La Jolla Neurosurgical Associates, AMC
9834 Genesee Ave. Suite 411
La Jolla, Ca 92037
PH: (858) 677-1755
FAX: (858) 677-1771

REQUEST FOR MEDICAL RECORDS

Date of Request: _____
Name of Doctor/Clinic/Hospital that records are being released from:

_____
Address: _____

Requesting the following records/reports/films:

☐ Recent Medical/Chiropractic Records as of _____ and afterwards (no billing please)
☐ All Medical/Chiropractic Records as of this patient on file (no billing please).
☐ X-ray reports
☐ X-ray films
☐ MRI reports/films
☐ CT reports/films
☐ EMG, SSEP, and NCV studies
☐ Emergency room treatment records
☐ Other _____
☐ Concerning my: ☐ Accident ☐ Injury ☐ Illness ☐ Other ☐ DOI: ☐

_____

According to section 25252 of the California health safety code, these records must be provided within 15 days of receipt of this notice.

PATIENT INFORMATION:

Patient Name (print): _____
Social Security #: _____
Date of Birth: _____
Other Names Used: _____

I, _____, hereby request and authorize the above records and tests to be released and mailed to the doctor/facility indicated at the top of this form. It is understood that any x-rays, CT, or MRI original films (not copies) will be returned to the original facility within 30 days after receiving them.

Signature of Patient: _____ Date: _____

IF THERE ARE ANY PROBLEMS WITH RECEPTION, PLEASE CALL THE ABOVE NOTED NUMBER.

Authorization For Use or Disclosure of Protected Health Information

La Jolla Neurosurgical Associates, AMC
9834 Genesee Ave. Suite 411
La Jolla, CA 92037

Your completion of this form means that you are giving permission for the uses and disclosure described below. Please review and complete this form carefully. It may be invalid if not fully completed.

I hereby authorize this medical practice to use and disclose health information concerning

_____

(*patient name, address, and date of birth*) as follows:

Health information to be used or disclosed (check *only one box*):

☐ Any and all health information other than psychotherapy notes may be released, including, but not limited to mental health records, drug and/or alcohol abuse records and/or HIV test results, if any, except as specifically provided below:

_____

_____

☐ Only those records specifically listed below:

_____

_____

This health information may be disclosed to:

_____

_____

(*Name and address of person to use or receive the health information*)

The information may be used only for the following purposes (if you do not want to explain the purpose, write "At the request of the individual"

_____

I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

This authorization is effective now and will remain in effect until _____
(*Expiration event or date*).

I understand that I have the right to receive a copy of this authorization.

Signed: _____ Dated: _____

Print Name: _____

If not signed by the patient, please indicate relationship:

- ☐ parent or guardian of minor patient (to the extent minor could not have consented to the care)
- ☐ guardian or conservator of an incompetent patient
- ☐ beneficiary or personal representative of deceased patient
- ☐ spouse or person financially responsible (where information solely for purpose of processing application for dependant health care coverage)

La Jolla Neurosurgical Associates, AMC

Last Name _____ First Name _____ M I _____

Address _____ City _____ ZIP _____

Phone _____ Cell _____ SS# _____ Sex: ☐☐

Birthdate _____ Email _____ Marital Status: ☐☐☐☐

Occupation _____ Employer _____

Employer's Address _____ Phone _____

Primary MD _____ Phone _____

Referring MD _____ Phone _____

Person Responsible For Payment

Name _____ Relationship to Patient _____

Address _____ City _____ ZIP _____

SS# _____ Birthdate _____ Sex: ☐☐

Employer _____ DMV LIC # _____

Employer Address _____ Phone _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Insurance Information

Primary Insurance _____

Address _____ Phone _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SS# _____ Birthdate _____ Sex: _____

Certificate # _____ Group # _____ Plan# _____

Secondary Insurance _____

Address _____ Phone _____

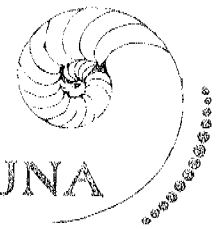
Subscriber Name _____ Relationship to Patient _____

Subscriber SS# _____ Birthdate _____ Sex: _____

Certificate # _____ Group # _____ Plan# _____

Assignment & release: I hereby assign my insurance to be paid directly to the undersigned physician. I am financially responsible for noncovered services, I also authorize the undersigned physician to release to my insurance carriers any information required to process this claim.

Signature _____ Date _____



La Jolla Neurosurgical Associates, AMC

Frank J. Coufal, M.D.

ELIGIBILITY GUARANTEE

I, _____, hereby certify that I am eligible
Name of patient/ member
For _____ effective _____.
Health plan date
I understand that if the above is not true or if I am not eligible under the terms of my Health Plan Agreement, I agree to pay in full for all services received within 30 days of receiving a bill from Dr. Frank J. Coufal.
provider

_____
Signature of patient/ member

_____
Subscriber number/ social security number

Scripps Memorial Campus - La Jolla • HM Poole Bldg.
9834 Genesee Ave. Suite 411 • La Jolla, CA. 92037
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LJNA
La Jolla Neurosurgical Associates, AMC

Frank J. Coufal, M.D.

NO SHOW POLICY

This new policy is being instituted for Dr. Frank J. Coufal's patients. Please read carefully and ask any questions you have about this notice before you sign.

The new policy is that you cannot have **two** no show appointments in a row. If you do we will no longer be able to make appointments for you. You will then have to transfer treatment to another physician.

Thank you for understanding the importance of Dr.Coufal's time and wanting to see patients as soon as he can to treat them.

_____ _____

Signature date

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Acknowledgement of Receipt of Notice of Privacy Practices

La Jolla Neurosurgical Associates, AMC
9834 Genesee Ave. suite 411
La Jolla, CA 92037
Privacy Officer, Office Manager, (858) 677-1755

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I will be given a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____.

Signed: _____ Date: _____

Print Name: _____ DOB: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____