KURLAN SPECIALIZED NEUROLOGY, LLC

Specializing in Movement, Cognitive and Behavioral Disorders

Dear New Patient:

Thank you for choosing Kurlan Specialized Neurology (KSN) as your healthcare provider. In close collaboration with the Cognitive and Research Center of New Jersey, LLC (The CRCNJ), KSN is part of a multidisciplinary center bringing together a specialized team in the fields of psychology, neurology, and psychiatry to provide the highest standard of care. Through our collaborative expertise, we can provide the most comprehensive diagnostic work-ups and treatment plans, resulting in a more successful outcome for you and your loved ones. We are pleased that you have selected us as your providers and we look forward to seeing you at your upcoming appointment.

Enclosed please find the following documents:

Neurological Evaluation:
New Patient Information
Fees and Payment Policies
Self-Report Questionnaire
Authorization Form
Patient Registration Form
Acknowledgement of Notice
New Jersey Notice Form
General Consent to Treat
Private Health Insurance Reimbursement Agreement

Please complete the packet and return it in the envelope provided at least a week before your first appointment. Please also include in this packet any relevant medical records or arrange to have them faxed to at 973-850-4621. Please arrive 15 minutes early to your appointment for registration purposes.

KSN participation in a variety of health insurance plans is in flux as we enter the New Year. We expect that he will be a participant in Medicare as of January 1. KSN will also be participating in a number of private health insurance plans. Unfortunately, the processing of KSN's participation is not under our control and so the starting dates are uncertain. We will try to inform you when such participation begins.

If you have any questions or need assistance completing this packet, please do not hesitate to contact us at 973-850-4622. Thank you for allowing us to participate in your care.

Sincerely,

Roger Kurlan, M.D.

Office Location: The Cognitive and Research Center of New Jersey, LLC.
www.thecrcnj.com
195 Mountain Avenue
Springfield, NJ 07081
Phone: 973-850-4622
Fax: 973-850-4621

KURLAN SPECIALIZED NEUROLOGY, LLC

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New Patient Information Sheet

Name: ____ Date of Birth: _________________________

SSN: ______________________________________

Home Address: ____

____

Phone Number: ____

Is it OK for the doctor or a staff member to leave messages? _______Yes _______No

Email: ____

Contact Name (if Different than Patient): ____

Address: ____

____

Phone Number: ____ Ok to leave messages? ____Y _____N

Email Address: ____

Is the contact a legal guardian or holder of POA/Health Proxy? _______Y _______N

If yes, please provide documentation.

Office use only: documentation provided? Yes ________ No _________
POA ________ Health Proxy _________

How were you referred to Kurlan Specialized Neurology (KSN)?

(Physician's name and specialty, or other source): ____

Insurance Information
Primary Insurance Carrier: ____

Policy Number: ____

Secondary Insurance
Secondary Insurance Carrier: ____

Policy Number: ____

Please provide copies of your insurance cards (front and back) or bring them to the first scheduled appointment so that we may make copies.

Pharmacy Information
Pharmacy Name and Address: ____

____

Pharmacy Phone Number: ____

Medicare Authorization and Release:

If Medicare is your primary insurance carrier, we will bill Medicare on your behalf. In order for us to do so, you must sign the authorization below:

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to Kurlan Specialized Neurology (KSN) for services provided.

____ ____________________________
Signature of Patient Date

____
Print Name Patient

____ ________________________
Signature of Legal Guardian* (Relationship) Date

____
Print Name Legal Guardian* (Relationship)

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

Authorization to be contacted in the future for research or other opportunities:

KSN, in conjunction with The Cognitive and Research Center of New Jersey LLC, conducts clinical trials, other research, and offers workshops and other educational programs. Please check below to indicate whether we may enter your information into a database and contact you in the future to let you know of these opportunities.

□Yes □No

____ ________________________
Signature of Patient Date

____
Print Name Patient

____ ________________________
Signature of Legal Guardian* Date

____
Print Name Legal Guardian*

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

FEES AND PAYMENT POLICIES

Neurological Evaluations:
Kurlan Specialized Neurology ("KSN") bills per 60 minute session for new patient visits and 30 minute sessions for follow-up visits.

Cancellation / Missed Appointment Policy:
A 48 hour cancellation policy is strictly enforced. Without 48-hour notice, all patients are responsible for paying for reserved and pre-preparation time at the **out of pocket rate**.

KSN reserves the right to utilize a legal collections process for any unpaid balances.
If balances remain unpaid, even after multiple attempts to receive payment owed, a legal collections process will be employed by KSN to collect outstanding balances. In such cases, the following information about the patient will be disclosed to the third party represented by KSN: name, address, social security number, date of birth, dates of service for which payment is due, amount owed.

Traditional and Private Medicare:
If Medicare is your primary insurance carrier, we will bill Medicare on your behalf. Since plans may or may not include benefits for neurological services, the patient is responsible for learning about the relevant policies of his/her health insurance plan that may make reimbursement possible. In all cases, patients are responsible for any charges not covered by their insurance.

Private Health Insurance:
KNS participates in many but not all private health insurance plans. We will check to see if you will be covered for your visit, but it is your ultimate responsibility to verify coverage. Since plans may or may not include benefits for neurological services, the patient is responsible for learning about the relevant policies of his/her health insurance plan that may make reimbursement possible. In all cases, patients are responsible for any charges not covered by their insurance.

Any account balances must be paid in full at the time of the appointment.

If KSN is not a participating provider, the fees are as follows:

New Patient – 60 minutes - $275.00
Follow up appointment – 30 minutes - $165.00

I have read the above statements regarding fees and payment policies and agree to these terms.

____
Print Name of Patient

____
Signature of Patient   Date

____
Print Name of Legal Guardian* (Relationship)

____
Signature of Legal Guardian* (Relationship)   Date

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

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CREDIT CARD AUTHORIZATION

I authorize Kurlan Specialized Neurology (KSN)to charge the credit card below for any unpaid balances for services rendered. Charges will correspond to amounts detailed in the Fees and Payment Policies Agreement. This authorization shall remain in effect until terminated by me in writing.

Cardholder Name:

____

Billing address (please include city, state and zip code):

____

____

Card Type: _______Visa _______MasterCard _______American Express _______Discover

Card Number: ____

Expiration Date: ____

3-Digit Security Code: _________________ (on back of card)

I understand that, in order for the KSN to bill the credit card above, the following information will be released to the credit card company: the cardholder's name, date of service for which cardholder is being charged, and the amount owed.

____ _________________

Cardholder's Signature Date

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SELF-REPORT QUESTIONNAIRE

The information requested below will be used to help the doctor understand the presenting problem and the medical, psychological, and social context in which these symptoms have occurred. Please complete the following questionnaire as accurately and honestly as possible. The information that you provide is confidential and will be used to aid in the evaluation, diagnosis, and treatment plan.

Name____ Date__________________

Age: __________ Gender: _________ Height: _________ Weight: _________

Handedness: Right handed _______ Left Handed _______ Ambidextrous ___________

Relevant History:

What are you experiencing in your daily life that has caused you to seek an evaluation?

____

____

____

____

When did these symptoms begin? ____________________________________ (approximate date)

Did the symptoms appear gradually or very suddenly?

____

Have the symptoms gotten worse, better, or stayed the same?

____

____

____

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Review of Symptoms: Have you had any of the following **symptoms in the past month?** Provide details below if necessary:

	Yes	No	Describe
Loss of Consciousness			
Daytime Lethargy/sleepiness			
Disturbed Sleep			
Abnormal Vision			
Loss of Hearing			
Ringing in the Ears			
Dizziness/Vertigo			
Weakness in one part of the body			
Tremor/Shaking			
Involuntary movements			
Problems with Walking			
Imbalance			
Frequent Falling			
Frequent Headaches			
Weight Loss			
Weight Gain			
Depression			
Anxiety			
Hallucinations			
Delusions			
Incontinence			
Persistent pain			

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Reason for referral:

Who referred you for this evaluation? ____

What information is being sought by this evaluation**?** ____

____

Neuropsychiatric Work-up:

Have you recently been evaluated by a neurologist or psychiatrist or had any related testing? ____________________

If so, please use the chart below to describe the purpose and status of these assessments. Please also list any pending evaluations.

Type of Evaluation or Test	Physician or Facility	Date	Results	Did You Provide Copies of the Report? Yes /No Will These Be Mailed, Faxed or Brought to the Appointment?
Neurological Evaluation				
Psychiatric Evaluation				
Neuropsychological Evaluation				
MRI				
CT				
EEG				
Blood work				
Other				

Please mail copies of the above records with this packet, or arrange to have copies of those records sent to KSN prior to the scheduled date of the neurological evaluation. Records can be faxed to 973-850-4621 or mailed to: Kurlan Specialized Neurology, 195 Mountain Avenue, Springfield, NJ 07081.

Past Medical History: Have you been **diagnosed** as having any of the following medical conditions? Please provide details as necessary.

	Yes	No

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Visual Loss or Glaucoma		
Loss of Hearing		
Recurrent Vertigo		
High Blood Pressure		
High Cholesterol		
Heart disease (angina, heart arrhythmia)		
Lung disease (emphysema, COPD, asthma)		
Gastrointestinal disease		
Liver disease		
Chronic skin condition		
Arthritis		
Chronic sleep disorders		
Stroke or TIA		
Alzheimer's or other cognitive disorders		
Parkinson's or other movement disorders		
Chronic tremor		
Fainting or blackouts		
Seizures/epilepsy		
Seizures with high fever as child or baby		
Head trauma w/loss of consciousness		
Back Trouble		
Hematological disorders (sickle cell, hemophilia)		
Bleeding tendency		
Diabetes		
Thyroid condition		
Immunologic disorders (rheumatoid arthritis, lupus)		
Chronic allergies/hay fever		
Depression		
Psychiatric illness other than depression		
Kidney disease or other urological disorders		
Tuberculosis		
HIV or AIDS		
Encephalitis or Meningitis		
Polio		
Infections (Lyme)		
Chronic gynecological disorders		
Cancer		

Additional Medical History:

Please list any past or current medical conditions, along with dates: ____

____

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____

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Please list any past or current hospitalizations, along with dates: ________________________________

____

____

____

____

Head Injury Assessment:

Date of Injury			
Age at injury			
Was there a loss of consciousness? How long?			
Event that caused the injury			
Post – injury symptoms/problems			
Treatment for injury			

Current Medications:
(Please include a "B" for Brand Name and "G" for generic after stating medication name)

Please list any medications you are currently taking including over the counter medications, supplements and vitamins.

Medication Include form: ie tablet, liquid, capsule, etc.	**Start Date**	**Reason for Medication**	**Strength** (mg of each tablet/mg per ml)	**Dosing** How many tablets/ml per dose? (with times; ex: one tablet @8am & 8pm	**Medication side effects**

Medication Allergies and type of reaction:

____

____

____

____

Past Medications:

Please list any medications prescribed in the past:

Medication	Start Date	End Date	Reason for Med	Dosing	Medication side effects

Family History:

Does anyone in your family (i.e., blood relative) have a history of **neurological** or **psychiatric** illness? Please use the chart below to list these relatives and their history.

Family Member/Relation	Illnesses	Age of Onset of Illness

Additional Comments: ____

____

____

____

Psychiatric History:

Do you have a history of psychiatric or psychological disorders? ______________________________

If so, please describe: ____

____

____

____

____

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Are you **currently** in treatment with a psychologist or therapist? ____

If so, for how long? _______________________ Is it helpful? ____

Name of Psychologist or Therapist: ____

Phone Number: _______________________________________ Fax Number: ______________________________________

Are you **currently** in treatment with a Psychiatrist? ____

If so, please provide name: __________________________________Phone Number: ________________________

Please list any prescribed medication, including dose and duration of treatment:
____
____
____

Please describe any **previous history** of psychological or psychiatric treatment:
____
____
____

Have you ever been hospitalized for a psychiatric illness? ____

If so, please describe (and provide dates):
____
____
____
____

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www.thecrcnj.com

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Social History:

How many years of education did you complete? ____

What is the highest degree you obtained? ____

From what school did you receive your degree? ____

Are you retired? ____________________ If so, for how many years? ______________________________

What is your current occupation? ____

For how long have you been at your current job? ____

Please describe your previous employment history:

____

____

____

____

What is your marital status? ____

If married, for how many years? ____________________

Are you divorced or widowed? __________________ If so, for how many years? ________________________

Do you have any children? _______________________ If so, how many? ______________________________

Do you live alone or with others? ____

Do you need help with your daily routine (e.g., grooming, dressing, driving, eating)?

____

____

____

____

If so, do you have adequate help and support? ____

____

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Do you have a driver's license? ________________ If so, which state? ______________________________________

How do you like to spend your leisure time? ____

____

Do you exercise regularly? _______________

If so, please describe your exercise routine:

____

____

Alcohol/Drug Use:

Do you smoke cigarettes? __________________ If so, how many per day? ___________________________

For how long have you been smoking? ____

If you do not smoke currently, have you ever smoked cigarettes? ____

If so, for how long did you smoke? ____________________ How many per day? _____________________________

Do you smoke any other substances? _________________ If so, please describe:

____

____

Do you, or have you ever, used any illicit drugs? ___________________ If so, please describe:

____

Do you consume alcohol? _____________ If so, please describe daily or weekly use: ____________________________

Did the patient fill out the questionnaire? ______Yes ______No

If not, please explain and list the name of the person who completed this: ___________________________________

Is there anything else you would like to add?

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Thank you for completing this questionnaire.

Authorization Form

This form, when completed and signed by you, authorizes Kurlan Specialized Neurology ("KSN") to release Protected Health Information ("PHI") from your clinical record to the person you designate, and to obtain PHI from entities designated by you. **Please note, that, as per our standard practice, we will automatically send a copy of the neurological consultation report to the referring physician.**

You have the right to revoke this authorization, in writing, at any time, by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Please complete the following:

I authorize Kurlan Specialized Neurology, LLC to release:
____ All KSN records
____ These specific records only:
____
____
(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

This information should only be released to:
____
____
____
____
(Provide the name of person to whom the information is to be released, including the relevant family members.)

KSN has collaborative, consultative relationships with the Cognitive and Research Center of New Jersey, LLC and Pelorus Memory and Behavioral Health. Please check below if you wish to authorize KSN to release and/or obtain all records, including demographic paperwork that may be used across practices, to these entities. Please release all records, including forms, to:

____ The Cognitive and Research Center of New Jersey, LLC **____ Pelorus Elder & Behavioral Health**

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195 Mountain Avenue
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I understand that I am responsible for arranging for my medical records to be sent to KSN. However, if needed, I also give permission for KSN to obtain medical records and/or discuss my medical information with:
_____ Check here if list is the same as above
_____ or list each person or entity below:
____

I am requesting KSN to release/obtain this information for the following reasons:
____
("at the request of the individual" is all that is required if you are a patient of KNS and you do not desire to state a specific purpose.)

This authorization shall remain in effect until ___________________ (fill in **expiration date**) or until __________________________________ (fill in an event that relates to the individual or the purpose of the use or disclosure, or you may write "until further notice").

I am aware of my right to confidential communications under physician - patient privilege.

I understand that my physician generally may not condition services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by designated recipients and may no longer be protected by the HIPAA Privacy Rule.

____ ______________________________
Signature of Patient Date

____ ______________________________
Print Name of Patient Date of Birth

____ ______________________________
Signature of Legal Guardian* (Relationship) Date

____
Print Name of Legal Guardian* (Relationship)
**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

Kurlan Specialized Neurology, LLC
195 Mountain Ave
Springfield, NJ 07081

PATIENT REGISTRATION FORM

MR # ____________________ Date: ____________________

PATIENT INFORMATION

Patient Name: ______________________________ SSN # ____________________

Date of Birth: ____________________ Age ____________________ Sex (M/F): ____________________

Address: ______________________________ Email id: ______________________________

City ____________________ State ______ Zip Code ________ Home Phone # ____________________

Cell # ____________________ Emergency Contact # ______________________________

GUARANTOR INFORMATION

Guarantor Name: ______________________________ SSN # ____________________

Date of Birth: ________________ Age _____ Sex: ____M ___F Marital Status: ____ S _____M_____D_____O

Address: ______________________________ Relationship to Patient ____________________

City ____________________ State ______ Zip Code ________ Home Phone # ____________________

Email ID: ______________________________ Race/Ethnicity: ____________________

Emergency Contact Name: ____________________ Emergency Contact Phone # ____________________

Employer Name/Work Address: ____

INSURANCE INFORMATION * Please provide Insurance card and Photo ID to Front Desk**

Primary Insurance Name: ____

Subscriber Name: ______________________________ SSN #: ________________ DOB: ________________

ID # ________________ Group # ____________ Effective Date ____________ End Date ____________

Secondary Insurance Name: ________________ Subscriber Name: ______________________________

Subscriber Name: ______________________________ SSN #: ________________ DOB: ________________

ID # ________________ Group # ____________ Effective Date ____________ End Date ____________

Assignment of Benefits:

I hereby authorize the physician/provider to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; and thereby authorize payment of the insurance benefits directly to the physician for any and all services rendered.

Patient, power of attorney, spouse/partner, other Date

Office Policy:

- In the event you will not be able to keep an appointment, you must notify me 24 hours in advance, without advance notice, you will be responsible for paying a full fee
- If you change insurance plans or receive new insurance cards it is your responsibility to provide your updated cards. In the event your insurance company does not cover my services, you will assume full responsibility to pay for services provided.

Financial Liability:

I understand that as a recipient of medical care from Dr. Roger Kurlan I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. I understand that a fee is charged for all visits, examinations, or medical reports. I agree that the determination of the professional services to be rendered by Dr. Roger Kurlan and the fees to compensate Dr. Roger Kurlan for these services are matters which concern Dr. Roger Kurlan and me. I understand that I have the primary duty and obligation to pay Dr. Roger Kurlan for any services rendered at Dr. Roger Kurlan, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).

I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will ensure that Dr. Roger Kurlan responsible patients will not be penalized to cover costs incurred by those who do not pay on time

Patient, power of attorney, spouse/partner, other Date

Acknowledgment of Notice

1) I have reviewed and been offered written notice of physician policies and practices with regard to the HIPAA Privacy Act. I understand and agree to the contents of this Notice.

2) I understand that the professionals at Kurlan Specialized Neurology share confidential patient information in an effort to work as a collaborative team in the delivering of patient care.

3) I also understand that I may contact Kurlan Specialized Neurology should I have questions regarding my rights as a patient of this provider.

____ ______________________

Signature of Patient Date

____

Print Name of Patient

____ ________________________

Signature of Legal Guardian * (Relationship) Date

____

Print Name of Legal Guardian* (Relationship)

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

NEW JERSEY NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

Kurlan Specialized Neurology (KSN) refers to KSN and all employees/delegates.

I. Uses and Disclosures for Treatment, Payment, Health Care Operations, and Research

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, Healthcare Operations, Legal Collections, and Research"*

  – *Treatment* is when we provide, coordinate or manage your health care and other services related to your healthcare. An example of treatment would be when we consult with another healthcare provider, such as your family physician or another psychologist. The professionals at Kurlan Specialized Neurology share confidential patient information in an effort to work as a collaborative team in the delivering of patient care.

  - *Payment* is when we may assist you in obtaining reimbursement for your healthcare. Examples of payment are if we disclose your PHI to your health insurer to help you obtain reimbursement for your healthcare or to determine eligibility or coverage or when payment is made by credit card. In order for KSN to bill the credit card company, the following information will be released: the cardholder's name, date of service for which cardholder is being charged, and the amount owed.

  - *Healthcare Operations* are activities that relate to the performance and operation of our practice. Examples of healthcare operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

  -*Legal Collections* is when KSN employs a legal collections process for unpaid balances. As outlined in the Fees and Payment Policies, in such cases, the following patient information may be disclosed to a third party - name, address, social security number, date of birth, dates of service for which payment is due, amount owed.

- *Research* is when you consent to participate in a research study conducted at KSN or The Cognitive and Research Center of New Jersey, LLC (The CRCNJ). Monitors and auditors bound by HIPPA regulations may access your PHI in order to verify the work of our research team.

- "*Use*" applies only to activities within our [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when we ask for information for purposes outside of treatment, payment, healthcare, and research operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause to believe that a child has been subject to abuse, we must report this immediately to the New Jersey Division of Youth and Family Services.
- **Adult and Domestic Abuse:** If we reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, we may report the information to the county adult protective services provider.
- **Health Oversight:** If the New Jersey State Board of Psychological or Medical Examiners issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We must inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to us a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and we believe you intend to carry out that threat, we must take steps to warn and protect. We also must take such steps if we believe you intend to carry out such violence, even if you have not made a specific verbal threat.

  The steps we take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other healthcare facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

  Based on the new amendment, originating from bill A1181, signed into law by Governor Phil Murphy *(along with 5 other gun control bills)* on June 13, 2018, we are required to notify the chief law enforcement officer or the Superintendent of State Police (if you reside in a municipality that does not have a full time police department) in addition to taking other appropriate courses of action (such as arrange for a hospitalization, notifying the victim or their parents, notifying the parents of a minor) if we felt that there was a “duty to warn” (a threat of imminent, serious physical violence against a readily identifiable individual or against yourself). In such cases, we will provide your name and other nonclinical identifying information to law enforcement authorities.

- **Worker’s Compensation**: If you file a worker's compensation claim, we may be required to release relevant information from your mental health records to a participant in the worker’s compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker’s Compensation, or the Compensation Rating and Inspection Bureau.

There may be additional disclosures of PHI that we are required or permitted by law to make without your consent or authorization, however the disclosures listed above are the most common.

IV. Minors Consent to Behavioral Health Care

Unless otherwise ordered by a court, if the client is a minor, a parent or legal guardian will be deemed to be an authorized representative to consent to treatment and authorizations. When the patient is more than 14 years of age, but has not yet reached the age of majority, the authorization shall be signed by the patient and by the patient's parent or legal guardian.

However, by law, minors are not permitted to refuse treatment if their parent or legal guardian believes it is necessary.

Under the *"Boys and Girls Clubs Keystone Act,"* there are certain circumstances under which a minor may provide consent without the joint consent of their parent or legal guardian:

- If the minor is 16 or older, temporary outpatient treatment may be provided without parental consent, excluding the use or administration of medication.
- We are not required to release to a minor's parent or guardian records or information relating to the minor's sexually transmitted disease, termination of pregnancy or

substance abuse or any other information that in the reasonable exercise of our professional judgment may adversely affect the minor's health or welfare.

- The provisions above also apply to access to client records, access by a managed health care plan to information in client record and confidentiality of minors.

V. Patient's Rights and Physician Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Physician Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you at the time of your next visit.

VI. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Kurlan Specialized Neurology at (973) 850-4622.

If you believe that your privacy rights have been violated and wish to file a complaint with KSN, you may send your written complaint to Kurlan Specialized Neurology, 195 Mountain Avenue, Springfield, NJ 07081.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VII. Effective Date

This notice will go into effect on Oct. 1, 2018.

KURLAN SPECIALIZED NEUROLOGY, LLC

Specializing in Movement, Cognitive and Behavioral Disorders

General Consent to Treat

I_____________________________________ (name of patient or legal guardian) have the legal right to consent to medical treatment for _______________________________ (name of patient). I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that the Kurlan Specialized Neurology clinicians believe are necessary. I understand that by signing this form, I am giving permission to the doctors and other healthcare providers in this medical office to provide treatment as long as I am a patient in this office, or until I withdraw my consent. I have read this form, or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

____

Print Name of Patient

____ ______________________

Signature of Patient Date

____

Print Name of Legal Guardian* (Relationship)

____ ______________________

Signature of Legal Guardian* (Relationship) Date

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

KURLAN SPECIALIZED NEUROLOGY, LLC

Specializing in Movement, Cognitive and Behavioral Disorders

Private Health Insurance Reimbursement Agreement

KSN participation in a variety of health insurance plans is in flux as we enter the New Year. We expect that KSN will be a participant in Medicare as of January 1 as well as a number of private health insurance plans. Unfortunately, the processing is not under our control and so the starting dates are uncertain. We will try to inform you when such participation begins.

Services rendered to patients by Dr. Kurlan at KSN to patients covered by these plans may not be reimbursed depending on the specifics of your plan, and, per our Fees and Payment Policies, out-of-pocket payment is expected at the time of service.

For Horizon patients only. By signing this agreement, you agree that neither the patient nor KSN can bill Horizon for services rendered by Dr. Kurlan at KSN.

Your signature, below, attests to your understanding of the above.

____ ______________________

Print Name of Patient Date

____

Signature of Patient

____ ______________________

Print Name of Legal Guardian* (Relationship) Date

____

Signature of Legal Guardian* (Relationship)

**If the authorization is signed by a personal representative of the patient, a description and documentation of such representative's authority to act for the patient must be provided.*

Office Location: The Cognitive and Research Center of New Jersey, LLC.
www.thecrcnj.com
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