# Jasper Neurological Associates, P.C.

## 3850 Camp Road, Suite C

## Jasper GA 30143

ratient Name:	Date of Birth:	
	SSN:	
City:	State: Zip:	
Home Phone:		
Employer Name:	Work Phone:	
Employer Address:		
Marital Status: ( ) Married ( ) Divorced ( ) Single	e ()Widow(er)	
Spouse's Name:	Date of Birth:	
Spouse's Employer:	Work Phone:	
Spouse's SSN:		
Preferred Pharmacy:	Pharmacy Phone:	
Referring Physician:	Primary Care Physician:	
Company:	Company:	
Patient's Relationship to Insured:	Patient's Relationship to Insured:	
( )Self ( )Spouse ( )Child	()Self ()Spouse ()Child	
EMERGENCY CONTACT INFORMATION		
Contact Name:	Contact Phone:	
Contact's Relationship to Patient		
AUTI	HORIZATION	
I authorize the treatment of the above- named patient an filed on my behalf. I authorize payment of medical benef	nd release of any medical information to process insurance claims fits to Jonathan Pearlstein, M.D. for services rendered.	
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY	UNPAID BALANCE ON MY ACCOUNT.	
Patient Signature:	Date:	

# JASPER NEUROLOGICAL ASSOCIATES, P.C. 3850 CAMP ROAD, SUITE C JASPER, GA 30143 (706)-253-1401 FAX (706)-253-1405 AUTHORIZATION FOR RELEASE OF INFORMATION

Date of Birth:	Patient Name:		
The following type(s) of individually identifiable health information relating to me as described below:  understand that this information may contain history of illness or diagnostic and therapeutic information, necluding any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human mmunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.  The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite perior fitime unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my reatment, payment, enrollment in a health plan, or eligibility for benefits.  Signature of Patient  Witness  If the patient is unable to sign, the Personal Representative must complete the following:	SS#:		
The following type(s) of individually identifiable health information relating to me as described below:  understand that this information may contain history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human immunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.  The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period fitime unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my reatment, payment, enrollment in a health plan, or eligibility for benefits.  Signature of Patient  Witness  I the patient is unable to sign, the Personal Representative must complete the following:	Date of Birth:		
The following type(s) of individually identifiable health information relating to me as described below:  understand that this information may contain history of illness or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human immunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.  The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period of time unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my reatment, payment, enrollment in a health plan, or eligibility for benefits.  Signature of Patient  Witness  If the patient is unable to sign, the Personal Representative must complete the following:	I hereby release and authorize: <u>Jasper Neurological Associates, P.C.</u>		
understand that this information may contain history of illness or diagnostic and therapeutic information, ncluding any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human mmunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.  The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period of time unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my creatment, payment, enrollment in a health plan, or eligibility for benefits.  Signature of Patient  Witness  I the patient is unable to sign, the Personal Representative must complete the following:	To obtain from:		
understand that this information may contain history of illness or diagnostic and therapeutic information, ncluding any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human mmunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.  The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period of time unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my creatment, payment, enrollment in a health plan, or eligibility for benefits.  Signature of Patient  Witness  I the patient is unable to sign, the Personal Representative must complete the following:	5 112 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
ncluding any treatment for alcohol, drug abuse, or psychiatric disorders or tests for infection with human mmunodeficiency virus (AIDS). If released, I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.  The facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period fitime unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my reatment, payment, enrollment in a health plan, or eligibility for benefits.  Signature of Patient  Witness  If the patient is unable to sign, the Personal Representative must complete the following:	The following type(s) of individually identifiable	health information relating to me as described below:	
The release of health information to the extent indicated and authorized therein.  All information I hereby authorize to be obtained or released from this agency will be held strictly confidential and cannot be released without my written consent. I understand that this will remain in effect for an indefinite period of time unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my reatment, payment, enrollment in a health plan, or eligibility for benefits.  Date  Signature of Patient  Witness  If the patient is unable to sign, the Personal Representative must complete the following:	including any treatment for alcohol, drug abuse, immunodeficiency virus (AIDS). If released, I und is not a health plan or health care provider cover	or psychiatric disorders or tests for infection with human derstand that if the person or entity that receives this information red by federal privacy regulations, the released information may	
cannot be released without my written consent. I understand that this will remain in effect for an indefinite period of time unless I specify an expiration date here:  understand that I may refuse to sign this Authorization and that my refusal to sign in no way affects my reatment, payment, enrollment in a health plan, or eligibility for benefits.  Date  Signature of Patient  Witness  If the patient is unable to sign, the Personal Representative must complete the following:	그 사람이 되면 보다 하는 경기 없었다면 한 경기를 다 면서 있다. 그는 사람들이 되었다면 그렇게 되었다면 그 없다.	[20] [20] [10] [20] [20] [20] [20] [20] [20] [20] [2	
Date  Signature of Patient  Witness  f the patient is unable to sign, the Personal Representative must complete the following:	cannot be released without my written consent.	I understand that this will remain in effect for an indefinite period	
Witness f the patient is unable to sign, the Personal Representative must complete the following:	이 이 사람들은 사람들이 이번 이번 경기를 하게 되는 것이다. 아무리 아름다면 하다 것	그 이 경기 이 경기를 잃었다. 하고 있었다. 그만 하나 보고 있는데 경기를 하게 하다면 하다 하나 하나 하나 하나 하다.	
f the patient is unable to sign, the Personal Representative must complete the following:	Date	Signature of Patient	
Reason:	if the patient is unable to sign, the Personal Repr	resentative must complete the following:	
	Reason:		

Relationship to Patient

Signature of Personal Representative

Date

Practice: Jasper I	Neurological	Associates,	P.C.
--------------------	--------------	-------------	------

Address: 3850 Camp Road, Suite C, Jasper, GA 30143

Telephone: 706-253-1401

### Notice of Privacy Practices Receipt

경기 이 그 살이다. 그렇게 꾸는 이 없는데 하는데 하네. 그렇게 그 아이를 살려가면 하는데 하다.	ice of Privacy Practices of the Medical Practice named a
the top of this page.	
Print Name of Patient:	
Signature of Patient:	
Date:	
Patient's Date of Birth:	
Patient's ID/Chart Number:	
For Personal Representative of the Patient (if ap	plicable)
Print Name of Personal Representative:	
Describe Personal Representative Relationship_	
Signature of Personal Representative:	
Date:	
For Practice Use Only:	
The state of the s	
Signature of Practice Employee	Date