Georgia Neurodiagnostic and Treatment Center, LLC

3790 Pleasant Hill Rd., Ste 250, Duluth, GA 30096

Phone: 678-878-2989 Fax: 678-878-2990

Dong Wang, MD

Authorization for Release of Medical Records

I hereby authorize disclosure of health confirmation that may include MRI, CT, XRAY, psychotherapy notes, drug and alcohol abuse, and HIV related information from the following health record.

Patient name:_____ **DOB:**_____

This information is to be disclosed to:

Georgia Neurodiagnostic and Treatment Center, LLC

3790 Pleasant Hill Rd., Ste 250, Duluth, GA 30096

Phone: 678-878-2989 Fax: 678-878-2990

For the purpose of _____

I understand this authorization may be revoked in writing at any time, except to extent that action has taken in reliance in this authorization

Date:_____

Patient's Signature:_____

Signature of Legal representative and relationship to patient:_____

Witness:_____

Georgia Neurodiagnostic and Treatment Center,LLC

3790 Pleasant Hill Rd., Suite 250 Duluth, GA 30096
Phone: (678)-878-2989 Fax: (678)-878-2990
483 Upper Riverdale Rd., Ste F Riverdale, GA 30274
Phone: (770)-907-7665 Fax: (678)-878-2989
Dong Wang, MD

Patient Demographic Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: (_____)_____ Gender: MALE FEMALE

Cell/Other Phone Number: (_____)_____

Work Number: (_____)_____ Date of Birth:____/____/_____

Email Address: _____

Social Security: _____

Marital Status: SINGLE MARRIED DIVORCED WIDOWED OTHER

Ethnicity: HISPANIC OR LATINO NON - HISPANIC

Race:
AMERICAN INDIAN PACIFIC ISLANDER OTHER
ALASKA NATIVE BLACK OR AFRICAN AMERICAN
ASIA WHITE/CAUCASIAN

Preferred Language: ENGLISH SPANISH OTHER_____

Employer Name and Phone #:_____

Primary Care Physician Name and Phone #: _____

Referring Name and Phone #: _____

Pharmacy Name and Phone #: _____

Emergency Contact Name and Phone #: _____

GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER
DR. DONG WANG
PATIENT CONSENT FORM

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. If we change our notice, you may obtain a revised copy by asking our receptionist.

You may have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except here we have already made disclosures in reliance on your prior consent.

PLEASE SIGN BELOW TO INDICATE YOU HAVE RECEIVED A COPY OF OUR PRIVACY POLICIES

Print Name: _____

Patient Signature Date

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ IT AND FULLY UNDERSTAND IT'S CONTENT

I hereby give permission to Dr. Wang to release my medical information to the individual(s) listed below. (Examples, Spouse, Children, Friends, Family Members)

_____ _____

Person Giving Consent (Patient) Witness by Physician Staff

1. _____
   Individual given permission to receive medical information and Relationship

2. _____
   Individual given permission to receive medical information and Relationship

3._____
   Individual given permission to receive medical information and Relationship

GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER
DR. DONG WANG
Financial Policy

1. I understand that GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER files claims to my insurance company as a courtesy and it is not a guarantee of payment.

2. I understand that I am fully responsible for charges that are not covered by my Insurance.

3. I understand that payment of co pays, deductibles, co-insurances or self-pay amounts are due at the time of service.

4. I understand that GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER does not accept check for payment but may pay cash or credit card.

5. I understand that if I have a balance that has not been paid and gets assigned to an outside collection agency, I will be assessed and addition fee up to 35% of my balance.

6. I understand that if I have Private Insurance and Medicaid, that Medicaid will always be the secondary insurance. I understand that if I do have other insurance in addition to Medicaid, and Do not let GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER know, that I am committing Medicaid fraud, and may be reported to the state.

7. I understand that it is my responsibility to make sure I have a referral for GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER if my insurance company requires one.

8. I understand that it is my responsibility to make sure GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER is In or Out of Network with my insurance company.

9. My signature on this financial policy will not expire.

Print Patient/Guardian Name: _____

Signature of Patient/Guardian Date

GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER
DR. DONG WANG
PAIN MEDICATION AND PRESCRIPTION AGREEMENT

Any Class II and Class III medications can be very useful but can have a high potential for misuse. Because of this, they are closely controlled by local, state, and federal governments. Because Dr. Wang may prescribe these medications as part of my treatment, a signed contract between the patient and physician will be kept in my record. I agree to the following condition's:

1. I am responsible for my medications that have been prescribed to me.
2. If my prescription is lost, misplaced, spilled, or stolen, it will not be replaced
3. My doctor gives me enough medication until my next appointment, usually 30 days and the prescription will not be refilled until that time.
4. Refills of Class II and Class III medications will only be given during a schedule office visit, during regular business hours of Monday-Friday, 8am-5pm.
5. If I need a refill of medication other than Class II and Class III, I must give a 48 hour notice.
6. I will take the prescription exactly as instructed by my physician. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
7. I will be terminated form the practice for noncompliance in the taking of my medications.
8. I will not give, trade, or sell medications.
9. It is considered a felony for altering or forging of a prescription and will result in immediate termination form the practice.
10. If I obtain Class II and Class III from any other physician will under GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER care, I will be immediately terminated form the practice and reported to my other physicians and medical facility I am seen at.
11. I agree to comply with the random urine, blood, sweat or serum testing,and document proper use of medication
12. I understand that most manufacturers of Class II and Class III medication recommend the use of heavy equipment, which included driving a motor vehicle. Please be aware that if you choose to drive a vehicle, ou could be charged with DUI.
13. I will not combine any Class II and Class III medications with the consumption of alcohol.
14. I understand that if the physician feels that I am at risk for psychological dependence/addiction, my medication will no longer be refilled, and I will be sent to a medication use specialist.
15. If Class II and Class III medications are stopped, my physician will help me do this safely
16. I understand that there may be unknown risk associated with long term use of controlled substance and that my physician will advise me of any advances and make changes as needed.
17. I understand that abusive behavior or harassment towards any GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER employee will not be tolerated, and will result in immediate termination from the practice.
18. My signature on the Medication agreement will not expire.

I have read,understand, and agree to the polices above. I understand that if I do not sign this document, my physician may refuse to prescribe my any medications. Failure to adhere to these polices may result in dismissal form the practice.

Patient Signature Date

CANCELLATION AND NO SHOW POLICY

Georgia Neurodiagnostic and Treatment Center

Due to the number of cancellations and "No Show" appointments, patients who are ill have been unable to make appointments with us in a timely manner. Therefore, we have decided to institute a Cancellation and No Show policy to our practice.

We provide reminder calls before your appointment as a courtesy, but not receiving a reminder call does NOT excuse a missed appointment. YOU are responsible for remembering scheduled appointments. It is requested that If you must cancel your appointment, you must provide at least 24-hour notice prior to your appointment time. Appointments which are canceled with less than 24 hours notification may be subject to a $25.00 cancellation fee.

A pattern of missed appointments may result in a $25.00 cancellation fee and/or our no longer being able to provide care for you.

The Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before patient's next appointment.

We understand that special, unavoidable circumstances may cause you to be unable to cancel within 24 hours. Fees in this instance may be waived at the discretion of management approval. Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. We greatly appreciate your participation in our Cancellation and No Show policy.

Thank you for your understanding!

I, the undersigned, have been informed about Georgia Neurodiagnostic and Treatment Center's Cancellation and No Show policy. I understand that missed appointments that is not canceled at least 24 hours in advance may result in cancellation fees and/or termination of my care at this center. I have been informed that reminder calls are made as courtesy but that I am responsible for remembering my appointment.

X_____ X_____

Signature Date

New Patient Questionnaire

Name: Date of Birth:

1. Do you have any allergy to medication or food? And reactions if you take them?

Medication:

Food:

2. Could you list the medication name and dosage that you are currently taking?

3. Do you smoke? How many packs per day?

4. Do you drink? How many glasses per day?

5. Do you use any recreational drug?

6. Do you have any other medical issue? Or surgeries?

7. Do you have the significant family history of diseases?

GEORGIA NEURODIAGNOSTIC AND TREATMENT CENTER
DR. DONG WANG
Notice of Privacy Practice

As required by the Privacy Regulations created as a result of Health Insurance Portablility and Accountablity Act of 1996 (HIPAA). This notice describes how health information about you (as a patient of this practice) may be use and disclosed, and how you can get access to your individually identifiable health information. Please review carefully.

A. Our commitment to your privacy: our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIH). In conducting our business, we will create records regarding you and the treatment and services provided to you. We are required by law to maintain the confidentially of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

B. IF YOU HAVE ANY QUESTION ABOUT THIS NOTICE, PLEASE CONTACT GNDTC AT 770-907-7665

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

1. TREATMENT: Our practice may use you IIHI to treat you. For example, we may ask you to have a laboratory test (such as blood work or urine test), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you or we might disclose you IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice - including but not limited to, our doctors and nurses may use or disclose your IIHI in order to treat you or assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care such as your spouse, children, or parents.

2. PAYMENT: Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may received from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for costs, such as a family member. Also, we may use your IIHI to bill you directly for services and items.

3. HEALTH CARE OPERATIONS: Our practice may use and disclose your IIHI to operate our business. Examples of ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you receive from us, or to conduct cost-management and business planning activities for our practice.

4. APPOINTMENT REMINDERS: Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. TREATMENT OPTIONS: Our practice may use and disclose your IIHI to inform you of potential treatment options and alternatives.

6. HEALTH-RELATED BENEFITS SERVICES: Our practice may use and disclose your IIHI to inform you of health related benefits or services that may be of interest to you.

7. RELEASE OF INFORMATION TO FAMILY/FRIENDS: Our practice may use and disclose your IIHI to a friend or family member that is involve in your care, or who assist in taking care of you. For example a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. DISCLOSURES REQUIRED BY LAW: Our practice may use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSUR OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. PUBLIC HEALTH RISK: Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

-maintaining vital records, such as births and deaths
-reporting child abuse or neglect
-preventing or controlling disease, injury, or disability
-notifying a person regarding potential risk for spreading or contacting a disease or condition
-reporting reactions to drugs or problems with products or devices
-notifying individuals if a product or device they may be using been recalled
-notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence), however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
-notifying your employer under limited circumstances related primarily to workplace injuries or illness or medical surveillance.

2. HEALTH OVERSIGHT ACTIVITIES: Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example investigations, inspections, audits, surveys, licensure, and disciplinary actions, civil, compliance with civil rights laws and the health care system in general.

3. LAWSUITS AND SIMILAR PROCEEDINGS: Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we made an effort to inform you of the request or obtain an order protecting the information the party has requested.

4. LAW ENFORCEMENT: We may release your IIHI if asked to do so by law enforcement official:

-regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
-concerning a death we believe has resulted from criminal conduct
-regarding criminal conduct at our office(s).