



**8333 Cross Park Drive, Austin, TX 78754**  
(Phone) 512-494-6024 (Fax) 866-563-6244  
admin@wellnessbrainspine.com www.wellnessbrainspine.com

Welcome to Wellness Brain & Spine, the neurosurgery practice of Dr. Stanley Kim.

1. Please complete the attached New Patient Forms and return them to our office as soon as possible. Some ways to return the completed forms to us include:
  - a. Fax to 866-563-6244
  - b. Mail to **8333 Cross Park Drive, Austin, TX 78754**
  - c. Scan forms and email to admin@wellnessbrainspine.com
  - d. If you require assistance completing the forms, please call us or email us.
  - e. In order to give our staff time to build your patient chart for Dr. Kim's review, we must receive your completed paperwork in our office at least **one business day prior** to your appointment. If we do not receive your paperwork, your appointment may be rescheduled.
2. Please bring the following with you to your first appointment:
  - a. **Valid Photo ID** (Drivers license, Military ID, State issued ID or Passport).
    - i. Expired IDs are not accepted.
    - ii. Our office will not be able to bill your health insurance without a valid photo ID on file.
  - b. **Please bring the BOTTLES of ALL MEDICATIONS, VITAMINS and SUPPLEMENTS you are currently taking.**
3. Please arrive at least 15 minutes before your appointment time.

Thank you! We look forward to seeing you soon.



Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Social Security Number \_\_\_\_\_ Email \_\_\_\_\_

Do you wish to access online patient portal? Yes No

**\*For appointment reminders or scheduling changes, what is your preferred method of communication?**

Text Voicemail Other: \_\_\_\_\_

**\*For detailed medical information (e.g., imaging results and responses to your questions) we will call you by phone. If we cannot reach you, how would you like us to relay the information?**

Detailed Voicemail Web Portal Message Direct Phone Call Only Other: \_\_\_\_\_

Race \_\_\_\_\_ Primary Language \_\_\_\_\_

Ethnicity: Hispanic or Latino Non-Hispanic Decline to Specify

US Citizen? Yes No Hearing Impaired? Yes No

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact's Cell Phone \_\_\_\_\_

Emergency Contact's Home/Work Phone \_\_\_\_\_

Emergency Contact's Email \_\_\_\_\_



Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician's Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Primary Care Physician's Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Primary Health Insurance Company \_\_\_\_\_ PPO/POS \_\_\_\_\_ HMO \_\_\_\_\_

Member ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_

Patient's Relationship to Subscriber \_\_\_\_\_

**If you have a *secondary* insurance policy, please complete the following:**

Secondary Health Insurance Co. \_\_\_\_\_ PPO/POS \_\_\_\_\_ HMO \_\_\_\_\_

Member ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Subscriber's Date of Birth \_\_\_\_\_

Patient's Relationship to Subscriber \_\_\_\_\_

**\*All patients MUST provide valid identification in order for us to bill their insurance company.\***

**Please read and sign to indicate that you agree to the following:** I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician or supplier for services described in the insurance claim. I understand that my insurance plan(s) MAY NOT COVER THE TOTAL COST OF TREATMENT (Due to the nature of insurance plan or that some treatment(s) may not be considered medically necessary by the insurance company/ies) and that I AM RESPONSIBLE FOR ANY COPAYMENT, DEDUCTIBLE, COINSURANCE AND OTHER CHARGES NOT COVERED BY MY INSURANCE PLAN(S).

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



**Discussing Health Information with Other Individuals**

If you would like to grant us permission to discuss your personal health information and appointments with other individuals, please list their names and information below:

Name	DOB	Relationship	Phone
Name	DOB	Relationship	Phone
Name	DOB	Relationship	Phone
Name	DOB	Relationship	Phone
Name	DOB	Relationship	Phone
Name	DOB	Relationship	Phone

**I understand that all precautions will be taken to protect my privacy. I will notify this office in writing of any changes to this document or the associated permissions.**

\_\_\_\_\_  
**Signature of Patient or Patient’s Representative** **Date**

**Acknowledgment of Review of Notice of Office Policies,  
 Financial Policy and Privacy Practices**

I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I have read and understand the Financial Policy of WBS. I agree to the terms outlined in the policy and understand that if I do not adhere to WBS’s financial policies, I may be turned over to an attorney and/or a collection agency for payment of debt.

I have read and understand the Policies of Wellness Brain & Spine. I agree to the terms outlined and understand that these policies are subject to change without notice.

\_\_\_\_\_  
**Signature of Patient or Patient’s Representative** **Date**

\_\_\_\_\_  
**Name of Patient or Personal Representative** **Description of Personal Representative’s Authority**



## E-PRESCRIBING CONSENT FORM

ePrescribing is defined as a physician's ability to electronically send an accurate and understandable prescription directly to a pharmacy from the point of care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an ePrescribing program.

These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notifications** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

**Please provide the name and location of your preferred pharmacy:**

Pharmacy Name \_\_\_\_\_

Pharmacy Address or Closest Street Intersection \_\_\_\_\_

Pharmacy Phone \_\_\_\_\_

Pharmacy Fax \_\_\_\_\_

By signing this consent form you are agreeing that Wellness Brain & Spine (also known as Stanley H. Kim, MD PA) can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Wellness Brain & Spine (also known as Stanley H. Kim, MD PA) to enroll me in the ePrescribing Program. I have had the chance to ask questions, and all of my questions have been answered to my satisfaction.

\_\_\_\_\_  
**Print Patient Name**

\_\_\_\_\_  
**Patient Date of Birth**

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient (If different from the Patient)**



Patient Name \_\_\_\_\_

**Please complete the following questions & date and sign at the bottom.**

Do you have any of the following advanced directives?

- |                                |     |    |
|--------------------------------|-----|----|
| A) DNR 'DO NOT RESUSITATE'     | Yes | No |
| <hr/>                          |     |    |
| B) LW 'LIVING WILL'            | Yes | No |
| <hr/>                          |     |    |
| C) NAD 'NO ADVANCED DIRECTIVE' | Yes |    |
| <hr/>                          |     |    |
| D) OD 'ORGAN DONOR'            | Yes | No |
| <hr/>                          |     |    |
| E) POA 'POWER OF ATTORNEY'     | Yes | No |
| <hr/>                          |     |    |

Please provide us with a copy of any of your Advanced Directives to keep as part of your medical chart.

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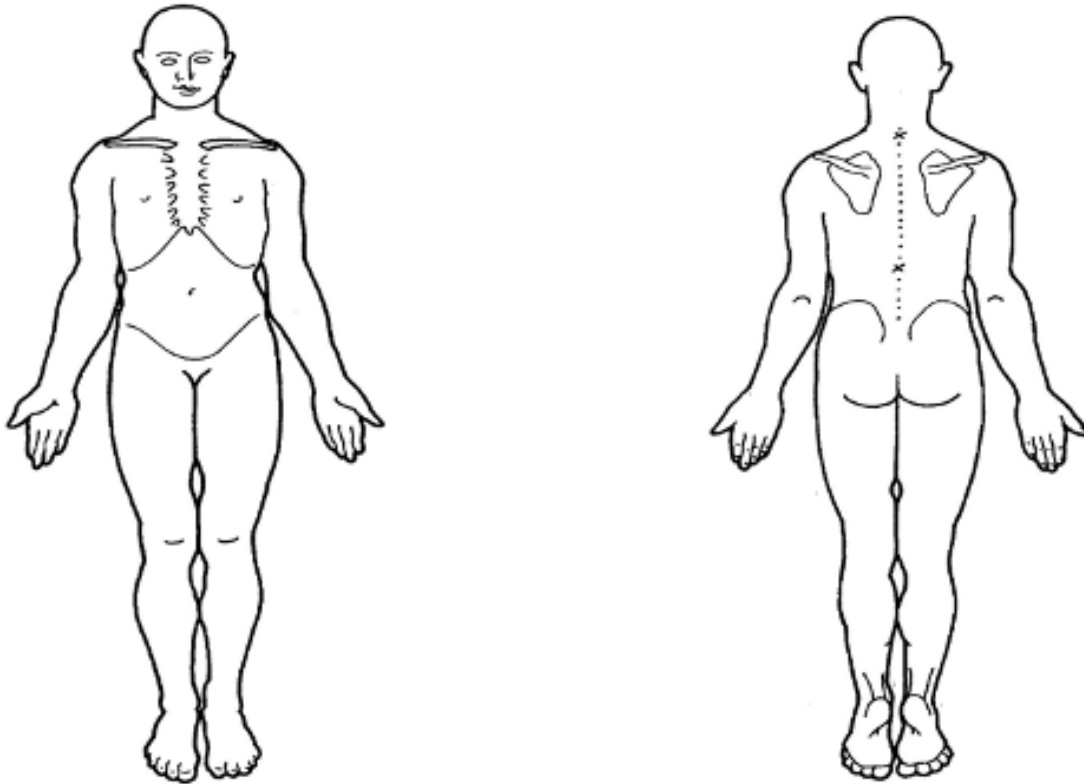
**Signature of Patient or Patient's Representative** \_\_\_\_\_ **Date** \_\_\_\_\_

Patient Name \_\_\_\_\_

Initial Visit

Follow Up Visit

**Please mark or shade the areas of your body where you feel pain on the diagrams below:**



**Next to each area marked above, please note the intensity of pain:**

- 0 = No pain
- 1-2 = Minimal pain
- 3-4 = Tolerable, but hinders activities
- 5-6 = High, 50% of activities impaired
- 7-8 = Extreme, most activities impaired
- 9-10 = Unbearable



Patient Name \_\_\_\_\_

### Review of Systems

Please Check Either Yes or No. Do Not Leave Any Blank.

#### General/Constitutional Y / N

- Change in appetite .....
- Chills .....
- Fatigue .....
- Fever .....
- Headache .....
- Lightheadedness .....
- Sleep Disturbance .....

#### Gastrointestinal Y / N

- Change in bowel habits .....
- Difficulty Swallowing .....
- Exposure to Hepatitis .....

#### Genitourinary Y / N

- Difficulty urinating .....
- Pain in lower back .....
- Incontinence .....

#### Respiratory Y / N

- Tuberculosis .....
- Chest Pain .....
- Pain with breathing .....
- Wheezing .....
- Pain with breathing .....

#### Neurologic Y / N

- Balance difficulty .....
- Coordination .....
- Difficulty speaking .....
- Fainting .....
- Gait issue .....
- Headache .....
- Irritability .....
- Loss of strength .....
- Loss of use arm/leg .....
- Low back pain .....
- Memory loss .....
- Pain .....
- Seizures .....
- Tics .....
- Tingling/numbness .....
- Tremor .....

#### Peripheral Vascular Y / N

- Absent pulse hands .....
- Absent pulse feet .....
- Cold extremities .....
- Decreased sensation .....
- Pain/cramping in legs .....
- Painful extremities .....

#### Ophthalmologic Y / N

- Near-Sighted .....
- Far-Sighted .....
- Wear Contacts .....
- Glaucoma .....
- Cataracts .....
- Double Vision .....
- Diminished Vision .....
- Floating Lights .....
- Eye Pain .....

#### Skin Y / N

- Discoloration Moles .....
- Rash .....
- Scaly lesions .....
- Skin cancer .....
- Skin lesions .....

#### Heart Y / N

- High Blood Pressure .....
- Heart Disease/Defects .....
- Pacemaker .....
- Chest Pain .....
- Chest Pain at rest .....
- Chest Pain with activity .....
- Irregular heartbeat .....
- Shortness of breath .....

#### Musculoskeletal Y / N

- Numbness Arm/Leg .....
- Tingling arm/leg .....
- Difficulty walking .....
- Muscle jerking .....
- Paralysis .....
- Shaking/Tremors .....
- Limited motion .....
- Carpal tunnel .....
- Joint stiffness .....
- Leg cramps .....
- Muscle pain .....
- Painful joints .....
- Sciatica .....

#### Allergy/Immunology Y / N

- Rash .....
- Rheumatoid Arthritis .....
- Lupus .....

#### Endocrine Y / N

- Diabetes .....
- Difficulty Sleeping .....
- Dizziness .....
- Excessive Thirst/Hunger .....
- Heat Intolerance .....
- Weakness .....

#### Hematology Y / N

- Anemia .....
- HIV Positive .....
- Night Sweats .....
- Frequent Infections .....
- Easy Bruising/Bleeding .....
- Swollen Lymph Nodes .....

#### Psychiatric Y / N

- Anxiety .....
- Hallucinations .....
- Depression .....
- Difficulty Sleeping .....
- Stressors .....

#### Ear, Nose, Throat Y / N

- Discharge from ear .....
- Nose obstruction .....
- Sore gums .....
- Dentures .....
- Prolonged hoarseness .....
- Decreased hearing .....
- Dry mouth .....
- Ear pain .....
- Hearing loss .....
- Nosebleeds .....
- Ringing in ears .....
- Sore throat .....
- Swollen glands .....

**Additional Symptoms:**

Physician Signature \_\_\_\_\_

Stanley H. Kim, MD

Date \_\_\_\_\_





Patient Name \_\_\_\_\_

**Medication List**

Please list any medications, including vitamins and herbal supplements you currently take

Name of Medication	Dose	Frequency

**Allergies**

Please list any known allergies below

Medications (i.e., Penicillin)	Environmental ( i.e. latex)



Patient Name \_\_\_\_\_

### **Medical History**

Medical Problems	Dates

Previous Surgeries	Approx. Date of Surgery	Name of Surgeon	City & State

Hospitalizations – Please List Reasons	Dates



Patient Name \_\_\_\_\_

**Family History**

Please list any family medical problems below

Paternal Grandfather
Paternal Grandmother
Maternal Grandfather
Maternal Grandmother
Siblings
Children
Father
Mother
Spouse
Maternal Uncle
Maternal Aunt
Paternal Uncle
Paternal Aunt
Daughter
Son

**1. Did you drink alcohol in the past year?**      Yes      No                 If yes, how often?  
 If yes, how many drinks did you have on a typical day when you were drinking? \_\_\_\_\_

**2. Do you use tobacco?**      Yes      No                 If yes, what year did you begin use?  
 If yes, how much per day? \_\_\_\_\_

**3. Have you used tobacco in the past?**      Yes      No                 If yes, what year did you end use?  
 If yes, what year did you begin use? \_\_\_\_\_

**4. Do you drink caffeine?**      Yes      No                 If yes, how much a day? \_\_\_\_\_

**5. Do you live alone?**      Yes      No

**6. Do you use E-cigarettes?**      Yes      No

**7. Have you had a pneumonia vaccine?**      Yes      No                 Month/Year

**8. Have you had an influenza vaccine?**      Yes      No                 Month/Year

# Wellness Brain & Spine Office and Financial Policies

## PAYMENT FOR ALL SERVICES

If you are a member of an insurance plan in which WBS participates, we will file your claims. Co-payments, co-insurances and deductibles are due at the time services are provided REGARDLESS of whether or not WBS is participating with your insurance company. Federal law requires that we collect copays at the time of service; otherwise we can be charged with fraudulent business practices. Exclusions to this policy include patients who are members of a Health Maintenance Organization (HMO).

All patients eighteen (18) years of age or older will be financially responsible for all charges incurred. WBS does not get involved with divorce or separation issues. We do not accept patients under the age of 18. WBS accepts cash, credit cards, checks, and money orders as payment for services rendered. A \$38.00 insufficient funds fee will be charged for returned checks. If you have a payment plan in effect and your credit card is declined for any reason, you will be charged a \$38.00 fee.

## COLLECTION FEES / AGENCY / ATTORNEY TERMINATION OF PATIENT CARE

We reserve the right to send only TWO (2) statements to the address on file. It is your responsibility to send the full balance within 30 days of receiving the first statement. If you do not respond within 30 days of receiving the second statement, your account to be sent to collections, and your account will be closed. WBS reserves the right to turn any patient's account over to an attorney and/or a collection agency if it is deemed that the account is in default of the payment obligations or compliance of these policies. A 35% processing fee will be added to your account balance if it is turned over to a collection agency. WBS will also terminate the doctor/patient relationship and any further medical care. Payment plans may be arranged if requested \*prior\* to your account being past due.

## APPOINTMENT CANCELLATIONS / NO-SHOWS

We make a sincere effort to adhere to our appointment schedule. However, an appointment may require extended time or an emergency may arise. We appreciate your understanding and patience when this happens. Due to the high demand for appointments with Dr. Kim, we must enforce a **2 business day** cancellation time frame. The following fees will be charged to your account if you do not give us advance notice of 2 business days:

**New Patients: FIRST VISIT TO OFFICE: LATE CANCEL / NO SHOW APPOINTMENTS:** We require advance notice of 2 business days before your scheduled appointment if you cannot keep it. This courtesy allows others to be scheduled in that time slot. A New Patient must secure their appointment with a credit card. A Late Cancel /No Show fee of \$175.00 will be charged to your credit card if the proper notice is not given. This fee must be paid in full before we can schedule another appointment. (No exceptions)

**Established Patients: SUBSEQUENT OFFICE VISITS: LATE CANCEL / NO SHOW APPOINTMENTS:** In the event that you cannot keep an appointment, we require advance notice of 2 business days. This courtesy will allow others to be scheduled in that time slot. If you do not contact us at least 2 business days before your appointment, you will be charged a \$75.00 Late Cancel / No Show Fee. If you No Show/Late Cancel more than two times, your relationship with Dr. Kim may be terminated. This fee must be paid before we can schedule another appointment. (No exceptions)

**I have read the above Appointment Cancellations/No-Shows Policy. I agree to pay the applicable fee in full before my cancelled or missed appointment is rescheduled.**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

## NEW PATIENT STATUS

You are considered a NEW PATIENT if you have not been treated by Dr. Kim in the past 3 years. Please note that Dr. Kim will be unable to order imaging, prescribe medications, or provide medical advice if you have not been treated by him for 3 or more years.

## MISCELLANEOUS PAPER WORK

**FMLA/DISABILITY PAPERWORK:** (10 business day to complete) If you request a letter or any insurance documents to be generated on your behalf, there will be a **\$25 charge per form** being completed. The fee is due at the time of the request. This is not a covered insurance benefit, and the patient is responsible for the charge.

## MEDICAL RECORDS

**PATIENT MEDICAL RECORDS REQUESTS:** (15 business day to complete with properly executed release form) If you request a copy of your medical records, there will be a **minimum \$25 charge**. Payment is due in full before records are released. This is not a covered insurance benefit, and the patient is responsible for the charge. There is no charge for faxing records directly to another treating physician's office.

## RECORDING VISITS

If you would like to record (video or audio) your visit with Dr. Kim and/or his staff, please inform Dr. Kim and the staff in the room \*prior\* to recording. Recording at WBS (in person or over the phone) without prior notification will be cause for termination of the physician/patient relationship.

## **PARKING**

Patients are welcome to park in the Wellness Brain & Spine parking lot during their appointments. Vehicles should not be left in the WBS parking lot after the appointment. Unauthorized vehicles parked at WBS will be towed at 5 pm each day at the owner's expense.

## **PRESCRIPTION & REFILLS**

**PRESCRIPTION REFILL REQUESTS: (3 business day turn around)** Please contact your pharmacy and ask them to fax a prescription refill request to our office at **866-563-6244**. Dr. Kim will approve or deny the request at that time. Please plan ahead.

## **PROHIBITION OF FIREARMS at the WBS Cross Park Drive Office**

\*Pursuant to Section 30.06, Penal Code (trespass by license holder with a concealed handgun), a person licensed under Subchapter H, Chapter 411, Government Code (handgun licensing law), may not enter this property with a concealed handgun.

\*Pursuant to Section 30.07, Penal Code (trespass by license holder with an openly carried handgun), a person licensed under Subchapter H, Chapter 411, Government Code (handgun licensing law), may not enter this property with a handgun that is carried openly.

## **NOTICE OF PRIVACY PRACTICES**

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### **1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our offices who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

**Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office:**

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing, or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

### **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object:**

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury, or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

## **2. YOUR RIGHTS**

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also 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. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

## **3. COMPLAINTS**

You may submit a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

**I HAVE READ AND UNDERSTAND THE POLICIES OF WELLNESS BRAIN & SPINE. I AGREE TO THE TERMS OUTLINED AND UNDERSTAND THAT THESE POLICIES ARE SUBJECT TO CHANGE WITHOUT NOTICE.**

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_