before March 15, 2003.

- **Request a restriction on certain uses and disclosures** of information as provided by 45 CFR 164.522, and you must request this in writing to DEBASISH MRIDHA, M.D.

- **Revoke your authorization to use or disclose** health information except to the extent that action has already been taken.

Our Responsibilities:

DEBASISH MRIDHA, M.D. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice; notify you if we are unable to agree to a requested restriction.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

If you have questions or would like additional information, you may contact CHINU MRIDHA at (989)799-2770.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. All complaints must be submitted in writing. This office will not penalize you in any way for filing a complaint.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post in the office. In addition, each time you visit the office you are welcome to ask for the most recent Notice in effect.

Revision No. 1

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RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I understand I have the right to review Dr. Mridha's "Notice of Health Information Practices" prior to signing this document. A copy of this Notice has been provided to me. The "Notice of Health Information Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Michigan Advanced Neurology Center. This "Notice of Health Information Practices" also describes my rights and Dr. Mridha's duties with respect to my protected health information.

Debasish Mridha, M.D. reserves the right to change the practices that are described in the "Notice of Health Information Practices." I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

The undersigned Patient or Authorized Representative acknowledges that he or she personally received and or was offered a copy of the "Notice of Health Information Practices" on the date indicated below.

_____ _____
Name of Patient (please print) Date

_____
Signature of Patient or Authorized Representative

_____
Relationship to Patient (if signed by Representative)

FOR OFFICE USE ONLY

_____ _____
Office Representative Signature Date