12180 N Mopac Suite A, Austin, TX 78758 Ph: 512-494-6024 Fax: 512-836-3903

NEW PATIENT REGISTRATION FORM

Name:____ **Social Security #:** ______ - _______ - _________

Address: ____

City: __________________________ **State:** __________________ **Zip:** ________________________

Home Phone: ____________________ **Work Phone:**___________________ **Cell Phone:** __________________

DOB: _____/_____/_____ **Age:** ________ **Marital Status: M S D W** **Sex: M F TG**

E-mail: ____

Race: _________________________ **Ethnicity:** ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Refuse To Report

Language: _____________________ **U.S. Citizen:** ☐ Yes ☐ No **Hearing Impaired?** ☐ Yes ☐ No

Employer: ____

☐ Full Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Disabled

Emergency Contact: ____________________________________ **Relationship:** _______________________

Phone: _________________________

Referred By: ____ **Phone:** _____________________

Address: ___________________________________ **City:** ____________________ **Zip:** ____________

Primary Care Physician: ____________________________________ **Phone:** ____________________

Address: ___________________________________ **City:** ____________________ **Zip:** ____________

Please give us your insurance card(s) and driver's license so we can make a copy of them for our records

If covered under your spouse's or partner's insurance, please provide the following information:

Spouse's/Partner's Name: _____________________________________ **Social Security #:** ______ - _______ - _________

DOB: _____/_____/_____ **Age:** ________ **Is insurance: Primary / Secondary / Both**

Employer: ____ **Phone:** ______________________

All patients MUST provide some form of identification

Please read and sign the following statements:

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 the insurance plan or that some treatment(s) may not be considered as medically necessary by the insurance company(s)) AND THAT I AM RESPONSIBLE FOR ANY COPAYMENT, DEDUCTIBLE, COINSURANCE AND OTHER CHARGES NOT COVERED BY MY INSURANCE PLAN(S).

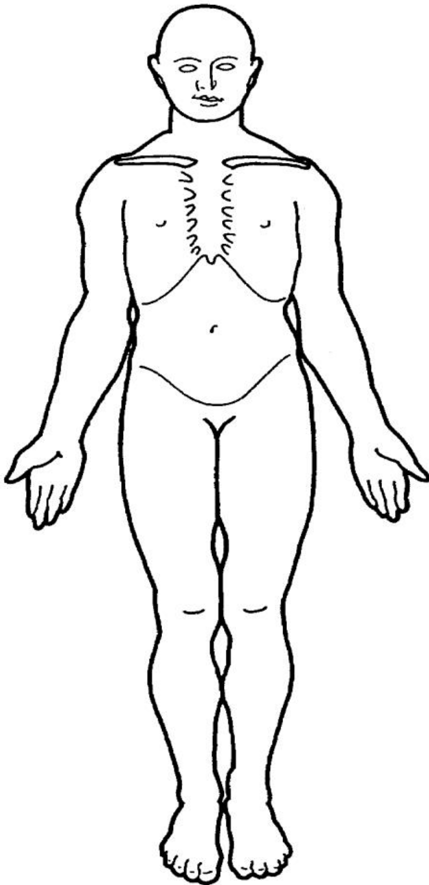
Signature: ____ **Date:** ________________

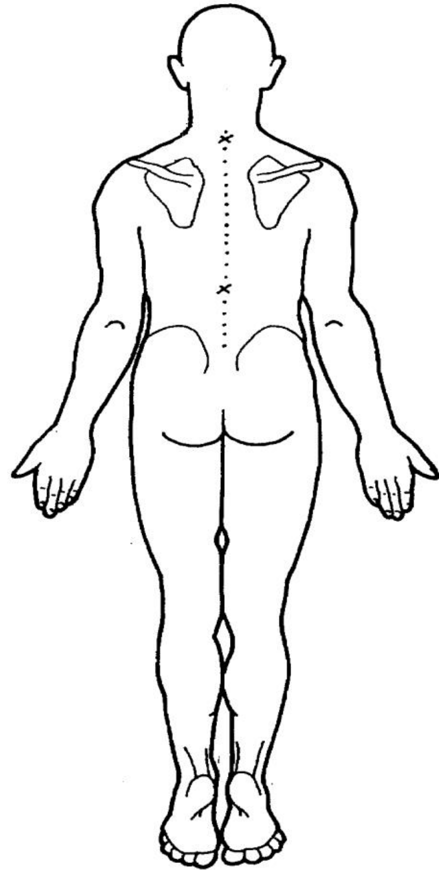
WELLNESS
BRAIN & SPINE
Stanley H. Kim, MD

Patient Name:
Date of Birth:
Date of Service:

1. Initial Visit ____________ 2. Follow Up Visit __________

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





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3. **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

Dr. Stanley H. Kim, MD _____________

Patient Name:
Date of Birth:
Date of Service:

MEDICAL HISTORY

Please list any major medical problems below:

Medical Problems:	Dates:

Surgeries:	Dates:

Hospitalizations- Please List Reasons	Dates:

Dr. Stanley H. Kim, MD ____________________

Patient Name:
Date of Birth:
Date of Service:

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	

SOCIAL HISTORY

Do you drink alcohol?

☐ Yes
☐ No

☐ If yes, how often? ________________________________

Do you live alone?

☐ Yes
☐ No

Do you smoke tobacco?

☐ Yes
☐ No
☐ If yes, how often/many a day? ________________________________

Do you drink caffeine?

☐ Yes
☐ No
☐ If yes, how much a day? ________________________________

Dr. Stanley H. Kim, MD ______________________

REVIEW OF SYSTEMS

Please Circle Either Yes or No- Do Not Leave Any Blank

General/Constitutional
Change in appetite Y / N
Chills Y / N
Fatigue Y / N
Fever Y / N
Headache Y / N
Lightheadedness Y / N
Sleep Disturbance Y / N

Gastrointestinal
Change in bowel habits Y / N
Difficulty Swallowing Y / N
Exposure to Hepatitis Y / N

Genitourinary
Difficulty urinating Y / N
Pain in lower back Y / N
Incontinence Y / N

Respiratory
Tuberculosis Y / N
Chest Pain Y / N
Pain with breathing Y / N
Wheezing Y / N
Pain with breathing Y / N

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

Peripheral Vascular
Absent pulse hands Y / N
Absent pulse feet Y / N
Cold extremities Y / N
Decreased sensation Y / N
Pain/cramping in legs Y / N
Painful extremities Y / N

Ophthalmologic
Near-Sighted Y / N
Far-Sighted Y / N
Wear Contacts Y / N
Glaucoma Y / N
Cataracts Y / N
Double Vision Y / N
Diminished Vision Y / N
Floating Lights Y / N
Eye Pain Y / N

Skin
Discoloration Moles Y / N
Rash Y / N
Scaly lesions Y / N
Skin cancer Y / N
Skin lesions Y / N

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

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

Additional Symptoms:

Allergy/Immunology
Rash Y / N
Rheumatoid Arthritis Y / N
Lupus Y / N

Endocrine
Diabetes Y / N
Difficulty Sleeping Y / N
Dizziness Y / N
Excessive Thirst/Hunger Y / N
Heat Intolerance Y / N
Weakness Y / N

Hematology
Anemia Y / N
HIV Positive Y / N
Night Sweats Y / N
Frequent Infections Y / N
Easy Bruising/Bleeding Y / N
Swollen Lymph Nodes Y / N

Psychiatric
Anxiety Y / N
Hallucinations Y / N
Depression Y / N
Difficulty Sleeping Y / N
Stressors Y / N

Ear, Nose, Throat
Discharge from ear Y / N
Nose obstruction Y / N
Sore gums Y / N
Dentures Y / N
Prolonged hoarseness Y / N
Decreased hearing Y / N
Dry mouth Y / N
Ear pain Y / N
Hearing loss Y / N
Nosebleeds Y / N
Ringing in ears Y / N
Sore throat Y / N
Swollen glands Y / N

PHYSICIAN SIGNATURE: ______________________________ **DATE:** ______________

Dr. Stanley H. Kim, MD

Patient Name:
Date of Birth:
Date of Service:

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)

Dr. Stanley H. Kim, MD ______________

12180 N. Mopac Suite A, Austin, TX 78758
Phone: 512-494-6024 Fax: 512-836-3903

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 for the pharmacy of your choice:

_______________________________ _______________________________
Name of Pharmacy Closet Intersection of Pharmacy

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 Guardian Date

_______________________________ _______________________________
Relationship to Patient **Pharmacy Name and Location**

Authorization for Release of Protected Health Information (PHI)

Patient Name Date of Birth

____/_________________________________

Address Telephone / Cell

____/________________/________________

I hereby authorize (name of facility/provider releasing information) to disclose the above-named individual's health information:

____

____

Name (facility releasing information) Address City State Zip

____

____

Telephone Number Fax Number

Date(s) of Service Requested (if known) or Provider: ____

____

Description of information to be released: (check all that apply)

____ Progress Notes
____ Consultations
____ Most recent history & physical
____ Laboratory Reports
____ Radiology/Imaging reports
____ Immunization record
____ Other
____ Entire medical record

____

I understand that the information in my health record may include information relating to communicable disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV), behavioral or mental health, alcohol/drug (substance) abuse or any such related information.

____

This information may be disclosed to and used by the following individual or organization (receiving the information)

____

____

Name (Facility receiving information) Address City State Zip

____

Telephone Number Fax Number

____

Description of the purpose of the use and/or disclosure: (check one)

____ Continuing Care
____ Collaboration of Care
____ Confidential Legal Purposes
____ Second Opinion
____ Emergency/Acute Care
____ Personal Use
____ Social Security/Disability
____ Insurance
____ Other______________________

____

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I may inspect or copy the information to be used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient, and may no longer be protected by federal and state privacy regulations. Wellness Brain & Spine may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until __________________________) day or event.

I further understand that I may revoke this authorization at any time by notifying Wellness Brain & Spine. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect my actions taken before the receipt of the written revocation.

____ _____________________________

Signature of Patient or Patient's Representative Date

12180 N. Mopac, Ste A, Austin, TX 78758
Phone: 512-494-6024 Fax: 512-836-3903 www.wellnessbrainspine.com

Discuss Health Information with another Individual

**If you would like to grant access for us to discuss your personal health information with another Individual, please list them below.

Name: ______________________________ DOB: _______________ Relationship: _________________ Phone No.: __________________________

Name: ______________________________ DOB: _______________ Relationship: _________________ Phone No.: __________________________

Name: ______________________________ DOB: _______________ Relationship: _________________ Phone No.: __________________________

Name: ______________________________ DOB: _______________ Relationship: _________________ Phone No.: __________________________

Name: ______________________________ DOB: _______________ Relationship: _________________ Phone No.: __________________________

Name: ______________________________ DOB: _______________ Relationship: _________________ Phone No.: __________________________

I understand 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 Personal Representative Date

______________________________________ ______________________________________

Name of Patient or Personal Representative Description of Personal Representative's Authority

OFFICE & FINANCIAL POLICIES

This document is to inform you of Wellness Brain & Spine's (WBS) office & financial policies. It is the philosophy of WBS that all of our patients receive the best possible care and service; therefore, your complete understanding of our office policies & your financial obligations are an essential part of our philosophy. Please read this document thoroughly, then sign and date in the appropriate location indicating that you understand and agree to comply with these policies.

PAYMENT FOR ALL SERVICES

If you are a member of an insurance company that WBS participates with, we will file your claims. Co-payments, co-insurances and deductibles are due *at the time services are provided* REGARDLESS if WBS is participating *OR* non-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 those patients who are a member of a Health Maintenance Organization (HMO).

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. Failure to respond within 30 days of the second statement will cause your account to be sent to collections and your account will be closed. WBS reserves the right to turn any patient 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 if this action is taken. WBS will also terminate the doctor/patient relationship and any further medical care.

(Payment plans may be accepted if arranged **prior** to your account being passed due)

APPOINTMENT CANCELLATIONS / NO-SHOWS

We make a sincere effort to adhere to our appointment schedule. However, an appointment may take longer than planned or an emergency may arise. We appreciate your understanding and patience when this happens.

Due to the high demand of patients needing to be seen at Wellness Brain & Spine, we must enforce a ***48 working hours*** cancellation time frame in order to get patients in at the soonest available opening. The following fees will be charged to your account if you do not comply with the Forty-eight (*48) working hour* time frame.

SUBSEQUENT OFFICE VISITS TO OFFICE: LATE CANCEL / NO SHOW APPOINTMENTS: In the event that you cannot keep an appointment, we require twenty-four (24) *working hours* notification. This courtesy will allow others to be seen sooner. If you do not contact us within the twenty-four (24) *working hours* 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.

FIRST VISIT TO OFFICE: LATE CANCEL / NO SHOW APPPOINTMENTS: We require Forty-Eight (48) *working hours* notification if you cannot keep an appointment. This courtesy allows others to be seen sooner. 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)

MISC 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. 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 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 physician to physician requests

*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.

PRESCRIPTION & REFILLS

PRESCRIPTION REFILL REQUESTS: (**72 hour** turn around) Please contact your pharmacy and ask them to fax a prescription refill request to our office. *No refills are filled on Friday*. Dr. Kim will approve or deny the request at that time. Please plan properly for your refill requests.

It is the policy of WBS that any patient 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 yrs. WBS accepts Cash, Credit Cards, Checks, Money Orders as payment for services rendered. There is a $38.00 fee charged for returned checks. If you have a payment plan in effect and your Credit Card does not go through – you will be charged a $38.00 fee.

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

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 complain 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.