The Pain, Spine, and Sports Institute

NEW PATIENT INTAKE FORM

Name: _____ **DOB:** ____/____/____ **SSN:** ____-____-_____

Age:_____**Sex:** M F **Marital Status:** S M W D **Height:** _____**Weight:** _____

Address: **City/State:** **Zip:**

Phone #: (**)** **-** **Cell #: (** **)** **-**

_____ _____

Email:_____

Occupation:_____

Referred By: _____

How did you hear about our office? Doctor / Attorney / Friend / Internet / Ad

Please circle for the following questions:

Race: White / Black / Hispanic / American Indian / Alaska Native / Asian / African American / Native Hawaiian /Other

Language: English / Spanish / Italian / French / German / Chinese / Arabic / Other

Emergency Contact:_____**Relation:**_____**Phone: (**_____**)** _____**-**_____

PCP:_____**Phone: (** **)** **-** **Address:**

Is your pain related to: Work Injury / Motor Vehicle Accident /Other: _____

INSURANCE INFORMATION

If your pain was caused by an accident please use that information as your ***primary insurance***

	Primary Insurance	**Secondary Insurance**
Company:	_____	_____
Card Holder: Name:	_____	**Name:** _____
Card Holder: DOB:	____/____/____ **SSN:** ____-____-_____	**DOB:** ____/____/____ **SSN:** ____-____-_____
Policy #	_____	_____
Group #	_____	_____

Employer: _____

Date of Accident:_____/____/_____**Claim #** _____

Attorney: _____ **Phone # ( ) - Fax # ( ) -** _____

Phone # ( ) - Fax # ( ) - _____

Adjuster: _____

MEDICAL INTAKE FORM

NAME:_____**DOB:**_____

Medication/ Supplement	Amount(Mg)	Frequency	What is it for?	Who prescribed?

Check if you have no known drug allergies

Allergy (medication, food, etc.)	Reaction

Medical History: **Past Surgeries:**

Please List Diagnoses		Please List	Date

Have you ever been diagnosed with?

Cancer **Stomach Ulcers** **Kidney Disease** **Liver Disease** **Bleeding Problem** **Depression**

Questions about Your Pain: *Please check below which of the treatments below you have had for your pain*

	Chiropractor		TENS		Epidural/Injection		Anti-inflammatory
	Physical Therapy		Brace		Surgery		Narcotic
	Acupuncture		MRI		Neurology Consult		Muscle relaxant
	MUA		CT scan		Orthopedic Consult		Antidepressant
	X-ray		EMG		Surgical Consult		Other procedure

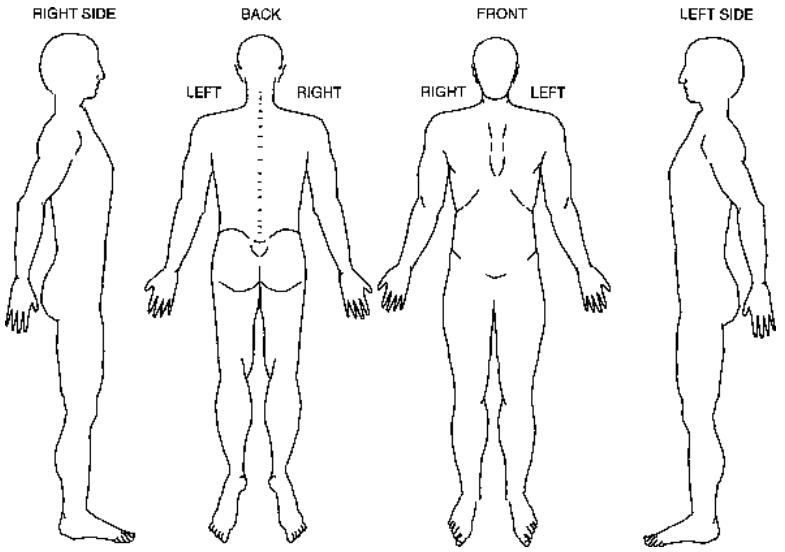
Social History: Please check if you Have/or had an addiction problem:

☐ **Drink Alcohol (or used to)** ☐ **Use Illicit drugs** ☐ **Smoke_____packs per day_____years, or used to smoke**

Do any of your family members have medical problems? Please list: High Blood Pressure, Diabetes, Cancer, Addiction

NAME:_____**DOB:**_____

INSTRUCTIONS: Please mark the areas on your body where you feel your **PAIN**. If the pain radiates, draw an arrow from where the pain starts to where it stops. Please extend the arrows as far as the pain travels.



Please *rate your pain below on a scale of 1 to 10, 10 being* the worst pain:

WORST_____**BEST**_____**NOW** _____

REVIEW OF SYMPTOMS

Please check off symptoms

	Fever		Arthritis		Heart Problems
	Headaches		Bursitis		High Blood pressure
	Sleep Loss		Foot Trouble		Heart Murmurs
	Weight Loss		'Poor Posture		Poor Circulation
	Nausea		Chronic Cough		Swelling of Ankles
	Wheezing		Spinal Curvature		Chest Pain
	Hearing Loss		Frequent Colds		Depression/ Nervousness
	Bowel/Bladder Problems		Tingling/Numbness		Hemorrhoids
	Earache		Constipation		Diarrhea
	Weakness		Frequent Urination		Difficult Breathing
	Fatigue		Inability to Control Bladder		Kidney Infection or Stones
	Bloody Stool		Fainting		Vomiting
	Sinus/Hay Fever		Painful Menstruation		Loss of Energy

	Heat/Cold Intolerance		Joint Pain/Swelling/ Stiffness		Loss of Appetite
	Dizziness		Excessive Hunger/Thirst		Loss of Consciousness
	Vision Problems		Muscle Pain/Cramps		Thyroid Problem
	Glasses/Contact Lens		Irritable		Asthma
	Sexual Dysfunction		Memory Problems		Back or Neck Pain
	Speech Problems/Hoarseness		Clumsiness		Stress (Emotional)
	Excessive Sweating		Diabetes		Seizures or Convulsions
	Swallowing Difficulties		Palpitations		Easy Bruising or Bleeding

Authorization Of Record Release

NAME:_____DOB: _____

I _____ , authorize the release of all medical records to Dr. Rehan Ali.

I understand that "all" medical information includes all of my medical information, including reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B and C testing/treatment and/or sensitive information.

If at any time you wish to revoke this authorization, please request so in writing.

Thank you.

Patient Signature:_____Date: _____

The Pain, Spine, and Sports Institute

Patient Bill of Rights

As a patient at The Pain, Spine, and Sports Institute, a New Jersey healthcare facility, you have the following rights under state law and regulations.

- **To be informed** of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical *record,* that the patient was offered a written copy of these rights. Also given a written and verbal explanation of these rights, in terms the patient could understand. The Pain, Spine, and Sports Institute shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
- **To be informed** of services available in the facility, of the names and Professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
- **To be informed** if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions and to refuse to allow their participation in the patient's treatment;
- **To receive** from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health; or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
- **To be given** informed written consent prior to the start of specified, non-emergency medical procedures or treatments. Your physician should explain to you-in words you understand-specific details about the recommended procedure or treatment, any risks involved, time required for recovery, and any reasonable medical alternatives;
- **To refuse** medication and treatment after possible consequences of this decision have been explained clearly to you, unless the situation is life threatening or the procedure is required by law. Such refusal shall be documented in the patient's medical record.
- **To expect** and receive appropriate assessment, management and treatment of pain and reasonable continuity ofcare.
- **To be included** in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, role and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
- **To obtain a copy of your medical record, at a** reasonable fee, within 30 days after a written request to The Pain, Spine, and Sports Institute.
- **To be advised in writing of** The Pain, Spine, and Sports Institute' rules regarding the conduct of patients, family members and visitors.
- **To be free from mental** and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to, protect the patient or others. Drugs and other medication shall not be used for discipline of patients or for convenience of facility personnel;
- **To confidential treatment of** information about the patient Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health facility to which the patient was transferred required the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
- **To be treated** with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient. Also to have physical privacy during medical treatment and personal hygiene functions, unless you need assistance;
- **To not be required** to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, state, and federal laws and rules;
- **To exercise civil** and religious liberties, including the right to independent personal decisions. No religious beliefs, or practices or any attendance at religious services, shall be imposed upon any patient;
- **To not be discriminated** against because of race, age, religion, sex, national origin, sexual preferences, handicap, diagnosis, ability to pay, source of payment or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility:
- **To present questions or grievances** to Dr. Rehan Ali and receive a response in a reasonable time. The Pain, Spine, and Sports Institute must provide you or your guardian with the names, addresses, and telephone numbers of the government agencies to which you can make a complaint and ask questions. Such as the New Jersey Department of Health & Senior Services. You may call the complaint hotline at (800) 792-9770.

Below is the patient and family responsibility as a patient at The Pain, Spine, and Sports Institute

1. To provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations and other issues related to his/her health.
2. To make it known whether he/she clearly comprehends the course of his/her medical treatment and what is expected of him/her.
3. To follow the treatment plan established by the provider, including the instructions of health professionals as they carry out the physician's order.
4. To keep appointments and/or notify the clinic when he/she is unable to do so.
5. To assure that the financial obligations of his/her medical care are fulfilled as promptly as possible.
6. To follow The Pain, Spine, and Sports Institute policies and procedures.
7. To be considerate of the rights of other patients and personnel.

This Patient Bill of Rights is an abbreviated summary of the current New Jersey law and regulations governing the rights of our patients. For more complete information, consult the NJ Department of Health regulations at v.vm.state.ni.us/health regarding NJAC 8:43 G-4, or Public Law 1989 Chapter 170.

Out of Network Disclosure

Please take notice that *Dr. Rehan Ali* is **non-participating or contracted** with any insurance provider EXCEPT Medicare. Such part or all of your upcoming visit/procedure may be considered "out-of-network". You may be personally responsible for the co-payment, co-insurance, deductible, or other charges associated with such "out-of-network" services that are not covered by your insurance carrier.

Patient Signature:_____**Date:**_____

(Parent or Legal Guardian)

The Pain, Spine, and Sports Institute

NOTICE OF PRIVACY/PATIENT RIGHTS/OWNERSHIP ACKNOWLEDGEMENT

Please complete the following and check all that apply:

HIPAA DISCLOSURE AND AUTHORIZATION

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, Patient Rights and Physician Ownership, but was not able to because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us
- ☐ Other (Please specify)

Please Print Name _____

Patient Signature _____
(Parent or Legal Guardian)

I hereby acknowledge that I have been given opportunity to request materials of the Health Information Portability and Accountability Act (HIPAA)/Notice of Privacy Practice. I have received a copy of The Pain, Spine, and Sports Institute Notice of Privacy Practices. I give my permission to release information to the following individuals during my visit.

I wish to have the following restrictions to the use or disclosure of my health information:

Note: Our office reserves the right to leave messages on your answering machine regarding your appointment and/or billing issues, if our attempts to speak with you personally have failed.

I authorize my physician and/or clinical staff to disclose the following protected health information to:

Myself Only **My spouse, partner, or parent** ***(specify name)*** _____ **Other Specify:** _____

Lab Test Results **Prescriptions** **Referrals** **Diagnosis**

Check the phone number to be contacted:

Home phone # ( ) - **Cell # ( ) -** **Work phone # ( ) -**

Check your choice:

Yes, I give permission for medical information to be left on my answering system.

No, I do not want medical information left in my answering system.

STATEMENT OF FINANCIAL RESPONSIBILITY

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to The Pain, Spine, and Sports Institute of any insurance benefits otherwise payable to me or on my behalf for the services performed by PSS staff, its affiliates and subsidiaries. This Assignment of Benefits is valid for all insurance companies and programs, including Medicare.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize The Pain, Spine, and Sports Institute, it affiliates and subsidiaries to release medical information related to the procedure(s) as may be requested by third party payers in order to process payment of my claims.

CHARGES

I understand that the fees for anesthesia services are separate from the Surgery Center's facility fees and my surgeon's fees. I understand that Dr. Ali is only a network provider with Medicare. The payment by your insurance company may be based on your out-of-network benefits and the status of your deductible.

APPEAL, DOBI AND ARBITRATION

I consent to and authorize The Pain, Spine, and Sports Institute to file any appeal for payment, mediation by DOBI and arbitration by an attorney on my behalf.

CREDIT POLICY

After your procedure, a claim will be filed with your insurance carrier. You will be notified when an action by your insurance company has been taken. At all times, you are fully responsible for any and all deductible, co-pays and co- insurance. Your insurance contract is between you and the insurance company. It is your responsibility to question your insurance company about delays in payment, amount of payment and/or denial of coverage, as well as any requirements to have a second surgical opinion and pre-certifications if any funds are owed, payment will be expected within 30 days of the receipt of the notice.

If your insurance company issues payment to you, you are responsible to send The Pain, Spine, and Sports Institute the full payment along with a copy of the Explanation of Benefits that came with your insurance company check. In the event that you do not forward your insurance payment in timely manner and we are forced to utilize the services of a collection agency and/or an attorney, you will be responsible for all of the costs of collection *in* addition to the amount originally owed by you.

I HAVE READ AND UNDERSTAND THE TERMS OF THIS FINANCIAL RESPONSIBILITY STATEMENT

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

(Parent or Guardian if minor/dependent)

The Pain, Spine, and Sports Institute

ASSIGNMENT OF BENEFITS

PATIENT'S NAME: _____

I IRREVOCABLY ASSIGN TO **The Pain, Spine, and Sports Institute** ALL OF MY RIGHTS AND BENEFITS UNDER ANY INSURANCE CONTRACTS FOR PAYMENT FOR SERVICES RENDERED TO ME BY **The Pain, Spine, and Sports Institute** I IRREVOCABLY AUTHORIZE ALL INFORMATION REGARDING MY BENEFITS UNDER ANY INSURANCE POLICY RELATING TO ANY CLAIM BY **The Pain, Spine, and Sports Institute** TO BE RELEASED TO **The Pain, Spine, and Sports Institute** I IRREVOCABLY AUTHORIZE **The Pain, Spine, and Sports Institute** TO FILE INSURANCE CLAIMS ON MY BEHALF FOR SERVICES RENDERED TO ME. I IRREVOCABLY DIRECT THAT ALL SUCH PAYMENTS GO DIRECTLY TO **The Pain, Spine, and Sports Institute** I IRREVOCABLY AUTHORIZE **The Pain, Spine, and Sports Institute** TO ACT IN MY BEHALF AND REPORT ANY SUSPECTED VIOLATIONS OF PROPER CLAIMS PRACTICES TO THE PROPER REGULATORY AUTHORITIES.

I IRREVOCABLY AUTHORIZE **The Pain, Spine, and Sports Institute** TO OBTAIN COUNSEL AND ENTER LEGAL OR OTHER ACTION ON MY BEHALF AND/OR IN MY NAME, INCLUDING THE ARBITRATION/DISPUTE RESOLUTION PROCESS, TO COLLECT SUCH SUMS DUE IT SHOULD SUMS NOT BE PAID WITHIN THE LEGALLY PRESCRIBED TIME FRAME. IN THE EVENT THAT **The Pain, Spine, and Sports Institute** ELECT TO BRING A LAWSUIT OR PETITION FOR ARBITRATION/DISPUTE RESOLUTION AGAINST THE INSURANCE CARRIER, I IRREVOCABLY ASSIGN MY RIGHTS TITLE, AND INTEREST UNDER THE MEDICAL EXPENSE BENEFITS AND/OR PIP SECTION OF ANY INSURANCE POLICY UNDER WHICH I AM ENTITLED TO PROCEED FOR BENEFITS. THIS ASSIGNMENT SHALL ALLOW AN ATTORNEY OF **The Pain, Spine, and Sports Institute's** CHOOSING TO BRING SUIT OR SUBMIT TO ARBITRATION/DISPUTE RESOLUTION THEIR CLAIM FOR ANY UNPAID BILLS FOR SERVICES RENDERED FOR INJURIES THAT I SUSTAINED IN THIS OR ANY ACCIDENT.

IN THE EVENT THAT THIS ASSIGNMENT IS HELD INVALID FOR ANY REASON, I HEREBY AUTHORIZE **THE Pain, Spine, and Sports Institute** TO APPOINT ANY ATTORNEY OF ITS CHOICE TO REPRESENT ME DIRECTLY AGAINST AN INSURER FROM WHICH I MAY COLLECT PIP BENEFITS AND TO BRING A CLAIM IN A FORUM OF IT'S CHOICE. THIS APPOINTMENT IS INTENDED ON ENABLING THE ATTORNEY TO COLLECT THE BILLS OF **The Pain, Spine, and Sports Institute** THE UNDERSIGNED PATIENT DOES HEREBY AGREE AND ACKNOWLEDGE THAT HE/SHE MAY RECEIVE BENEFIT CHECKS DIRECTLY FROM THE INSURANCE CARRIER FOR SERVICES RENDERED BY THE PROVIDER. THE UNDERSIGNED PATIENT HEREBY AGREES TO IMMEDIATELY FORWARD SAID CHECKS TO **The Pain, Spine, and Sports Institute** UPON RECEIPT OF THE SAME.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE VALID AS THE ORIGINAL. THIS ASSIGNMENT OF BENEFITS HAS BEEN EXPLAINED TO MY FULL SATISFACTION, AND I UNDERSTAND ITS NATURE AND EFFECT.

PATIENT'S SIGNATURE:_____DATE: _____

The Pain, Spine, & Sports Institute, LLC

NOTICE OF PRIVACY PRACTICE

Effective Date: 06/01/19

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.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

If you have any questions about this notice, please contact us

WHO WILL FOLLOW THIS NOTICE:

This notice describes The Pain, Spine, and Sports Institute practices and that of:

> Any health care professionals authorized to enter information into your medical chart.

> All departments and units of The Pain, Spine, and Sports Institute.

> My member of a volunteer group we allow to help you while you are in The Pain, Spine, and Sports Institute.

> All employees, staff and other The Pain, Spine, and Sports Institute personnel.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Pain, Spine, Sports Institute. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by The Pain, Spine, Sports Ins, whether made by the practice, personnel or your personal doctor. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identified you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you, and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosure we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. We may use and disclose your protected health information (PHI) to provide, coordinate, or manage your medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other The Pain, Spine, and Sports Institute personnel who are involved in taking care of you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. This includes the management or coordination of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Also your protected health information may be provided to a physician ta whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

For Payment. We will use and disclose medical information about you so that the treatment and services you receive or may receive at The Pain, Spine, and Sports Institute maybe billed to an insurance company, third party or you. For example, obtaining approval for a hospital stay may require that your relevant protected health information (PHI) be disclosed to the heath plan to obtain approval for the hospital admission.

For Health Care Operations. We may use and disclose, as needed, your protected health information (PHI) in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of Medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the front 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.

- **Appointment Reminders.** We may use and disclose your protected health information, as necessary, to contact you to remind you of your appointment.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care or Payment for your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Organs and Tissue Donation** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transportation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose medical information about you for public health activities.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections and licensure.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, warrant, summons, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process.
- **Coroners, Medical Examiners and Feral Directors.** We may release medical information to a coroner, medical examiner or funeral director as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services of the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized person or foreign heads of state or conduct special investigations.
- **Inmates.** We may release information about inmates to a correctional institution or law enforcement.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Rights to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed by another licensed health care professional chosen by the Privacy Officer will review your request and the denial. The person conducting the review will not be the person who denied your request We win comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for The Pain, Spine, and Sports Institute.

To request an amendment, your request must be made in writing and submitted to the Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if you ask us to amend information not created by us, unless the person that created the information in longer available; is not part of the information kept by the practice; is not information which you would be permitted to inspect and copy; or is accurate and complete.

Rights to an Accounting of Disclosures. You have the right to request an "account of disclosures". This is a list of the disclosure we made of medical information about you.

Rights to Request Restrictions, You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment and/or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request, if we do agree; we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Privacy Officer. In your request, you must tell us (I) what information you want to limit. (2) Whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply, for example disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical *matters in a certain* way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Office Manager. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you with to be contacted. We have the right to deny your request.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of the notice at any time. Even if you have agreed to receive this notice electronically you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, ask any front desk person.

CHANGES TO THIS NOTICE

We reserve the rights to change this notice. We reserve the right to make the revised or changed notice effect for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice.

Each time you register at our clinic for treatment or health care services as an outpatient, we will offer you a copy of the current protocol.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke-that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.