CAROLINA NEUROLOGY

WELCOME TO OUR PRACTICE!

Please help us serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

SOCIAL SECURITY NUMBER	TITLE	LAST NAME	FIRST NAME	MI

PATIENT MAILING ADDRESS	CITY	STATE	ZIP CODE
HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	E-MAIL	REFERRING DOCTOR

BIRTHDAY	AGE	SEX (M, F)	RACE	PRIMARY DOCTOR

MARITAL ☐ M-Married ☐ W-Widowed ☐ S-Single ☐ D-Divorced ☐ X-Separated	EMPLOYMENT ☐ R-Retired ☐ F-Full ☐ P-Part ☐ N-None	STUDENT ☐ P-Part ☐ F-Full ☐ N-None	HISPANIC ORIGIN ☐ Yes ☐ No

EMPLOYER	EMPLOYER/SCHOOL NAME	PREFERRED LANGUAGE

STREET ADDRESS (ROAD OR STREET)	(APARTMENT # OR SECOND ADDRESS LINE

ZIP CODE	CITY	STATE	BUSINESS PHONE

BILLING INFORMATION

PERSON RESPONSIBLE FOR BILL	RELATIONSHIP
ADDRESS (IF DIFFERENT)	EMPLOYER
HOME PHONE	WORK PHONE

ANY MEDICAL OR HOSPITAL INSURANCE INFORMATION

PRIMARY INSURANCE CO.		
MAILING ADDRESS		
POLICY HOLDER'S NAME		RELATIONSHIP TO PATIENT
POLICY HOLDER'S SEX	BIRTHDATE	SOCIAL SECURITY NUMBER
POLICY OR I.D. NUMBER		GROUP NUMBER
SECONDARY INSURANCE CO.		
MAILING ADDRESS		
POLICY HOLDER'S NAME		RELATIONSHIP TO PATIENT
POLICY HOLDER'S SEX	BIRTHDATE	SOCIAL SECURITY NUMBER
POLICY OR I.D. NUMBER		GROUP NUMBER

EMERGENCY CONTACT NAME:	PHONE#

I authorize the release of any medical or other information necessary to process insurance claims.	I authorize payment of medical benefits directly to this practice for the services rendered.
Signed ____________ Date ______	Signed ____________ Date ______

A119 PI (09.08.14)

UNIVERSAL MEDICATION FORM

Carolina Neurology

Date form started:

NAME	ADDRESS
PHONE NUMBER	
BIRTH DATE	
EMERGENCY CONTACT/PHONE NUMBERS	

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

ALLERGIC TO/DESCRIBE REACTION:	ALLERGIC TO/DESCRIBE REACTION:

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

DATE	NAME OF MEDICATION / DOSE	DIRECTIONS: Use patient friendly directions. (Do not use medical abbreviations.)	DATE STOPPED	NOTES: Reason for taking / Doctor's Name

A119 UM (04.08.10) TO REORDER CALL INHEALTH RECORDS SYSTEMS (800) 477-7374 OR IN ATLANTA (770) 396-4994

CAROLINA NEUROLOGY

NAME ______________________________ DATE ____________________

PROBLEM YOU ARE HAVING ______________________________

____

____

LIST ANY HOSPITALIZATIONS: (NAME OF HOSPITAL AND ADMISSION DATES:

____

____

____

____

____

____

____

____

LIST CHILDREN'S NAME, AGE, AND HEALTH ______________________________

____

____

LIST BROTHERS AND SISTERS NAME , AGE AND HEALTH ____________________

____

____

FATHER'S AGE (IF LIVING)___ HIS HEALTH ______________________________
MOTHER'S AGE (IF LIVING)___ HER HEALTH ______________________________

FATHER'S AGE AT DEATH AND CAUSE ______________________________
MOTHER'S AGE AT DEATH AND CAUSE ______________________________

HAS ANY MEMBER OF YOUR FAMILY EVER HAD CANCER, HIGH BLOOD PRESSURE, EPILEPSY, DIABETES OR DISEASE OF THE NERVES OR MUSCLES: IF SO, LIST RELATIONSHIP AND DISEASE: ______________________________

____

____

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT TO CAROLINA NEUROLOGY FOR PAYMENT OF THIS ACCOUNT. AS A COURTESY, WE WILL FILE YOUR INSURANCE FOR YOU. IF FOR ANY REASON THEY DO NOT PAY, THEN YOU ARE STILL RESPONSIBLE FOR YOUR BILL IF YOU HAVE A COPAY, PERCENTAGE OR DEDUCTIBLE, YOU ARE RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.

I AUTHORIZE THE DOCTORS OF CAROLINA NEUROLOGY TO RELEASE ANY INFORMATION REQUESTED IN THE COURSE OF MY EXAMINATION OR TREATMENT FOR INSURANCE PURPOSES.

SIGNATURE ______________________________ DATE ____________________

Carolina Neurology
541 Floyd Road
Spartanburg, South Carolina 29307
Telephone: (864) 585-6179 • Fax: (864) 583-5403

REVIEW OF SYSTEMS

Please indicate any personal history below)

CONSTITUTIONAL SYMPTOMS
Recent Weight Loss ____Yes _____ No
Fever ____Yes _____ No
Fatigue ____Yes _____ No
Night Sweats ____Yes _____ No

ENT
Blurred or double vision ____Yes _____ No
Hearing loss or ringing ____Yes _____ No
Earaches or drainage ____Yes _____ No
Nosebleeds ____Yes _____ No
Bad Breath or bad taste ____Yes _____ No
Swollen glands in neck ____Yes _____ No
Mouth sores/ulcers ____Yes _____ No

CARDIOVASCULAR
Chest pain or angina ____Yes _____ No
Palpitations ____Yes _____ No
Swelling of feet/ankles ____Yes _____ No
Sleeping w/more than ____Yes _____ No
3 pillows ____Yes _____ No

RESPIRATORY
Chronic or frequent cough ____Yes _____ No
Spitting up blood ____Yes _____ No
Shortness of breath ____Yes _____ No
Wheezing ____Yes _____ No
Pain with breathing ____Yes _____ No

GENITOURINARY
Frequent urination ____Yes _____ No
Burning or painful urination ____Yes _____ No
Blood in urine ____Yes _____ No
____Yes _____ No

MUSCULOSKELETAL
Joint Pain/Swelling ____Yes _____ No
Weakness ____Yes _____ No
Back Pain ____Yes _____ No

PSYCHIATRIC
Memory Loss (confusion) ____Yes _____ No
Depression/Anxiety ____Yes _____ No
Sexual/Physical Abuse ____Yes _____ No

INTEGUMENTARY (skin)
Rash or itching ____Yes _____ No
Change in skin color ____Yes _____ No
Change in hair or nails ____Yes _____ No

NEUROLOGICAL
Frequent or recurring ____Yes _____ No
headaches ____Yes _____ No
Seizures ____Yes _____ No
Numbness or tingling ____Yes _____ No
Tremors ____Yes _____ No
Fainting Spells ____Yes _____ No
Loss of Feeling ____Yes _____ No
Focal Weakness ____Yes _____ No

ENDOCRINE
Excessive thirst or urination ____Yes _____ No
Heat/cold intolerance ____Yes _____ No
Sweating spells ____Yes _____ No

HEMATOLOGIC/LYMPHATIC
Bleeding or bruising tendency ____Yes _____ No
Anemia ____Yes _____ No
Large nodes on glands ____Yes _____ No

HABITS
Please indicate current/past use of any of the following: (Please list amounts,)
☐ Alcohol ______________________ ☐ Caffeine ______________________
☐ Tobacco ______________________ ☐ Illicit Drugs ______________________

DOCTOR
Which Doctor(s) has been treating you?: ______________________
____

To my knowledge, the questions on this form have been accurately answered. I understand that by providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Signature ______________________ Date ____________

NAME ______________________________

* RETURN TO THE RECEPTIONIST AFTER COMPLETION*

PLEASE CHECK THE FOLLOWING TEST THAT YOU HAVE HAD PERFORMED.

CIRCLE ONE

MRI ______ BRAIN, HEAD, CERVICAL, THORACIC, LUMBAR
WHERE WAS TEST PERFORMED __________ WHEN ____________

CT _______ BRAIN, HEAD, CERVICAL, THORACIC, LUMBAR
WHERE WAS TEST PERFORMED __________ WHEN ____________

X-RAY'S _______ WHAT TYPE OF X-RAY'S WERE PERFORMED
____
WHERE WAS TEST PERFORMED __________ WHEN ____________

LAB'S __________ WHAT LAB WORK HAVE YOU HAD RECENTLY PERTAINING TO YOUR CURRENT PROBLEMS ________________
____
WHERE WAS TEST PERFORMED __________ WHEN ____________
PLEASE LIST ANY OTHER ADDITIONAL LABS YOU MAY HAVE HAD DONE THAT MAY BE HELPFUL TO A DOCTOR.
______________________ WHERE ___________ WHEN __________

OTHER ____

I AGREE THAT IT IS OKAY FOR CAROLINA NEUROLOGY TO OBTAIN DOCUMENTS.

________________________________ DATE ________________________

Carolina Neurology of Spartanburg LLC
541 Floyd Road
Spartanburg, SC 29307
864-585-6179

Carol S. Nichols, M.D.
Carol A. Kooistra, M.D.

Practice Limited to Neurology
Nerve Conduction Studies
Evoked Potentials
Sleep Disorder Studies
Appointments by Referral

Controlled substance medications (i.e. Narcotics, tranquilizers, and barbiturates) are very useful, but have a high potential for misuse and therefore are closely controlled by the local state, and federal government. They are intended to relieve pain to improve function and/or ability to work, NOT simply to feel good. Because my physician is prescribing such medication for me to help manage my pain, I agree to the following conditions:

1. I am responsible for my controlled substance medications. If the prescription of medication is lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.

2. I will not request or accept controlled substance medication from any other physician or individual while I am receiving such medication from my physician at Carolina Neurology. Besides being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.

3. Refills of controlled substance medications:

   a. Will only be made during regular office hours, Monday through Thursday between 9 a.m. – 4 p.m., and Friday between 9 a.m. – 12 p.m. Refills will not be made at night, on holidays, or weekends.

   b. Will not be made if I "run out early", "lose a prescription", "spill or misplace my medication". I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

   c. Will not be made as an "emergency", such as Friday afternoon because I suddenly realize I will "run out tomorrow". I will call at least twenty-four (24) hours ahead if I need assistance with a controlled substance medication prescription.

4. It may be deemed necessary by my doctor for me to see a medication use specialist at any time while I am receiving controlled substances. I understand if I do not attend this appointment that my medications may not be continued or refilled beyond a tapering dose completion. I understand that if this specialist feels I am at risk for psychological dependence (addiction) that my medications will no longer be refilled.

Please Sign Third (3rd) Page

Poisons and Controlled Substances 44-53-100

44-53-395. Prohibited acts; penalties

(A) It shall be unlawful:

(1) for any practitioner to issue any prescription document signed in blank. The issuance of such document signed in blank shall be prima facie evidence of a conspiracy to violate this section. The possession of prescription document signed in blank by a person other than the person whose signature appears there on shall be deemed prima facie evidence of a conspiracy between the possessor and the signer to violate the provisions of this section.

(2) for any person other than a practitioner registered with the Department under this article to possess a blank prescription not completed and signed by the practitioner whose name appears printed thereon.

(3) for any person to withhold the information from a practitioner that such person is obtaining controlled substances of like therapeutic use in a concurrent time period from another practitioner.

(B) Any person who knowingly and intentionally violates this section a first time shall be deemed guilty of a misdemeanor and upon conviction shall be punished by a term of imprisonment for not more than two years or by a fine of not more than two thousand dollars, or both. Any person who knowingly and intentionally violates this section a second time shall be deemed guilty of a felony and upon conviction shall be punished by a term of imprisonment for not more than five years.

44-53-390. Prohibited acts C; penalties

(a) It is unlawful for any person knowingly or intentionally:

(1) to distribute as a registrant a controlled substance classified in Schedules I or II except pursuant to an order form as required by 44-53-350.

(2) to use in the course of the manufacture of distribution of a controlled substance a registration number which is fictitious, revoked, suspended, or issued to another person.

(3) to acquire or obtain possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge.

(4) to furnish false or fraudulent material information in, or omit any material information from, any application, report, or other document required to be kept or filed under this article, or any record required to be kept by this article.

(5) to make, distribute, or possess any punch, die, plate, stone, or other thing designed to print, imprint, or reproduce the trademark, trade name, or other identifying mark, imprint, or device of another or any likeness of any other then foregoing upon any drug or container or labeling thereof so as to render the drug a counterfeit substance.

(6) to distribute or deliver a non controlled substance or an imitation controlled substance.

5. I agree to comply with random urine, blood, or breath testing documenting the proper use of my medications as well as confirming compliance. I understand that driving a vehicle may not be allowed at times while am taking controlled substances and that it is my responsibility to comply with the laws of the state while taking the medication prescribed.

6. I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatment at Carolina Neurology may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, or the concomitant use of nonprescription illicit (illegal) drugs, I may also be reported to my physician, medical facilities, and other appropriate authorities.

7. I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. In consideration of that goal and the fact that I am being given potent medication to help me reach that goal I agree to help myself by the following better health habits: exercise, weight control, avoiding the use of tobacco and alcohol. I must comply with the treatment plan as prescribed by my doctor. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

8. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined and that treatment may change throughout my time as a patient at Carolina Neurology. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that my physician will advise me as knowledge and training advances and will make appropriate treatment changes.

I have been fully informed by Dr. Kooistra and Dr. Nichols and their staff regarding psychological dependence (addiction) of a controlled substance, which I understand is rare. I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect, and I do know that will become physically dependent on the medication. This will occur if I am on the medication for several weeks, and when I stop the medication, I must do so slowly and under medical supervision or I may have withdrawal symptoms.

I have read this contract and the same will be explained to me by Dr. Kooistra/Nichols and/or their staff. In addition, I fully understand the consequences of violating this contract.

In addition, I state that I can and understand the ENGLISH language.
I have completed the _______________ grade.

____________	____________	____________
Date	**Patient's Signature**	**Witness Signature**

Carolina Neurology of Spartanburg LLC

541 Floyd Road
Spartanburg, South Carolina 29307
Telephone: (864) 585-6179 • Fax: (864) 583-5403

HIPAA CONSENT FORM

Patient Name (Print): ______________________________ Date of Birth ______________

I give my permission to release any of my protected health information to the names below:
(This includes, but not limited to: test results, medical records, general medical information, appointment information, billing financial information, etc. Also includes records stored and protected electronically on computer.)

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

Name: ______________________________ Relationship: ______________________

Permission for voicemail / messages Yes ☐ No ☐

Acknowledgement of Receipt of Notice of Privacy Practices
I we have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time.

____
Date and Time

____
Signature of Patient. Guardian or Lcgal Rep.

____
Witness

____
Signature of Guarantor

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW CAROLINA NEUROLOGY MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Carolina Neurology is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by Carolina Neurology or received by Carolina Neurology from other healthcare providers.

We are required to provide you with notice of our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. Carolina Neurology will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

Carolina Neurology reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

Carolina Neurology may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which include registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:
- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies.

For example, Carolina Neurology may determine that you require the services of a specialist. In referring you to another doctor, Carolina Neurology may share or transfer your healthcare information to that doctor.

Payment activities may include:
- Activities undertaken by Carolina Neurology to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, Carolina Neurology will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include
- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, Carolina Neurology may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess the effectiveness of your treatment when compared to patients in similar situations.

Carolina Neurology may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when Carolina Neurology is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
  Mental health records may be disclosed to law enforcement authorities for the purpose of reporting an apparent crime on our premises.

- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

[1] This Notice is prepared in accordance with the Health Insurance Portability and Accountability Act, 45 C.F.R. 164.520.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positive for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except for HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to help conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name and other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent and substantial danger.

- For workers' compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

Carolina Neurology will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that Carolina Neurology has taken action in reliance thereon. Any revocation must be in writing.

Your Rights Regarding Your Protected Health Information

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by Carolina Neurology to carry out treatment, payment, or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also, a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with the exception of psychotherapy notes, or information compiled for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. Carolina Neurology may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that Carolina Neurology send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that Carolina Neurology not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests by you.

You have the right to request that Carolina Neurology amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by Carolina Neurology for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with Carolina Neurology and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Carolina Neurology, please contact the Privacy Officer at the following:

Privacy Officer
Carolina Neurology
541 Floyd Road
Spartanburg, SC 29307
(864) 585-6179

It is the policy of Carolina Neurology that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003.