



**Jefferson Comprehensive Epilepsy Center  
Jefferson Hospital for Neuroscience  
909 Walnut Street, 2<sup>nd</sup> Floor COB  
Philadelphia, PA 19107**

APPOINTMENT WITH DR. \_\_\_\_\_

AT \_\_\_\_\_ ON \_\_\_\_\_.

Dear \_\_\_\_\_,

Welcome and thank you for choosing Jefferson Department of Neurology for your care! Enclosed for your convenience, you will find a patient registration and history form to be completed. This form should be brought with you at the time of your visit. **PLEASE DO NOT MAIL THESE FORMS BACK TO THE OFFICE.** Completing these forms prior to your visit will help make your encounter with us as timely and pleasant as possible.

**Please bring relevant medical records** – MRI and CT Images on a CD and reports, lab results, inpatient hospital and outpatient reports – to this appointment. If your records are being faxed or mailed to us prior to your appointment, **please send them to Attention: Epilepsy Chart Preparation.** Please fax medical records to **(215) 955 0606.**

*\*Please remember that your most recent EEG results and tracings are important criteria for your new patient appointment. Please contact the hospital where the EEG was done to obtain results and tracings; you can ask for the EEG department.*

In addition, we would like to make you aware of a few office policies. In accordance with insurance company regulations, we are required to collect all necessary co-pays and referrals at the time of service. Please remember to bring your insurance card. Should your referral not be available, you have the option to either reschedule or pay for your visit at the time of service. In order to accommodate the high patient volume in our office, **we require a minimum of 3 days notice if you plan on canceling your appointment.** Failure to provide us with adequate notice may result in our inability to reschedule you.

Our physicians make every effort to see patients within 15 minutes of their scheduled appointment time. To accomplish this, they require that patients arriving more than 15 minutes late for their appointment be rescheduled. We understand that traffic and parking can be difficult; please leave adequate time for unanticipated delays.

Thank you once again for choosing the Jefferson Department of Neurology. We look forward to providing you the care that you expect and deserve!



## APPOINTMENT POLICY NOTIFICATION:

Dear Mr./Ms. \_\_\_\_\_:

You have a **New Patient** appointment with Jefferson University Physicians, Jefferson Neurology Associates scheduled for \_\_\_\_\_ (*date*) at \_\_\_\_\_ (*time*).

In advance of your appointment, we have sent you information about our scheduling practice, which requests that you attend your appointment as scheduled or notify our Practice **at least three (3) business day prior** to that time if you need to cancel. We do ask that our New Patients understand that if they do not present for their appointment and do not cancel in advance, we will not schedule another New Patient appointment for them.

Please do not hesitate to contact me if you have any questions or concerns on which I may be of further assistance. We look forward to seeing you.

Sincerely,

Russell Starkey, MBA  
Director of Operations  
Jefferson Neurology Associates



## **ROUTINE EEG**

Patient Name: \_\_\_\_\_

Date of Appointment: \_\_\_\_\_

Registration Time: \_\_\_\_\_ - 1<sup>st</sup> Floor 900 Walnut Street

EEG Time: \_\_\_\_\_ - 2<sup>nd</sup> Floor 900 Walnut Street

### **Registration Instructions: ABSOLUTELY NO HAIR PRODUCTS, NO PERFUMES**

On the day of your appointment, please register on the first floor of the JHN Building, 900 Walnut Street. At that time you will be asked to present your insurance information, which may include referrals and/or authorization numbers. It is your responsibility to check with your insurance company to see what is required by them in order to have this study approved for payment.

### **Preparation Instructions for Routine EEG:**

We ask that on the day of the study you wash and dry your hair. Do not use gel, mousse, hairspray, etc. The EEG cannot be done on wet hair or with hair weaves, braids, or hairpieces.

Please **DO NOT HAVE ANY CAFFEINE** (coke, coffee, tea, or chocolate) **FOR 6-12 HOURS BEFORE THE STUDY, BUT YOU MAY EAT AS USUAL.**

Take your medications as you normally would, unless otherwise instructed by your physician. Please bring a list of your present medications and dosages.

Please **REFRAIN FROM USING ANY PERFUMES OR COLOGNES** on the day of your appointment. This also applies to anyone accompanying you for your appointment. We have staff and other patients with asthma who may have severe reactions.

Try to get two hours less sleep than usual so that you will sleep during the study.

**PARENTS:** Please wake your child very early on day of exam (no later than 6 AM).

The study will take about an hour (in some cases longer) depending on patient cooperation.

Please call us directly at (215) 955-6598 if you have any questions or if you need to reschedule or cancel.

**APPOINTMENT CANCELLATIONS REQUIRE AT LEAST 24-HOURS NOTICE**



Dear Jefferson Neurology Patient,

We are writing to advise you of our office guidelines regarding form completion. Our practice is experiencing a significant increase in the volume and type of requests for completion of forms and letters by our physicians and staff. These include, but are not limited to the following:

- ❖ Disability Forms
- ❖ FMLA Forms
- ❖ Insurance Forms
- ❖ Employment Forms/Letters
- ❖ Driving Privileges Forms
- ❖ Copies of Office Visits (beyond those for referring/primary care physicians)

*Please note: We are unable to complete forms for patients **who have not been seen within 9 months (3 months disability forms)**. In certain cases, a follow-up appointment may be required to ensure the accurate completion of any forms.*

You will be charged \$10.00 for a single-page form and \$30.00 for each multi-page form (up to 4 pages). Additional pages are \$5.00 each up to a maximum form fee of \$50.00. The standard turn around time for forms is 12 business days after receipt of payment. An additional fee of \$10 is due for any form that needs to be expedited (5 to 12 business days).

**The completion of forms is a non-covered benefit as far as your insurance is concerned.** The form fee is distinct and separate from any co-pay, co-insurance or insurance fee. Please contact the office if the form fee represents a significant financial hardship. Methods of payment include credit card, cash, money order, or check.

**Please enclose payment with your form(s) or call in to pay over the phone by credit card to ensure timely processing. Forms will be completed and released only after receipt of payment. Please Make payment to Jefferson Neurology Associates.**

The decision to charge for forms was not made lightly, even though many practices in the area charge for completion of forms. Unfortunately, the volume and the time commitment have become overwhelming to our staff.

We appreciate your understanding and thank you in advance for your help and cooperation!

**Jefferson Department of Neurology**



**DIRECTIONS TO:**        **DEPARTMENT OF NEUROLOGY**  
**909 Walnut Street, 2<sup>nd</sup> Floor COB**  
**Philadelphia, PA 19107**  
**Telephone: 215-955-1222**

**BY CAR**

**From the Betsy Ross Bridge and points Northeast of Philadelphia**

- Take I-95 South to Exit 22 (Central Philadelphia/Independence Hall/Callowhill Street).
- At the end of the ramp, turn right onto Callowhill Street.
- Continue on Callowhill Street to 8th Street.
- Turn left onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

**From points North and West of Philadelphia (76 East)**

- Take PA Turnpike to Exit 326 (Valley Forge).
- Take 76 East (Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Philadelphia/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Get into left lane and follow signs for Vine Street.
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

**From Northeast Extension of the Pennsylvania Turnpike (Route 476)**

- Take Exit 20 and follow signs for Route 476. Take Route 476 to Exit 16A; then take Route 76 East (Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Phila/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Get into left lane and follow signs for Vine Street.
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street



### **From Route 309**

- Take Route 309 South to the end of the expressway.
- Turn right onto Route 611 South (Broad Street).
- Continue on Broad Street (approximately six miles) to Vine Street.
- Turn left onto Vine Street
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

### **From Delaware and points South of Philadelphia**

- Take Rt. I-95 North to Exit 22 (Central Phila./Independence Hall/Callowhill St.) – a left-lane exit.
- Stay in right lane and exit onto Callowhill Street.
- Once on Callowhill Street, stay in middle lane and continue to 8th Street.
- Turn left onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

### **From the Main Line**

- Take Route 476 North to exit 16A (Route 76 East/Schuylkill Expressway) to Philadelphia.
- Take Exit 344 (Central Phila/676 East) – a left-lane exit.
- Take the Broad Street Exit – a right-lane exit.
- Stay in left lane and follow signs for Vine Street.
- Turn left onto Vine Street
- Follow Vine Street to 8th Street and turn right onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street



**From New Jersey via Walt Whitman Bridge**

- Cross Walt Whitman Bridge. After the toll booth, take I-95 North to Exit 22 (Central Phila./Independence Hall/Callowhill St.) – left-lane exit.
- At the end of the ramp, turn right onto Callowhill Street.
- Once on Callowhill Street, stay in middle lane and continue to 8th Street.
- Turn left onto 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

**From New Jersey via the Ben Franklin Bridge**

- Take bridge and stay in left lane and turn left on 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

**From New Jersey Turnpike**

- Take Exit 4 (73 West) off NJ Turnpike.
- Follow 73 West to 38 West.
- Continue on 38 West, following signs for the Ben Franklin Bridge. (38 West will turn into Admiral Wilson Blvd.) Continue to bridge.
- Take bridge and stay in left lane and turn left on 8th Street.
- Follow 8th Street to Walnut Street and turn right.
- Follow Walnut Street past 9th Street. Make a right into the Parking Garage.
- Parking garage is on the right at the corner of 10<sup>th</sup> and Walnut.
- Garage Address: 925 Walnut Street

**PARKING OPTIONS:**

**Other Suggested Parking Locations:**

- |    |                                      |                                    |
|----|--------------------------------------|------------------------------------|
| A. | Downtown Garage                      | - 10th & Sansom Streets            |
| B. | Jefferson Hospital For Neuroscience  | - 9 <sup>th</sup> & Locust Streets |
| C. | Jefferson University Hospital Garage | - 10 <sup>th</sup> and Chestnut    |

**PARKING GUIDE:** Valet parking is available at the 11th Street entrance of the Gibbon Building (between Chestnut and Sansom Streets) and at the Emergency and Trauma Center entrance on the corner of 10th and Sansom Streets. The University garage is located between Walnut and Locust Streets. Entrances to the garage are on 10th and 11th Streets. If you do not wish to use Jefferson Valet Parking Service, there are a number of parking lots and garages in the area. Patients may be dropped off at either the 11th or 10th Street entrance of the Gibbon Building.



## **BY PUBLIC TRANSPORTATION**

### **From Northeast Philadelphia**

- Take westbound Market-Frankford elevated to 8th and Market Streets
- Walk south on 8th
- Turn right onto Walnut
- Go 1 ½ block, entrance to building is on the right

### **From South Philadelphia**

- Take Broad Street subway to Broad and Locust Streets
- Walk east on Locust Street to 9<sup>th</sup> Street
- Turn left onto 9<sup>th</sup> and walk North to Walnut Street.
- Turn Left onto Walnut Street
- Go ½ block, entrance to building is on the right

### **From West Philadelphia**

- Take the eastbound Market-Frankford elevated to 8th and Market Streets
- Walk south on 8<sup>th</sup>
- Turn right onto Walnut
- Go 1 ½ block, entrance to building is on the right

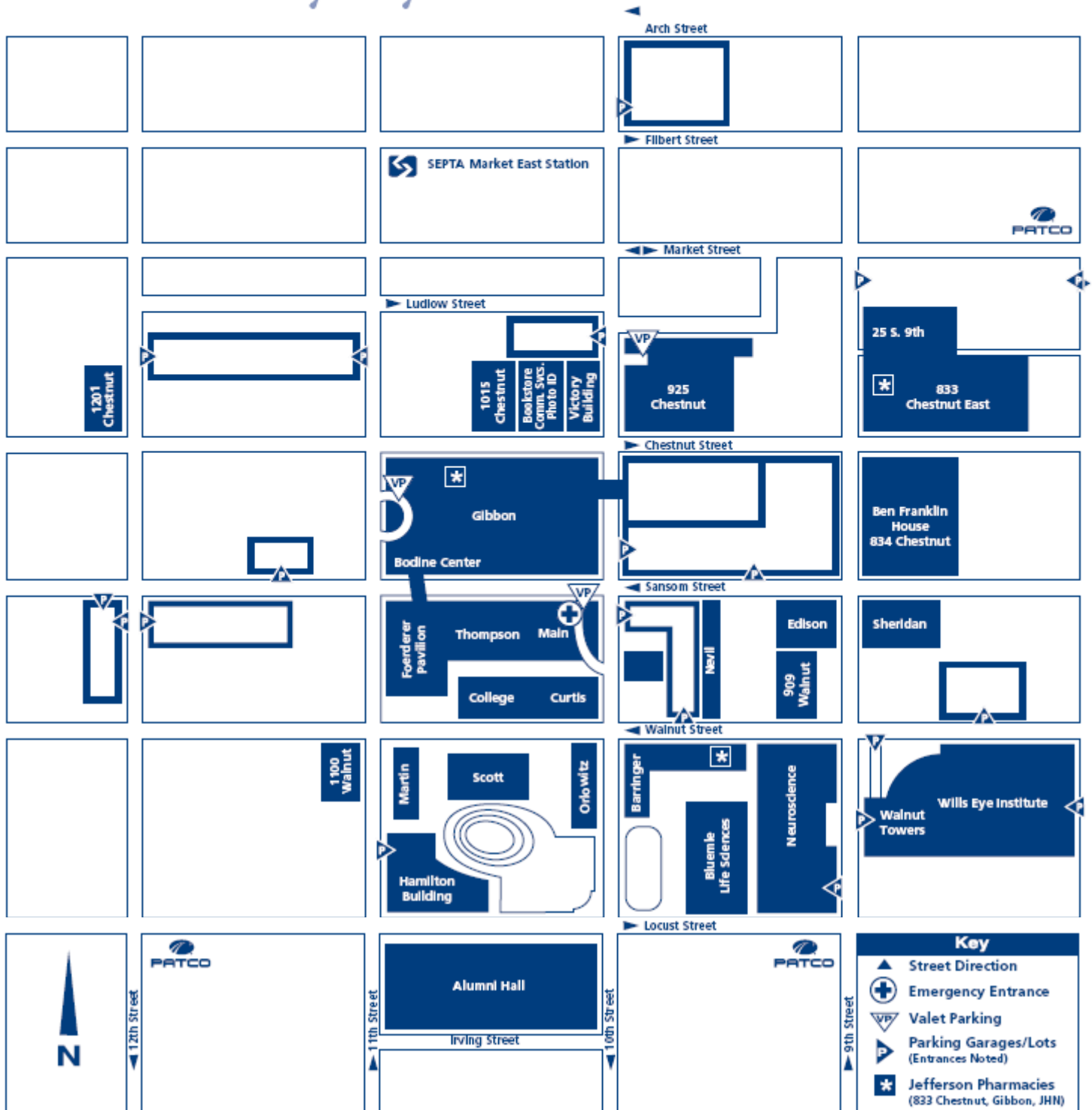
### **From the suburbs**

- Call SEPTA at 215-580-7800 to determine the regional rail line closest to your home
- Take the train to the Market East Station at 11th and Market Streets
- Go right at 9<sup>th</sup> and Market onto 9<sup>th</sup> Street. Go to corner of 9<sup>th</sup> and Walnut
- Turn right onto Walnut
- Go 1 ½ block, entrance to building is on the right

### **From New Jersey**

- Take the PATCO High Speed Line to the 10th and Locust Station
- Follow signs to 9th Street
- Turn left onto 9<sup>th</sup> and walk North to Walnut Street.
- Turn Left onto Walnut Street
- Go ½ block, entrance to building is on the right





Please check with individual JUP practices regarding their policy for area parking validation or discounted rates.



# COMMUNICATION OF PROTECTED HEALTH INFORMATION

I would like Jefferson University Physicians ("Jefferson") to share my protected health information, which includes billing information, with the individuals (e.g., my spouse, parent(s), etc.) listed below.

After providing Jefferson with this completed and signed form, Jefferson agrees to communicate with the individuals listed below unless I provide Jefferson with written notice to no longer do so.

## I. Patient Identification

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## II. Authorization of Communication

I hereby grant Jefferson's Department/Division of \_\_\_\_\_ permission to communicate my protected health information to the following individuals:

1. Name: _____ Address: _____ _____ Patient Relationship: _____ Telephone No.: (_____) _____ - _____	4. Name: _____ Address: _____ _____ Patient Relationship: _____ Telephone No.: (_____) _____ - _____
2. Name: _____ Address: _____ _____ Patient Relationship: _____ Telephone No.: (_____) _____ - _____	5. Name: _____ Address: _____ _____ Patient Relationship: _____ Telephone No.: (_____) _____ - _____
3. Name: _____ Address: _____ _____ Patient Relationship: _____ Telephone No.: (_____) _____ - _____	6. Name: _____ Address: _____ _____ Patient Relationship: _____ Telephone No.: (_____) _____ - _____

I understand that completing this form is voluntary. I am not required to list any individuals.

\_\_\_\_\_

Patient's Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

MRN: \_\_\_\_\_

**Associated Providers**

Please list any physicians below who should receive information regarding your care/visit.

**Primary Care Provider**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Referring Provider**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Pharmacy Information**

Please complete your pharmacy information below.

**Retail Pharmacy**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Mail Order Pharmacy**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Laboratory/Radiology Information**Are your laboratory and radiology studies capitated to a specific performing location?  Y  N

Laboratory: \_\_\_\_\_ Radiology: \_\_\_\_\_

MRN # \_\_\_\_\_

Patient Name (Please Print): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Provider you are seeing today: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Please state your problem in your own words as to why you are here today: \_\_\_\_\_

Did a physician request that you see one of our providers today?  Yes  No If yes, name of physician: \_\_\_\_\_

**Past Medical History** (check all that apply):  No Past Medical History

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Acute Myocardial Infarction (Heart Attack) | <input type="checkbox"/> Chronic Liver Disease                        | <input type="checkbox"/> Kidney Disease                                   | <input type="checkbox"/> Seizure Disorder                             |
| <input type="checkbox"/> Anemia (Low Blood Count)                   | <input type="checkbox"/> COPD (Chronic Obstructive Pulmonary Disease) | <input type="checkbox"/> Lower Back Pain                                  | <input type="checkbox"/> Sinusitis                                    |
| <input type="checkbox"/> Arthritis                                  | <input type="checkbox"/> Diabetes Mellitus                            | <input type="checkbox"/> Mitral Valve Disorder                            | <input type="checkbox"/> Stroke Syndrome                              |
| <input type="checkbox"/> Asthma                                     | <input type="checkbox"/> Emotional Disturbance                        | <input type="checkbox"/> Murmurs  | <input type="checkbox"/> Thromboembolic Disease (Blood Clot Disorder) |
| <input type="checkbox"/> Autoimmune Disorder (Lupus/Scleroderma/RA) | <input type="checkbox"/> Gastric/Duodenal Ulcer                       | <input type="checkbox"/> Obesity  | <input type="checkbox"/> Thrombophlebitis                             |
| <input type="checkbox"/> Blood Transfusion Complications            | <input type="checkbox"/> Heart Disease                                | <input type="checkbox"/> Obstructive Sleep Apnea                          | <input type="checkbox"/> Thyroid Disorder                             |
| <input type="checkbox"/> Cancer - list type(s):<br>_____<br>_____   | <input type="checkbox"/> Heartburn                                    | <input type="checkbox"/> Osteoporosis                                     | <input type="checkbox"/> Transient Ischemic Attack (Mini Stroke)      |
|   | <input type="checkbox"/> Hepatic (Liver) Disorder                     | <input type="checkbox"/> Peripheral Vascular Disease (Poor Circulation)   | <input type="checkbox"/> Tuberculosis                                 |
|   | <input type="checkbox"/> Hepatitis                                    | <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Other (specify):<br>_____                    |
|   | <input type="checkbox"/> HIV Infection                                | <input type="checkbox"/> Pulmonary Disease (Lung Disease)                 | _____   |
| <input type="checkbox"/> Chest Pain (Angina)                        | <input type="checkbox"/> Hypercholesterolemia                         | <input type="checkbox"/> Recent Methicillin-resistant Staph aureus (MRSA) | _____   |
|   | <input type="checkbox"/> Hypertension                                 | <input type="checkbox"/> Rheumatic Fever                                  | _____   |
|   | <input type="checkbox"/> Irritable Bowel Syndrome                     |   |   |

**Surgery:**  No Surgical History

Surgery	Date	Surgery	Date

**Family History** (check all that apply):  No Family Medical History

	Family Member*		Family Member*
<input type="checkbox"/> Anemia (Low Blood Count)		<input type="checkbox"/> Hypercholesterolemia	
<input type="checkbox"/> Cancer - list type(s):		<input type="checkbox"/> Hypertension	
		<input type="checkbox"/> Osteoporosis	
		<input type="checkbox"/> Pulmonary Disease	
<input type="checkbox"/> COPD		<input type="checkbox"/> Renal Disease	
<input type="checkbox"/> Diabetes Mellitus		<input type="checkbox"/> Stroke Syndrome	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Thromboembolic Disease	
<input type="checkbox"/> Heart Disease		<input type="checkbox"/> Unattainable-Patient Adopted	
<input type="checkbox"/> Hepatic (Liver) Disorder		<input type="checkbox"/> Other:	
Family Health Status of Father – Deceased Age: _____ Cause: _____			
Family Health Status of Mother – Deceased Age: _____ Cause: _____			

\*Please indicate the family member affected: mother, father, brother, sister, maternal or paternal grandmother/grandfather, etc.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Social History:**

Marital Status:  Married  Single  Widowed  Separated  Divorced  Life Partner

(check all that apply)

Alcohol Use: Weekly: \_\_\_\_\_

Drug Use (Recreational): Explain: \_\_\_\_\_

Using Intravenous Drugs: Explain: \_\_\_\_\_

Previous History of Smoking: Date Quit: \_\_\_\_\_ Packs Per Day \_\_\_\_\_ Years of Smoking: \_\_\_\_\_  
 Attempts to Quit: \_\_\_\_\_ Methods Used to Quit: \_\_\_\_\_

No History of Smoking  Wishing to Stop Smoking

Smoking/Nicotine Substances:  Cigarettes: Packs/Times Per Day: \_\_\_\_\_ Years \_\_\_\_\_  
 Cigars  Chewing  Tobacco  Pipe

Current Diet: Explain: \_\_\_\_\_

Exercise Habits: Times per week: \_\_\_\_\_  Being Sedentary (Do not exercise)  Sexually Active

Occupation: List All: \_\_\_\_\_

Travel: If recently out of the country, where? \_\_\_\_\_

Do you have an advanced directive?  Yes  No

**Allergies:**  No Known Allergies

Allergy	Reaction	Allergy	Reaction

**Medications** (Include vitamins, herbal supplements and over the counter medications):  No Current Medications

Medications	Dosage	Frequency	Reason for Taking

Have you participated in any clinical trials or used experimental drugs?  Yes  No Explain: \_\_\_\_\_

Are you pregnant?  Yes  No Last Menstrual Period Date: \_\_\_\_\_

Is there anything else about your medical history that we should know? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have reviewed the above information with the patient.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# AUTHORIZATION TO RELEASE AND/OR COPY HEALTH INFORMATION

Copy of this consent given to patient?  Yes  Patient Refused Copy

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize the release of health information relating to me as described below:

**Physician Office/Department Authorized to Release My Information:**

Physician Name: \_\_\_\_\_ Office/Department (e.g. Internal Medicine): \_\_\_\_\_

**To Whom My Information May be Provided:**

Name of Individual (includes self) or Organization Receiving Information: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Specific Information to be Released: [copying fee may be charged]**

- Summary of Records  
To be prepared by doctor after Patient agrees to additional fees imposed.
- Entire Record
- Other (Please Specify): \_\_\_\_\_
- EKG
- Progress Notes
- Imaging Reports
- Lab Reports
- Billing
- History & Physical
- Pathology Report
- Immunizations
- Cardiac Testing

Covering the period(s) of treatment from \_\_\_\_\_ to \_\_\_\_\_

**Purpose/Use of Released Information:**

- Personal Use by Patient
- Workers' Compensation
- Medical Care
- Social Security
- Legal/Litigation
- Other: \_\_\_\_\_

**Authorization Expiration (date or event):**

- Date from signature : \_\_\_\_/\_\_\_\_/\_\_\_\_ (if not provided, than 180 days)
- Date of following event (please specify): \_\_\_\_\_

I understand that information in response to this request may be related to diagnosis or treatment for AIDS/HIV, psychiatric care and treatment, and/or treatment for drug and alcohol abuse. Please check the appropriate box(es) below:

- |  |  |  |
|--|--|--|
| <b><u>AIDS/HIV Information</u></b>           | <b><u>Psychiatric Care/Treatment**</u></b>   | <b><u>Drug or Alcohol Treatment</u></b>      |
| <input type="checkbox"/> Yes, disclose       | <input type="checkbox"/> Yes, disclose       | <input type="checkbox"/> Yes, disclose       |
| <input type="checkbox"/> No, do not disclose | <input type="checkbox"/> No, do not disclose | <input type="checkbox"/> No, do not disclose |

\*\*I have been informed of my right to inspect my mental health records to be released, subject to the limitations imposed by 55 Pa. Stat. §5100.33

I understand that if the person or entity receiving my individually identifying information is not a health care provider covered by federal privacy regulations, my information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand authorizing the use or disclosure of the information identified above is voluntary. My refusal to sign this form in no way affects my treatment, payment, enrollment in health plans or eligibility for benefits, unless:

- (a) This authorization is for the use or disclosure of health information obtained in a research study. If you do not sign this authorization, you will be ineligible to participate in the research study for which this authorization is being requested.
- (b) You have requested a service by Jefferson (for example, a physical examination, a letter about your medical problems, or a medical second opinion consultation) solely to provide the health information related to that service to a third party at your request.

I understand that I may revoke this authorization at any time, except to the extent it has been relied upon. I understand that if I revoke this authorization, I must do so in writing and give my written revocation to my physician's office/department authorized to release the information.

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative

\_\_\_\_\_  
Date

Print Name of Personal Representative (if applicable): \_\_\_\_\_

Describe Relationship/Authority to act for patient (parent, guardian, etc.): \_\_\_\_\_  
(Please provide necessary documentation proving your authority)

**Verbal Consent** (If the patient is physically unable to provide a signature, two responsible people must sign below)

The patient understands the nature of this release and freely gives his or her verbal consent, as witnessed by the following responsible individuals. The patient further understands that this verbal consent is subject to revocation at any time except to the extent that it has been relied upon. To revoke this verbal consent, the patient must understand the nature of the revocation and freely give his or her verbal revocation, as verified in writing by two responsible witnesses.

Witness 1 \_\_\_\_\_ Witness 2 \_\_\_\_\_ Date \_\_\_\_\_

**REVOCACTION SECTION** (to be completed and signed by the patient):

This consent has been revoked on \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Signature of Patient



**Jefferson**

## **STATEMENT TO ACCOMPANY RELEASE OF MENTAL HEALTH, DRUG AND ALCOHOL AND HIV-RELATED RECORDS**

**Check Applicable Statement(s)**

- STATEMENT TO ACCOMPANY RELEASE OF MENTAL HEALTH RECORDS**  
"This information has been disclosed to you from records whose confidentiality is protected by State statute. State regulations limit your right to make any further disclosure of this information without prior written consent of the person to whom it pertains." 55 Pa. Code section 5100.34(d).
- STATEMENT TO ACCOMPANY DISCLOSURE OF CONFIDENTIAL HIV-RELATED INFORMATION**  
"This information has been disclosed to you from records protected by Pennsylvania law. Pennsylvania law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose." 35 Pa. Stat. section 7607(e).
- STATEMENT TO ACCOMPANY RELEASE OF DRUG OR ALCOHOL ABUSE RECORDS**  
"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Today's Date:
---------------

Please complete this form in order to ensure proper billing of your services. **Please Print.**

Patient's Last Name		Patient's First Name		MI
DOB	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Language <input type="checkbox"/> English <input type="checkbox"/> Other _____	
Race <input type="checkbox"/> African American or Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Unknown <input type="checkbox"/> Declined				
Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Non-Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____				
Address Line 1		Address Line 2		
City			State	Zip
Home Phone		Daytime Phone		Cell Phone
Home E-mail				
Emp Status <input type="checkbox"/> Employed Full Time <input type="checkbox"/> Employed Part Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Active Military <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Other _____				
Employer			Work Phone	
Employer's Address Line 1		Employer's Address Line 2		
City			State	Zip

**Please complete if guarantor is other than self. (Guarantor is the person financially responsible for this patient's bill.)**

Guarantor's Last Name		Guarantor's First Name		MI
DOB / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number - -	Patient's Relationship to the Guarantor	Home Phone
Guarantor's Address Line 1		Guarantor's Address Line 2		
City			State	Zip
Guarantor's Employer				
Guarantor Employer's Address Line 1		Guarantor Employer's Address Line 2		
City			State	Zip

**Emergency Contact Information**

Emergency Contact's Last Name		Emergency Contact's First Name		MI
Patient's Relationship to the Emergency Contact		Daytime Phone		Cell Phone

**Please select the source in which you heard of our practice**

<input type="checkbox"/> Billboard	<input type="checkbox"/> Brochure	<input type="checkbox"/> Health Fair	<input type="checkbox"/> Health Plan	<input type="checkbox"/> Internet	<input type="checkbox"/> JEFF NOW®	<input type="checkbox"/> Mass Mailing	<input type="checkbox"/> Newspaper/Mag.	<input type="checkbox"/> Ongoing Care
<input type="checkbox"/> Patient	<input type="checkbox"/> Phone Book	<input type="checkbox"/> Phys. Off./ER	<input type="checkbox"/> Relative	<input type="checkbox"/> Radio	<input type="checkbox"/> TV	<input type="checkbox"/> Word of Mouth	<input type="checkbox"/> Other _____	

**Insurance Information** *A separate form is required for workers' compensation, automobile liability, or legal services.*

Primary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	
Secondary Insurance Company Name			
Subscriber's Last Name	Subscriber's First Name	Subscriber's DOB / /	Patient's Relationship to the Subscriber
Subscriber's Last 4 digits of SS#		Subscriber's Employer	