PATIENT INFORMATION

Is your visit related to a motor vehicle injury? YES / NO	Is your visit related to an on-the-job injury? YES / NO

Today's date:	Patient's last name:	First name:	Middle initial:
Mailing Address:	City:	State:	Zip:
Home phone:	Work phone:	Cell Phone:	
Sex:	Birth Date:	Employer Name and Address:	
Email Address:	Patient's Social Security Number:		
Referring Physician:	Primary Care Physician :		
Marital status: ☐ single ☐ married ☐ divorced ☐ widowed ☐ separated	Race:	Ethnicity:	Language:
Secondary Address (from:_________ to _________):	City, State, Zip	Secondary Address Phone:	

EMERGENCY CONTACT PERSON

Last Name:	First Name:	DOB:	
Home phone:	Work Phone:	Cell phone:	
Address:	City:	State:	Zip:

RESPONSIBLE PARTY (GUARANTOR) *(if different from patient)*

Guarantor's last name:	First name:	Middle name:	
Address:	City:	State:	Zip:
Guarantor's phone number:	Guarantor's Sex:	Guarantor's DOB:	Guarantor's Social Security Number:

INSURANCE INFORMATION – Provide Copy of Insurance card or fill out section

☐ Self-Pay / No Insurance ☐ Patient is the Insured Subscriber	Name of primary insurance:	Effective Date:
Primary insurance address:	Insurance Phone Number:	
Subscriber name:	Subscriber DOB:	
Patient's relation to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other, please specify:		
Subscriber Number:	Group Number:	Specialist Co-Pay Amount:
Name of secondary insurance:	Secondary insurance address:	
Subscriber Number:	Group Number:	

PHARMACY INFORMATION

Pharmacy name:	Pharmacy location (address or intersection is okay):	Pharmacy phone number :

History & Intake Form

Patient Name: ______________________________ Date of Birth: ____________________________

Today's Date: ____________________ Date of Injury (if applicable): ______________________

Briefly describe your injury/accident/problem: ____

____

____

Past Medical History (please check all that apply):

- ❑ ***NONE***
- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Hyperlipidemia
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ Other__________________

Past Surgical History (please check all that apply):

- ❑ ***NONE***
- ☐ Appendix (Appendectomy)
- ☐ Breast: Mastectomy
  ○Right ○Left ○Both
- ☐ Breast: Lumpectomy
  ○Right ○Left ○Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA (Stents)
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsilectomy
- ☐ Hysterectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ Other__________________

Past Orthopedic History (please check all that apply):

- ❑ ***NONE***
- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Handedness -
  ○Right ○Left
  ○Ambidextrous
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ Other__________________

Past Orthopedic Surgery (please check all that apply):

- ❑ ***NONE***
- ☐ Achilles Tendon Repair
  ○Right ○Left ○Both
- ☐ ACL Reconstruction
  ○Right ○Left ○Both
- ☐ Ankle Fracture ORIF
  ○Right ○Left ○Both
- ☐ Bunion Correction
  ○Right ○Left ○Both
- ☐ Carpal Tunnel Decompression
  ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF
  ○Right ○Left ○Both
- ☐ Ganglion Cyst Excision
- ☐ Intermedullary Nailing Femur
  ○Right ○Left ○Both
- ☐ Intermedullary Nailing Tibia
  ○Right ○Left ○Both
- ☐ Joint Replacement: Hip
  ○Right ○Left ○Both
- ☐ Joint Replacement: Knee
  ○Right ○Left ○Both
- ☐ Joint Replacement: Shoulder
  ○Right ○Left ○Both
- ☐ Knee Arthroscopy
  ○Right ○Left ○Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
  ○Right ○Left ○Both
- ☐ Reverse Total Shoulder Replacement
  ○Right ○Left ○Both
- ☐ Revision of Total Knee Arthroplasty
  ○Right ○Left ○Both
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ ○Right ○Left ○Both
- ☐ Rotator Cuff Repair
  ○Right ○Left ○Both
- ☐ Shoulder Arthroscopy
- ☐ ○Right ○Left ○Both
- ☐ Trigger Finger Release
  Location: ______________________________
- ☐ Other__________________________________

LIST OF CURRENT MEDICINES

Medication (Brand or generic Name)	Dose	How and how often you take the medicine	Reason for taking	Date started	Date stopped	Doctor Name
Example: Lisinopril	10mg	Oral - Once a day	High blood pressure	01/10/15		Dr. Smith

List all tablets, patches, inhalers, drops, liquids, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, nitroglycerin).

Allergies (please list all known allergies or check option which applies):

☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Social History (please check all that apply)

Cigarette Smoking **(MUST ANSWER)**
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Vaccination Status

Pneumonia Vaccine - Have you received a pneumonia vaccination? ○Yes ○No

Flu Vaccine – Have you had the Flu Vaccine within the last year? ○Yes ○No

Advance Care

Do you have a health care proxy in the event you are unable to make your own medical decisions? ○Yes ○No

Designee's Name ________________________________ Designee's Phone # ____________________

Do you have a living will? ○Yes ○No

Which statement best reflects your wishes on advanced care recommendations?

○ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

○ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

○ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Family History (please inform us of your family members' medical history by marking the appropriate box)

☐ **No Family History** (checking this box indicates no past family medical history)

	Mother	**Father**	**Sister**	**Brother**	**Daughter**	**Son**	**Other:**
Cancer							
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
Ischemic Heart Disease							

Review of Systems* (Are you currently experiencing any of the following):

Musculoskeletal:

No complaints ❑

Joint Pains	❑ Yes	❑ No
Joint Swelling	❑ Yes	❑ No
Joint Stiffness	❑ Yes	❑ No

Psychology:

No complaints ❑

Generally Satisfied with Life	❑ Yes	❑ No
Suicidal Ideation	❑ Yes	❑ No

Neurology:

No complaints ❑

Tremor	❑ Yes	❑ No
Dizziness	❑ Yes	❑ No
Tingling numbness	❑ Yes	❑ No

Constitutional:

No complaints ❑

Fever	❑ Yes	❑ No
Chills	❑ Yes	❑ No
Headache	❑ Yes	❑ No

Ophthalmology:

No complaints ❑

Blurring of vision	❑ Yes	❑ No
Double vision	❑ Yes	❑ No
Pain	❑ Yes	❑ No

Allergy:

No complaints ❑

Hay fever	❑ Yes	❑ No
Drug allergies	❑ Yes	❑ No

Endocrinology:

No complaints ❑

Excessive thirst	❑ Yes	❑ No
Heat intolerance	❑ Yes	❑ No
Cold intolerance	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No

Gastroenterology:

No complaints ❑

Abdominal pain	❑ Yes	❑ No
Nausea	❑ Yes	❑ No
Vomiting	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No

Cardiology:

No complaints ❑

Chest pain	❑ Yes	❑ No
Varicose veins	❑ Yes	❑ No
High blood pressure	❑ Yes	❑ No

Dermatology:

No complaints ❑

Rash	❑ Yes	❑ No
Boils	❑ Yes	❑ No
Itch	❑ Yes	❑ No

ENT:

No complaints ❑

Ear infection	❑ Yes	❑ No
Sore throat	❑ Yes	❑ No
Sinus problem	❑ Yes	❑ No

Urology:

No complaints ❑

Urine retention	❑ Yes	❑ No
Painful urination	❑ Yes	❑ No
Frequent urination	❑ Yes	❑ No

Respiratory:

No complaints ❑

Wheezing	❑ Yes	❑ No
Cough	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No

Hematology/Lymph:

No complaints ❑

Swollen glands	❑ Yes	❑ No
Blood clotting problems	❑ Yes	❑ No

Patient Name: ____ Date: ____________

This information is true and correct to the best of my belief.

Patient Signature: _____________________________________

Provider Signature: ____________________________________ Date: ____________

Alerts* (check yes or no for the following):

Alert	Yes	No
Allergy to Latex		
Under Pain Management Contract		
Pacemaker		
Deaf / Hard of hearing		
Blind		
Spinal Cord Stimulator		

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Consent to Obtain Patient Medication History

Patient medication history is a list of prescription medicines that our practice providers, or other providers, have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system (EHR/EMR) and becomes part of your personal medical record. Medication history is very important in helping healthcare providers treat your symptoms and/or illness properly and in avoiding potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to insure that your recorded medication history is 100% accurate. Some pharmacies do not make drug history information available, and your drug history might not include drugs purchased without using your health insurance. Also over-the-counter drugs, supplements, or herbal remedies that patients take on their own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

____ ________________

Patient/Parent/Guardian Signature Date

By signing this consent form you are giving your healthcare provider permission to collect and giving your pharmacy and your health insurer permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

NEUROSCIENCE & SPINE ASSOCIATES, P.L.

PATIENT FINANCIAL POLICY

As health care providers we are committed to providing our patients with the best medical care possible. As a business, we are committed to providing a streamlined fiscal process that allows our patients to clearly understand their financial responsibility. Our Business Office is committed to providing outstanding customer service for all financial questions, and our professional staff members are experts working with commercial insurance companies, Medicare, and Workers' Compensation.

Identification
- Proper identification must be presented prior to service being rendered.
- Current insurance cards must be presented prior to service being rendered.

Commercial Health Insurance
- Co-Payments
  - Insurance companies require that co-payments are collected prior to service.
- Co-Insurance/Deductibles
  - New co-insurance or deductible amounts will be billed after the date of service.
  - These amounts can only be calculated after your appointment.
- Non-Participating Insurance
  - NASA does not contract with every insurance company.
  - Patients are responsible for asking if NASA is a participating provider with their insurance company.
  - NASA will bill non-participating insurances. However, outstanding balances are the responsibility of the patient.
- Secondary Insurance – as a courtesy NASA will file to your secondary insurance carrier one time.

Medicare
- NASA will submit claims to Medicare, however you may need to sign an ABN form for non-covered services.
- NASA will submit to Medicare as your secondary insurance carrier one time.

Workers' Compensation
- Patients are financially responsible for medical services related to Worker's Comp.
- Patients will supply WC contact information prior to services being rendered.

Motor Vehicle/Third Party Liability
- Patients are financially responsible for medical services related to motor vehicle accidents.
- Patients shall supply auto insurance, third party, and/or attorney information as requested by NASA.

Self-Pay
- Self-pay account exist if patient has no insurance coverage.
- Full payment is due at the time of service for all self-pay patients

Statements/Payments
- Statements
  - Statements are sent to patients on a monthly basis and will show outstanding balances.
  - After insurance pays, patients are responsible for all outstanding balances.
- Payment Methods
  - We accept all major credit cards, checks, money orders, and cash.
  - Low interest payment plans are available. Patients need to discuss options with the Customer Service Representative.
- Returned Check Fees – a fee of $25.00 will be charged for all returned checks.
- **Durable Medical Products (DME) purchased in our office are non-refundable.**

I hereby assign, to Neuroscience & Spine Associates, payment of medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine my benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by my insurance policy, as well as any co-payments or co-insurance.

Printed Name: ______________________________

Signature: ______________________________

Date: ______________________________

MRI WRITTEN NOTICE

Today's Date: ___________________________________

Patient's Name:__________________________________

DOB: ____

We appreciate the opportunity to provide you with a wide variety of medical treatment and care. This includes offering state of the art **Magnetic Resonance Imaging (MRI)** at our own Neuroscience and Spine Associates, P.L. (NASA) MRI Center. The NASA MRI Center is owned by the physician owners/members of Neuroscience and Spine Associates, P.L. By using our own facility, we can quickly and easily schedule your appointment. More importantly, we can rely on the quality of the work performed.

New Federal Legislation (Section 6003 of the Patient Protection and Affordable Care Act), requires us to provide you with options to get the MRI ordered by your NASA doctor. Other local facilities that can provide you with the MRI's ordered are:

Fort Myers Locations

1. Summerlin Imaging – 20 Barkley Circle Suite 104
   Fort Myers, FL 33907
2. A1 Imaging – 1003 Del Prado Suite 103
   Cape Coral, FL 33990
3. Florida Radiology Consultants – 6311 South Point Blvd, Suite 600
   Fort Myers, FL 33919
4. Advanced Radiology: 2721 Del Prado Blvd S. Cape Coral, FL 33904
5. Radiology Regional: 6140 Winkler Rd. Fort Myers, FL 33919

Naples Locations

1. NDIC: 1715 Medical Blvd Naples, FL 34110
2. Proscan: 1020 Crosspointe Dr Ste 103, Naples FL, 34109
3. Partners Imaging: 730 Goodlette Road North Suite 101, Naples, FL 34102
4. Stand up MRI of SW Fl : 4521 Executive Drive suite 104 Naples, FL 34119

The facilities listed above are not exhaustive of all local facilities that are available to perform the diagnostic testing; to obtain further possible locations we recommend that you consult the area phone directory.

Neuroscience and Spine Associates P.L. has no financial interest in any of these other facilities. Further, we cannot assist you in scheduling or conducting the MRI study or ensure the quality of those studies. We cannot recommend or "vouch for" one facility over another. The choice of facility at which to have your study is entirely your own. If you have any questions about this written notice, or about your healthcare, please feel free to discuss them with us.

_______________________________ Patient Signature

_______________________________ Date

_______________________________ Print Patient Name

____

_______________________________ Patient Telephone Number

_______________________________ Patient e-mail address

PLEASE FAX BACK TO: (NASA Location)_____________________ FAX#_____________________

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003
Revised March/26/2013

Neuroscience and Spine Associates, P.L.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent**, **authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

HIPAA

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Kelley Sharon	239-631-7166	ksharon@nasamri.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Notice of Privacy Practices

I understand that Neuroscience & Spine Associates, PL reserves the right to modify the privacy practices outlined in the notice in order to remain compliant with Federal Law changes.

____

Signature

❑ I have received a copy of the notice of privacy practices for Neuroscience & Spine Associates, PL

____

Name of Patient (Print or Type)

____ ______________________

Signature of Patient Date

____ ______________________

Signature of Patient Representative Date

(Required if the patient is a minor or an adult who is unable to sign this form)

____

Relationship of Patient Representative to Patient