James Wang, M.D.

Rada Petrinjac-Nenadic, M.D.

Pawan Rawal, M.D.

EAST MEMPHIS OFFICE
5100 SANDERLIN AVE.
MEMPHIS, TN 38117

PHONE 901-820-0141
FAX 901-820-0144

HIPAA RIGHT OF ACCESS

I, _____, direct Tri-State Neurology, PLLC, to disclose and release my protected health information described below to:

Name _____Relationship _____

Contact Information: _____

_____

Health Information to be disclosed upon the request of the person named above:

_____ Disclose my complete health record (including but not limited to diagnosis, lab test, prognosis, treatment, and billing, for all conditions.

_____ Disclose my health record, as above, BUT does not disclose the following:

_____ Mental Health records

_____ Communicable diseases (including HIV and AIDS)

_____ Alcohol/drug abuse treatment

_____ Other (please specify)

_____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

_____ An electronic record or access through an online portal

_____ Hard Copy

_____

The authorization shall be effective for:

_____ All past, present and future periods

_____ Specifically for the dates of: _____

Please note you may revoke this authorization at any time but only in writing to Tri-State Neurology.

Patient Signature _____ DOB _____

Date _____

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Authorization to Provide Treatment - Insurance Agreement and Release

I hereby authorize the providers of TRI-STATE NEUROLOGY, PLLC, or any other medical provider authorized by it, to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interests (or the best interests of my dependent if I am signing as a parent or guardian).

Further, I hereby assign, transfer, and set over to TRI-STATE NEUROLOGY, PLLC, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy listed below or any other third-party payor that may be responsible for paying me for these services. Should payment be made directly to me, I agree to immediately endorse such payment to TRI-STATE NEUROLOGY, PLLC.

In those cases where payment is not collected at the time for service, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within ninety (90) days from the date billed unless there are other agreements between me and my insurance company and TRI-STATE NEUROLOGY, PLLC. I agree to pay an attorney's fee if it becomes necessary to turn this account over to an outside party for collection. If at any time a single visit is overpaid and amounts from other visits remain unpaid, I agree that TRI-STATE NEUROLOGY, PPLC, may apply the overpayment from one visit to outstanding balance(s) from other visits. I understand that a refund will not be issued to me until all visits are paid in full and my account retains a credit balance.

I understand that it is my responsibility to know the requirements of my insurance policy and comply with them. If the providers of TRI-STATE NEUROLOGY, PPLC, do not participate in my plan, I agree to be responsible for any costs not paid by my insurance company. Further, if my plan requires a referral, I agree that it is my responsibility to obtain the referral. If I do not obtain such referral and my plan does not pay because of my failure to do so, I agree to be responsible for the costs of my treatment. If my plan requires precertification for certain services, I agree to inform TRI-STATE NEUROLOGY, PLLC, of these requirements and to be responsible for any bill if I did not inform them of the precertification requirements.

I specifically give TRI-STATE NEUROLOGY, PLLC, the authority to release my medical records to any medical provider who needs access to them to provide appropriate medical care. Further, my medical records may be released to those who perform TRI-STATE NEUROLOGY, PPLC, billing services and to any third party payors who are responsible for my bill. I have been given a copy of TRI-STATE NEUROLOGY, PLLC, privacy guidelines and been given opportunity to object to other listed reasons for release.

These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to TRI-STATE NEUROLOGY, PLLC.

Patient/Responsible Party: _____ Date: _____

Insurance Company _____

Is there any additional information we need to properly file your insurance?

_____

Medicare Patients with Medigap insurance:
I request that payment of authorized Medigap benefits be made on my behalf to TRI-STATE NEUROLOGY, PLLC, for any services furnished to me by that supplier. I authorize any holder of medical information about me to be released to my Medigap insurer to determine these benefits. This authorization is in effect until I choose to revoke it.

Patient/Responsible Party: _____ Date: _____

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Acknowledgement of Financial Responsibility

Patient: _____ **Date: _____**

Physician: _____ **Chart #: _____**

I have been informed that my insurance carrier may determine that any service(s) that I have may be deemed a Investigational Service, may not be a Covered Service, may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member Healthcare Benefits Plan.

I understand that, if I elect to receive any service(s) and my insurance plan determines that the service(s) is not to be a Covered Service, Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses, I acknowledge that my insurance plan may not pay for the service(s)

This form covers all treatment rendered to me by Tri-State Neurology, PLLC Providers.

_____ _____

Signature of Patient or Responsible Person Date

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MEDICAL RECORDS RELEASE FORM

I, _____ authorize Tri-State Neurology, PLLC to release or obtain my medical records from the following physicians and or hospitals:

_____ FAX: _____

_____ FAX: _____

_____ FAX: _____

_____ FAX: _____

_____ FAX: _____

_____ FAX: _____

_____ FAX: _____

_____ FAX: _____

Patient Name: _____ Patient Date of Birth: _____

Patient's Signature: _____ **Date:** _____