



1151 Old York Rd. Suite 200 Abington, PA 19001  
(P): 215-957-9250 (F): 215-957-9254

Welcome to Abington Neurological Associates!

Thank you for choosing us for your care. To ensure your appointment goes smoothly, follow these instructions:

### **Confirm your appointment.**

To ensure timely access to care and better accommodate our patients, **all appointments must be confirmed at least 24 hours in advance**, or they will be **automatically cancelled** and offered to patients on our waitlist. You may confirm your appointment by responding to our reminder message via text message or calling our office at 215-957-9250. This helps us provide the best possible care to every patient.

### **Arrive half an hour early.**

We ask that you **arrive 30 minutes prior** to your scheduled appointment, as this allows us time to update your records and prepare you for your visit. *Please note that if you arrive after this time, your appointment may be rescheduled.*

### **Come prepared.**

*Required for your first appointment:*

- **Photo ID, insurance card(s), and prescription card (if applicable).**
- **Payment method.** We accept cash, check, Visa, MasterCard, Discover, and American Express. Copayments/coinsurance/deductible amounts are contractually required and must be paid at the time of the visit.
- **Relevant medical records (if applicable).** If you have imaging results on CD/DVD, drop the discs off at the x-ray file room in Abington Jefferson Hospital (Buerger Building, ground floor) prior to your visit.
- **Current list of medications and supplements.**
- **Referral (if applicable).** If your insurance requires an electronic referral, you must obtain it from your primary care physician **prior** to your appointment. Our group **NPI number is 1154432227**.
- **All forms in this packet must be completed prior to your visit.** All forms in this packet must be filled out completely and returned to us by mail, by fax, or in person. If you arrive for your appointment without completed forms, your visit may be delayed or rescheduled. These forms are mailed out to all new patients and are also available at [www.abingtonneurology.com](http://www.abingtonneurology.com).

### **No-Show Fee.**

Patients who no-show or do not cancel their appointment 24 hours prior to their visit will be charged a \$100 no-show fee for new patient appointments and \$75 for follow-up visits.

If you have any questions or concerns prior to your appointment, please feel free to contact the office. Thank you and we look forward to meeting you soon!

Sincerely,  
Abington Neurological Associates

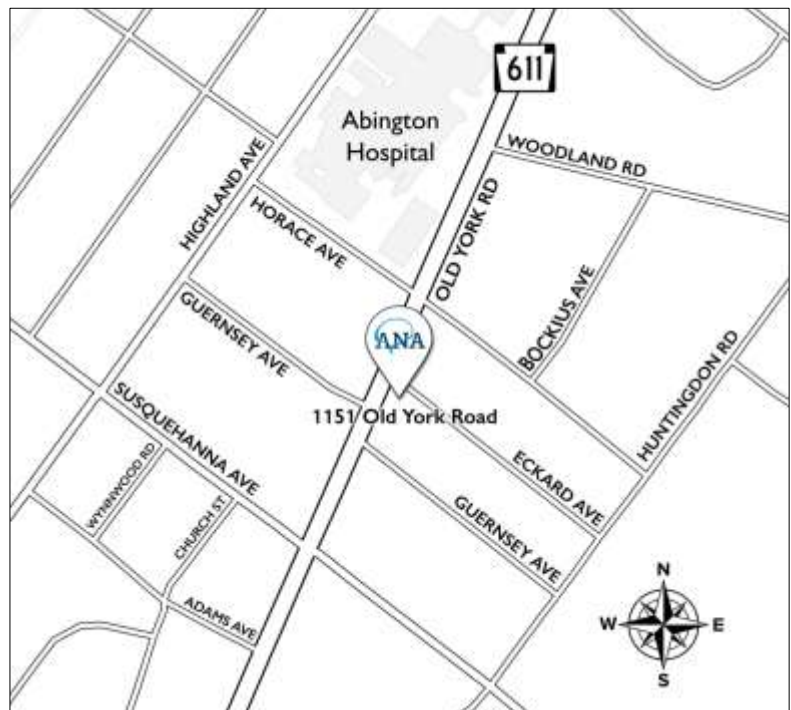
## Directions to our office:

### 1151 Old York Road, Suite 200, Abington, PA 19001

**Southbound on Route 611 (Old York Road):** After you pass Abington Hospital on your right, look for our office one block further south. Our office will be on your **left**. *Note: There is a left turn lane at Eckard Avenue that your GPS might not know about.*

**Northbound on Route 611 (Old York Road):** After you pass Wells Fargo on your right, look for our office two blocks further north. Our office will be on your **right**.

Our office is on Old York Road, across from the magistrate's court and police station. The parking lot is accessible from the two side streets, Eckard Avenue and Guernsey Avenue.



When you enter our building, go up to the second floor.

Please allow extra time for travel. **We ask that you arrive at our office 30 minutes before your scheduled appointment time.**

# Patient Information Sheet



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

Gender: \_\_\_\_\_ Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation: \_\_\_\_\_

Last 4 digits of Social Security # \*: \_\_\_\_\_ Email: \_\_\_\_\_

*\*Required for us to access your electronic medical records*

Home address: \_\_\_\_\_

**List your phone numbers and check the number where we can leave voice messages.**

☐ Home: \_\_\_\_\_ ☐ Cell: \_\_\_\_\_ ☐ Work: \_\_\_\_\_

**Occupation:** (If you are retired and you get your insurance through your former employer, provide their information below.)

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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

**Who should we contact in case of an emergency?**

Emergency contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone: \_\_\_\_\_ Are we allowed to release health information to this person? ☐ Yes ☐ No

**The responsible party is responsible for any unpaid balances:**

Responsible party: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

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

**Tell us about your primary health insurance. Call us if any of this information changes.**

Primary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Tell us about your secondary health insurance. Call us if any of this information changes.**

Secondary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Do you have a separate prescription card?**

Prescription plan: \_\_\_\_\_ ID: \_\_\_\_\_

**Do you have a Medical Power of Attorney?** ☐ Yes ☐ No

**Do you have a living will?** ☐ Yes ☐ No

*If Yes, please bring a copy with you to your first appointment or fax it to us at 215-957-9254.*

**Which doctor referred you to us? (Leave blank if not applicable)**

Referring physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Who is your primary care physician?**

Primary care physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**Write down any other physicians you see on a regular basis. We will send copies of our office notes to them and to your primary care physician unless we are instructed not to. If it's a long list, you can bring it on a separate piece of paper.**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

**What local pharmacy do you use?**

Local pharmacy: \_\_\_\_\_

Local pharmacy address: \_\_\_\_\_

**Do you use a mail order pharmacy?**

Mail order pharmacy: \_\_\_\_\_

Mail order pharmacy address: \_\_\_\_\_

**Answer these questions if you are a Medicare patient.**

Is Medicare your primary insurance? ☐ Yes ☐ No

Do you or your spouse work for a company that provides you with health insurance? ☐ Yes ☐ No

Are you entitled to Medicare because of disability or end-stage renal disease? ☐ Yes ☐ No

Are you entitled to any benefits under the Federal Black Lung Program? ☐ Yes ☐ No

Has the Department of Veterans Affairs authorized treatment for this illness? ☐ Yes ☐ No

# New Patient History



Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Handedness: ☐ Left ☐ Right ☐ Ambidextrous

Occupational: \_\_\_\_\_ Marital Status: \_\_\_\_\_

**What is the main reason for your visit? Describe your symptoms and how long you have experienced them.**

---

---

**Have you had any tests or specialty evaluations for the problem? Include date, body part, and location.**

|                                                  |                                             |
|--------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> MRI scans: _____        | <input type="checkbox"/> Blood tests: _____ |
| <input type="checkbox"/> CT scans: _____         | <input type="checkbox"/> Specialty: _____   |
| <input type="checkbox"/> Vascular studies: _____ | <input type="checkbox"/> Other: _____       |

**Describe when and how long you have experienced any of the following conditions.**

|                                                     |                                            |
|-----------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> High blood pressure: _____ | <input type="checkbox"/> Bleeding: _____   |
| <input type="checkbox"/> Diabetes: _____            | <input type="checkbox"/> Ulcers: _____     |
| <input type="checkbox"/> Thyroid disease: _____     | <input type="checkbox"/> Arthritis: _____  |
| <input type="checkbox"/> Heart failure/CHF: _____   | <input type="checkbox"/> HIV/AIDS: _____   |
| <input type="checkbox"/> Heart attack/MI: _____     | <input type="checkbox"/> Lupus: _____      |
| <input type="checkbox"/> Emphysema/COPD: _____      | <input type="checkbox"/> Anxiety: _____    |
| <input type="checkbox"/> Bipolar Disorder: _____    | <input type="checkbox"/> Depression: _____ |
| <input type="checkbox"/> Anemia: _____              |                                            |

**List any other major illnesses. Include the year of onset.**

---

---

**List any important previous injuries. Include the date of the incident.**

---

---

**List any important hospital visits or surgeries. Include the date, hospital, and reason for admission.**

---

---

**If you have any allergies, check the appropriate box and write your allergy/allergies in the space below.**

|                                                   |
|---------------------------------------------------|
| <input type="checkbox"/> Drugs/medications: _____ |
| <input type="checkbox"/> X-ray dye: _____         |
| <input type="checkbox"/> Other: _____             |

List your medications, including supplements, drops, sprays, birth control, over-the-counter meds, pain pills, etc. If you can't fit them all in the space below, write the list on a separate sheet of paper.

| Name of medication | Dosage | # per day | Year started | Year stopped |
|--------------------|--------|-----------|--------------|--------------|
|                    |        |           |              |              |
|                    |        |           |              |              |
|                    |        |           |              |              |
|                    |        |           |              |              |
|                    |        |           |              |              |

**Tell us about any tobacco use.**

☐ Current smoker: How many cigarettes or packs do you smoke per day? \_\_\_\_\_

☐ Former smoker: For how many years? \_\_\_\_\_ Why did you quit? \_\_\_\_\_

☐ Never a smoker    ☐ Light smoker    ☐ Other tobacco products: \_\_\_\_\_

**How many alcoholic drinks do you have during an average day?**

**Weekdays:** Bottles/cans of beer: \_\_\_\_\_ Glasses of wine: \_\_\_\_\_ Shots of liquor: \_\_\_\_\_

**Weekends:** Bottles/cans of beer: \_\_\_\_\_ Glasses of wine: \_\_\_\_\_ Shots of liquor: \_\_\_\_\_

Do you consume significantly less alcohol now than you did in the past? ☐ Yes ☐ No

**How many caffeinated drinks do you have during an average day?**

Cups of coffee: \_\_\_\_\_ Cups of tea: \_\_\_\_\_ Bottles/cans of soda: \_\_\_\_\_

**Write the age of each of your relatives. If they are deceased, write the letter D next to their age at death.**

Mother: \_\_\_\_\_ Sisters: \_\_\_\_\_ Daughters: \_\_\_\_\_

Father: \_\_\_\_\_ Brothers: \_\_\_\_\_ Sons: \_\_\_\_\_

**Check any conditions that your blood relatives have had.**

| Mother:                                       | Father:                                       | Sisters:                                      | Brothers:                                     | Daughters:                                    | Sons:                                         |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    | <input type="checkbox"/> Epilepsy/seizures    |
| <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   | <input type="checkbox"/> Multiple sclerosis   |
| <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Parkinson's disease  |
| <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  | <input type="checkbox"/> Alzheimer's disease  |
| <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          | <input type="checkbox"/> Brain tumor          |
| <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   | <input type="checkbox"/> Other neurological   |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Hypertension         |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Cancer               |
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart disease        |
| <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              | <input type="checkbox"/> Thyroid              |
| <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         | <input type="checkbox"/> Lung disease         |
| <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Kidney disease       |
| <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Psychiatric problems |

**Tell us anything else we should know about your family history. Are other diseases common in your family?**

---



---

# General Consent To Treat Form

Abington Neurological Associates (ANA)  
1151 Old York Rd. Suite 200, Abington, PA 19001



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## PURPOSE OF CONSENT:

This consent authorizes Abington Neurological Associates (ANA), its physicians, advanced practice providers, clinical staff, and affiliated personnel to provide medical evaluation, treatment, and services as deemed medically necessary.

## SCOPE OF SERVICES:

Services provided by this practice may include, but are not limited to:

- Neurological evaluations and consultations
- Diagnostic testing, including:
  - Electromyography (EMG)
  - Electroencephalography (EEG)
  - Sleep studies (in-lab or home-based)
- Infusion therapies
- Injectable medications and treatments
- Lumbar punctures (spinal taps)
- Laboratory testing and specimen collection
- Imaging coordination and interpretation (when applicable)
- Other ancillary and supportive neurological services

## RISKS AND BENEFITS:

I understand that medical procedures and treatments may involve risks, benefits, and alternatives. These may include, but are not limited to, discomfort, bleeding, infection, allergic reactions, and other complications depending on the procedure performed. I understand that no guarantees have been made regarding the outcome of any treatment or procedure.

## TREATMENT AUTHORIZATION:

I voluntarily consent to the provision of medical care, including examinations, diagnostic testing, procedures, infusions, injections, and other treatments deemed appropriate by my healthcare providers. I understand that I may refuse or discontinue treatment at any time, and that doing so may affect my medical care.

## MEDICATIONS AND INFUSIONS:

If applicable, I consent to the administration of medications, including infusion therapies and injections. I understand that medications may carry risks and that I will be informed of potential side effects prior to administration when feasible.

## PROCEDURE-SPECIFIC CONSENT ADDENDUMS

### INFUSION THERAPY CONSENT:

I understand that infusion therapy involves the administration of medications or fluids intravenously. Risks may include, but are not limited to, vein irritation, infiltration or extravasation, infection at the infusion site, allergic or adverse reactions, fluid overload, and discomfort. I understand that trained clinical staff will monitor me during infusion and that emergency interventions may be provided if necessary.

**INJECTION CONSENT:**

I understand that injections may include intramuscular, subcutaneous, or intravenous administration of medications. Risks may include pain, bleeding, bruising, infection, nerve irritation or injury, and allergic reactions.

**LUMBAR PUNCTURE (SPINAL TAP) CONSENT:**

I understand that a lumbar puncture is a procedure used to obtain cerebrospinal fluid for diagnostic purposes. Risks may include headache, bleeding, infection, back pain, nerve irritation, and, rarely, more serious complications. I understand that I may experience discomfort during and after the procedure and that specific post-procedure instructions will be provided.

**DIAGNOSTIC TESTING CONSENT (EMG / EEG / SLEEP STUDIES):**

I understand that diagnostic testing such as EMG, EEG, and sleep studies may involve the placement of sensors, electrodes, or needles (in the case of EMG). Risks may include mild discomfort, skin irritation, minor bleeding, or temporary soreness at electrode or needle insertion sites.

**STUDENT / TRAINEE INVOLVEMENT:**

I understand that this is a teaching environment and that medical students, residents, fellows, or other trainees may participate in my care under supervision.

**PHOTOGRAPHS / RECORDING (OPTIONAL):**

☐ I consent to photographs or recordings being taken for medical documentation purposes only.

☐ I do NOT consent to photographs or recordings.

*I certify that I have read and understand this General Consent to Treat. I have had the opportunity to ask questions and have received satisfactory answers. I voluntarily agree to receive care and services from Abington Neurological Associates.*

**ACKNOWLEDGEMENT OF UNDERSTANDING/SIGNATURE**

---

Patient/Authorized Representative Signature

---

Date

---

Printed Name of Authorized Representative

---

Relationship to Patient (if applicable):

# Financial Disclosure Form

Abington Neurological Associates (ANA)  
1151 Old York Rd. Suite 200, Abington, PA 19001



We, the staff of Abington Neurological Associates, Ltd. thank you for choosing us as your healthcare provider. We believe that it is important for our patients to understand their financial responsibility. Please read the following information and sign below acknowledging your understanding. Thank you.

We accept cash, check, Visa, MasterCard, Discover, and American Express. Our office collects all expected patient responsibility amounts prior to service. A \$35.00 service fee will be charged for all returned checks.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will gladly submit the claim to your insurance carrier on your behalf for insurances that we are in network. Please note that any copays, deductibles or non-covered services are your responsibility and will be collected on the day of your appointment. If a referral is required, and is not obtained prior to your appointment, we reserve the right to reschedule your appointment, or bill you for services rendered. If you choose to be seen at our practice, outside of your insurance network/coverage, you will be solely responsible for all fees. In addition, if you require testing or medication that requires preauthorization, our office will not be able to obtain this for you due to our non-participation with your plan.

Any non-covered services such as injections of any kind, including Botox, Occipital, Nerve Blocks of any type, or infusions will be the responsibility of the patient. All balances for these services are due immediately.

**Starting 6/1/2023, Physician, PA and NP phone calls for medical advice that last over 5 minutes that are not within 7 days of a visit and do not result in an emergency appointment or ER visit, are considered billable encounters under the CPT codes G2012. The Medicare payment for this code is \$15.42. Your insurance provider may vary from these rates. Please check with your insurance company what your out of pocket expenses may be for these new services.**

**Forms:** Effective October 1, 2019, physicians may fill out appropriate forms (i.e. disability, FMLA, life insurance, etc.) for a \$20 service fee for the first page plus \$5 per additional page. Forms are to be given to the receptionist at the front desk when you check in. Do not give forms to the provider during the appointment. All forms must go through the Medical Records Department first - **no exceptions**. If you mail or fax a form to us, we cannot fill it out if it has been more than 30 days since your last appointment. Exceptions are made on a case-by-case basis. Please allow **at least** 5-10 business days for us to complete the forms.

**Missed Appointments: We require notice of cancellation 24 hours in advance.** This allows us to offer the appointment to another patient. If you fail to keep your appointment without notifying us at least 24 hours in advance, a no-show fee will apply. **This fee is \$100.00 for new patients and \$75.00 for follow-ups.** **Repeated missed appointments without notification, or frequent cancellations, may result in being discharged from the practice so that we can provide care to other patients.**

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Payment contracts are not available on elective services such as injections or infusions. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification.

***I have read and understand the above financial policy.***

**Patient name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Today's date:** \_\_\_\_\_  
*Patient or authorized representative*

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

# Medical Records Release & HSX Consent Form

Abington Neurological Associates (ANA)  
1151 Old York Rd. Suite 200, Abington, PA 19001



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

### Release my medical records TO:

Name/Facility: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Obtain my medical records FROM:

Name/Facility: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Information to be Released (check all that apply):

- ☐ Office Visit Notes   ☐ Diagnostic Reports (EEG, EMG, Sleep Studies, Imaging)   ☐ Laboratory Results
- ☐ Medication Records   ☐ Billing Records   ☐ Entire Medical Record
- ☐ Other: \_\_\_\_\_

### Sensitive Information (Initial if authorized):

- ☐ Mental Health Records: \_\_\_\_\_   ☐ HIV/AIDS-Related Information: \_\_\_\_\_
- ☐ Drug and Alcohol/Substance Use Records (42 CFR Part 2): \_\_\_\_\_   ☐ Genetic Testing: \_\_\_\_\_

### HSX CONSENT (HEALTH INFORMATION EXCHANGE)

I authorize Abington Neurological Associates (ANA) to access, use, and share my health information electronically through HSX for treatment, payment, and healthcare operations.

I understand my information may be shared with authorized healthcare providers involved in my care.

I understand participation is voluntary and may be revoked at any time in writing.

My information will be protected under HIPAA and applicable privacy laws.

### ACKNOWLEDGEMENT & SIGNATURE

\_\_\_\_\_  
Patient/Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient Authorized Representative (if applicable)

\_\_\_\_\_  
Relationship to Patient (if applicable)

# Patient Consent to Jurisdiction and Venue for Malpractice Claims

Practice Name: Abington Neurological Associates (ANA)  
Address: 1151 Old York Rd. Suite 200, Abington, PA 19001



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Consent and Agreement

I, the undersigned patient (or authorized representative), acknowledge and agree to the following:

1. LOCATION OF CARE:

I understand that the medical care and services I receive from Abington Neurological Associates are rendered in the Commonwealth of Pennsylvania.

2. AGREEMENT TO VENUE:

In the event of any claim, dispute, or legal action arising out of or related to the medical care provided to me, including but not limited to medical malpractice claims, I agree that:

a. Any such claim shall be brought exclusively in a court of competent jurisdiction located within the Commonwealth of Pennsylvania and county (Montgomery) where the care was provided.

b. I will not initiate or pursue such claims in any other jurisdiction or venue.

3. GOVERNING LAW:

I understand and agree that any such claims shall be governed by the laws of the Commonwealth of Pennsylvania in which the care was provided.

4. VOLUNTARY AGREEMENT:

I acknowledge and agree to the above paragraph that:

- a. I have had the opportunity to ask questions about this agreement.
- b. I understand its terms and implications.
- c. I am signing this agreement voluntarily and without coercion.

5. SEVERABILITY:

If any provisions of this agreement is found to be invalid or unenforceable, the remaining provisions shall remain in full force and effect.

## Acknowledgement and Signature

*The undersigned certifies that he/she has read the above and is the patient, guardian or representative authorized to execute the above and accept its terms and risks.*

\_\_\_\_\_  
Patient/Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient Name or Authorized Person

\_\_\_\_\_  
Relationship to Patient (if applicable):

# Personal Health Data Consent Form For Future Research Use

Practice Name: Abington Neurological Associates (ANA)  
Address: 1151 Old York Rd. Suite 200, Abington, PA 19001



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Purpose of Authorization

You are being asked to allow your Protected Health Information (PHI) to be used and disclosed for future, unspecified research studies. These studies may help improve medical knowledge, treatments, and healthcare outcomes.

**Description of Information to Be Used or Disclosed:** Your PHI may include medical history, diagnoses, medications, lab results, imaging, billing information, and demographic data.

**Persons/Entities Authorized to Disclose Information:** Healthcare providers, hospitals, clinics, and laboratories.

**Persons/Entities Authorized to Receive Information:** Researchers, research institutions, IRBs, regulatory agencies, and data repositories.

**Purpose of Use/Disclosure:** For future, unspecified research purposes.

**Expiration of Authorization:** This authorization does not expire unless revoked, if permitted by law.

**Right to Revoke Authorization:** You may revoke this authorization at any time in writing. Revocation does not affect prior disclosures.

**Redisclosure Notice:** De-identified information disclosed may no longer be protected under HIPAA.

**Voluntary Authorization:** Signing this form is voluntary and will not affect your care or benefits.

**Privacy Safeguards:** Reasonable safeguards will be used. Data will be de-identified where possible.

**Risks and Benefits:** Risk: potential loss of confidentiality. Benefit: contribution to research.

**Future Research Use:** Your data may be used in future unspecified studies.

☐ I agree      ☐ I do NOT agree

## Copy of Authorization

Upon patient request we will provide a copy of this signed form.

## Authorization Statement

I have read and understand this form and voluntarily authorize the use of my PHI.

Patient/Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Authorized Representative (if applicable): \_\_\_\_\_