WILLIAM MUIR MD

Procedural Pain Managment & Spine Surgery

653 Town Center #210, LV, NV 89144
phone: 702.254.3020 . fax: 702.255.2620

PATIENT INFORMATION

Today's date: ____ /____ /_____

Patient Name: Last: _____ First: _____ Middle: _____

Please fill ALL contact information. If our office has confidential information that needs to be provided to you, which method of contact would you prefer?

(Please Check Mark)

☐ Home Phone: (_____)_____ ☐ Work Phone: (_____)_____Ext._____ ☐ Mobile: (_____)_____

☐ Email Address: _____

☐ Street Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: ____ /____ /_____ Age: _____ Social Security#: _____ Driver's License#/ State: _____

Marital Starus: ☐Married ☐Separated ☐Divorced ☐Widowed ☐Single Sex: ☐Male ☐Female Race: _____

Referring Physician Name: _____ Phone #: _____ Fax #: _____

Primary Care Physician: _____ Phone #: _____ Fax #: _____

Employer: _____ Employer's Phone: _____ Usual Work Hours: _____

Employer's Address: _____ City: _____ St: _____ Zip: _____

Name of Spouse (if applicable): _____ Spouse Date of Birth: _____

Spouse's Employer: _____ Employer's Phone: (_____)_____

Employer's Address: _____ City: _____ St: _____ Zip: _____

Nearest relative/ Friend (Not living with you): _____ Phone: (_____)_____

INSURANCE INFORMATION

Type of Insurance: ☐Commercial ☐Medicare ☐Medicaid ☐Champus ☐Private Pay ☐Other: _____

☐Worker's Compensation Worker's Compensation Date of Injury: ____ /____ /_____

Primary Insurance Company Name: _____ Phone: (_____)_____

Policyholder's Name: _____ Soc. Sec.#: _____ Date of Birth: ____ /____ /_____

Group#: _____ ID#: _____

Patient's relationship to the Policyholder? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance Company Name: _____ Phone: (_____)_____

Policyholder's Name: _____ Soc. Sec.#: _____ Date of Birth: ____ /____ /_____

Group#: _____ ID#: _____

Employer: _____ Employer's Phone: (_____)_____

Patient's relationship to the Policyholder? ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

ATTORNEY NAME (IF APPLICABLE)

☐ Legal Case: I Authorize release of information to the named attorney:

Attorney Name: _____ Phone: (_____)_____

Address: _____ City: _____ St: _____ Zip: _____

ASSIGNMENT AND RELEASE

REGARDLESS OF ANY INSURANCE COVERAGE I/WE MAY OR MAY NOT HAVE, IT IS MY/OUR RESPONSIBILITY TO PAY THE ENTIRE BILL. IN THE EVENT THAT THIS OFFICE NEEDS TO OBTAIN LEGAL ASSISTANCE IN COLLECTION OF ANY UNPAID BALANCE, I/WE AGREE TO PAY COLLECTION COSTS AND ATTORNEY FEES, AS ALLOWABLE BY LAW. I/WE ACKNOWLEDGE RECEIPT OF A PHOTOCOPY OF THIS AGREEMENT. I/WE HEREBY AUTHORIZE DR. WILLIAM MUIR TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I/WE AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE : _____ DATE : _____

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INITIAL VISIT QUESTIONNAIRE

DATE: _____

PLEASE PRINT NAME: _____ INSURANCE: _____

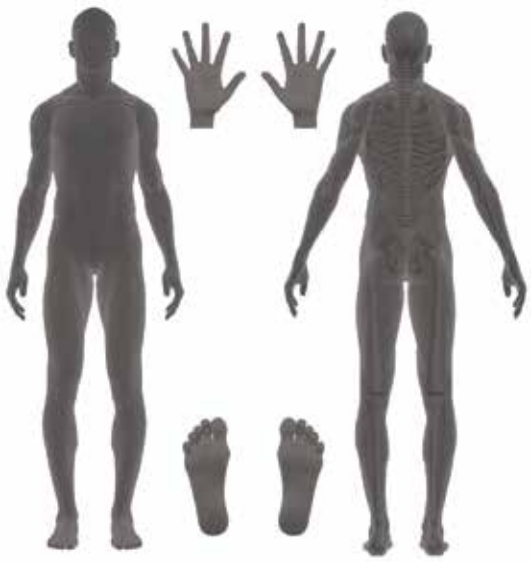
Is your case under active litigation or Workers Compensation? ☐Yes ☐No

Chief complaint? _____

When did your pain begin? _____

What caused your pain? _____

Please circle the painful area(s) on the diagram below & make dashes(//////) on any numb areas



Please circle all the following words that describe your pain:

Sharp	Shooting	Stabbing
Burning	Aching	Sickening
Throbbing	Dull	Cramping

Please circle the duration of the pain:

Brief Intermittent Continuous

Other: _____

Do you have any **weakness** or **numbness**? ☐Yes ☐No

If "Yes", please explain: _____

Does your pain radiate anywhere? ☐Yes ☐No

If"Yes", where does it radiate? _____

What makes your pain **worse**? _____

What makes your pain **better**? _____

Please circle the one number below that best describes:

1. You pain level **RIGHT NOW**?

0 1 2 3 4 5 6 7 8 9 10
NO PAIN **WORST PAIN EVER IMAGINABLE**

2. Your **AVERAGE** pain level?

0 1 2 3 4 5 6 7 8 9 10
NO PAIN **WORST PAIN EVER IMAGINABLE**

3. Your **HIGHEST** pain level in the past week?

0 1 2 3 4 5 6 7 8 9 10
NO PAIN **WORST PAIN EVER IMAGINABLE**

4. Your **LOWEST** pain level in the past week?

0 1 2 3 4 5 6 7 8 9 10
NO PAIN **WORST PAIN EVER IMAGINABLE**

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INITIAL VISIT QUESTIONNAIRE (cont.)

In what ways does your symptoms/pain limit your function? _____

_____

Circle the one number that indicates how pain interferes with the above activities?

0	1	2	3	4	5	6	7	8	9	10
DOES NOT INTERFERE										COMPLETELY INTERFERES

Are there any **PENDING/PAST** tests performed for this problem? (Circle all applicable)

X-rays CT Scan MRI

EMG & NCV (Electromyography & Nerve conduction test)

Other; Please specify: _____

None

Are there any **CURRENT/PAST** treatments you have undergone for this problem? (Circle all applicable & provide details)

Medications If yes, which meds? _____

Physical Therapy If yes, where & when? _____

Injections If yes, when & what type? _____

Surgery If yes, when & what type? _____

Chiropractic If yes, where & when? _____

Acupuncture If yes, where & when? _____

Other If yes, please specify: _____

Do you have or have you experienced any of the following? (Please circle **all** that apply)

- Recent Fevers
- Chills
- Night Sweats
- Cough
- Shortness of Breath
- COPD
- Trouble Sleeping
- Constipation
- Diarrhea
- Pain with Urination
- Urinary Retention
- Nausea
- Vomiting
- Memory Loss
- Bowel Incontinence
- GI bleeds/ulcers
- Bladder Incontinence
- Kidney Disease
- Hepatitis
- HIV/AIDS
- Seizures
- Pain in other joints/areas of the body Please specify: _____
- Heart Problems (Heart failure, arrhythmias)
- Diabetes, thyroid Dysfunction
- Significant Unintentional Weight Loss or Gain
- Skin Ulceration or Breakdown
- Bleeding/Clotting Problems, Blood Thinner Use (Ex: Coumadin, Heparin, Plavix, Pletal, Ticlid Aggrenox, Argatroban, Pradaxa, Xarelto)

Please list any psychiatric diagnoses (past & current): _____

_____

_____

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Screener and Opioid Assessment for Patients with Pain (SOAPP®)

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:
0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1.	How often do you have mood swings?	0 1 2 3 4
2.	How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4.	How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5.	How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6.	How often have you attended an AA or NA meeting?	0 1 2 3 4
7.	How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8.	How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9.	How often have your medications been lost or stolen?	0 1 2 3 4
10.	How often have others expressed concern over your use of medication?	0 1 2 3 4
11.	How often have you felt a craving for medication?	0 1 2 3 4
12.	How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14.	How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

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Using and Disclosing Protected Health Information for Involvement in the Individual's Care And Notification Purposes

As per the notice of privacy practices, William Muir MD Spine Surgery must provide the patient with an opportunity to agree or disagree to the use or disclosure of patient health information to a patient's family members, friends or acquaintances involved in their care.

This document will serve as a written agreement between _____
And William Muir MD Spine Surgery as a list of those designated by the patient as having direct involvement in the patient's care.

In the event you are unable to sign a medical release for your records, please provide us with a list to include your next of kin and/or persons names you will authorize us to release your medical records to, It will be the patient's responsibility to update as necessary.

Next of kin:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

☐YES ☐NO Per my pemission - Leave medical Information on my answering machine

I HEREBY AUTHORIZE WILLIAM MUIR MD SPINE SURGERY TO USE OR DISCLOSE MY PERSONAL HEALTH INFORMATION TO THE ABOVE MENTIONED FOR THE PURPOSE OF MY CARE OR PAYMENT RELATED TO MY CARE. THIS INFORMATION MAY ALSO BE USED FOR THE PURPOSE OF NOTIFYING, OR ASSIST IN NOTIFICATION OF (INCLUDING IDENTIFYING OR LOCATING), A FAMILY MEMBER, PERSONAL REPRESENTATIVE OR ANOTHER PERSON RESPONSIBLE FOR MY CARE, OF MY LOCATION AND/OR CONDITION.

SIGNATURE: _____ SS#: _____ DATE: _____

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HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I Authorize: _____

_____

To release my health care information to: William S Muir Spine Surgery
Name of designated Individual, Organization, or Provider

653 N. Town Center Suite 210 LV. NV 89144
Address

(702) 254 3020 - OFFICE, (702) 255 2620 - FAX

Information to be Released:		Dates of Treatment:	
X	All Medical Records	X	All Dates
	All Medical Billing Records		Specific Dates:
	X-Ray and imaging reports		

Other: _____

Purpose of disclosure: _____

1. I understand that my express consent is required to release any health care information relating to testinglciagnosis, and/or treatment for HIV (AIDS Virus), sexually transmined diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.

3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.

4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

_____ _____
Printed Name DATE

_____ _____
Signature of Patient: or Legal Representative DATE

Authorization will expire 12 months from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

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CONTRACT FOR CONTROLLED SUBSTANCE NARCOTIC PRESCRIPTIONS

I, _____ authorize and direct my Provider William Muir, M.D./or associates or assistant(s) of his/her choice to prescribe controlled substances (CS):

Like all medications, CS have potential for both benefit and harm. The purpose for this document is to outline the benefits and harms so you can determine if the prescribed medication is suitable for you at this time.

Possible Benefits: Minimized pain improved mobility and movement

Possible Risks / Side Effects: Addiction, Physical Dependence, and Tolerance

Possible Side Effects: Constipation (common & persistent), nausea and vomiting (usually only in first few days), reduced production of testosterone (may cause reduced libido and fertility in men), reduced production of estrogen & progesterone (may cause periods to stop, reduced libido & fertility in women), excessive sweating, weight gain, swollen ankles/legs, sedation, drowsiness, clouded thinking, sleep apnea, paradoxical worsening of (hypersensitivity) to pain (also known as hyperalgesia).

Addiction: is a disease that occurs in some individuals. Taking opioids does not necessarily cause addiction, however, if you have risk factors for addiction (such as a strong family history of drug or alcohol abuse) or have had problems with drugs or alcohol in the past you must notify me since using strong painkillers will put you at greater risk. The extent of this risk is not certain.

Physical dependence: abruptly stopping the CS can create withdraw symptoms.

Tolerance: The body becomes "used to" the CS and maybe less effective.

Do not use any other substances (alcohol, cocaine, marijuana or other illegal substances) while taking the prescribed CS.

Proper use, storage, and disposal of CS: Take only as directed and by the person for whom the prescription is written. Keep all CS in a safe place, with the childproof containers. Controlled substances that are expired or unused, can be taken to Las Vegas Metropolitan Police Department Substation. Disposal is anonymous and drop-off boxes are located inside substations, providing a secure method for disposal. If you are unable to get to one of the drop off locations, or if you have a small amount of medicine to dispose of, placing outdated or unneeded medications in the garbage is the best way to get rid of them.

For more information, visit the Southern Nevada Health District website:
http://southemnevadahealthdistrict.org/health-topics/medication-disposal.php

Treatment plan and alternatives discussed: The CS is prescribed in a limited quantity and has been prescribed following a visit, has been seen by a Provider and is warranted given the patient condition. There will be no refills for lost or stolen prescriptions. **Refills will not be made at night, holidays, nor weekends. YOU MUST ALLOW 3(THREE) DAYS FOR REFILL REQUESTS.** In addition to this prescription, you are recommended to pursue nonpharmacologic treatment for pain including but not limited to psychotherapy and physical therapy. Over the counter options, non-opioid analgesics, heat and cold therapy were discussed as options of care.

I will not request, nor accept CS medication from any other physician nor individual while I am receiving such medications from Dr. William Muir and associates. (Except I am a patient from the hospital)
Besides, it is illegal to do so (NRS 453.391)

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I understand that the MAIN TREATMENT GOAL is to improve my ability to function and/or work, not simply to decrease pain; in consideration of that goal and that I am being given potent narcotic pain medication to help me reach my goal. I agree to help myself by following better health habits including regular exercise, achieving optimal weight control, and limiting the use of unhealthy substances. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treannent.

I also agree that I will submit to a blood or urine test if requested by my provider to determine my compliance with my program of pain control medicine.

Risk of CS exposure to fetus of childbearing age women: Newborn abstinence syndrome if the mother took opioids/opiates during pregnancy on a routine basis.

If the patient is an unemancipated minor, the risk that the minor will abuse, misuse, or divert the CS and ways to detect those issues.

Patient Risk Assessment & Score

Mark each box that applies	Female	Male
1. Family history of substance abuse Alcohol Illegal Drugs Perscription Drugs	 ☐ 1 ☐ 2 ☐ 4	 ☐ 1 ☐ 2 ☐ 4
2. Personal history of substance abuse Alcohol Illegal Drugs Perscription Drugs	 ☐ 3 ☐ 4 ☐ 5	 ☐ 3 ☐ 4 ☐ 5
3. Age (mark box if 16-45)	☐ 1	☐ 1
4. History of preadolescent sexual abuse	☐ 3	☐ 3
5. Psychologic disease ADD, OCD, bipolar, schizophrenia Depression	 ☐ 2 ☐ 1	 ☐ 2 ☐ 1
Scoring Total:	_____	_____

Scoring (Risk)
0-3 Low Risk
4-7 Moderate Risk
≥ 8 High Risk

My signature indicates:

- I have read and understand the information provided in this form;
- My Provider has adequately explained to me the prescribing of controlled substances, along with the risks, benefits, and alternatives, and the other information described above in this form;
- I have had a chance to ask my Provider(s) questions.

Patient Name: _____ Signature: _____ Date: _____

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PATIENT CARE AGREEMENT & ACKNOWLEDGEMENT OF RECEIPT OF WILLIAM S MUIR MD SPINE SURGERY

I look forward to working with you and hope my staff and I can be successful in meeting your goals for your pain control. In striving to meet these goals, we all must adhere to certain standards.
Please initial the statements below to acknowledge your understanding.

_____William S. Muir MD staff will treat you with respect and compassion, and we recognize that your time is important. In return, we ask that you respect our time by giving us at least 48 hours notice of cancellation of appointments. Failure to do so, will incur a $50 fee for missed office visits and a fee of $500 for a missed procedure/ surgery.

_____Patient co-pays, deductibles and co-insurance amounts are due at the time of service.

_____It is our policy that a $50 fee is assessed for any returned checks.

_____ In order to avoid any unnecessary charges billed to the patient, we ask that you update us immediately with any information on changes of insurance, address, name or phone number.

_____There is a form fee that is needed to be collected prior to forms being completed.
$25.00 fee for FMLA $50.00 fee for short term disability.

_____The office tests all patients randomly as part of our prescription monitoring program. As part of your narcotics agreement you have agreed to these tests. Our facility uses a contracted out-sourced laboratory. You will be responsible for any deductibles/ co-insurances towards these tests.

I, _____ undesrstand the above and agree to abide by the policies outlined in this agreement.

SIGNATURE: _____ DATE: _____

PRIVACY NOTICE

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

This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. We must follow the privacy practices described in this Notice while it is in effect. We reserve the right to change the terms of this Notice and to make the new Notice effective for all future protected health information we maintain. We will post the most current Notice and make the new Notice available to anyone. You may request a copy of current Notice at any time. This Privacy Notice also describes your rights to access and control your "protected health information" which is health information that is created or received by your health care provider.

We may contract with business associates through the course of our operations such as those companies that process your health care claim, review insurance information, provide coding and billing services. We require the business associate sign an agreement and agree to safeguard the security and privacy of your health information.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We will use and disclose health information to provide treatment, obtain payment, and conduct health care operations.

1. **Treatment:** To provide, coordinate, and manage your health care. For example, we may disclose protected health information to physicians or other health care professionals who may be treating you or consulting with us. Examples include your physicians, anesthesia provider, or pharmacist. We may disclose information to a pharmacy to fill a prescription or to a laboratory to contact a lab test or provide specimen results.
2. **Payment:** To obtain payment for the services. This may include contact with your insurance company to get the bill paid and to determine benefits of your health plan. We may also disclose information to another provider involved in your care so the provider can get paid. For example, we may give information to anesthesia providers so they can contact your insurer about payment for their services.
3. **Operations:** To perform our own health care activities such as quality assessment and improvement, licensing or credentialing, medical record reviews, and general business administration.
4. **Other Uses and Disclosures:** To remind you of appointments or to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, or to notify family or others involved in your care concerning your location or condition. You may object to these disclosures. If you do not or cannot object, we will use our professional judgment to make reasonable assumptions about to whom we can make disclosures.
5. **Other Uses and Disclosures Permitted:** to comply with laws and regulations.
   - A. **When Legally Required** by any federal, state or local law.
   - B. **When There Are Risks to Public Health** such as:
     - To prevent, control, or report disease, injury or disability as required or permitted by law.
     - To report vital events such as birth or death as required by law.
     - To conduct public health surveillance, investigations and interventions as required by law.
     - To collect or report adverse events and product defects, track Food and Drug Administration (FDA) regulated products, enable product recalls, repairs or replacements and review.
     - To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
     - To report to an employer information about an individual who is a member of the workforce as legally permitted or required.
   - C. **To Report Suspected Abuse, Neglect Or Domestic Violence** as required by law.
   - D. **To Conduct Health Oversight Activities** such as audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensing or disciplinary actions; or other activities necessary for appropriate oversight as required or authorized by law.
   - E. **In Connection With Judicial And Administrative Proceedings** such as in the course of any judicial or administrative proceeding or in response to a subpoena we receive.
   - F. **For Law Enforcement Purposes**. Examples are:

- As required by law for reporting of certain types of wounds or other physical injuries.
- Upon court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To law enforcement if there is concern that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. For Organ Donation or to Coroners or Funeral Directors such as for organ, eye or tissue donations; identification purposes; performing other duties authorized by law.

H. For Research Purposes when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. In the Event of a Serious Threat to Health or Safety and consistent with applicable law and ethical standards of conduct, if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat. to your health or safety or to the health and safety of the public.

J. For Specified Government Functions relating to military and veterans activities, national security and intelligence activities, protective services, medical suitability determinations, correctional institutions, and law enforcement situations.

K. For Worker's Compensation to comply with worker's compensation laws or similar programs.

PATIENT RIGHTS

Uses and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member or a close personal friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved with your care concerning your location and condition. You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to that person's involvement with your care, we may disclose your protected health information.

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action based upon the authorization. At the end of this Privacy Notice is information about how to contact the Privacy Officer to request information, copies, express concerns, complain, or authorize additional uses and disclosure of your health information.

YOU HAVE THE RIGHT TO:

1. See and copy your medical records and other records used to make treatment and payment decisions about you. There are some limitations, based upon the federal law. You must submit a written request. We may charge you a fee for copying, mailing or incurring other costs in complying with your request. We may deny your request to see or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger life or safety of you or another person. Depending upon circumstances, you may have the right to request a review of this decision.

2. Request a restriction on uses and disclosures of your protected health information. You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes. Your request must state the specific restriction requested and to whom you want the restriction to apply. If you request that the Surgery Center not disclose your protected health information to your health plan for purposes of payment or healthcare operations (but not treatment) and if you are paying the full amount from your own money for your treatment, the Surgery Center must honor your requested restriction. Otherwise, the facility is not required to agree to a restriction and we will notify you if we deny your request. If the facility does agree to the requested restriction, we will abide by this agreement unless use or disclose of the information

becomes essential to provide emergency treatment. You may request a restriction by contacting the Privacy Officer.

3. **The right to request to receive confidential communications by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will not require you to provide an explanation for your request. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.
4. **The right to request we amend your protected health information.** A request for an amendment must be in writing and it must explain why the information should be amended. Under certain circumstances, we may deny your request.
5. **The right to receive an accounting of disclosures.** You have the right to request an accounting of certain disclosures for purposes other than treatment, payment or health care operations. We are not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing and specify a time period. We are not required to provide an accounting for disclosures that occurred prior to April 14, 2003 or for periods of time in excess of six years. The first accounting you request during any 12-month period will be without charge. Additional accounting requests may be subject to a reasonable fee. After January 1, 2014 (or a later date as permitted by HIPAA), the list of disclosures will include disclosures made for treatment, payment, or health care operations using an electronic health record, if we have one for you.
6. **The right to obtain a paper copy of this notice at any time.**
7. **The right to be informed in writing of a breach** where your unsecured protected health information has been accessed, acquired, used or disclosed to an unauthorized person or entity.

OUR DUTIES

The Surgery Center is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the Surgery Center changes its Notice, we will provide a copy of the revised Notice at your next visit. In the event there has been a breach of your unsecured protected health information, we will notify you.

COMPLAINTS

You have the right to express complaints to the facility if you believe that your privacy rights have been violated. We encourage you to express any concerns you have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint. You may complain to the facility's Privacy Officer in person, by phone, or in writing. You also have the right to express complaints to the Secretary of the United States Department of Health and Human Services.

CONTACT PERSON

TO MAKE REQUESTS, TO LEARN MORE, TO FILE A COMPLAINT, OR TO EXPRESS CONCERNS, PLEASE CONTACT THE PRIVACY OFFICER. YOU MAY MAKE CONTACT IN PERSON, BY PHONE, OR IN WRITING. CALL TO ASK FOR THE PRIVACY OFFICER OR SEND MAIL ADDRESSED TO THE PRIVACY OFFICER AT THE SURGERY CENTER.

SIGNATURE: _____ DATE: _____