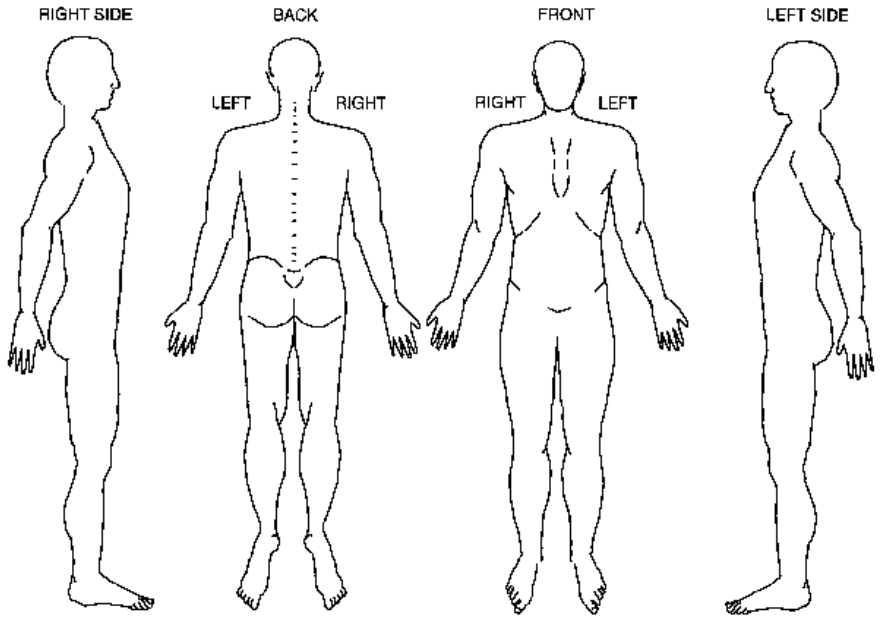
Neurospine Institute
2706 Rew Circle
Ocoee, FL 34761
407-649-8585

New Patient Health History Questionnaire

Patient Name: _____
Age: _____
Date of Birth: _____

In the diagram below please identify those areas where you currently have pain requiring evaluation during your visit.



Chief Complaint:
What is the problem you are being seen for today?
_____
When did this begin? (Month, Day, Year) _____
How did this begin? _____

Please list any injuries (including car accident, fall, lifting, etc.)

Work Related: □ Yes, □ No
Auto Related: □Yes, □ No

Medical History:
Height: _____ Average Weight: _____
If you are a woman of childbearing years, is there a possibility you may be pregnant? □ Yes, □ No

Circle any medical conditions you have been diagnosed with:

AIDS	Hepatitis	Other Blood Disease	Blood Clot
Heart Disease	High Blood Pressure	Diabetes	Thyroid Disorder
Irritable Bowel Syndrome	Ulcers	Heart Valve Condition	Lung Disease
Polio	Theumatoid Arthritis	Tuberculosis	GERD
Psychiatric Disorder	Stroke	Peripheral Artery Disease	Kidney Disease

Medications:

List all medications, diet pills, herbs or vitamins that you currently take: (Use back of form for additional space)

Name	Dose	How Often	Prescriber	Lake Taken

Allergies:

Do you have an allergy to and list the type of reaction?

☐ X-raye Dye _____ ☐ Latex _____ ☐ Tape _____

List any other ALLERGY to MEDICATIONS and reaction:

Name of Medication	Reaction

Surgical History:

Please list any surgies: (Use back of form for additional space)

Procedure	Year	Surgeon	Hospital/City

Family History:

Circle if any of your relative have ever had any of the following:

Hypertension	Tuberculosis	Diabetes	Heart Disease	Arthritis
Epilepsy / Seizure Disorder	Cancer	Psychiatric	Drug Use Problems	Alcohol Use Problems

Social History:

Employed: ☐ Full Duty, ☐ Light Duty, ☐ Disabled Most Recent Occupation: _____

Children: ☐ Yes, ☐ NoIf yes, how many/ages? _____

Do you live: ☐ Alone, ☐ With Spouse, ☐ Roommate, ☐ Assisted Living / Nursing Facility

Are you at risk for HIV/AIDS? ☐ Yes, ☐ No

Do you have a history of substance abuse? ☐ Yes, ☐ No If yes, what type? _____

Do you currently use alcohol? ☐ Yes, ☐ No If yes, how often? ☐ Rarely, ☐ Weekends, ☐ Heavy

Do you smoke or use tobacco products? ☐ Yes, ☐ No If yes, how often: ____packs per day for ____years

If you quit, when did you quit? _____

Review of Systems:

Circle any of the following symptoms that you are having:

Head, Ears, Eyes, Nose, Throat (HEENT) Difficulty hearing Ringing in ears Dizziness Sinus trouble Frequent sore throat	**Genitourinary** Frequency or urgency of urination Polyuria (excess urine output) Dysuria (painful urination) Incontinence Hematuria (blood in urine)
Gastrointestinal Nausea and/or vomiting Hematemesis (vomiting blood) Indigestion or heart burn Dysphagia (difficulty swallowing) Abdominal pain Change in Bowel movements Diarrhea Constipation or melena (black stool due to blood)	**Cardiovascular** Chest pain or discomfort Palpitations, heart trouble High blood pressure Heart murmurs Orthopnea (discomfort in breathing) Dyspnea (shortness of breath) Pedal edema Claudication (limping) or pain in legs when walking Coldness of extremities Past myocardial infarction
Respiratory Cough with sputum (color, consistency, odor, amount) Asthma with wheezing Chronic obstructive pulmonary disease Hemoptysis (spitting of blood)	**Hematologic / Lymphatic** Anemia Enlarged lymph nodes Enlarged Spleen Excess bruising or bleeding
Skin Rashes, hives or eczema with itching Bruising Jaundice Cyanosis Change in color Dryness Lumps or growths	**Musculoskeletal** Muscle or joint pain or stiffness Muscle wasting, swelling or redness Limitation of motion Arthritis Gout Backache or neck pain
Endocrine History of thyroid trouble Diabetes Heat intolerance Cold intolerance	**Constitutional Symptoms** Unusual weight change Easy fatigue
Neurological Syncope Weakness Unsteadiness of gait Paralysis Paresthesias (numbing or tingling) Loss of sensation Loss of memory Disorientation	

To my knowledge, I attest that the above information is true and accurate:

_____ _____

Patients Signature Date

Neurospine Institute
2706 Rew Circle
Ocoee, FL 34761
407-649-8585

Patient Information Questionnaire

How did you learn about our practice? ☐ Website, ☐ Referring Physician, ☐ Friend,
☐ Magazine: _____ ☐ Other: _____

PHYSICIAN REFERRING YOU TO OUR PRACTICE:

Dr. _____ Phone # _____

Address _____

PRIMARY CARE PHYSICIAN:

Dr. _____ Phone # _____

Address _____

PATIENT INFORMATION:

Last Name: _____ First Name _____

Patients Social Security # _____ Date of Birth _____

Marital Status: ☐ Married, ☐ Single, ☐ Divorced, ☐ Widowed, ☐ Separated

Race: ☐ White, ☐ Hispanic, ☐ Black or African American, ☐ Native Hawaiian, ☐ Pacific Islander, ☐ Asian,
☐ American Indian / Alaska Native, ☐ Other

Sex: ☐ Male, ☐ Female, ☐ Other Email Address: _____

Home Phone #_____ Mobile # _____

Home Address _____

City _____ State _____ Zip _____

Alternate Address _____

Pharmacy Name: _____ Address: _____ Phone: _____

EMPLOYMENT INFORMATION:
Employment Status: ☐ Full Time, ☐ Part Time, ☐ Retired, ☐ Disabled, ☐ Other: _____

Employer _____ Occupation _____

Employer Address _____

PRIMARY INSURED PERSON ON YOUR INSURANCE (GUARANTOR):

Last Name: _____ First Name _____ M.I ____

Social Security # _____ Date of Birth _____

EMERGENCY INFORMATION: (NOT LIVING IN THE SAME HOUSEHOLD)

Please Notify (Name) _____

Relationship to Patient: _____ Phone _____

Address _____

INSURANCE INFORMATION:

Is your visit today related to an auto accident? ☐ YES, ☐ NO
Is your visit today related to a work injury? ☐ YES, ☐ NO

Health Insurance Information: (Please provide card at time of visit)

Primary Insurance Company _____

I.D. # _____ Group # _____ Phone _____

Address _____

Secondary Insurance Company _____

I.D. # _____ Group # _____ Phone _____

Address _____

Workers Compensation Information

Insurance _____ Claim # _____

Claim Address _____ Date of Injury _____

Adjuster Name _____ Phone # _____

Attorney Name _____ Phone # _____

Auto Carrier Information

Insurance _____ Claim # _____

Claim Address _____ Date of Injury _____

Adjuster Name _____ Phone # _____

Attorney Name _____ Phone # _____

Conditions of Treatment

Assignment of Insurance Benefits: In the event I am entitled to benefits or other recovery of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, including but not limited to private and group health and hospitalization benefits, automobile liability, general liability, personal injury protection, medical payment and uninsured and underinsured medical benefits, such benefits or recovery are hereby assigned directly to Neurospine Institute for application to the patient's bill, and I authorize direct payment to the Neurospine Institute of such benefits or recovery. I acknowledge that Section 817.234, Florida Statutes, provided that "any person who knowingly and with intent to injury, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

Authorization to Release Confidential Information: I hereby authorize the Neurospine Institute and it's physicians and employees, to release all or part of the patient's records to any person or entity that is or may be liable for any of the Neurospine Institute's charges, including but not limited to public or private health insurers, managed care organizations, worker's compensation carriers and other third party payers, for the purpose of securing payment of any charges by Neurospine Institute for services rendered or otherwise. The information to be released includes all information in the patient's record including where applicable, information about HIV testing and results, psychiatric treatment, and treatment for drug and alcohol abuse, unless specific instructions are given particular information below.

I request that the Neurospine Institute without the following information from release:

_____

I understand that if I do not authorize release of this information for the purpose of securing payment, I will be billed directly for the Neurospine Institute's charges. The authorization will remain in effect until the Neurospine Institute bas been paid or settled, and may be revoked prior to that time, except to the extent that action has already been taken in reliance on it. Patients with implantable devices authorize the release of their Social Security number to the device manufacturer to comply with the Safe Medical Devices Act.

Patient / Guarantor Agreement: Whether I sign as agent/representative or patient, in consideration of the services to be rendered to patient, I hereby individually obligate myself to pay and unconditionally guarantee payment to the Neurospine Institute of patient's co-payments, deductible and non-covered charges, in accordance with the regulate rate of the physicians of the Neurospine Institute or any of it's allied health stage, or such other rates and terms as are applicable to patient's account(s) by contract or regulation. Should any portions of the patient's account be referred to an attorney for collection, I agree to pay all expenses of collection, including reasonable attorney's fees whether suit is filed or not. For purposed of this agreement, non-covered charges are those charges not covered by a third party payer for any reason.

Consent for Evaluation and Treatment: The patient hereby consents to any evaluation and treatment the assigned physician of the Institute may deem necessary to the patient named above.

Assignment of Medicare Benefits: Patient Certification, Authorization to Release Information. I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or is intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the Neurospine Institute or authorize the physician or the Neurospine Institute to submit a claim to Medicare for payment to me. I understand that I am responsible for any applicable deductible and co-insurance, and non-covered services, including personal charges.

Execution of my signature below authorizes and agrees with all conditions above:

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Guardian, and/or Responsible Party Date

Neurospine Institute
2706 Rew Circle
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407-649-8585

HIPAA Authorization for Release of Information to Family and/or Friends

Name of Patient: _____

Date of Birth: _____

Neurospine Institute is authorized to release protected health information about the above named patient in the following manner:

_____ Leave information on voicemail at: □ Home, □ Work, □ Cell Phone

_____ Give information to spouse Spouse Name: _____

_____ Give information to: _____

Description of information to be released:
□ Appointment Reminders Cards
□ Medical Information
□ Financial Information
□ Information results from tests or x-rays
□ Other information as described: _____

Rights of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Neurospine Institute.

I understand that a revocation is not effective in cases where the information has already been disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attached necessary documentation)

Neurospine Institute
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407-649-8585

PATIENT CONTRACT BETWEEN NEUROSPINE INSITUTE AND PATIENTS WHO ARE PRESCRIBED CONTROLLED SUBSTANCES FOR CHRONIC PAIN

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

Patients being treated with long-term use of such substances, such as opioids (narcotic pain medicines) tranquilizers, muscle relaxants and barbiturate sedatives have some risk of developing an addictive disorder or developing or suffering a relapse of a prior addiction. The extent of this risk in not certain.

Because these drugs can be used by the patients who receive them, or by others, it is necessary to observe strict rules when they are prescribed over the long term. For this reason we require each patient receiving treatment with these medications to read and agree to the following policies.

It is agreed by you, the patient, as consideration for, and a condition of, the willingness of the physician whose signature appears below to consider prescribing or to continue prescribing controlled substance to treat your pain caused by your spinal condition.

1. All controlled substances must come from a practitioner in this office. My controlled substances will come from the physician whose signature appears below, or during his or her absence, by the covering practitioner unless specific authorization is obtained for an exception.
2. I will inform my physician of any current or past substance abuse.
3. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies, I will inform the Neurospine Institute staff. The pharmacy I am selecting is:
   Pharmacy _____ Phone_____
4. I will inform the Neurospine Institute office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.
5. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professional who provide my health care for purpose of maintaining accountability.
6. I will not allow anyone else to have, use, sell or otherwise have access to these medications.
7. I understand that tampering with a written prescription is a felony and I will not change or tamper with my doctor's written prescription.
8. I will take my medication as prescribed and I will not exceed the maximum prescribed dose.
9. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop.
10. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder.
11. I understand that these drugs may be hazardous or lethal to a person who is not tolerate to their effects, especially a child, and that I must keep them out of reach of such people for their own safety.
12. I understand that medication may not be replaced if they are lost, damaged, or stolen. If any of these situations arise that cause me to request an early refill of my medication I will be required to complete a statement explaining the circumstances. At that time a determination will be made as to whether I may receive an early refill. If I request an early refill secondary to lost, damaged or stolen prescriptions twice within a year I will possibly be discharged from the practice.
13. I understand that a prescription may be given early if the physician or the patient will be out of town when the refill is due. These prescriptions will contain instructions to the pharmacist that the prescription(s) may not be filled prior to the appropriate date.
14. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.
15. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by this physician or referral for further specialty assessment
16. I will keep my scheduled appointments in order to receive medication renewals. No refills will be given at night or on weekends.
17. I understand that any medical treatment is initially a trial, and that continued prescription is contingent on whether my physician believes that the medication usage benefits me.
18. I have been explained the risks and potential benefits of these therapies, including, but not limited to psychological addiction, physical dependence, withdrawal and over dosage.
19. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accepts all of its terms.
20. I am aware that attempting to obtain a controlled substance under false pretenses is illegal.

_____ _____

Physician Signature Date Patient Signature

_____

Patient Name (Printed)

NeuroSpine Institute
2706 Rew Circle
Ocoee, FL 34761
407-649-8585

Signature on File, Assignment of Benefits, Financial Agreement

1. MEDICARE: I request that payment of the authorized Medicare benefits be made on my behalf to NeuroSpine Institute for services furnished me by NeuroSpine Institute. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. NeuroSpine Institute accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to NeuroSpine Institute, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** NeuroSpine Institute may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to NeuroSpine Institute for reimbursement for services rendered, and (2) any health care provider for continues patient care. NeuroSpine Institute may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. HIPAA PRIVACY STATEMENT: By signing I acknowledge that NeuroSpine Institute made available to me their Privacy Policy Statement and that I had the choice to accept or deny the brochure and read it and that it is also available for download on their website. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in the process of providing treatment, seeking payment or carrying out our own health care operations. This notice contains a Patient Rights section describing your rights under the law. A copy of the current notice in effect will be posted. Each time you receive treatment or healthcare services you may request a copy of the current notice.

5. INSURANCE COVERAGE: NeuroSpine Institute contracts with most of the major health plan payers; however, I acknowledge that is my responsibility to confirm specific health plan coverage and benefit levels. Our business office is available for assistance at 407-649-8585. I understand that I am responsible to pay for any health care services for which my health plan denies coverage.

6. NON-COVERED SERVICES: I understand that NeuroSpine Institute contracts with health care plans that identify items and services, which are "covered services." Accordingly, the undersigned accepts full financial responsibility for all items or services, which are ultimately determined by the health care service, plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with NeuroSpine Institute to obtain necessary health care service plan authorizations. Payment for non-covered services is expected at time of service.

7. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by NeuroSpine Institute, I will pay my account at the time service is rendered or will make financial agreements satisfactory to NeuroSpine Institute for payment. I understand that if my account is not paid by my insurance in full within **60 days** of the date of service, I am responsible for payment in full. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to NeuroSpine Institute. If copayments and/or deductibles are designed by my insurance company or health plan, I agree to pay them to NeuroSpine Institute. *However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.*

8. **MISSED APPOINTMENTS:** NeuroSpine Institute requires 24-hour advance notice for all missed, cancelled or rescheduled appointments. Failure to notify our office will result in a **$30 fee**. Emergencies will be considered on a case-by-case basis for waiver of this fee.

Date: _____
Patient Name: _____
Patient Signature: _____
Parent or Guardian Signature (if minor): _____
Print Name: _____

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

_____

_____

2. I have the right and the **duty to confirm** that the services have already been provided.

3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.

4. The medical provider has **explained** the services to me for which payment is being claimed.

5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her **own hand**):*

Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Neurospine Institute
2706 Rew Circle
Ocoee, FL 34761
407-649-8585

Patient Information-Privacy Notice

This notice describes how your health information may be used and disclosed, and how you can get access to this information.

Read Carefully

OUR COMMITMENT

As an individual who receives health care services, we understand that you may be concerned about how your health information may be used, disclosed, created, maintained, or otherwise handled. As your health care provided, we are committed to maintaining the privacy and confidentiality of your individual health information. This notice is provided to our patients in order to comply with the HIPAA Privacy Rules pertaining to your individually identifies health information, referred to a "Protected Health Information" (PHI).

CHANGES TO THIS NOTICE

We may change our policies at any time. Changes will apply to health information that we already hold, as well as new health information that we obtain after the change. After a significant change to our policy, we will change our public notices to reflect this change and post them in the waiting area, the exam rooms, and the check out area. You may receive a current notice at any time. The effective date will be listed under the title. You will be offered a copy of the current notices each time you come in for treatment at our facility. You will also be asked to acknowledge in writing your receipt of this notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

We may use and disclose your treatment (such as sending information to another treating physician or pharmacy as part of your ongoing treatment); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our health care operations (such as comparing patient information to improve treatment methods).

In certain instances, we may use of disclose your health information without your prior authorization, such as for public health purposes, FDA regulation of products, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, worker's compensation purposes, and emergencies. We also disclose medical information when required by law such as to assist law enforcement in cases legally required and to comply with orders issues by judicial or administrative proceedings. Even in these instances, we intend to ensure that PHI is not used or disclosed unless all applicable prerequisites and preconditions set forth in the HIPAA Privacy Rules are met. In addition, where patient PHI is disclosed without the patient's verbal or written pre- approval, we shall endeavor to account for the disclosures of such PHI to the extent required by the HIPPA Privacy Rules.

We may disclose medical information to a friend or a family who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

Unless you choose to decline the information, we may contact you to tell you about healthcare alternatives of for the purposes of development, marketing, or fundraising activities. In addition, we may use of disclose your PHI for patient scheduling purposes, and we may also use or disclose incidentally to other permitted uses or disclosures.

RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to request additional restrictions on the use or disclosure of your Protected Health information; that is, restrictions beyond those otherwise required by the HIPAA Privacy Rules. This includes the right to request that your Protected Health Information (PHI) be communicated to you in a confidential manner. All requests must be in writing. Although we will act in good faith in addressing any such requests, we are not obligated to agree to additional restrictions.

You have a right to request review and obtain copies of your Protected Health Information. Under Florida law, a written consent, signed by you or your legal representative is required before we may release copies of your medical record. In addition, if you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

You have the right to request an amendment to your Protected Health Information. Your request must be in writing and give the reason for the requested amendment or correction. We can deny your request to amend a record if we did not created the information; if it is not a part of the medical information that we maintain; or if we determine that the record is accurate. You may appeal, in writing, our decision not to amend the record.

You have a right to request an accounting or list of disclosures of your Protected Health Information. We are not required to account

for the following disclosures: for treatment purposes; for disclosures to the patient of the patient's legal representative; for the purpose of notifying family members and loved ones of the patient's condition of location; for national security or intelligence purposes; for certain correctional institution and law enforcement purposes; or those disclosures occurring before the HIPAA Privacy Rules Compliance Date of April 14, 2003. The first disclosure list request in a 12-month period is free; other requests will be charged a fee as allowed by Florida law.

You have a right to obtain a paper copy of this Privacy Notice. You may request a copy at any time by contacting the office at the address below. We may also provide copies of this Privacy Notice via E-mail and/or website, as applicable, and as permitted by the HIPPA Privacy Rules.

HIPAA COMPLIANT AUTHORIZATIONS

A HIPAA complaint Authorization may be required under certain circumstances. For example, we may ask you to execute an Authorization when an employer asks us to disclosure PHI about a patient-employee; or when a family member requests to see your PHI; or for public relations/media purposes; of for the use of disclosure of patient psychotherapy notes. Should you ever be asked to execute an Authorization, it is important that you are aware of the following:

In most cases, we may not condition health care services or treatment, payment, enrollment, or eligibility on your providing an Authorization.

In some cases, we may condition our services upon receipt for you of an Authorization. For example, we may condition the provision of health care services when the health care services are solely for the purpose of creating PHI for the benefit of a third party. You always have the right to request, in writing, that an Authorization executed by you be revoked. When you revoke a prior Authorization, the revocation does not apply to actions taken in reasonable reliance on your prior Authorization.

Whenever you execute an Authorization that refers you to our Privacy Notice for more information, the applicable Privacy Notice is in the one in effect at the time of your reference.

For that reason, should we ever revise our Privacy Notice after you have executed and Authorization, the revised Notice will apply whether or not the revised Notice was in effect at the time that you executed the Authorization. HIPPA Privacy Rules do not require us to account for disclosures of your PHI that are made in accordance with an Authorization that you executed.

COMPLAINTS:

You have a right to complain about you're your Protected Health Information is handled. If you ever have questions, concerns, issues and/or complaints regarding your privacy or confidentiality rights, you may contact our Privacy Responsibility Officer at 407-649-8585 or by mail to the address listed below. In addition, should you find that we have not been attentive to your privacy, confidentiality or other rights under the HIPPA Privacy Rules, you may contact the U.S. Department of Health and Human Services Office of Civil Rights at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C., 20201; Voice Hotline Number: (800) 368-1019; Internet Address: www.hhs.gov/ocr: E-mail Address: ocrmail@hhs.gov. Under no circumstances will you be penalized or retaliated against for filing a complaint.

WRITTEN ACKNOWLEDGEMENT OF PATIENT OR PERSONAL REPRESENTATIVE OF PATIENT THAT THEY HAVE READ NEUROSPINE INSTITUTE'S PRIVACY PRACTICE PROVIDED VIA WEBSITE OR PHYSICAL ADDRESS LISTED BELOW

_____ _____

Signature of Patient/Personal Representative Social Security Number

Date _____

REQUESTS FOR COPIES OF THE NEUROSPINE INSTITUTE PRIVACY PRACTICE CAN BE MADE IN WRITING TO THE FOLLOWING ADDRESS:

Neurospine Institute
2706 Rew Circle
Ocoee, Florida 34761

NeuroSpine Institute
2706 Rew Circle
Ocoee, FL 34761
407-649-8585

Patient Information – Payment Policies

Private Insurance

Office Visits: If our physicians are participating providers for your insurance company, we will file office visit charges. **You are required to pay your co-pay when you check in for your appointment. Self-pay patients are required to pay full fee at the time of service.**

Hospital Services: As a service to our patients, we will file all of our physicians' charges for your surgery. Our Patient Account Representatives will review with you your estimated surgical charges. She will calculate what we expect your insurance company to pay and what your financial obligation to our office will be. Prior to your surgery, you are required to pay a portion of the charges not covered by your insurer. The balance will be due within 30 days of your discharge from the hospital, unless other arrangements have been made with our Billing Supervisor.
We will send you a monthly statement that will indicate if your insurance company has paid. If you receive two statements and your insurance company has not paid, it is your responsibility to contact your insurance company to see if there is a problem. If your insurance company has still not paid after three months, it then becomes your responsibility to pay the bill and wait for reimbursement from your insurer.
Usual and customary is the term that insurance companies use to indicate what they allow for procedures. Different insurance companies have completely different usual and customary allowances for procedures. This office does not base its fees on any usual and customary schedule.

Auto or Work Injuries

If you are seeing us due to an injury you had at work or due to an auto accident, please call one of our Patient Account Representatives, as your appointment must be pre-authorized by your Worker's Compensation Representative or Automobile Insurance Claims Adjuster. If your appointment is not pre-approved, your appointment may be rescheduled.

Medicare

Our physician is a Medicare Participating Provider, which means that Medicare will tell us that amount to charge for our services. Of the amount Medicare allows us to charge, Medicare will pay 80% and you (or your supplemental insurance) will pay 20%. In addition, Medicare has a yearly deductible that you will need to pay before Medicare pays. **Your co-pay (which is 20% of Medicare's allowed amount) is due at the time of your appointment unless you have a supplemental insurance policy.**

If you have a supplemental insurance policy, we will file with that secondary insurer after we receive a response from Medicare. You will receive a bill from us the month following Medicare's response. We allow 60 days from the date Medicare responds for your supplemental policy to pay. After 60 days, the balance becomes your responsibility.

Please bring your Medicare card with you so that we can copy it for our records. If your spouse is employed and has insurance covering you, or if you have other insurance that is primary over Medicare, please bring those insurance cards with you also.