



## PLEASE READ THE FOLLOWING CAREFULLY

1. Please make sure all forms are completed prior to your arrival (no need to mail it back to us). Do not leave anything blank. If it does not apply to you, write "None" or "N/A". If your paperwork is not completed upon your arrival you may be asked to reschedule.
2. Please arrive 15 minutes prior to your appointment time to allow us sufficient time to complete our check-in procedures. For the benefit of all of our patients, we try very hard to stay on time, so you may be asked to reschedule your appointment should you arrive late.
3. As a courtesy, we call to confirm appointments one business day prior to all appointments. However, it is still your responsibility to call our office if you need to cancel or change your appointment. For your initial consultation, we do wish to speak with you directly to confirm. If we have to leave a message, we ask that you return the call no later than 4:00PM the same day of our call.
4. A 24-hour notice is required to reschedule or cancel an appointment. Please be aware that our phone hours end at 4:30PM.
5. **Please bring your health insurance card and driver's license for proper identification.** We will need to make a copy of both for our records.
6. All co-payments, co-insurance amounts, or deductibles will be collected at the time of check-in.
7. If you have a language barrier, please bring someone who can help with translation.



**HEADACHE & PAIN CENTER**  
 Rajat Gupta, M.D.  
 www.headacheandpain.com

The Park at Eanes Creek  
 4407 Bee Cave Rd. Bldg 2, Ste 211  
 Austin, Texas 78746

512.330.0961  
 512.330.0962 (Fax)

www.HeadacheandPain.com

**PATIENT INFORMATION**

**Please fill out completely. Write "None" or "N/A" on any line that does not apply to you.**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

MIDDLE INITIAL: \_\_\_\_\_ NICK NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_ APT NO: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

HOME #: \_\_\_\_\_ WORK#: \_\_\_\_\_ EXT: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ PAGER/OTHER: \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ MARITAL STATUS: S M W D (Please Circle One)

SOCIAL SECURITY #: \_\_\_\_\_ (This information is strictly guarded in accordance with HIPAA guidelines)

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE #: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ (If Policy Holder is other than patient.)

SECONDARY INSURANCE: \_\_\_\_\_

POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_

IS THIS A WORKERS' COMPENSATION CLAIM? YES \_\_\_\_\_ NO \_\_\_\_\_

ARE YOUR INJURIES THE DIRECT RESULT OF A MOTOR VEHICLE ACCIDENT? YES \_\_\_ NO \_\_\_

IN CASE OF EMERGENCY NOTIFY: \_\_\_\_\_ PHONE# \_\_\_\_\_

ADDRESS: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

**I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**



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IT IS THE POLICY OF THIS OFFICE TO SEND TYPED CONSULTATION, FOLLOW-UP VISITS, AND TESTING REPORTS PREPARED BY DR. RAJAT GUPTA TO OTHER DOCTORS WHO MAY BE INVOLVED IN YOUR CARE.

**I authorize Dr. Rajat Gupta to release reports regarding my care to:**

1. Referring Doctor.: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

2. Primary Care Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

3. Other Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

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

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



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**ASSIGNMENT OF BENEFITS – PLEASE READ CAREFULLY**

I hereby assign to Dr. Rajat Gupta and the Headache & Pain Center any and all rights, title and interest in any payment due by the patient and/or undersigned for medical care, services, or supplies described in any health insurance claim form or statement issued by Dr. Rajat Gupta and the Headache & Pain Center. I understand that this agreement will not eliminate or effect in any way the obligation of the patient and/or the undersigned to pay Dr. Rajat Gupta and the Headache & Pain Center for all services and supplies rendered, including, but not limited to any co-payments or deductibles required by a particular health care program or plan.

Insured/Patient Initials \_\_\_\_\_

**RELEASE OF MEDICAL INFORMATION**

I hereby authorize the release of any medical records, inclusive of all results of all testing and other pertinent information acquired during treatment, to the physician as deemed necessary. I agree that a photocopy of this authorization shall be considered as effective and valid as the originals.

Insured/Patient Initials \_\_\_\_\_

**RESPONSIBILITY OF CO-PAYMENT**

Based on the particular plan of insurance carried by the patient and/or insured, and such financial responsibilities set forth within this policy shall be made payable during that particular visit to the physician or provider of service. These include co-payments, deductibles and co-insurance amounts when deemed appropriate.

Insured/Patient Initials \_\_\_\_\_

**RESPONSIBILITY OF REFERRALS**

The patient and/or insured agrees that it is their responsibility to obtain any such referrals deemed necessary by their insurance in order to be seen by a provider in this office. Patient and/or insured further agree to accept financial responsibility for visits that were not prior authorized by their particular insurance plan.

Insured/Patient Initials \_\_\_\_\_

**ARRIVAL TIME FOR APPOINTMENTS**

I understand it is important that I try and arrive 10-15 minutes prior to my appointment time each and every time to allow for any updates to paperwork, copying of new insurance cards and collection of co-payments. I understand that if I arrive more than 15 minutes late for my appointment, I may be asked to reschedule.

Insured/Patient Initials \_\_\_\_\_

**CANCELLATION / NO-SHOW POLICY**

I understand that a 24-hour notice is required for cancellation of an appointment and failure to do so will result in a \$50 no-show fee. I also understand that Saturday and Sunday are not business days and therefore a cancellation for a Monday appointment must be made prior to 4 pm on Friday. If I fail to keep an appointment without the courtesy of calling to reschedule or cancel, I am aware that after two such occurrences that it is possible that I may be dismissed from the practice.

Insured/Patient Initials \_\_\_\_\_

**X-RAYS AND TEST RESULTS**

It is the express policy of Dr. Rajat Gupta and the Headache & Pain Center, that no patient shall receive the results of any such diagnostic or laboratory testing by means of telephone or written letter unless previously agreed to and documented in the medical record by the attending physician.

Insured/Patient Initials \_\_\_\_\_

**MEDICATION REFILL POLICY**

I understand that prescriptions, refills, or renewals for narcotics and other controlled drugs will not be handled over the phone.

Insured/Patient Initials \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICE**

The federal government recently published regulations designed to protect the privacy of your health information. This "privacy rule" protects health information that is maintained by physicians, hospitals, other health care providers and health plans. The Notice of Privacy Practices attached to this letter explains our privacy practices. It contains very important information about how confidential health information is handled in our office. It also describes how you can exercise your rights with regards to your protected health information. By initialing here, you are acknowledging that you have received this information about our privacy practices.

Insured/Patient Initials \_\_\_\_\_

Insured/Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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

Witness: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES – PLEASE READ CAREFULLY

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **If you have any questions about this Notice please contact our Privacy Contact, our Office Manager.**

### 1. Our Pledge 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 at the Headache and Pain Center. 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.

### 2. Our Legal Duty

**The Law Requires Us to** keep your medical information private, give you notice describing our legal duties, privacy practices, and your rights regarding your medical information and to follow the terms of the notice that is now in effect.

**We Have the Right to** change our privacy practices and terms of this notice at any time, provided that the changes are permitted by law as well as make 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 a Change to Our Privacy Practices** we will first change the notice and then make the new notice available upon request.

### 3. Use and Disclosure of Your Medical Information

This is how we use and disclose medical information. Note: We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific authorization you provide may be revoked at any time by writing to us.

**For Treatment** we may provide 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.

**Example:** You are in the hospital with a broken leg. You also have diabetes. A number of health care and support staff need to know about your diabetes during you stay:

1. The doctor treating you for the broken leg needs to know if you have diabetes because diabetes may slow the healing process.
2. The dietician needs to know about your diabetes to arrange proper meals.
3. The pharmacy needs to know about possible medicines that you may need as a diabetic.
4. The information about your diabetes may help in diagnostics, testing, and x-ray work.

We may also share medical information about you with your other healthcare providers to assist them in treating you.

**For Payment:** We may use and disclose your medical information for payment purposes.

**Example:** You are treated in the office for a headache.

1. We may need to give your health insurance plan information about treatment you received at the Headache and Pain Center so that your health plan will pay us or repay you for any services that you paid for.
2. We may also tell your health plan about a treatment you are going to receive in order to get approval or to determine if your health plan will pay for the treatment.

**For Health Care Operations** we may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

**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:** Medical information to notify or help notify: a family member, your personal representative, 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 information, or give you the opportunity to refuse permission. In cases of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary to 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, or medical information for you.

**Disaster Relief:** Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Research in Limited Circumstances:** Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to insure the privacy of medical information.

**Funeral Director, Coroner, Medical Examiner:** We may share the medical information about a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization to help carry out their duties.

**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, other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may share your medical information with law enforcement officials. 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 purposes of reporting adverse events associated with product defects or problems, to enable product recall, 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.

**Victim of Abuse, Neglect, or Domestic Violence:** We may 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.

**Worker Compensation:** We may disclose health information when authorized and necessary to comply with laws relating to worker compensation or other similar program.

**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 health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to 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 of a law enforcement, reporting death, crimes on our premises, and crimes in emergencies.

## 4. Your Individual Rights

### You Have The Right To:

1. Look at or get copies 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. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be a charge for copying and for postage if you want copies mailed to you. Ask the receptionist about our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

3. 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 an emergency).
4. 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 at different locations must be made in writing to our Privacy Officer.
5. Request that we change 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 deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. 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.

### **QUESTIONS AND COMPLAINTS**

If you have any questions about this notice, please ask the receptionist for help or ask to speak to our Privacy Officer / Office Manager. If you think that we may have violated your privacy rights, contact our Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services at 200 Independence Ave., S.W. in Washington, DC 20201.

These privacy practices are in effective as of 4-6-03 and will remain in effect until further notice.



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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ [BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ Temp: \_\_\_\_\_]  
 (TO BE COMPLETED BY MEDICAL ASSISTANT DURING OFFICE VISIT)

So that the maximum amount of time can be spent addressing your main concern(s) during your office visit with Dr. Gupta, kindly provide some preliminary medical information below. Complete the following pages prior to your visit and bring them with you to your appointment.

**MEDICAL HISTORY:** List all medical conditions diagnosed by your doctor(s) that are being treated currently or have been treated in the past (circle all that apply).

- |            |                     |                              |                       |
|------------|---------------------|------------------------------|-----------------------|
| Alcoholism | Glaucoma            | Lung Disease                 | Ulcers                |
| Arthritis  | Asthma              | Osteoporosis                 | <b><u>Others:</u></b> |
| Cancer     | Heart Disease       | Seizures                     |                       |
| Depression | High Blood Pressure | Sexually Transmitted Disease |                       |
| Diabetes   | Kidney Disease      | Stroke                       |                       |
| Drug Abuse | Liver Disease       | Thyroid Disease              |                       |

**PAST SURGERIES:** Please list all the surgeries you have undergone and approximately when they were performed.

**MEDICATIONS:** Please list all of your current medications (prescription and over-the-counter), including the strength (mg's), quantity, and the number of times per day that you take each one.







**NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please indicate if you have any current or recurring problems with any of the following symptoms. Circle each symptom that applies.

- Recent weight loss or gain, loss of appetite, fatigue, weakness, fever, chills, insomnia, irritability, increased urination, increased thirst, heat / cold intolerance, dizziness, fainting.
- Rashes, itching, sunburn, non-healing sores, easy bruising, bleeding and / or changing moles.
- Headaches, loss of consciousness, seizures, head trauma.
- Vision changes, glaucoma, light sensitivity, eye pain, redness irritation, excessive tearing or dryness, double vision.
- Hearing change or loss, discharge from ear, ear pain, spinning / vertigo, ringing in the ears.
- Colds, sinus trouble, postnasal drip, nosebleeds, congestion, snoring, cough, sore throats, shortness of breath, decreased exercise tolerance, wheezing, coughing up blood, asthma, emphysema, bronchitis, pneumonia, history of Tuberculosis.
- Painful or painless nodules (where and when first noticed).
- Chest pain, palpitations, irregular pulse, high blood pressure, sleeps sitting up, swelling of leg/ankle, heart murmurs, blood clots, varicose veins, large heart, high cholesterol, diabetes, increased urination at night, history of Rheumatic fever.
- Tooth pain, bleeding gums, mouth ulcers or sores, painful swallowing, heartburn, bloating, belching, flatulence, nausea, vomiting (blood noticed?), abdominal pain, blood in stool, black / tarry stool, jaundice, change in stool habits, diarrhea, constipation.
- Painful urination increased frequency, blood in urine, hard to start stream, poor stream, dribbling, history of urinary infections, testicular swelling, urinary stones.
- {Women Only} - taking birth control pills, age at first period \_\_\_\_\_, period comes every \_\_\_\_\_ days (regular/irregular), last menstrual period \_\_\_\_\_, last PAP smear \_\_\_\_\_, PMS, painful periods.
- Breasts - last mammogram \_\_\_\_\_, swelling or lumps (transient, persistent, or menstrual), pain, discharge, do you do self-exams (Y or N).
- Joint pain or stiffness, neck pain / stiffness, low back problems, joint injuries, fractures, gout, changes in hat or glove size.
- Strokes, seizures, involuntary movements, numbness, tingling, weakness in any part of body, visual disturbance, memory change, clumsiness, falls, headaches, loss of control of bladder or bowel.

**To the best of my knowledge, the information that I have provided is correct and complete.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## FINANCIAL POLICY - PLEASE READ CAREFULLY

To help us provide the most efficient healthcare services, it is necessary for us to have a Financial Policy outlining our requirements for payment of services provided by the Headache and Pain Center to our patients. As a courtesy to you, we will file insurance claims on your behalf if we are provided accurate and complete insurance information. It is your responsibility for providing a change of address, telephone number, and/or insurance information any time such a change occurs to help prevent delay of payment of services. Failure to notify our office of any such changes could result in your account becoming due and payable immediately.

If you have health insurance, a co-payment, co-insurance, or a deductible may be due at the time of your visit per your contract with your insurance company. It is your responsibility to understand your benefits per your contract with your insurance company. Any amounts collected at the time of visit are calculated based on the amount allowed by the insurance companies. These are best estimates that may result in a difference that may be billed or refunded to you. Any balance due that is your responsibility should be paid within 30 days of the statement date.

You, as the patient and/or insured, agree that it is your responsibility to obtain any such referrals deemed necessary by your insurance in order to be seen by a provider in this office. You further agree to accept financial responsibility for any visits that take place that were not prior authorized by your insurance plan.

If you do not have health insurance, you are considered a "Self Pay" patient. Full payment will be due at the time of service.

Our office requires a 24-hour notice for cancellation of an appointment. Saturday and Sunday are not business days and therefore a cancellation for a Monday appointment must be made prior to 4 pm on Friday. Failure to keep an appointment without the courtesy of calling to reschedule or cancel will result in a \$50.00 fee for a missed appointment. After two such occurrences it is possible that you may be dismissed from the practice.

Your account will be charged \$25.00 for each returned check.

**Past due accounts will be automatically turned over to a collection agency after 90 days of failure to pay. Due to additional costs to the practice with this occurrence, the balance due amount will be doubled and sent to the collection agency for collection.**

**I acknowledge and understand the above statement policy.**

**Insured/Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Witness:** \_\_\_\_\_



## PRESCRIPTION POLICY

1. I understand that Dr. Rajat Gupta may prescribe pain medication to reduce pain and improve the quality of my life. I recognize that some medications prescribed have the potential for being habit-forming, overused, or misused.
2. I agree to follow the regimen exactly as prescribed. I agree that Dr. Gupta must be the only doctor prescribing pain medication for me and that I will use one pharmacy to fill these prescriptions.
3. I understand that certain medications are not refillable during non-office hours. Further, I understand that lost prescriptions, medications, broken bottles, etc. will not be replaced.
4. I understand that this agreement is imposed for my benefit to ensure safe and effective use of the medication. I understand that if I violate this agreement I am subject to termination of further prescriptions for pain medications and that I may be dismissed from Dr. Gupta's practice.
5. Dr. Gupta will carefully review with me the pros and cons of any medication and its possible side effects at the time that the prescription is written, but it is my responsibility to make my doctor aware of any issues or concerns that may arise regarding the prescribed medications.

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

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



## Patient Information Regarding Our Therapy Services

Dr. Rajat Gupta may order a therapy plan for you and it is very important that you understand the necessity of following his recommendations so that you may get the full benefit of these services.

The Headache and Pain Center works with independent contractors to perform our therapy services. They work in our office on specific days of the week to treat our patients. Our contractors are paid only for those patients they treat. Consequently, if you miss an appointment, that therapist does not get paid. Therefore, as a courtesy to them and to inform you, the patient, we ask that you read and sign the following contract.

### Therapy Contract

I understand that Dr. Rajat Gupta may order a plan of **Physical Therapy/ Massage Therapy/ Acupuncture/ Biofeedback/Relaxation Training** for my chronic pain condition. This therapy, if ordered by Dr. Gupta, will be one to two visits per week for at least 4 to 8 weeks. I may decline any such treatment recommendation, for any reason. If I choose to proceed with the recommended therapy, then I agree to the following:

1. I will arrive at least 10 minutes prior to each appointment to register and pay any co-payments or percentages due at the time of the visit.
2. I will give a 24-hour notice should I need to cancel or reschedule my appointment so that another patient might be able to use the allotted time. If I miss an appointment without 24-hour notice, I understand that I will owe a fee of \$50.00 for the missed appointment. Please keep in mind that this missed appointment fee is **not** covered by your insurance.
3. I understand that if I cancel or miss two appointments for therapy, that the remaining appointments will be cancelled and I will be required to see Dr. Gupta for a re-evaluation prior to restarting my therapy sessions.
4. I understand that I must be re-evaluated by Dr. Gupta every 30 days to continue therapy if needed.

I have read and understand all the above:

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

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



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## REQUEST FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I request and authorize that copies of my medical records be **sent to / received from** Dr. Rajat Gupta. These should include all PHI, such as: office notes, hospital summaries, EMG/NCV studies, laboratory and radiological reports, etc.

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
  - i. My treatment, payment, enrollment or eligibility for benefits may not be a condition on signing this authorization.
  - ii. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
  - iii. If the requestor or receiver is not a health plan or a health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed by that party.
  - iv. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if asked for it.
2. I will receive a copy of this form after I sign it.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Day Time Telephone:** \_\_\_\_\_

**I have read the above and authorize the disclosure of the protected health information as stated.**

**Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_