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

Patient Information Forms
Please complete the medical history and patient information forms. It is very important for our office to be familiar with your health history as well as have accurate insurance and contact information for you.

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

Controlled Substance Consent/Agreement
This document explains the potential risks and benefits of controlled substances. It also provides practice guidelines for prescribing medications. Please read this document carefully and be sure to include your pharmacy information.

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

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

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

If you have any questions, please feel free to contact our office at (702) 896-0940 for the Henderson location, (702) 851-0792 for the Sunset location or (702) 948-9088 for the New Patient Department. You may find additional information on our website at: www.thespinebrain.com.

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

Patient Information Form

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.,
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

Date: ____________________ I am seeing: ☐ Dr. Anson ☐ Dr. Cox ☐ Dr. Duke ☐ Dr. Forage ☐ Dr. Seiff ☐ Dr. Yi

Referring Doctor's Name: ____

Patient's Full Name: ____

Date of Birth: ______________________ **Age:** ________ **Social Security #:** ______________________

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

Home Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ______________

Home #: (________) ______________________ **Cell #:** (________) ______________________

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

Employer: ______________________________ **Employer#** (________) ______________

Employer's Address: ____

City: ______________________ **State:** ______________ **Zip code:** ______________

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

Primary Language: ☐English ☐Spanish ☐ Other:______________________________

Guardian/Parent (financially responsible, if other than patient)

Name: ______________________________ **Relation to patient:** ______________

Home Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ______________

Date of Birth: ______________________ **Social Security #:** ______________________

Home #: (________) ______________________ **Cell #:** (________) ______________________

Employer: ______________________________ **Employer#** (________) ______________

Employer's Address: ____

City: ______________________ **State:** ______________ **Zip code:** ______________

Emergency Contact

Name: ______________________________ **Relation to patient?** ______________

Home #: (______) ______________ **Cell #:** (______) ______________ **Work#:** (______) ______________

Patient's Name: ______________________________ **DOB:** ______________________

Insurance Information

Please provide insurance card and your driver's license

Are you being seen due to an accident or injury? ☐ Yes ☐ No If Yes, date of accident/injury: ______________________

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

Primary Insurance/Auto Insurance/Workers' Compensation Information

Insurance Company: ______________________________

Address: ______________________________

City: ______________________ **State:** ____________ **Zip Code:** ______________

Insured's Name: ______________________ **Insured's DOB:** ______________

Insured's SS#: ______________________ **Insured's Employer Name:** ______________

Policy/Claim #: ______________________ **Group #:** ______________

Adjuster/Contact Name: ______________________ **Phone #:** (   ) ______________

Secondary Insurance or Attorney Information

Insurance Company: ______________________________

Address: ______________________________

City: ______________________ **State:** ____________ **Zip Code:** ______________

Insured's Name: ______________________ **Insured's DOB:** ______________

Insured's SS#: ______________________ **Insured's Employer Name:** ______________

Policy/Claim #: ______________________ **Group #:** ______________

Adjuster/Contact Name: ______________________ **Phone #:** (   ) ______________

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

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

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

Signature Patient/Responsible Party: ______________________ **Date:** ______________

SBI Staff Signature: ______________________ **Date:** ______________

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

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

SBI
THE SPINE & BRAIN
INSTITUTE

Medical History

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

Patient Name: ______________________________ Date of Birth: ______________

Age: __________ Height: __________ Weight: __________

Staff Only BP:

Primary Care Physician: ______________________ Referring Physician: ______________________

Reason for visit (symptoms/problems): ______________________________

How long have you had symptoms? ______________________________

Is your current problem a result of an accident/injury? ☐ Yes ☐ No If yes, date of accident/injury ______________

Type of accident: ☐ Work Related ☐ Auto ☐ Other: ______________

Past Medical Problems

Any major illnesses and/or injuries?

Hypertension ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Recent Infections ☐ Y es ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Other: ______________________________
Blood Clotting ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No

Medications

Current Medications (including over the counter medications)	**Dose**	**Frequency**

Allergies to Medications: ______________________________

____

Surgeries/Hospitalizations

List previous surgeries and hospitalizations	**Year**	**Complications**

Have you ever had problems with anesthesia? ☐ Yes ☐ No Problem(s): ______________________________

Family History

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

Social History

Occupation: ______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

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

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

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

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

Do you drink alcohol? ☐ No ☐ No, but I used to ☐ Yes If yes, please answer questions below

How often did you have a drink containing alcohol in the past year?
☐ Never ☐ Once per month ☐ Two times per month ☐ Three times per moth ☐ Four or more times per week

How many drinks did you have on a typical day when you were drinking in the past year?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often did you have six or more drinks on one occasion in the past year?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

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

If yes, please explain: ______________________________

Spine problems

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

If yes, what type? ______________________________ How long? ______________

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

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

If yes, when? ______________________________How many? ______________

Which physician performed blocks? ______________________________

Imaging

Do you have any implanted metal objects in your body? ☐ Yes ☐ No

Where? ______________________________ When? ______________

Do you have any vascular grafts? ☐ Yes ☐ No

Where? ______________________________ When? ______________

Do you have a pacemaker? ☐ Yes ☐ No

Are you claustrophobic? ☐ Yes ☐ No Do you wish to be pre-medicated (sedated) for MRI scans? ☐ Yes ☐ No

Review of Systems

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

Constitutional:

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

Eyes:

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

Ear, Nose, Throat and Mouth:

Hearing Loss	☐ Yes	☐ No	If you wear hearing aids, when was your last exam? __________
Ear Pain	☐ Yes	☐ No	
Ear Infections	☐ Yes	☐ No	
Ringing in Ears	☐ Yes	☐ No	If yes, ☐ Left ☐ Right ☐ Both
Balance Disturbance (e.g. Vertigo, Spinning)	☐ Yes	☐ No	
Nosebleeds	☐ Yes	☐ No	
Nasal Congestion	☐ Yes	☐ No	
Nasal Drainage	☐ Yes	☐ No	
Inability to Smell	☐ Yes	☐ No	
Sinus Problems	☐ Yes	☐ No	
Sinus Headache	☐ Yes	☐ No	
Sore Throats	☐ Yes	☐ No	
Mouth Sores	☐ Yes	☐ No	

Cardiovascular:

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

Respiratory:

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

When was your last Chest x-ray? ____________________

Review of Systems (cont.)

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

Gastrointestinal:

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

Genitourinary:

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

Musculoskeletal:

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

Please list any broken bones ______________________________

Integumentary:

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

When was your last mammogram? ____________________

Neurological:

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

Psychiatric:

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

Review of Systems (cont.)

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

Endocrine:

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

Hematologic/Lymphatic:

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

Allergic/Immunologic:

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

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

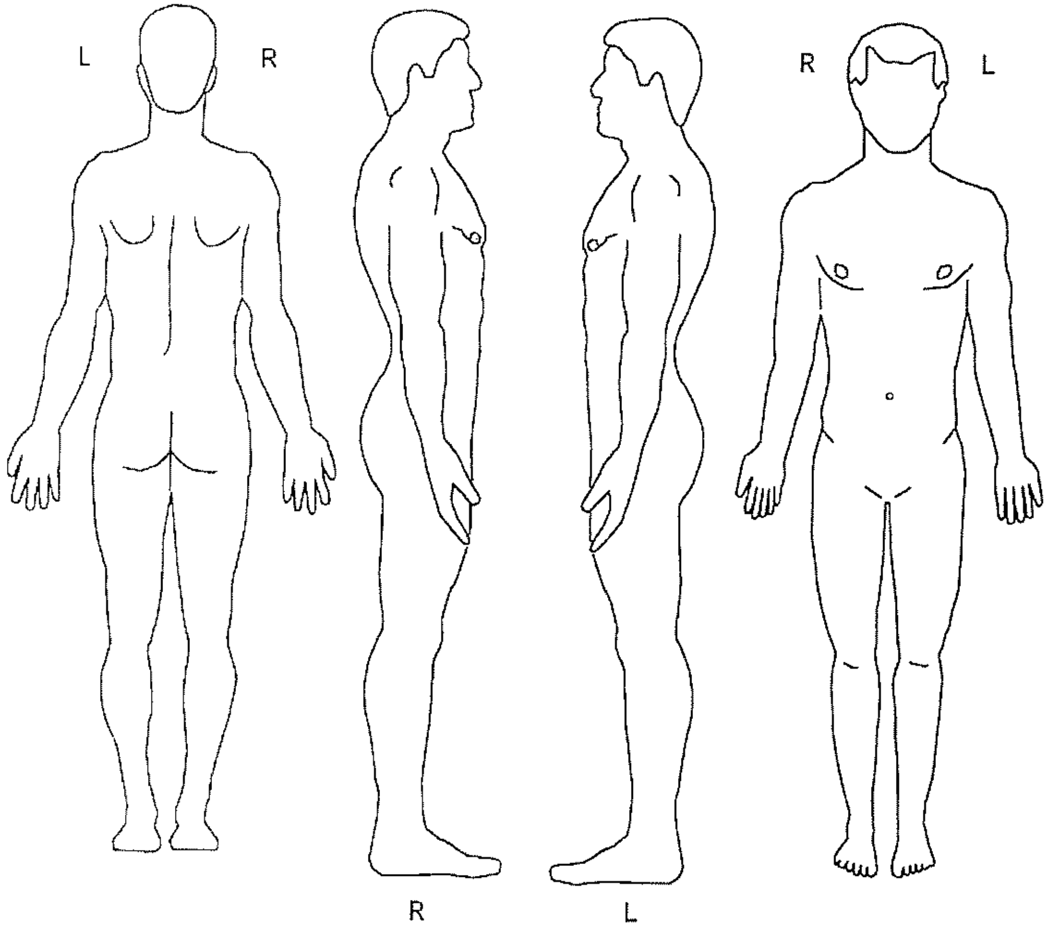
Patient's Signature: ______________________________ **Date:** ________________

PAIN DRAWING

Name: ______________________________________ Date: ________________

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

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



VISUAL ANALOGUE SCALE

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

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

THE SPINE & BRAIN INSTITUTE

Controlled Substance Consent and Agreement

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

Consent/Risk:

I, ____ authorize and direct my provider and/or associates or assistants of his/her choice to prescribe controlled substances (CS):
Like all medications, CS have potential for both benefit and harm. Potential benefits and harms are listed below, 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: Addiction, physical dependence, and tolerance.

Possible Side Effects: Constipation (common and 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 and progesterone (may cause periods to stop, reduced libido and 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: 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 strong family history of drug or alcohol abuse) or have had problems with drugs or alcohol in the past you must notify the prescribing provider 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 it may be less effective.

Risk of CS Exposure to Fetus: Newborn Abstinence Syndrome (NAS) is a group of conditions caused when a baby withdraws from certain drugs (usually opioids) when exposed to in the womb before birth.

Treatment Plan and Alternatives: The CS is prescribed in a limited quantity and has been prescribed following a patient visit with a provider. The CS is warranted given the patient's condition. In addition to CS prescription, you are recommended to pursue non-pharmacologic treatment for pain, including but not limited to, psychotherapy and physical therapy (as approved by your provider). Over the counter option, non-opioid analgesics heat and cold therapy are other options.

Proper Use, Storage, and Disposal of CS: Take CS only as directed by the person for whom the prescription is written. Keep all CS in a safe place in the childproof containers. CS that are expired or unused, can be taken to a Las Vegas Metropolitan Police Department Substation. Disposal in anonymous and drop-off boxes are located inside substations, providing 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 in a sealed bag is the safest way for the environment.

Patient Risk Assessment and Score:

Mark each box that applies	
1. Family history of substance abuse:	
Alcohol	☐ 1
Illegal Drugs	☐ 2
Prescriptions Drugs	☐ 4
2. Personal history of substance abuse:	
Alcohol	☐ 3
Illegal Drugs	☐ 4
Prescription Drugs	☐ 5
3. Age (mark box if patient is 16-45 years old)	☐ 1
4. History of preadolescent sexual abuse	☐ 3
5. Psychological disease:	
ADD, OCD, bipolar, schizophrenia	☐ 2
Depression	☐ 1
Total (add scores from each questions):	

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

Agreement:
The following terms must be acknowledged and adhered to for all medication prescriptions. Failure to adhere to the terms may result in discontinuance of medication and/or dismissal from the practice.

- Medications should be taken exactly as prescribed. Do no change the medication dosage and/or frequency without the approval of the provider.
- The CS prescribed is being given in order to control pain and improve function. If there are any significant changes to activity level or physical condition, the treatment may be changed or discontinued. Patients are responsible for notifying provider of such changes.
- Patients with multiple conditions that require the prescription of a CS (narcotics, tranquilizers, barbiturates, or stimulants) will be asked to coordinate all medications with one prescribing physician, including any medication needed for a neurosurgical condition.
- CS must be handled responsibly, including protecting and limiting access to prescribed medications, and to dispose of any unused medication in a proper manner. CS will not be shared or given out to anyone other than the patient.
- Stolen or lost prescriptions or pills will not be replaced. Please take appropriate precautions.
- There may be times when medications will need a refill between office visits. Please have the pharmacy submit refills requests to the office at least 3 days before your medication runs out. Refill requests will only be taken on Monday - Friday from 8:30 a.m. to 5:00 p.m.
- Medications will not be refilled after hours or on weekends. If you have uncontrolled pain during a weekend, medical care should be sought from an emergency room or immediate care center.
- The goal is to taper or discontinue the CS as medical conditions improve. If medical conditions do not improve, the provider may recommend additional conservative treatment, invasive neurosurgical procedures or referral to a pain management specialist for management of medications.
- It is essential that only one physician monitor and evaluate the use of CS. Patients must not accept or seek CS from any other physician or health care provider outside of this practice, including their primary care physician (NRS 453-391). It is required that one single pharmacy or pharmacy chain be used for all prescriptions. This is required to make certain that medications are known by a pharmacist to evaluate any concerns about interaction of medications.
- Use of illegal and/or recreational drugs, especially while also taking CS, is extremely dangerous and potentially lethal. CS can also interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol, codeine or hydrocodone. Inform the provider of all medications being taken.
- Altering a prescription in any way is against the law. Fabricating prescriptions or forging a provider's signature is also against the law. Understand that The Spine and Brain Institute cooperates fully with law enforcement agencies in regards to infractions involving prescription medications. Violations of law will be reported to pharmacies, local authorities, and the Drug Enforcement Agency (DEA).

Pharmacy Name/Cross Street: ____ **Phone:** ___________________________

I have read this consent and agreement. I fully understand the risks, benefits and alternatives of taking controlled substances. I fully understand the terms of this agreement.

____ _____________________________

Patient Name D.O.B.

____ _____________________________

Patient Signature or Surrogate (If patient unable to sign) Date

Request for Medical Records

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

Physician: ____

Address: ____

City: ____ State: ______________ Zip: _____________________________

To be faxed or mailed to:

The Spine and Brain Institute
John A. Anson, M.D.
Efrem M. Cox, M.D.
Derek A. Duke, M.D.
James S. Forage, M.D.
Michael E. Seiff, M.D.
Julia Yi, M.D.

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

9280 W. Sunset Rd., Suite 210
Las Vegas, NV 89148
Phone: (702) 851-0792
Fax: (702) 896-6173

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

Patient's Name: ____

Social Security #: ____ D.O.B.: ___________________________

Signature: ____ Date: _____________________________

Disclosure of Information

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

I, ____, give permission for this office to leave detailed messages on the answering machine/voicemail:

☐ My home (please initial) _________ ☐ My cellular phone (please initial) _________

(Initial) _________ I authorize The Spine and Brain Institute to send unencrypted emails from the email provided that may include patient healthcare information.

Disclosure of Information

The physicians at The Spine and Brain Institute are committed to complying with HIPAA regulations. Therefore, we require our patients to sign authorization stating those individuals (s) (family members, friends, etc.) that are approved to hear discussion and obtain patient health information.

TO BE COMPLETED BY THE PATIENT:

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

Name:	**Relationship:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Patient Name: ______________________________________ **D.O.B.:** ____________________

Patient Signature: ____________________________________ **Date:** ____________________

NOTICE OF PRIVACY POLICY

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

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

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

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

Without Your Consent

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

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

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

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

As Required by Law

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

conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

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

Miscellaneous Activities, Notice

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

Your Rights With Respect to Your Personal Health Information
Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right to Request Restrictions on Use or Disclosure

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

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

Right to Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you. With your permission, you may receive unencrypted emails, text, voice, and pre-recorded messages from your healthcare provider that may contain health-related information or healthcare management advice at the telephone number(s) and/or email that you have provided. Please note, that by accepting these terms, you understand that such methods of delivery may be unsecure and may be intercepted by unrelated third parties.

Right to Inspect and Copy Your Personal Health Information

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

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

Right to Amend Your Personal Health Information

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

Right to Receive an Accounting of Disclosures of Your Personal Health Information

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

Complaints

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

Amendments to this Privacy Policy

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

On-going Access to Privacy Policy

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

Acknowledgment of Receipt of Notice of Privacy Practices

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

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

Patient Name: ____ D.O.B.: ____________________

Patient/Representative Signature: __________________________________ Date: ____________________

COMPLETE SECTION BELOW IF WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

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

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

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

SBI Staff Signature: ____ Date: ____________________

Advanced Care Plan / Surrogate Decision Maker Questionnaire

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

Patient Name: ____ D.O.B.: ____________________________

Do you have an Advanced Care Plan (instructions on how you wish to be treated by doctors and other healthcare providers should you no longer be able to make treatment decisions)? ☐ Yes ☐ No

If yes, please provide the office with a copy of the plan.

Do you have a surrogate decision maker? ☐ Yes ☐ No

If yes, please list the decision maker's name: ____

Patient Signature: ____ Date: _____________________________

Fall Risk Assessment / Plan of Care

John A. Anson, M.D. ▪ Efrem M. Cox, M.D. ▪ Derek A. Duke, M.D.
James S. Forage, M.D. ▪ Michael E. Seiff, M.D. ▪ Julia Yi, M.D.

To be completed by patient:

Patient Name: ____ D.O.B.:__________________________

Have you fallen (sudden unintentional fall) within the last 12 months? (check one)

☐ No falls in the past year

☐ One fall with injury in the past year

☐ One fall without injury in the past year

☐ Two or more falls with injury in the past year

☐ Two or more falls without injury in the past year

Do you have any balance or gait problem? ☐ Yes ☐ No

If yes, please describe: ____

____

Do you have any visual impairment that may contribute to falling? ☐ Yes ☐ No

If yes, please describe: ____

____

Are there any hazards in your home that may contribute to falling? ☐ Yes ☐ No

If yes, please describe: ____

Patient Signature: ____ Date: __________________________

To be completed by physician:

Did patient report falling 2 or more times within last 12 months? ☐ Yes ☐ No

If yes, check all that apply:

________ Patient referred to PCP for Vitamin D supplementation advice

________ Patient referred to physical therapy for balance/gait/strength training

Physician Signature: ____ Date: __________________________