

Dr. Julie A. Griffith
Neurology
1099 D Street, Suite 208 San Rafael, CA 94901
(415) 925-1616
Fax (415) 259-4011
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What is included:

Welcome Letter
New Patient Registration Form
Neurological History and Physical Examination Form
Physician and other health provider name, address and phone list
Medication Summary
HIPPA letter
Predetermination of benefits
Referral form for your primary care provider to sign
Phone appointments & case management
My fees and services
Authorization of disclosure
Re- disclosure

Welcome to our Office!

Embarking on this neurological evaluation and treatment plan is not only a commitment to your present health, but more importantly it is an investment in your academic, vocational, emotional, physical, and social well-being. Frequently, early accurate diagnosis and treatment of neurological or neuropsychiatric disorders can positively and significantly alter a person's life pattern, enabling the person to pursue a wider scope of life choices. Treatment or therapy for neurological disorders often leads to a better outcome and can avoid the development of emotional, psychiatric or behavioral disorders, as well loss of income, self-esteem, neurological function, psychiatric stress or even criminality, in some cases.

The full service that I offer, including extra research or contact with other specialists, can provide needed information to positively affect your care. I prefer to get to the underlying problem and to use a comprehensive multidisciplinary therapeutic approach either to reach a cure or implement a program that would significantly enhance a person's quality of life. I would appreciate feedback to ensure that you are getting the service that you or your child deserves.

Prior to confirming the appointment, we must receive a referral to Dr. Griffith from your primary care physician, health care provider, therapist, employer or other professional, non family member, educational advocate.....

Please complete all enclosed forms, especially the neurological history portion of the neurological history and physical form before your appointment. It takes approximately 45 minutes to complete all of the forms. On the form, please complete all that you know. Birth history and developmental history are important, since difficulties at these times may indicate that the neurological problem may have started at birth. You may wish to ask other family members about any family history of medical problems; especially if there were any neurological disorders in the family (it is helpful then to get the name of a specific diagnosis). Sometimes it is helpful to have a spouse, a family member, or a friend attend the appointment, to provide you emotional support, to be an extra set of ears to auditorially “record” what Dr. Griffith says, and also to provide needed medical history, when this is applicable. Dr. Griffith welcomes and encourages tape recordings of the appointment so you can review information if you wish, after the appointment. The history from sleep partners or family members can be quite useful in a patient who has a sleep disorder, seizure disorder, and change in personality or cognitive disorder. I will complete the physical examination portion of the history and physical form when I examine you.

If you have difficulty completing this form, Pamela, our receptionist can assist you if you come a little early for your appointment.

Please be sure to fill out the medication form and list all medications (this includes herbs, vitamins, prescriptions, over the counter drugs and homeopathic remedies, food supplements, etc.). Please bring all prescription drugs and supplements, herbs, vitamins, etc. with you or a detailed list (including dosage in mg, times per day) to your first visit. It is important that you also bring all labs, diagnostic, educational, legal, or other reports. Use the Records Release form to obtain records from your health care provider and please have records sent to your home before bringing them to your appointment.

Please bring us a copy of the medical records that we may keep.

Medical records that can be useful, if applicable, include the following:

- Audiologic testing (audiogram and tympanogram)
- BSAER (brainstem auditory evoked response)
- Central auditory processing testing
- Genetic consultation
- Neurologic examination (s) from the past, if any
- Neuropsychological or psychological (psychoeducational) evaluation(s)
- Occupational therapy evaluation
- Ophthalmologic consultation
- Optometric (vision therapy) evaluation
- Physical therapy evaluation
- Psychiatric evaluation
- Speech and language therapy evaluation

Hospital discharge summary from birth (only if there were medical problems, a complicated pregnancy or abnormal delivery/need for resuscitation).

Hospitalization discharge summary (especially for any neurologic or psychiatric cause) and emergency room notes for any head trauma or seizures (if unusual or unique). Growth charts for head circumference, height and weight (if previously abnormal or of any concern).

Additionally, if any head imaging (head MRI or CT scan) and/or electroencephalogram (EEG) was completed in the past, then please bring the actual scan and/or EEG along with the typed report(s) to the appointment. You can request the scans from the imaging center where the scan was performed. You can arrange to either have the imaging center mail me the scan to the above address or you can pick it up from the center and hand carry it to the appointment. Your previous neurologist will not likely have the scan. You may want to request a copy of the scan for your personal use if you don't currently have a copy of the scan. The imaging center may destroy the scans after they hold them for a certain number of years (i.e. 7 years).

You will want to have the insurance provide you with the allowable amounts in the lines indicated on the allowable amounts form, so you will know whether or not the insurance will pay for these services. If the insurance does not pay for these services, then you will be responsible for payment.

My services and fees:

In general, I have kept my fees average throughout the community; however, I bill differently than many general physicians because I provide a comprehensive and sub-specialized service. Some insurance companies pay for this service. I think that comprehensive service is necessary to maintain the high quality of care especially needed for patients with neurological conditions. Due to the low reimbursement by insurance companies and the time and expense in billing them, I am now accepting only Blue Shield of California.

Please see information about my fees below. My bookkeeper and I want to develop an appropriate financial plan that fits your needs. This will enable you to make a financial commitment to support your desire to improve or protect you or your child's health.

My services include an initial diagnostic neurological evaluation, case management which may include referring you or your child to different specialists for consultations, along with my critique and interpretation of the consultant's results, and ongoing neurological care which includes prescriptions for medications, nutritional recommendations, etc. The comprehensive history and physical exam may take between 1 to 2 hours, occasionally longer. This initial history and examination is \$525.00 for the first hour. All subsequent hours of in office patient care is \$525.00 per hour. All other physician service, including phone calls, case management (phone calls to other physicians or arrangements for other tests or studies), research (as needed), development of the impression and plan, etc. will be billed prorated at \$375/hour. I will not charge for my time spent streamlining the dictation regarding the information we have covered during the appointment. However, I do charge time for formulating additional recommendations to the plan, writing additional lab slips, prescriptions, calling to coordinate the management plan with other physicians, reviewing abnormal lab results and contacting patients if there is any urgent management need, etc.

Insurance companies reimburse you for approximately 80 minute new patient appointments and 45 minute follow up appointments. **All additional time for service, such as additional time for appointments, phone calls, and case management may or may not be covered by your insurance. You will need to check with your insurance company to determine which services will be allowable or covered by your insurance.**

The bookkeeper will bill only once for local Blue Shield PPO patients. Any necessity for subsequent billing, for whatever stated reason by Blue Shield, will be given to the patient to pursue. If a deductible is owed (per insurance statement from the computerized databank), if the insurance company cannot be reached regarding the deductible and allowed amount and/or co-pays, or if the Blue Shield is part of an HMO (i.e. Marin IPA or other HMO), or if the Blue Shield PPO is outside of California, then the appointment will be paid at the start of the appointment by the patient. For Blue Shield PPO insurance, and Blue Cross/Blue Shield PPO (not Blue Cross), that is within the area, and for which we can confirm the correct deductible and co-pay via the computer prior to the appointment, then we can send the bill to insurance for payment. Of course, if the insurance does not pay, then it is still the patient's responsibility to pay.

By the new HIPAA law, your insurance company should take no longer than 30 days to reimburse you for what you pay to me. Additionally, you should get preauthorization (authorization before any service occurs), since insurance companies often refuse to pay for service that has already occurred. Evaluations of such conditions as autism or learning disabilities each take a minimum of 80 minutes to 2 hours. Insurance companies may not pay for educationally- based service, such as my attendance at IEP's (individualized educational plans) or for the writing of medical legal documents with an intention to acquire service or therapies for your child through the school district. Insurance companies also may not provide coverage for all of my services on legal cases. Patients or their parents/legal guardian(s) will be responsible for payments and for obtaining reimbursement to themselves by sending forms to the insurance company. My office will provide you with the needed diagnostic (ICD-9) and service (CPT) codes and two copies of the bill for the insurance company. Additionally, we will provide you with itemization for all prorated services, the billing record.

***Please note:** For office appointments, the balance is due when the service is rendered and may be paid by cash, credit card or check. For telephone calls and case management services, we accept credit card payment only and charge the same day as the service is provided. No checks please for case management.

Phone calls. My preference is that you schedule an appointment (either a phone appointment or office appointment) for medical questions. If you call when the line is busy or after hours, it is helpful if you leave a message for an appointment, giving my receptionist 2 or 3 specific dates and times so that she can call you back or leave a message with a secured appointment. If it is an emergency, such as if a child is having a seizure or has a side effect to a medication, etc., then please pages me at (800) 376-4995. Please realize that I am on call 24 hours/day, 7 days/week and would appreciate that pager calls be restricted to true emergencies.

Medication refills.

I have started to request that patients call in to have their medications refilled 2 weeks in advance so that my office has time to fill the prescription. This will avoid any panic in possibly running out of the medications. I usually prescribe (refill) the medication for 6 months at a time (except for stimulant medications which is a maximum of 2 months - by law). Thus, when it is time to have a new prescription, it is also time for a follow-up appointment (to determine if the medication is still needed and to ensure safe administration). Thus, if you are out of refills, then please call in for an appointment two weeks before running out of the medicine so that the medication can be refilled during the appointment.

Directions to our office:

From San Francisco, take 101 north to Central San Rafael take exit 452 onto Irwin Street – turn left onto 5th Street, turn left on D Street we are on the right.

From the East Bay & Sacramento take 80 to 580 West, 101 North to Central San Rafael Exit 452 onto Irwin Street – turn left onto 5th Street, turn left on D Street we are on the right.

From the North, take 101 South to Central San Rafael Exit 452, continue on Hetherton Street turn right onto 5th Street, turn left on D Street we are on the right.

To make an appointment, please call us at (415) 925-1616

Or email us at mybrainhealth@comcast.net.

Check out our website at www.mybrainhealth.com

Suggestion box.

Please let us know your suggestions. We will review them regularly and incorporate as many great ideas as we can. We appreciate your feedback.

Julie Griffith, M.D.

Pediatric and Adult Neurology

Signature showing that you have read, understand, and agreed to the above _____

Date _____

Printed Name

Patient's full name (printed)

PATIENT REGISTRATION FORM

PATIENT NAME

DATE OF BIRTH

SEX

ADDRESS

CITY

STATE

ZIP

PHONE: DAY: (____) _____ EVE (____) _____ CELL (____) _____

BEST PHONE # TO REACH YOU (____) _____ BEST TIME OF DAY TO CALL _____

FAX: HOME:(____) _____ WORK (____) _____ E-MAIL _____

Social Security # _____

EMERGENCY Contact person (not living with you): Name: _____

Phone # _____ Relationship _____

SPOUSE'S NAME

DATE OF BIRTH

SOCIAL SECURITY #

PHONE NUMBER

SPOUSE'S ADDRESS, IF DIFFERENT

INSURANCE COMPANY

ADDRESS

PHONE NUMBER

POLICY NUMBER

GROUP NUMBER

FOR FINANCIALLY RESPONSIBLE PERSON FOR PAYMENT OF MEDICAL BILLS:

1) Name: _____

2) Address : _____

3) Telephone number: _____ Social security number: _____

4) _____ I own my home: YES NO

Address: _____ City _____ State _____ Zip _____

5) Employer:

Name: _____ Phone # _____

Address: _____ City _____ State _____ Zip _____

6) Bank account # _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Please note that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. I understand that I am financially responsible for all charges, and that there is no guarantee of health outcome or resolution of disease for service or product provided. I understand that I am financially responsible for any cost accrued for the collection of this charge, whether or not paid by said insurance. Interest will be charged on any overdue amount at a 10% interest rate. \$25.00 will be charged automatically to the credit card for any and every charge back, if initiated by the client. For Master card transactions, up to a \$150.00 filing fee and or a \$250.00 review fee will be charged to clients' credit card, if client pursues the chargeback and Dr. Griffith gets charged by the service provider. For Discover card's charge back, the client will be charged charge fees and arbitration fees, which may be levied upon Dr. Griffith by the service provider. Patients who have Medicare agree by signing below that they will not bill Medicare, since Dr. Griffith is not a Medicare Provider.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT EACH VISIT. YOUR CREDIT CARD WILL BE CHARGED ON THE DAY OF SERVICE, UNLESS YOU CALL THE OFFICE TO OFFER ANOTHER FORM OF PAYMENT.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize release of all information necessary to secure payment, including disclosure of portions of the patient's records.

I agree that I am financially responsible for emergency care should the need for the patient arise, whether or not Dr. Griffith has my permission to proceed with emergency care or the payment of the emergency care, and whether or not I am reimbursed for the emergency care by the medical insurance. Emergency care may occur in the form of case management (phone calls, management of abnormal labs received, in office appointments, and calls made or taken from other physicians or health care providers). I agree that I am financially responsible for medical emergency care performed by Dr. Griffith for the patient until the patient is sufficiently transferred to an appropriate physician.

I AGREE, YOU CAN LEAVE CONFIDENTIAL MESSAGES ON ANY OF THE ABOVE PHONE NUMBERS OR FACSIMILE NUMBERS.

SIGNATURE _____ DATE _____

PRINTED NAME _____ RELATION TO PT _____

SPECIFY PHONE AND FACSIMILE NUMBERS TO WHICH YOU DO NOT WANT CONFIDENTIAL MESSAGES LEFT

PHONE: _____ FACSIMILE _____

PRINTED NAME OF SECOND PERSON ALSO FINANCIALLY RESPONSIBLE FOR
MEDICAL CARE OF PATIENT _____

SIGNATURE OF SECOND PERSON _____

DATE: _____

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Adult

Neurological History and Physical

Patient's name: _____

Date of birth: _____

Date of examination: _____

Referring Practitioner: _____

Address: _____

City / State / Zip Code: _____

Phone Number: () _____ Fax Number: () _____

How did you find out about us or who referred you to this practice?

Identification: _____ (nickname, if has one) is a _____ yr old right/left handed/ambidextrous _____ female / male referred for evaluation of

_____.

What brings you for a neurological evaluation now? _____

What specific questions do you want answered from this appointment?

(Please prioritize)

Hospitalizations(please give dates and for what medical problem):

Surgeries (please give dates and type of surgery)

Medications:

name of drug _____, dosage (mg)_____, # times/day ____
name of drug _____, dosage (mg)_____, # times/day ____
name of drug _____, dosage (mg)_____, # times/day ____

Allergies

to medications:_____ what happened to body?_____ to food
_____ what happened to body?_____
to mold _____ what happened to body? _____
to environmental allergens _____ (which kind) _____
RAST testing results _____ Skin
scratch _____

Review of systems:

Dermatologic: white, brown or red birthmarks _____, arm pit or groin birth marks

Endocrine: heat or cold sensitive, hair thinning/falling out, dry skin_____
ENT: ear aches, problems with hearing _____
Genito: abnormal development of genitalia:_____
precocious puberty or abnormal menses:_____
difficulty with erection or ejaculation:_____
sexual abuse: _____
Gastrointestinal: difficulties with swallowing/appetite/eating problems _____
failure to thrive/obesity _____
stomach upset, belly pains, blood in stools _____
diarrhea, constipation, fatty stools _____
Heme: easy bruising or bleeding after injury _____
Immunologic: frequent infections (pneumonias, urinary tract infections, many
ear infections, sinusitis) _____
sexually active _____
Neuro: balance/coordination problems _____
excessive fatigue/taking naps during the day _____
muscle aching/cramping/twitching or fasciculating muscles,
muscle weakness _____

sleeping difficulties _____, snoring _____,
restless sleep _____
unusual spells or behavior not mentioned anywhere above _____

Oncologic: unexplained weight loss, fatigue _____
Orthopedic: significant accidents or traumas, bone aches, frequent fractures,
scoliosis or abnormal back curvature _____
Psychiatric: emotionally labile, weepy, sad, depressed, unusual behavior,
Ophthalmologic: difficulty with vision or with eye movements _____
Urinary: urinary urgency, frequency or new incontinence, bedtime
enuresis _____

Family history (please circle and/or comment):

abnormal anatomy of any body parts _____
autoimmune disorder (lupus, diabetes mellitus, colitis, rheumatoid arthritis,
Hashimoto's thyroiditis, inflammatory bowel disease such as Crohn's disease
or ulcerative colitis, Sjogren's Syndrome) _____

_____ birthmarks
(white, red, brown) _____
grey hair, prematurely by the 30's _____
headaches or migraines _____
head size, unusually large or small _____

learning difficulties (held back in school a year, dyslexia, math problems, autism,
Aspberger's, nonverbal learning disorder, attention deficit hyperactivity
disorder) _____

left-handedness or ambidexterity _____
mental retardation _____
miscarriages/stillbirths, sudden infant death syndrome _____
neurological disease (multiple sclerosis, Guillain-Barre' Syndrome, other) _____
seizures _____
early stroke or heart attack (before or at 55 yrs of age) _____

Other diseases that run in the family:

tics _____
PANDA _____
mood disorders _____
aggression _____

PE: general: HC () (%); Ht () cm, (%); wt (kg), (%)

morphology:
HEENT
CV
Abd
vertebrae, skull
derm:
GU:

Neurologic: MSE:

attn:

memory /3 encoding /3regis /3 at 5 minutes
right-left

Oldfield criteria:

praxis Berges-Lezine

Luria sequence

cn: visual acuity OD /20 OS /20

motor:

gait:

cerebellar: FTN, HTS

sensory:

Romberg:

	Face	UE	LE
LT	_____	_____	_____
vib	_____	_____	_____
pin	_____	_____	_____
cold	_____	_____	_____

Labs/Studies:

Impressions:

Assessment:

Plan:

1)

Thank you for referring _____ to my neurology office. If you have any questions or suggestions, please feel free to call me at (415) 925-1616.

Respectfully,

Julie A. Griffith, M.D., M.S.

Julie A. Griffith, M.D., M.S.
120 Ross Valley Drive
San Rafael, CA 94901
Phone (415) 925-1616
Fax (415) 259-4011

CONFIDENTIAL

Immunologic

any risk of HIV? (blood transfusion, IV drug abuse or known exposure?)

Psychiatric

past/present physical abuse _____

Patient Name: _____

D.O.B: _____

Physician and other health provider list:

PLEASE ASTERICK (*) IF OK TO SEND DICTATION TO PRIMARY MEDICAL DOCTOR

PROVIDER	NAME	PHONE	FAX	ADDRESS
Primary Care Physician				
Pharmacy				
Laboratory				
School				
Occupational Therapist				
Physical Therapist				
Speech Therapist				
Other Providers				

HIPAA Notice of Privacy Practices

From the office of ...

Dr. Julie A. Griffith

Pediatric Neurology

1099 D Street, Suite 208 San Rafael, CA 94901

(415) 925-1616

Fax (415) 259-4011

[e-mail:mybrainhealth@comcast.net](mailto:mybrainhealth@comcast.net)

www.Mybrainhealth.org

This Notice details how your protected health information “PHI” may be used and disclosed to third parties. This Notice also details your rights regarding how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This office/Practice is committed to maintaining the privacy of your protected health information (“PHI”), which includes information about your health condition and the care and treatment you receive from this practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.

I. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

II. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization, others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

The Office/Practice may use and/or disclose your PHI for the following purposes:

- (a) Treatment - In the course of treatment, my office uses the patient name on each chart instead of a numerical coding system; my office staff briefly attempted the numerical coding system, but found that this system too time-consuming to provide the *timely* service I feel is required. For instance, I want my staff to rapidly find the chart when the patient or parent is calling in with a question. Additionally, I have a list of patient names on my laptop when I am seeing patients. I have positioned the furniture and computers, laptop in such a way as to avoid patients seeing other patient names; however sometimes this is not able to be fully avoided. However, certainly no other patient name and diagnosis will be able to be viewed in the office by another patient.
- (b) In order to provide you with the health care you require, this practice will provide your PHI to those health care professionals directly involved in your care so that they may understand your health condition and needs. The health care professionals aforementioned may or may not be part of this practice. For example, a primary care physician treating you or your child for headaches may need to know the results of your or your child's latest physician examination performed by me. Payment - In order to get paid for services provided to you, the Office/Practice will provide your PHI, directly or through a billing service, to appropriate third party payors, pursuant to their billing and payment requirements. For example, the Practice may need to provide your insurance with information about health care services that you received from the Practice so that the Practice can be properly paid or so you may be reimbursed for payment to me. The Practice may also need to tell your insurance plan about the treatment you are going to receive so that it can determine whether or not your insurance will cover the treatment expense.
- (c) Health Care Operations - In order for the Office/Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Office/Practice may also use and/or disclose your PHI without your specific authorization in the following additional instances:

- (a) De-Identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.
- (b) Business Associate - To a business associate if the Office/Practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking

some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations-

- (i) for the purpose of obtaining or rendering emergency treatment to you if the opportunity for you to object cannot be obtained due to your incapacity or emergent treatment circumstances and the treatment is consistent with your prior expressed preferences and is in your best interest; or
- (ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(f) Abuse, Neglect or Domestic Violence - to a government authority if the Office/Practice is required by law to make such disclosure.

(g) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, when compelled by a U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

(h) Judicial and Administrative Proceeding - For example, the Office/Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena. If an arbitrator or arbitration panel requires disclosure, medical records including or not including more confidential records (involving details of psychiatric, drug abuse history or laboratory results, etc) may be provided when it is lawfully requested by either party, i.e. a subpoena authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

(i) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or, the Practice may disclose your PHI if the Practice believes your death was the result of criminal conduct.

(j) Coroner or Medical Examiner. The Office/Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) Organ, Eye or Tissue Donation. If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(l) Research- If the Office/Practice Is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(m) Averts Threat to Health or Safety - The Office/Practice may disclose your PHI if it believes disclosure is necessary to prevent or lessen a serious and eminent threat to the health or safety of a person or the public and disclosure is to an Individual who is reasonably able to prevent or lessen the threat.

(n) Specialized Government Functions- This refers to disclosure of PHI that relate primarily to military and veteran activity.

(o) Workers' Compensation~ If you are involved in a Workers' Compensation claim, the Office/Practice may be required to disclose to your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) National Security and Intelligence Activities- The Office/Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(q) Military and Veterans- If you are a member of the armed forces, the Office/Practice may disclose your PHI as required by the military command authorities.

(r) If disclosure is otherwise specifically required by law.

III. MY OFFICE CONTACTING YOU

APPOINTMENT REMINDER

The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; b) telephoning your home, cellular phone or work phone, depending on the time of day, and leaving a message on your answering machine or with the individual answering the phone and occasionally, by a letter to the address you have provided.

OFFICE STAFF OR I MAY CONTACT YOU

The Office/Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

IV. CERTAIN USES AND DISCLOSURES FOR WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

(a). Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

V. OTHER USES AND DISCLOSURES REQUIRE YOUR WRITTEN

AUTHORIZATION In any other situation not described above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by me.

VI. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

(a). The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you 25c/ page and \$20 /hr for the work of reviewing the chart and in photocopying and mailing, in addition to storage retrieval fees, and Fed ex and mailing costs, as needed. For any attorney requesting medical records, I will charge them (rates by law), 10c/page, \$20/hr for the work of reviewing the chart and in photocopying and mailing, for storage retrieval fees, Fed ex and mailing costs, as needed. I may see fit to provide you with a summary or explanation of the PHI as well as to the cost, but only if you agree to it in advance.

(b). The Right to Request Limits on Uses and Disclosure of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations or in situations which require me by law to do otherwise. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

(c). The Right to Choose How I Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example. via facsimile instead of by mail). I am obliged to agree to your request providing that I can give you the PHI in the format you requested, without undue inconvenience. For privacy reasons, I will only receive email provided to me by patients, if patients choose to use this form of communication. I will not send a response to patients via email nor send medical records via email, due to the difficulty in maintaining security of those records.

(d). The Right to Get a List of the Disclosures I Have Made. You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e. those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003, After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

(e). The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI, most likely by an addendum (rarely by a line through the original with a handwritten correction). Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

(f). The Right to Get This Notice by Email. You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

VII. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

If you have any questions about this notice or any complaints about my privacy practices, please contact me at my address or phone number listed above.

VIII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice.

Patient Name: _____ *Signature:* _____ *Date:* _____

Legal guardian name: _____ Signature _____ Date: _____

Relationship to patient: _____

Legal guardian name: _____ Signature _____ Date: _____

Relationship to patient: _____

Dr. Julie A. Griffith

Neurology

1099 D Street, Suite 208

San Rafael, CA 94901

(415) 925-1616

Fax (415) 259-4011

[e-mail:mybrainhealth@comcast.net](mailto:mybrainhealth@comcast.net)

www.Mybrainhealth.org

Tax ID# 68-039-7796

Predetermination of benefits/ allowable amounts
Form to obtain from your insurance company

Please call your insurance and have them help you in completing this form and bring it with you on the day of your appointment.

Date: _____

To Whom It May Concern:

Patient Name: _____ DOB: _____

Insurance ID#: _____ Group#: _____

Please mail or fax within 5 business days the usual and customary maximal allowance for the codes below for this patient's contract. I am in the process of billing this patient and need this information immediately. See copy of insurance card, front and back, attached.

Your maximum usual and customary allowance for the current year for following codes:

_____ \$525.00	99245 initial office consult
_____ \$525.00	99354 Prolonged Service,
_____ \$375.00	99358 After or before face to face service, st hour.

Also, please send revised or updated amounts to me for allowable amounts EVERY TIME the allowable amounts change for this patient's contract. Please send a copy of every charge in the contract when changes are made.

Thank you for your attention to this matter.

You can also fax back to **(415) 259-4011**

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www.Mybrainhealth.org

REFERRALS & AUTHORIZATION REQUEST

I, Dr. _____

Of _____ Medical Facility

Hereby refer my patient: _____

To: Dr. Griffith M.D., for Consultation re: _____

For (please check ALL that apply)

- 1) Initial consultation
- 2) Consultation for re-evaluation & modification of plan & management
as new questions arise regarding neurological issues.
- 3) Other _____

Patient's Primary Care Physician or Therapist not Parents or Family Members

Sign: _____

Dated: _____

Julie A. Griffith, M.D.
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Re: Case Management and
Phone appointments

Phone Appointments, and the medical service associated.

It is preferable to schedule in office appointments for medical care. For a brief question or two lasting only a few minutes, regarding how to complete the labs or the plan discussed in the prior office appointment, there will be no charge.

However, some fee for service patients prefer to pay for medical service provided by Dr. Griffith that occurs in between in office appointments, because this is less expensive than the in office appointments, and because this saves driving time and expense.

To better serve you, appointments by phone are offered to fee for service patients who have medical issues not requiring a physical examination. The charge for these appointments is \$375.00 per hour, prorated. Blue Shield does not cover phone appointments; therefore for contracted Blue Shield of California patients, all medical care needs to occur as in-office appointments.

At the beginning of the phone appointment, we ask that you provide us with your credit card number, the expiration date, the 3 digit security code on the back of the credit card, and your billing zip code. We do not keep credit cards on file, by law. At the end of the appointment, you will be charged for the phone time as well as any other time required by Dr. Griffith to complete tasks which arose based on the phone conversation. Dr. Griffith does charge for the time for reviewing medical records, if this is requested by the patient or patient's legal guardian, to be done separate from the phone appointment. Dr. Griffith will review medical records during the appointment with the patient, to be the most conservative financially for the patient, unless the patient specifically requests Dr. Griffith to review the records before or after the appointment, to free up the patient to not be on the phone during this time. If after the appointment, Dr. Griffith needs to implement the plan, such as writing prescriptions or lab requisitions, calling pharmacies or other physicians, etc., then there will be a charge for this case management time. Again, this time may extend beyond the time spent directly on the phone with Dr. Griffith.

I understand Dr. Griffith's policy regarding phone appointments and the associated medical service time for which Dr. Griffith charges, and agree to pay for these services.

Patient Name: _____

Guaranteed payer name, Printed: _____

Signature of payer: x _____

Signing indicates that I agree to pay for services

I decline these services x _____

Non face to face medical service

It is preferable to schedule in office appointments for medical care. For a brief question or two lasting only a few minutes, regarding how to complete the labs or for clarification of the plan which was discussed in the prior office appointment, there will be no charge.

However, if the medical service provided by Dr. Griffith, which is requested by the patient or the patient's legal guardian, lasts longer than a few minutes, there will be a charge for this service. Non face to face medical service includes generating a treatment plan from review of lab results, consulting other physicians, therapists, pharmacists, school teachers, psychologists, the laboratory, etc. on behalf of the patient. Also, the non face to face medical service can include research (as needed), to develop the impression and plan, especially if Dr. Griffith begins new work or makes new recommendations not previously covered during the in office appointment.

I will not charge for my time spent streamlining the dictation regarding the information we have covered during the appointment. However, I do charge time for work the patient and I have agreed I would pursue after the appointment, such as writing additional lab slips, writing or calling prescriptions, calling to coordinate the management plan with other physicians, reviewing abnormal lab results and contacting patients if there is any urgent management need, etc. The patient or patient's legal guardian would always be consulted or would be aware of Dr. Griffith's work, and would give approval, prior to Dr. Griffith beginning this work, or as Dr. Griffith is doing the work, or the same day of the work (if the medical care is emergent or urgent).

Non face to face medical service is billed at \$375/hour.

I understand Dr. Griffith's policy regarding non face to face medical service and agree to pay for these services.

Patient Name: _____

Guaranteed payer name, Printed: _____

Signature of payer: _____ x
Signing indicates that I agree to pay for services

I decline these services _____ x

Dr. Julie A. Griffith
Pediatric Neurology

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[e-mail:mybrainhealth@comcast.net](mailto:mybrainhealth@comcast.net)

www.Mybrainhealth.org

My Services and Fees from June 1st 2010

Office visit	per	1 hour	\$525.00
Case Management	per	1 hour	\$375.00

Case management is any of the following

- ❖ Phone calls
- ❖ Phone call to other physicians or hospital staff
- ❖ Arrangements for tests and studies
- ❖ Conferences by phone with parents, teachers, counselors, lawyers, therapists, etc.
- ❖ Chart Maintenance, prescriptions and refills
- ❖ Literature search/ Research

Although I will give you a bill to submit to your insurance company, most insurance companies do cover the initial consultation and 45 minute follow up appointments.

They may or may not cover the extended in office appointments over 1 hour so please check with your insurance company.

Most insurance companies do not cover the cost of phone calls or case management.

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Pediatric & Adult Neurology

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AUTHORIZATION FOR USE OR DISCLOSURE
OF
PROTECTED HEALTHCARE INFORMATION

As required by the Health Information Portability and Accountability Act (HIPAA) and California law, a medical practice may not release or disclose individually identifiable health information without your authorization or as provided by the Notice of Privacy Practices. Your completion of this form means that you are granting permission for us to disclose your protected healthcare information as described below. Please review and complete this form carefully. An incomplete form is invalid.

Date: _____

To: Name of Medical Practice: _____

Phone: _____ Fax: _____

Dept: _____

I authorize the above named medical practice to release and disclose the following information concerning (Name of Patient) _____ Date of Birth: _____

Healthcare information to be released and disclosed:

<input type="checkbox"/> History	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> HIV Records
<input type="checkbox"/> Physical Exam	<input type="checkbox"/> X – Ray Reports	<input type="checkbox"/> STD Records
<input type="checkbox"/> Surgical Reports	<input type="checkbox"/> Pulmonary Funct. Test	<input type="checkbox"/> Psychiatry
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Out Patient Notes	<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> EKG Results	<input type="checkbox"/> Immunization History	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Consult(s) Reports	<input type="checkbox"/> Summary	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Other	

This information may be released /disclosed to:

Neurology Health Center, Office of Julie Griffith MD

Name and address of person or organization

The information may be used only for the following purposes:

Neurological Consultation/RX

If and explanation if not desired write “*at the request of the individual/patient*”.

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I understand I may revoke this authorization at any time by notifying this medical practice in writing. My revocation will not affect any disclosures made pursuant to this authorization before receipt of such revocation.

I understand I have a right to a copy of this authorization.

This authorization is effective now and shall remain in effect until _____
Expiration date

Re-disclosure: I understand that once my medical information is disclosed pursuant to this authorization there is no guarantee that the recipient will not re-disclose the information to others.

Effect of refusal to sign: If this authorization is for purpose of treatment, payment, enrollment, or eligibility for benefits the effect of refusing to sign may affect treatment by other providers, may result in a health care plan to enrolling me, may make me ineligible for benefits, may prevent me from participating in research-related treatment, or may prevent a physician from performing a medical evaluation for employment, life insurance, disability, or other evaluation that otherwise is done solely for disclosure to a third party.

Signed: _____ Date: _____

Print Name: _____

IF NOT SIGNED BY THE PATIENT INDICATE THE RELATIONSHIP BELOW:

- Parent/legal guardian of a minor (unless minor's consent is required)
- Guardian/Conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient's estate.
- Spouse or other person financially responsible for payment of healthcare claims/services (only information for purposes of processing an application for healthcare coverage or payment of healthcare services may be disclosed)