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: _____

_____

_____

Height: _____ Weight: _____

Past Medical History (please check all that apply):

- ❑ ***NONE***
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign prostatic hyperplasia
- ☐ Bipolar Disorder
- ☐ Cerebrovascular accident
- ☐ Chronic anaemia
- ☐ Chronic Obstructive lung disease
- ☐ Chronic Pain
- ☐ Coronary arteriosclerosis
- ☐ Deep vein thrombosis
- ☐ Depressive disorder
- ☐ Diabetic on insulin
- ☐ End Stage renal disease
- ☐ Epilepsy
- ☐ Essential hypertension
- ☐ Gastroesophageal reflux disease
- ☐ H/O: Hypertension
- ☐ H/O: Primary hyperparathyroidism
- ☐ History of radiation therapy
- ☐ HIV Infection
- ☐ Hypercholesterolemia
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Inflammatory disease of liver
- ☐ Ischaemic heart disease
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of colon
- ☐ Malignant tumor of prostate
- ☐ Morbid obesity
- ☐ Multiple Myeloma
- ☐ Obesity
- ☐ Obstructive sleep apnea syndrome
- ☐ Primary fibromyalgia syndrome
- ☐ Pulmonary embolism
- ☐ Rheumatoid Arthritis
- ☐ Type 2 diabetes mellitus
- ☐ Other_____

Past Surgical History (please check all that apply):

- ❑ ***NONE***
- ☐ Abdominoperineal resection
- ☐ Bypass of stomach
- ☐ Caesarean hysterectomy
- ☐ Coronary artery bypass graft
- ☐ Entire transplanted kidney
- ☐ Excision of basal cell carcinoma
- ☐ Excision of melanoma
- ☐ Excision of squamous cell carcinoma
- ☐ H/O: colostomy
- ☐ H/O: tubal ligation
- ☐ History of appendectomy
- ☐ History of bilateral mastectomy
- ☐ History of cholecystectomy
- ☐ History of colectomy
- ☐ History of liver excision
- ☐ History of percutaneous transluminal coronary angioplasty
- ☐ History of tissue graft heart valve replacement
- ☐ History of transurethral prostatectomy
- ☐ Hysterectomy
- ☐ Low anterior resection of rectum
- ☐ Lumpectomy of breast
- ☐ Lumpectomy of left breast
- ☐ Lumpectomy of right breast
- ☐ Mastectomy of left breast
- ☐ Mastectomy of right breast
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Pancreatectomy
- ☐ Percutaneous extraction of kidney stone with fragmentation procedure
- ☐ Portosystemic shunt operation
- ☐ Prostatectomy
- ☐ Surgical biopsy of skin
- ☐ Tonsillectomy
- ☐ Total hysterectomy
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other_____

Past Orthopedic History (please check all that apply):

- ❑ ***NONE***
- ☐ Acute poliomyelitis
- ☐ Adhesive capsulitis of shoulder
- ☐ Ambidextrous
- ☐ Ankylosing spondylitis
- ☐ Bursitis
- ☐ Carpal tunnel syndrome
- ☐ Chronic low back pain
- ☐ Complex regional pain syndrome
- ☐ Compression fracture of vertebral column
- ☐ Disseminated idiopathic skeletal hyperostosis
- ☐ Epidural steroid injection
- ☐ Fracture at wrist and/or hand level
- ☐ Fracture of ankle
- ☐ Fracture of bone
- ☐ Fracture of distal end of radius
- ☐ Fracture of vertebral column
- ☐ H/O: hip fracture
- ☐ H/O: rheumatoid arthritis
- ☐ History of osteoporosis
- ☐ Idiopathic scoliosis
- ☐ Impingement syndrome of shoulder region
- ☐ Left handed
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Primary gout
- ☐ Prolapsed cervical intervertebral disc
- ☐ Prolapsed lumbar intervertebral disc
- ☐ Psoriasis with arthropathy
- ☐ Rickets
- ☐ Right handed
- ☐ Sarcoma of bone
- ☐ Sarcoma of soft tissue
- ☐ Sciatica
- ☐ Secondary malignant neoplasm of bone
- ☐ Spinal stenosis in cervical region
- ☐ Spinal stenosis of lumbar region
- ☐ Vitamin D deficiency
- ☐ Other_____

Past Orthopedic Surgery (please check all that apply):

- ❑ ***NONE***
- ☐ Arthroplasty of left shoulder
- ☐ Arthroplasty of right shoulder
- ☐ Arthroplasty of the carpometacarpal joint of thumb
- ☐ Bilateral replacement of knee joints
- ☐ Decompression of lumbar spine
- ☐ Decompression of median nerve
- ☐ Diagnostic arthroscopy of shoulder joint
- ☐ Excision of bunion
- ☐ Excision of ganglion cyst
- ☐ Exploratory lumbar laminectomy
- ☐ History of arthroplasty of left knee
- ☐ History of arthroplasty of right knee
- ☐ History of arthroscopy of knee joint
- ☐ H/O: repair of musculotendinous cuff of shoulder
- ☐ Intramedullary nailing of femur
- ☐ Intramedullary nailing of tibia
- ☐ Kyphoplasty of fracture of spine using fluoroscopic guidance
- ☐ Lumbar spinal fusion
- ☐ Open reduction of fracture of radius with internal fixation
- ☐ Osteotomy and discectomy of cervical spine by anterior approach
- ☐ Primary posterior decompression lumbar spine and fusion
- ☐ Prosthetic arthroplasty of bilateral hips
- ☐ Prosthetic arthroplasty of left hip
- ☐ Prosthetic arthroplasty of right hip
- ☐ Prosthetic replacement of cervical intervertebral disc
- ☐ Prosthetic replacement of lumbar intervertebral disc
- ☐ Reconstruction of anterior cruciate ligament of knee joint
- ☐ Release of trigger finger
- ☐ Repair of ankle
- ☐ Repair of meniscus
- ☐ Repair of tendon achilles
- ☐ Revision of total hip arthroplasty, both components, with autograft
- ☐ Revision of total knee arthroplasty, all components
- ☐ Revision of total prosthetic replacement of shoulder joint
- ☐ Total reverse shoulder prosthesis
- ☐ Total shoulder replacement
- ☐ 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)

Smoking Habits
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

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

Alcohol Use
How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? _____

Do you consume alcohol?
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Pneumonia Vaccine - O Yes O No Date: _____
Flu Vaccine – O Yes O No Date: _____
Mammogram - O Yes O No Date: _____
Pap smear - O Yes O No Date: _____
Colonoscopy - O Yes O No Date: _____
Any Recent Falls during past 3 months? O Yes O No

Advance Care

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

Designee's Name _____ Designee's Phone # _____

Do you have a living will? O Yes O No

Which statement best reflects your wishes on advanced care recommendations?

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

O 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.

O 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		
Allergy to NSAID		

*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.

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

MEDICAL RECORDS RELEASE / REQUEST

I, _____ DOB _____ SS# _____

(Print patient's name)

Phone: _____ Fax: _____ Email: _____

herein give permission to *Neuroscience & Spine Associates*

1660 Medical Blvd, Ste 200, Naples, FL 34110 P 239.449.7937 / F 877.793.1399

to release my records to:

Name: _____

Address: _____Phone: _____ Fax: _____

OR request my records from:

Name: _____

Address: _____Phone: _____ Fax: _____

- **A copy of the ( ) *COMPLETE MEDICAL* RECORD OR choose of the following:**

( ) Progress Notes / Consultation Reports

( ) Lab Report(s)

( ) Computed Tomography (CT or CAT) Scans

( ) X-Ray / MRI Report(s) and/or MRI Disc

( ) EEG/EMG Reports

( ) Medication List / Medication Allergies

( ) Surgical Procedures / Biopsy Report(s)

( ) Other: _____

- **For the purpose of:** Personal Use _____ Insurance _____ Continuing Care _____ Legal _____ or Other: _____

- **Please initial to allow the designated facility to disclose information protected under federal law relative to**:

_____ drug and/or alcohol treatment
_____ psychiatric care
_____ diagnosis or information specific to HIV, AIDS
_____ Sickle Cell Anemia.

- **For dates of service** *from* _____ *to* _____ OR ALL DATES_____.

- **I wish to allow the following person(s) access to my medical records.**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This authorization will expire 2 (two) years following the last date of service. After this date, Neuroscience and Spine Associates can no longer use or disclose patient records without a new authorization form.

I have read this authorization and understand what information will be used or disclosed, by Neuroscience and Spine Associates PL. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth. The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Neuroscience and Spine Associates, P.L. must receive the revocation in writing

** The patient's name, address, and patient number, if applicable.* ****** *The effective date of this authorization, and the recipients of the protected health information according to this authorization,* ****** *The patient's desire to revoke this authorization, the date of the revocation, and the patient's signature*. All revocations must be sent to:

Neuroscience and Spine Associates, P.L. Attn: Medical Records 1660 Medical Blvd. Ste. 200 Naples, FL. 34110

Revocations are not effective until received by Medical Records. I fully understand and accept the terms of this authorization.

Patient or Authorized Personal Representative: _____ **Date:**_____