SBI
THE SPINE & BRAIN
INSTITUTE

www.thespinebrain.com

Welcome New Patient

Welcome to The Spine and Brain Institute, LLC. We look forward to meeting you soon. Please take a moment to read over the following information and fill out the enclosed forms. Bring the completed forms with you to your first appointment and give them to our receptionist upon arrival. Do not mail forms in advance.
PLEASE USE BLUE OR BLACK INK ONLY. PLEASE DO NOT COMPLETE FORMS IN PENCIL.

Patient Information Forms

Please complete the health questionnaire (history & review of systems) and new patient registration (intake) forms. It is very important for our office to be familiar with your health history as well as have accurate insurance and contact information for you.

Patient Contact Authorization Form

This form gives permission for our office personnel to discuss your medical information, including but not limited to appointment dates, test results, and medication requests with other family members, friends, etc. It is your decision who to include in this authorization. We are unable to discuss any information with another person if they are not listed on this form, even if they are a spouse or child. It is not necessary to list other physicians.

Patient Privacy Statement

Our Notice of Privacy Practices provides detailed information about how we may use and disclose your protected health information. We encourage you to read this form in full before coming to your first appointment, but it is not necessary to bring the statement with you.

Testing/Radiological Studies

Be sure to bring your most recent films (MRI, CT, Myelogram, X-ray, etc.) that you have had done to your appointment. If you have not had an MRI or CT done within the last year, please contact our New Patient Department at (702) 948-9088 to make sure that what you have will be sufficient for your appointment. You may bring older films for comparison. Our doctors study your tests very carefully to determine what type of treatment is best for you. Therefore, it is very important that you bring the ACTUAL FILM and WRITTEN REPORT. If you have your results on CD, please contact our office number below prior to your appointment date to verify you will be able to see the doctor with a CD. It is best to call the radiology facility where the tests were performed at least 48 hours in advance to let them know that you will be picking up your films/reports. If you do not know where the test was done, please contact the physician that ordered the test for you to obtain this information.

Insurance

It is the patient's responsibility to be sure that any required insurance referrals or authorization from Workers Compensation carrier is received PRIOR to your appointment. Without prior proper authorization, your insurance carrier or Workers Compensation carrier will not cover your visit. If our office does not receive prior authorization for your visit, your appointment may be rescheduled to a future date. Please bring your insurance card(s) and current driver's license with you to your appointment so that copies can be made for our records. Your insurance co-payment is also due at the time of service. **You must bring your insurance card(s) and photo I.D.**

If you have any questions, please feel free to contact our office at (702) 896-0940 for the Green Valley location for Derek Duke, MD & James Forage, MD or (702) 851-0792 for the Sunset location for John Anson, MD & Michael Seiff, M.D. You may find additional information on our website at: www.thespinebrain.com.

Thank you for choosing The Spine & Brain Institute for your neurosurgical care.

The Spine and Brain Institute

Patient Information Form

Today's Date: _____

I am seeing (circle one): Dr. Duke Dr. Forage Dr. Anson Dr. Seiff

Date: _____ **Referring Doctor's Name:** _____
FIRST LAST

Patient's Name: _____
FIRST MIDDLE LAST

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Email Address: _____ May we send information here? ☐ Yes ☐ No

Employer: _____ **Occupation:** _____

Employer's Address: _____ **Work Phone:** (_____) _____

City: _____ **State:** _____ **Zip code:** _____

Race/Ethnicity: ☐ American Indian ☐ Asian ☐ African American ☐ White/Caucasian
☐ Hispanic ☐ Pacific Islander ☐ Other ☐ Do not wish to provide

Primary Language: ☐ English ☐ Spanish ☐ Other _____

GUARDIAN/PARENT INFORMATION (financially responsible, if other than patient)

Name: _____
FIRST MIDDLE LAST

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth: _____ **Age:** _____ **Social Security #:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____

Relationship to patient?: _____

Employer: _____ **Occupation:** _____

Employer's Address: _____

City: _____ **State:** _____ **Zip code:** _____

INCASE OF EMERGENCY CONTACT INFO

Name: _____ **Relationship to patient?** _____

Home Phone: (_____) _____ **Work Phone:** (_____) _____

Derek A. Duke, M.D., F.A.C.S., James S. Forage, M.D., F.A.C.S., John A. Anson, M.D., F.A.C.S., Michael E. Seiff, M.D., F.A.C.S.,

The Spine and Brain Institute

Patient Information Form

Today's Date: _____

Patient's Name: _____
FIRST MIDDLE LAST

INSURANCE INFORMATION

We will need your current insurance card and your driver's/form of identification.

Are you being seen due to an Accident or Injury? ☐ Yes ☐ No Is Yes, Date of Accident/Injury:_____

Type of Accident: ☐ Work Related ☐ Auto ☐ Other _____

Primary Insurance/Auto Insurance/ Workers' Compensation Information

Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's SS#: _____ **Insured's Employer Name:** _____

Policy/Claim #: _____ **Group #:** _____

Adjuster/Contact Name: _____ **Phone #:** (_____) _____

Secondary Insurance or Attorney Information

Insurance Company: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Insured's Name: _____ **Insured's DOB:** _____

Insured's SS#: _____ **Insured's Employer Name:** _____

Policy/Claim #: _____ **Group #:** _____

Adjuster/Contact Name: _____ **Phone #:** (_____) _____

All professional services rendered are charged to the patient. ***The patient is responsible for all fees, regardless of insurance coverage.*** *In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to Drs .Duke, Forage, Anson, and Seiff.*

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts.

The undersigned guarantees payment in full. Guarantor understands all patients including those with Medicare or other insurance, are personally responsible for the balance after the insurance company has made payment. I hereby assign and direct you to pay any surgical or medical benefits under claims submitted directly to Derek A. Duke, M.D, James S. Forage, M.D., John A. Anson, M.D., and Michael E. Seiff, M.D. I also authorize the release of any medical records or information requested by the insurance companies in connection with the above assignments. I understand that my doctor has no obligation to my attorney to furnish consult, narrative reports, or depositions. I also understand that under no circumstances, will my doctor appear as a witness in court on my behalf.

Signature of patient or responsible party: _____ **Date:** _____

SBI Staff Signature: _____ **Date:** _____

For internal use only: Patient present with ID and/or insurance card(s) Yes No

If no, reason card(s) are not presented _____

Derek A. Duke, M.D., F.A.C.S., James S. Forage, M.D., F.A.C.S., John A. Anson, M.D., F.A.C.S., Michael E. Seiff, M.D., F.A.C.S.,

SBI
THE SPINE & BRAIN
INSTITUTE

Derek Duke, M.D., F.A.C.S., James Forage, M.D., F.A.C.S., John Anson, M.D., F.A.C.S., Michael Seiff, M.D. F.A.C.S.,

Medical History

Patient Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ **Staff Only** BMI: _____ BP: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for today's visit: _____

Symptoms (specific problems): _____

How long have you had symptoms?: _____

Is your current problem a result of an accident? ☐ Yes ☐ No If yes, Date: _____

If yes, check ALL that apply:

☐ Car Accident ☐ Work Accident ☐ Other accident: _____

Social History

Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have any children? ☐ Yes ☐ No If yes, how many? _____

Do you live alone? ☐ Yes ☐ No If no, who lives with you? _____

Do you smoke? ☐ Yes, I smoke _____ packs of cigarettes per day for _____ years. ☐ No, I have never smoked.

☐ No, I quit _____ years ago. At the time, I smoked _____ packs of cigarettes per day for _____ years.

Do you drink alcohol? ☐ No ☐ No, but I used to ☐ Yes

How often did you have a drink containing alcohol in the past year? ☐ once a month or _____ times per month

How many drinks did you have on a typical day when you were drinking in the past year? _____

How often did you have six or more drinks on one occasion in the past year? _____

Are you at risk for AIDS (e.g. drug abuse, previous blood transfusion)? ☐ Yes ☐ No

If yes, please explain: _____

Family History

Family Member	Alive/Deceased	Age	Health Status/Cause of Death
Grandmother (Mother's)			
Grandfather (Mother's)			
Grandmother (Father's)			
Grandfather (Father's)			
Mother			
Father			
Sister/Brother			
Sister/Brother			

Past Medical Problems

Any major illnesses and/or injuries?

Hypertension ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Blood Clotting ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Recent Infections ☐ Yes ☐ No
Other _____

Please list surgical history and/or hospitalizations.

Surgery/Hospitalization	Year	Complications

Have you ever had problems with anesthesia? ☐ Yes ☐ No

_____

Current Medications (including over the counter medications)	Dose	Frequency

Allergies to Medications: _____

_____

Spine problems:

Have you had a trial of anti-inflammatory or muscle relaxants? ☐ Yes ☐ No

If yes, what type? _____ How long? _____

Have you had physical therapy? ☐ Yes ☐ No If yes, how long? _____

Have you had pain injections (e.g. epidural, facet or nerve block)? ☐ Yes ☐ No

If yes, when? _____ How many? _____

Which physician performed blocks? _____

Review of Systems

Have you ever had or are you currently having problems with any of the following?

Constitutional:

Fever	☐ Yes	☐ No
Weight Loss	☐ Yes	☐ No
Excessive Fatigue	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No

Eyes:

Do you wear glasses?	☐ Yes	☐ No	If yes, when was your last exam? _____
Infections	☐ Yes	☐ No	
Injuries	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No	

Ear, Nose, Throat and Mouth:

Hearing Loss	☐ Yes	☐ No	If you wear hearing aids, when was your last exam? _____
Ear Pain	☐ Yes	☐ No	
Ear Infections	☐ Yes	☐ No	
Ringing in Ears	☐ Yes	☐ No	If yes, please circle one: Left Right Both Not applicable
Balance Disturbance (e.g. Vertigo, Spinning)	☐ Yes	☐ No	
Nosebleeds	☐ Yes	☐ No	
Nasal Congestion	☐ Yes	☐ No	
Nasal Drainage	☐ Yes	☐ No	
Inability to Smell	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Sinus Headache	☐ Yes	☐ No	
Sore Throats	☐ Yes	☐ No	
Mouth Sores	☐ Yes	☐ No	

Cardiovascular:

Chest Pain/Angina	☐ Yes	☐ No	If yes, when was your last EKG? _____
High Blood Pressure	☐ Yes	☐ No	
Irregular Pulse	☐ Yes	☐ No	
Heart Murmur	☐ Yes	☐ No	
High Cholesterol	☐ Yes	☐ No	
Swelling in Feet/Hands	☐ Yes	☐ No	
Leg Pain while walking	☐ Yes	☐ No	

Respiratory:

Asthma	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Pneumonia	☐ Yes	☐ No
Lung Cancer	☐ Yes	☐ No
Bloody Sputum	☐ Yes	☐ No

When was your last Chest x-ray: _____

Review of Systems (cont.)

Have you ever had or are you currently having problems with any of the following?

Gastrointestinal:

Indigestion/Pain Eating	☐ Yes	☐ No
Nausea	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Blood in Vomit	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Abdominal Pain	☐ Yes	☐ No
Change in Bowel	☐ Yes	☐ No
Ulcers or Gastritis	☐ Yes	☐ No
Colon Cancer	☐ Yes	☐ No

Genitourinary:

Urinary Tract Infection	☐ Yes	☐ No
Painful Urination	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
Difficulty/Incontinence	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Prostate Cancer (male)	☐ Yes	☐ No
Endometriosis (female)	☐ Yes	☐ No
Uterine/Cervical Cancer	☐ Yes	☐ No

Musculoskeletal:

Arm/Leg Weakness	☐ Yes	☐ No
Back Pain	☐ Yes	☐ No
Arm/Leg Pain	☐ Yes	☐ No
Joint Pain or Swelling	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No

Please list any broken bones _____

Integumentary:

Skin Disease	☐ Yes	☐ No
Skin Cancer	☐ Yes	☐ No
Breast Pain/swelling	☐ Yes	☐ No
Nipple Discharge	☐ Yes	☐ No

When was your last mammogram? _____

Neurological:

Fainting/Black Outs	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Memory Problems	☐ Yes	☐ No
Disorientation	☐ Yes	☐ No
Trouble with Speech	☐ Yes	☐ No
Inability to Concentrate	☐ Yes	☐ No
Double/Blurred Vision	☐ Yes	☐ No
Facial Weakness	☐ Yes	☐ No
Coordination problems in arms/legs	☐ Yes	☐ No

Review of Systems (cont.)

Have you ever had or are you currently having problems with any of the following?

Psychiatric:

Anxiety	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Other Psychiatric Disorder	☐ Yes	☐ No	If yes, please list _____

Endocrine:

Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Increase in Appetite	☐ Yes	☐ No
Hormone Problems	☐ Yes	☐ No
Excessive Thirst or Urination	☐ Yes	☐ No

Hematologic/Lymphatic:

Anemia	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Bleeding Tendencies	☐ Yes	☐ No
Swollen Glands or Lymph Nodes	☐ Yes	☐ No

Allergic/Immunologic:

Food Allergies	☐ Yes	☐ No
Nasal/Inhalant Allergy	☐ Yes	☐ No
Immunologic Disorder	☐ Yes	☐ No

The above information is accurate to the best of my knowledge.

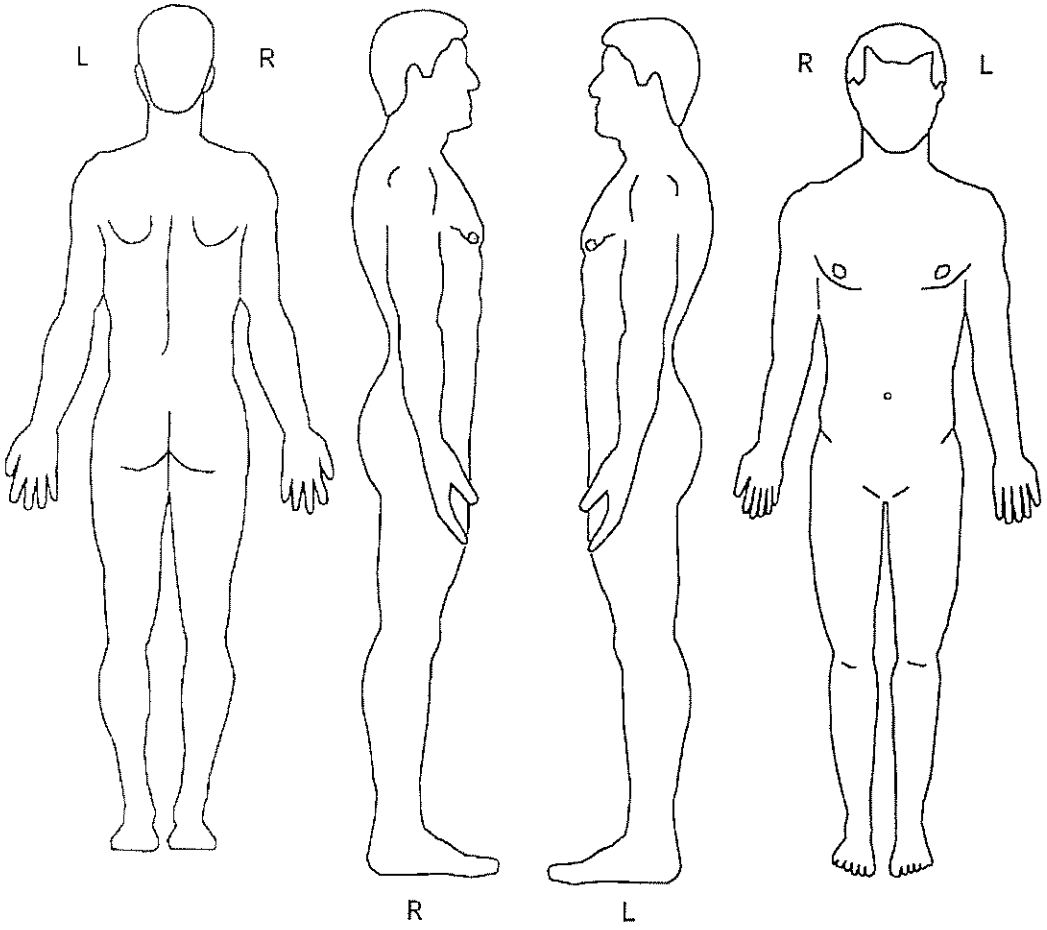
Patient's Signature: _____ **Date:** _____

PAIN DRAWING

Name: _____ Date: _____

Please be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain, and include all affected areas. You may draw in the face as well.

Numbness ----------	Pins & Needles ooooooo	Burning Pain xxxxxxxxx xxxxxxxx	Stabbing Pain ////////// //////////	Aching ((((((((((((((((



VISUAL ANALOGUE SCALE

Please mark on the line the pain level that most accurately represents your pain:

NO PAIN:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**UNBEARABLE PAIN**
a) Right Now:----	0	1	2	3	4	5	6	7	8	9	10	_____
b) Average Pain	0	1	2	3	4	5	6	7	8	9	10	_____
c) At Best ------	0	1	2	3	4	5	6	7	8	9	10	_____
d) At Worst-------	0	1	2	3	4	5	6	7	8	9	10	_____

SBI
THE SPINE & BRAIN
INSTITUTE

Controlled Substance Medication Agreement

I understand that my Physician or Physician Assistant (hereinafter to refer to as "Physician") is prescribing a controlled substance medication for pain management. This Controlled Substance Medication Agreement ("Agreement") is a tool for communication allowing us to work together in good faith and for you to understand the importance of this medication. In prescribing a controlled substance medication, we must partner with our patients to create the best treatment plan for your improvement and management of pain. This requires cooperation, trust and mutual respect. If you cannot agree with the following terms, we will be unable to prescribed controlled pain medication and the failure to continue to follow all terms will result in discontinuing the pain medication and/or dismissal from our practice.

1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my Physician.

2. I will keep regularly scheduled appointments with my Physician. There may be times when your medication will need a refill between office visits. In that occurs, please call our staff at least 5 days before your medication runs out. Refill requests will only be taken on Monday - Friday from 8 am to 5 pm. Please have your pharmacy contact the office for your refill requests. Your physician or an on-call physician will not refill any pain medications after hours or on weekends. If you have uncontrolled pain during a weekend, medical care should be sought from an emergency room or immediate care center.

3. The controlled substance pain medication prescribed is being given in order to control pain and improve function. If there are any changes to your activity level of physical condition, the treatment may be changed or discontinued. You are responsible for notifying your Physician of such changes.

4. I will be ready to taper or discontinue the controlled substance pain medication as my condition improves. If your condition does not improve, your Physician may recommend additional conservative or invasive neurosurgical procedures. **If your level pain still does not allow you to taper and discontinue the controlled substance pain medication, you will be referred to a pain management specialist for management of your pain medications.**

5. I agree to act responsibly, including protecting and limiting access to these medications, and to dispose of any unused medication in a proper manner.

6. **You are not to accept or seek controlled substance pain medication from any other physician or health care provider outside of our practice while we are prescribing pain medication, including your primary care physician** (NRS 453-391)**.** It is essential that only one physician monitor and evaluate your use of pain medication.

7. If you have another condition that requires the prescription of a controlled substance pain medication (narcotics, tranquilizers, barbiturates, or stimulants), you will be asked to coordinate all medications with that prescribing physician, including any pain medication for your neurosurgical condition.

8. It is required that you use a single pharmacy for all prescriptions (Provide pharmacy information below). You may use a chain of pharmacies with different branches, as the prescription information is available at all branches. This is required to make certain that your medications are known by a pharmacist able to evaluate any concerns about interaction of medications.

9. I understand that lost, stolen or misplaced prescriptions or pills will not be replaced. All patients are required to act responsibly with their medications. This medication is prescribed for you and only your specific pain needs. To allow other to use your pain medication is illegal and dangerous. This type of behavior will not be tolerated by your Physician or our practice.

10. I agree that I will not use any other illegal and/or recreational drug while receiving care and pain medication from this practice. Use of illegal and/or recreational drugs, especially while also taking pain medication, is extremely dangerous and potentially lethal.

11. I recognize altering a prescription in any way is against the law. Fabricating prescriptions or forging a provider's signature is also against the law. I understand The Spine and Brain Institute cooperates fully with law enforcement agencies in regards to infractions involving prescription medications. I realize if I commit this law violation it will be reported to my pharmacy, local authorities, and the Drug Enforcement Agency (DEA).

12. I agree and understand that my physician reserves the right to obtain random or unannounced prescription screening reports from the Drug Enforcement Agency (DEA). Any evidence of drug hoarding, acquisition of any controlled substances from other physicians (which includes emergency rooms), uncontrolled dose escalation or reduction, loss of prescriptions, or failure to follow the agreement may result in termination of the doctor/patient relationship.

13. You should inform your physician of all medications you are taking including herbal remedies, since Controlled substances can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone.

14. You agree to allow your physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about your care or actions, if the physician feels it is necessary.

Pharmacy Name: _____ **Phone Number:** _____

IF YOU HAVE ANY QUESTION CONCERNING OUR MEDICATION AGREEMENT OR WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF

I have read this agreement. I fully understand the consequences of violating this agreement may include cessation of therapy with controlled substances and/or discharge from The Spine and Brain Institute.

_____ _____

Print Name Patient Signature Date

_____

SBI Staff Signature Date

REQUEST FOR MEDICAL RECORDS

I hereby authorize the use or disclosure of my individually identifiable health information from:

Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

To be faxed or mailed to:

The Spine and Brain Institute

Derek A. Duke, M.D., F.A.C.S.
James S. Forage, M.D., F.A.C.S.
John Anson, M.D., F.A.C.S.
Michael Seiff, M.D., F.A.C.S.

861 Coronado Center Drive, #200
Henderson, NV 89052
P# (702) 896-0940
Fax# (702) 896-6173

8530 W. Sunset Road, #250
Las Vegas, NV 89113
P# (702) 851-0792
Fax# (702) 896-6173

By signing below, I understand that my Personal Health Information is protected by HIPAA Policies and Procedures.

Patient's Name: _____

Social Security #: _____ D.O.B.: _____

Signature: _____ Date: _____

THE SPINE AND BRAIN INSTITUTE

Patient Name: _____ D.O.B.: _____

Height:_____ Weight: _____

Do you have any implanted metal objects in your body?

No: _____ Yes: _____

Where: _____ When: _____

Do you have any vascular grafts?

No: _____ Yes: _____

Where: _____ When: _____

Do you have a pacemaker?

No: _____ Yes: _____

Are you claustrophobic?

No: _____ Yes: _____

Do you wish to be pre-medicated (sedated) for MRI scans?

No: _____ Yes: _____

How did you hear about our practice?

Physician: _____ Friend: _____ Magazine: _____

Hospital: _____ Newsletter: _____ Phone Book: _____

Patient: _____ Newspaper: _____ Internet: _____

Other: _____

DISCLOSURE OF INFORMATION

I, _____, give permission for this office to leave detailed messages on the answering service/voicemail messaging at:

□ My home (please initial) _____ □ My cellular phone (please initial) _____

DISCLOSURE OF INFORMATION TO PATIENT'S COMPANION(S)

The physicians at The Spine and Brain Institute are committed to complying with HIPAA regulations. Therefore, we require our patients to sign authorization stating that companion(s) (family members, friends, etc.) accompanying them to their appointment are approved to hear discussion regarding the patients health information.

TO BE COMPLETED BY THE PATIENT:

I authorize the following individuals to be involved in the discussion of my medical health information and relieve The Spine and Brain Institute of any responsibility for harmful neglect (release of medical health information) by my authorized companion(s):

Relationship	**Name**
_____	_____
_____	_____
_____	_____

Patient Name: _____

Patient Signature: _____ **Date:** _____

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

NOTICE OF PRIVACY POLICY

Effective July 1, 2010

The following is the privacy policy ("Privacy Policy") of The Spine and Brain Institute ("SBI") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires SBI by law to maintain the privacy of your personal health information and to provide you with notice of SBI's legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for SBI. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private SBI authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access.

If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to SBI.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the SBI or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to SBI.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer. A complaint must name the SBI that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to SBI. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer at the address, telephone number, or e-mail address listed above.

ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the *The Spine & Brain Institute's* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *The Spine & Brain Institute* and how I may obtain access to and control this information.

_____ _____

Signature of Patients or Personal Representative Date

_____ _____

Signature of Patients or Personal Representative Date

COMPLETE SECTION BELOW IF WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

_____The individual refuses to sign or otherwise fails to provide an acknowledgement

_____The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

_____ _____

The Spine & Brain Institute Representative Signature Date