KERN COUNTY NEUEROLOGICAL MEDICAL GROUP, INC.
Office Policy

As of August 12, 2020, Kern County Neurological Medical Group Inc. (KCNMG) has updated the office policies to reflect our growing demand and to protect and improve patient care.

Cancellations and Reschedules
We understand that there are times when schedules can change due to emergencies or other engagements. Appointments must be cancelled or rescheduled 24 hours in advance. More than three last minute cancellations and or last minute reschedules within a year may result in a formal discharge from the practice.

No-Shows
More than three (3) no-shows within a year may result in a formal discharge from the practice.

Late Arrivals
Our doctors make every effort to see the patients on time, but medical emergencies or other circumstances may cause wait times for the patients. Arriving more than 15 minutes past the start of an appointment results in the doctor's discretion to see the patient for the remaining appointment time. In the event the doctor is unable to accommodate the patient due to the patient's tardiness, the appointment will be marked as a last-minute cancellation and rescheduled.

Payments
Copays, coinsurances, and deductibles that apply to the office visit or testing are provided directly from the insurance company. Payments are to be made before being seen by the doctor. We accept all major credit cards.

Medical Records
Your medical records are confidential; to obtain your medical records and/or have it transferred to another physician, please ask the receptionist for the medical release authorization for you to complete and return. Records will not be released without authorization form.

By signing this form, I understand and agree to the policies stated above.

Patient Name Required

Date

Signature

Relationship if signed by person other than patient:

Date

Signature

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32) to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it

may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801- 3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

I, (Your Name)

Hereby appoint

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

Patient Information

Patient Name Required

Address Required

Mobile/ Primary Telephone Number Required

Home/ Secondary Telephone Number

Patient Date of Birth Required

Age

Email

Sex/ Gender Required

- Male
- Female
- Other

Marital Status

- Child
- Single
- Married
- Divorced
- Widow(er)

Spouse's Name

Occupation

Patient's Employer

Do you have any children?

- Yes
- No

Please indicate referring provider or how you found our practice. Required

Referred by a Healthcare Provider

In case of emergency, notify

Is patient's condition related to employment? Required

- Yes
- No

Is patient's condition related to a car accident? Required

- Yes
- No

Pharmacy Information Required

Primary Care Provider

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I verify the accuracy of the above information and authorize the release of information necessary to process any claims. I also request insurance payment directly to my physician for services rendered. In the event of the receipt of payments from my insurance carrier, I will forward all funds to Kern County Neurological Medical Group, Inc.

Signature

Date

Kern County Neurological Medical Group, Inc.

1705 28th Street, Bakersfield, CA 93301 661.322.3008

Name Required

Please State the main complaint/reason of this visit. Required

Please state any other complaints that you may have whether or not they are related to this visit

Please state whether any of these above complaints related to automobile/work, or injuries of any accidents whatsoever

- Yes
- No

Please state if any of the above reasons of today's visit is of any way associated with any ongoing or planned litigation

- Yes
- No

Please list ALL medications currently taking

Please list ALL previous medical problems aside from the one you are here for today

Please list ALL prior surgeries in the past

Please list ALL family history of any medical problems that you are aware of

Drug Allergies

Any Allergies

Do you smoke?

- Yes
- No

Illicit drug use?

- Yes
- No

Alcohol use

- Yes
- No

Height and weight

Insurance:

Do you have Insurance? Required

- Yes
- No

Do you have Secondary Insurance?

- Yes
- No

Signature

Date

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made during litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out online and downloaded to be signed by hand or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as “at the conclusion of my court case” or provide a specific date amount of time, such as “3 years from this date”.

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

Patient Name Required

Date of Birth

Patient Address

Our Assurance Regarding Medical Information The privacy of your medical information is important to us. We understand that your medical information is personal, and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duties The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your right regarding your medical information, as well as follow the terms of the current notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the change is permitted by law. We have the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

• For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.

• For Payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Additional Uses and Disclosures In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

• Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray, imaging or medical information for you.

• Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

• Research in Limited Circumstances: We may use medical information for research or health survey purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

• Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information, of a person who has died, with a coroner, medical examiner, funeral director, or an organ procurement organization. Page: 5/8

• Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

• Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

• Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for the purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

• Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

• Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

• Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

• Law Enforcement: Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request enforcement official, reporting death, crimes on our premises, in our presence, and crimes in emergencies.

• Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of appointments. Including, but not limited to, voicemails of future appointment date and time.

• Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You have the right to:

• Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request, unless it is not practical for us to do so. There may be charges for copying and for postage if you want copies mailed to you.

• Receive a list of all the times we and our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions. Page: 6/8

• Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).

• Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or different locations must be made in writing.

• Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

• Please be aware that this notice does not necessarily catalog an exhaustive list of your rights. It is your responsibility to be aware of all your rights as pertaining to protected health information. Questions and Complaints If you have any questions about this notice, please send us written correspondence. If you think that we have violated your privacy rights, you may speak to the Privacy Officer and submit a written complaint. I hereby acknowledge that I received a copy of the Notice of Privacy Practices, and I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Patient Name Date

Signature