NEUROSPINAL ASSOCIATES, PA

200 3rd Avenue West, Suite 200 • Bradenton, FL 34205
Phone: 941-794-3118 ♦ Fax: 941-782-2017

Phillip W. Tally, M.D.

Diplomate of the American Board of Neurological Surgery

Michael A. King, M.D.

Diplomate of the American Board of Neurological Surgery

James A. Tiesi. M.D.

INFORMATION NEEDED PRIOR TO/AT FIRST APPOINTMENT

Thank you for scheduling your appointment with ☑ **Dr. King** ☐ **Dr. Tally** ☐ **Dr. Tiesi**

Appointment Date: _____ Appointment Time: _____

Please complete the attached forms and arrive for your appointment **15 minutes prior to your appointment time,** so you can complete your new patient registration process with our check-in staff.

Below is a list of items that you will need to bring with you to your appointment, or items that you will need to ensure have been received in our office, prior to your appointment.

1. Photo ID - Driver's license , or ID CARD.
2. A List of medications you are currently taking (the medicine name, dosage, and the frequency you are taking the medicine).
3. **CD's or Films of any MRI'S, X-RAYS, or CT SCAN'S** along with reports that have been taken within the last 3 years, of the specific area you are being seen for.
4. Your insurance card(s).
   - If you do not have your insurance card, please call your insurance provider to obtain a new one or a temporary card.
   - You must have your insurance card upon check-in, if you do not have your insurance card at check-in, then we will have to re-schedule your appointment.
   - **Does your insurance require an authorization and/or referral** before you see a specialist? If so, it is *your responsibility* to ensure that our office has the required authorization and/or referral **PRIOR** to your scheduled visit. If this has not been received by our office prior to your scheduled visit, you must call your primary care physician to obtain the authorization and/or referral.

If you have any questions or concern's please call our office at 941-794-3118.

Sincerely,

The physicians and staff of Neurospinal Associates

04/05/16 JDM

DATE:	_____
DOCTOR:	_____

Michael A. King, M. D

Philip W. Tally, M. D.

James A. Tiesi, M. D.

PATIENT INFORMATION

Today's Date:							
Patient Name:					DOB:		
Spouse's Name:					Spouse DOB:		
Patient's Sex:	☐ M	☐ F	Race:	Decline to specify		Language:	Vietnamese
Social Security Number:							
Marital Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed			
Address:							
E-mail Address:							
Home Phone Number:							
Cell Phone Number:							
Alternate Phone Number:							
Preferred Method of Contact:	☐ Home Phone	☐ Cell Phone	☐ Alternate Phone	☐ E-mail			
Primary Care Physician:							
Do you have any implanted devices?	Yes ☐	No ☐					
Check applicable device: Cardiac Pacemaker ☐ Spinal Cord Stimulator ☐ Other:							
How did you hear about Neurospinal Associates?							
Doctor Referral	Name of Physician:						
Friend/Family Member	Name of Friend/Family Member:						
Physician Directory	Name of Directory:						
☐ Sarasota Herald Directory							
☐ Vertebroplasty/Kyphoplasty Informational patient CD							
Other:							

updated 01/15/19 lmr // 02/20/19 JDM

NEUROSPINAL
ASSOCIATES, PA

DATE:	_____
DOCTOR:	_____

Michael A. King, M. D

Philip W. Tally, M. D.

James A. Tiesi, M. D.

BILLING QUESTIONNAIRE

Patient Name:		Date of Birth:	
Primary Insurance:		Secondary Insurance:	
Subscriber's Name:		Subscriber's DOB:	
Reason for today's visit:			

	Yes	NO
Is the reason for today's visit due to an injury that occurred at work?	☐	☐
If Yes, Did you file a worker's compensation claim?	☐	☐
Date the injury occurred:		
Please provide a short description of where, when and how the injury occurred:		
Is the reason for your visit today due to a motor vehicle accident?	☐	☐
If Yes, Date of Accident:		
Is your Insurance an HMO?	☐	☐
Does your health insurance require authorization to be seen by a specialist?	☐	☐
Does your insurance require a co-payment?	☐	☐
If so, what is the amount due? $		
If you do not have insurance, you understand that you will be required to pay $150, at the time of check-in and the balance due at the time of check-out prior to leaving the office today?	☐	☐
If you do not have insurance, you understand that you will be required to pay $100 at the time of check-in and the balance due at the time of check-out prior to leaving the office for each revisit appointment made after the initial evaluation?	☐	☐
How will you be paying for this visit?	☐ Check	☐ Cash ☐ Credit Card

NEUROSPINAL
ASSOCIATES, PA

INSURANCE BILLING/FINANCIAL RESPONSIBILITY POLICY AND INSURANCE AUTHORIZATION

Neurospinal Associates, P. A. will file all claims with your insurance company. We will accept assignment for these services so your insurance company should forward payment directly to our office. If you have a secondary or tertiary insurance company, we will file any remaining balances with those insurance companies. If you do not have a secondary or tertiary insurance plan, the balance not paid by your primary insurance will be billed to you and payable upon receipt of your statement. **All co-payments, co-insurance and deductibles for office visits shall be due at the time of service.**

Please be advised that it is the patient's responsibility to ensure that his/her physician is currently in-network with his/her current insurance carrier. You may clarify this by calling the customer service phone number of your insurance carrier. If Neurospinal Associates receives notification from your insurance company that it does not recognize our practice as in their network, the balance due will be billed to you and you will be responsible for payment upon receipt of your statement.

It is the responsibility of the patient to ensure that Neurospinal Associates has current insurance information to ensure that billing is completed in a timely fashion. Should Neurospinal Associates receive denials from the insurance companies supplied by the patient due to terminated or inactive coverage, the balance will be billed to the patient and you will be responsible for payment upon receipt of your statement.

Neurospinal Associates does not accept letters of protection, except in cases discussed prior to the appointment's being scheduled. If there is a balance due after your auto insurance and/or health insurance has paid their portions of the claims, the balance will be your responsibility and must be paid in full upon receipt of a statement.

All patients referred to Neurospinal Associates from Manatee Memorial Hospital, Lakewood Ranch Hospital or HCA Blake Hospital who do not have insurance benefits and the appointment is within 10 days of the referral, will be required to make payment arrangements with our Billing Department for the initial office visit. All other visits will require payment at the time of service.

All efforts will be made to collect balances due from your insurance companies. Should Neurospinal Associates receive denials for terminated coverage, insured covered by another payer, responsibility of another payer, etc., the charges will be billed to you and you will be responsible for payment upon receipt of your statement.

For Patients with Insurance:

MEDICARE LIFETIME SIGNATURE AUTHORIZATION and CERTIFICATION FOR PAYMENT

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or the group medical practice, furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also request that this authorization apply to all other insurance.

- **MEDIGAP INSURANCE AUTHORIZATION**

I request that payment of authorized Medigap benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to [*see copy of Medigap card*] any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

- **OTHER INSURANCE AUTHORIZATION**

I request that payment of authorized benefits be made on my behalf to the physician or group medical practice for any services furnished to me by them. I authorize any holder of medical information about me to release to (*see copy of card)* any information needed to determine these benefits or the benefits payable for related services.

Please sign below acknowledging that you have read this form and understand the insurance billing policy of Neurospinal Associates as stated above.

_____ _____

Signature of Patient/Legal Guardian Date Signed

_____

Patient/Legal Guardian Printed Name

_____ _____

NEUROSPINAL
ASSOCIATES, PA

Patient Consent for Use and Disclosure of Health Information for treatment, payment, and healthcare operations

Patient Name: _____

Social Security Number: _____

This authorization affects your rights in the privacy of your personal health care information.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY BEFORE SIGNING.

By signing this form, I consent to the use or disclosure of my private health information by **Neurospinal Associates, PA** for the purposes of providing treatment or health services, obtaining payment for the treatment or health services provided, or conducting **Neurospinal Associates, PA**'s health care operations.

I understand I have a right to review **Neurospinal Associates, PA**'s **"**Notice of Privacy Practices" prior to signing this document. The "Notice" provides a more complete description regarding the potential uses and disclosures of my private health information that might occur in your treatment, payment activities, health care operations, and of other important matters. The Notice also describes my rights and **Neurospinal Associates, PA**'s duties with respect to my private health information.

I understand **Neurospinal Associates, PA** reserves the right to change its privacy practices as described in its Notice; and if **Neurospinal Associates, PA's** privacy practices do change, a revised Notice will be issued, which will contain the changes. Those changes may apply to any of my private health information that is maintained.

I understand that I have the right to revoke this Consent at any time, by giving you written notice, except to the extent that **Neurospinal Associates, PA** has taken action relying on this Consent prior to my revocation. I understand that **Neurospinal Associates, PA** may decline to treat me or to continue treating me if I revoke this Consent.

For All Patients:

The undersigned consents to any treatment or procedures rendered to the patient by Neurospinal Associates under the general and specific instructions of the physician. It is further understood that Neurospinal Associates is authorized to carry out all instructions of the patient's doctor and that Neurospinal Associates is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

I request and authorize the staff of Neurospinal Associates to provide me with the treatment, and to perform any procedures now contemplated or such additional procedures as my doctor may deem reasonable and necessary.

The undersigned certifies that (s)he has read the forgoing and is the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept it's terms.

_____ _____

Signature of Patient/Legal Guardian Date Signed

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

_____ _____

Personal Representative's Name: Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

NEUROSPINAL
ASSOCIATES, PA

PROTECTED HEALTH INFORMATION RELEASE

Patient Name: _____ SSN: _____

The above named patient authorizes the Neurospinal Associates, and its' employees, to furnish a copy of his/her medical records or allow these records to be copied or faxed and made available to and/or discussed with one or more of the following named persons or entities:

- **ANY** Doctor, Medical Practice, OR Diagnostic Facility to whom patient is referred by Neuro/Spinal Associate physician(s)
- **INSURANCE COMPANY (s)** as provided by patient
- **ATTORNEY (s)** [who provide a signed medical release and/or subpoena that meets HIPAA or state requirements]
- **HOSPITAL, AMBULATORY SURGERY CENTER, BLOOD BANK OR OTHER FACILITY** providing services ordered by Neuro/Spinal Associate physicians.
- **ANY** Doctor or affiliated entity as named above provided however, that such releases are on a **Need to Know** basis and meet guidelines of the Privacy Act as they pertain to Treatment, Payment, and/or Operations.
- **OTHER**_____

Please answer the following questions to help us protect your privacy:

1. May we leave a detailed message on your answering machine? YES ☐ NO ☐ Ph#_____

2. May we leave a message at your place of employment? YES ☐ NO ☐ Ph#_____

If the answer to the above questions is NO, please let us know how you wish to be notified by our office:

_____

3. May we release information to anyone other than you? YES ☐ NO ☐

If the answer is YES, please list each person:

Name: _____ Relationship:_____ Discuss Billing Information: Y ☐ N ☐

Name: _____ Relationship:_____ Discuss Billing Information: Y ☐ N ☐

Name: _____ Relationship:_____ Discuss Billing Information: Y ☐ N ☐

(WE WILL NOT RELEASE INFORMATION TO ANYONE NOT LISTED ABOVE)

This is to verify that I have read and understand the above information. By signing this statement I am giving permission to release my protected health information as described above and that I have read and acknowledge the receipt of the Privacy Notice.

_____ _____
Signature of Patient/Legal Guardian Date Signed

_____ _____

_____
If signature is that of one other than the patient, state reason patient was unable to sign.

updated 080513 lmr / updated 01/29/16 JDM

NEUROSPINAL ASSOCIATES

AUTHORIZATION FOR RELEASE/REQUEST OF MEDICAL RECORDS/FILMS

Please note there will be a 48-hour notice to release requested information

PATIENT INFORMATION			
Patient Name:		Date of Birth:	
Patient Phone Number:		Social Security Number:	

Please fill out the information requested below. By signing this form you will allow Neurospinal Associates to provide or request records as needed to/from your primary care provider, to/from diagnostic testing facilities or to/from any other persons designated on this form with regards to any treatment that was performed by our/their physicians and/or facilities.

Requests for patient data must follow both state law and HIPAA regulations. To produce the record, the request would have to contain an authorization from the patient, or a court order. Please note: For Requests to send records – Neurospinal Associates will only include medical records from Neurospinal Associates only.

PRIMARY CARE PHYSICIAN
Name of Primary Care Physician that you authorize our office to release records to and/or request records from:

OTHER PHYSICIANS	
Please list names of any other physicians that you authorize our office to release records to and/or request records from:	
PHYSICIAN NAME	ADDRESS AND PHONE NUMBER

OTHER COMPANIES OR PERSONS	
Please list names of any other companies or persons that you authorize our office to release records to and/or request records from:	
COMPANY/PERSON NAME	ADDRESS AND PHONE NUMBER

RECORDS REQUESTED TO BE SENT TO OR FROM NSA					
Please check all required:					
☐	Cervical:		☐	Thoracic:	
☐	Lumbar:		☐	Other:	
☐	All Records		☐	Office Notes	
☐	Diagnostic Films/CD/Reports		☐	Hospital Records	
☐	Labs		☐	Billing Information	
☐	Other				
Please check Yes or No - Send records in electronic format? (On a CD/DVD)			☐	**Yes**	☐ **No**

RECORDS REQUESTED	
Records can be mailed to 200 3rd Ave W, Suite 200, Bradenton FL 34205 or faxed to:	
Medical Records – 941-782-5431	Diagnostic Studies – 941-782-5421

Signature of Patient/Legal Guardian		Date:	

200 3rd Avenue West, Ste. 200 • Bradenton, FL 34205 • Phone: 941-794-3118

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT RECEIPT

Patient Name: _____

Patient's Date of Birth: _____

Last Four Numbers of Soc. Security: _____

I acknowledge that I have been provided a copy of Neurospinal Associates, PA's Notice of Privacy Practices.

_____ _____

Signature of Patient/Legal Guardian Date

*****

I acknowledge that I declined a copy of Neurospinal Associates PA's Notice of Privacy Practices provided:

_____ _____

Signature of Patient/Legal Guardian Date

200 3rd Avenue West Ste 200, Bradenton, FL 34205
Phone:941-794-3118 Fax: 941-782-2017

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.

I. Our Commitment To You

Neurospinal Associates PA is committed to maintaining the privacy of your health information. During your treatment with us, physicians, nurses, and other personnel may collect information about your health history and your current health status. This Notice explains how that information, called "Protected Health Information" (PHI) may be used and disclosed to others. The terms of this Notice apply to health information produced or obtained by Neurospinal Associates, PA.

II. Our Legal Duties

The U.S. HIPAA Privacy Law requires us to provide this Notice to you regarding our privacy practices, our legal duties to protect your private information and your rights in regard to health information about you. We are required to follow the privacy practices described in this Notice whenever we use or disclose your protected health information. Other companies or persons that perform services on our behalf (called Business Associates) must also protect the privacy of your information. Business Associates are not allowed to release it to anyone else unless specifically permitted by law. There may be other state and federal laws that we will follow that provide additional protections related to communicable disease, mental health, substance or alcohol abuse, or other health conditions. You have the right to be notified of a breach of unsecured PHI. It is our duty to make every reasonable effort to notify you should a breach of PHI occur.

III. Your Health Information May Be Used And Disclosed

Neurospinal Associates, PA is permitted by HIPAA Privacy Law to make uses and disclosures of your health information for purposes of treatment, payment and health care operations.

- **Treatment:** We will use and may share health information about you for your health care and treatments. For example, a nurse or medical assistant will obtain treatment information about you

and record it in a medical record. Alternatively, one of our physicians may use information about you for a consultation with or a referral to another physician to diagnose your illness and determine which treatment option, such as surgery or medication, will best address your health needs. Except in emergency circumstances, we will make a "good faith effort" to get your permission prior to making disclosures outside Neurospinal Associates, PA for treatment purposes.

Payment: We may use and disclose health information about you to obtain payment for the care and services that we have provided to you. For example, we may need to provide your health plan provider with information about you, your diagnosis, and the treatment provided to you at Neurospinal Associates, PA so that your health insurer will pay us or reimburse you for the treatment. We may also contact your health insurance to obtain prior approval about a potential treatment. Health plans that use or disclose PHI for underwriting are prohibited from using or disclosing genetic information about the individual for underwriting purposes.

Health Care Operations: We may use and share health information about you for Neurospinal Associates, PA's health care operations, which include planning, management, quality assessment, and improvement activities for the treatments that we deliver. For example, we may use your health information to evaluate the skills of our physicians, nurses, and other health care providers in caring for you. We also may use your information to review quality and health outcomes. We will obtain your written permission before making disclosures to others outside Neurospinal Associates, PA for health care operations purposes.

- **Appointment Reminders:** We may use your health information to contact you by phone to confirm an appointment, or to change one, or to send you reminders of a future appointment. For example, we may let you know that it is time for a follow-up appointment or a regular check-up.
- **People Assisting in Your Care:** In certain limited situations, Neurospinal Associates, PA may disclose essential health information to people such as family members, relatives, or close friends who are helping care for you or helping you pay your health care bills. We will disclose information to them only if these people need to know the information to help you. For example, we may provide limited information to a family member so that they may pick up a prescription for you. Generally, we will ask you prior to making disclosures if you agree to such disclosures. If you are unable to make health-related decisions or it is an emergency, Neurospinal Associates, PA will determine if it would be in your best interest to disclose pertinent health information about you to the people assisting in your care.
- **As Required by Law:** We must disclose health information about you if we are required by federal, state, or local law.
- **Serious Threat to Health or Safety:** We may use and disclose your health information when necessary to avert a serious threat to your health and safety, or the health and safety of the public or another person. We will only disclose your information to someone reasonable able to help prevent the threat, such as law enforcement, and when the disclosure is specifically required by law, including the limited circumstances in which Neurospinal Associates, PA]'s health care professionals have a "duty to warn."

IV. Special Situations In Which Your Health Information May Be Released

Your health care information may be released in the following special situations:

- **Public Health Risks:** As authorized by law, we may disclose health information about you to public health or legal authorities whose official responsibilities generally include the following:
    - to prevent or control disease, injury or disability;
    - to report births and deaths,
    - to report child abuse or neglect;
    - to report reactions to medications or problems with products;
    - to notify people of recalls of products they may be using;
    - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
    - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Organ and Tissue Donation:** Consistent with applicable law, we may release your health information to organ procurement organizations or others engaged in the transplantation of organs to enable a possible transplant.
- **Specialized Government Functions:** If you are a member of the military or a veteran, we will disclose health information about you as required by command authorities; or if you give us your written permission. We may also disclose your health information for other specialized government functions such as national security or intelligence activities.
- **Workers Compensation:** If you are seeking compensation due to a work-related injury, we may release health information about you to the extent necessary to comply with laws relating to Workers Compensation claims.
- **Employers:** We may release health information to your employer if we provide health treatment to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will provide you with written notice of such information disclosure. Any other disclosures to your employer will be made only if you sign a specific authorization for the release of that information.
- **Health Oversight Activities:** We must disclose health information to a health oversight agency for activities that are required by federal, state or local law. Oversight activities include investigations, inspections, industry licensures, and government audits. These activities are necessary to enable government agencies to monitor various health care systems, government programs, and industry compliance with civil rights laws. Most states require that identifying information about you, such as your social security number, be removed from information releases for health oversight purposes, unless you have provided written permission for the disclosure.
- **Lawsuits and Disputes:** If you are involved in a lawsuit, dispute, or other judicial proceeding, we may disclose health information about you in response to a court order or subpoena, other lawful

process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement:** We may disclose your health information to a law enforcement official if required or allowed by law, such as for gunshot wounds and some burns.

  We may also disclose information about you to law enforcement that is not a part of your health record for the following reasons:

  - to identify or locate a suspect, fugitive, material witness, victim of a crime, or missing person;
  - about a death we believe may be the result of criminal conduct;
  - about criminal conduct at our location; and
  - in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Correctional Facilities:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose health information about you to the correctional institution or law enforcement official only as required by law or with your written permission. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.

- **Coroners, Medical Examiners, and Funeral Directors:** We may disclose certain health information about you to a coroner or medical examiner in the case of certain types of death. This may be necessary, for example, to make a positive identification of you or to determine the cause of your death. We may also release the fact of death and certain demographic information about you to funeral directors as needed to carry out their duties. Other releases of your health information will require the written permission of a surviving spouse, parent, a person appointed by you in writing, or your legally authorized representative.

- **Required by HIPAA Law:** The Secretary of the Department of Health and Human Services (HHS) may investigate privacy violations. If your health information is requested as part of an investigation, we must share your information with the HHS.

V. Situations In Which Your Health Information May Be Disclosed With Your Written Consent

For any purpose other than the ones described above, we may only use or share your health information when you give us your written authorization to do so. For example, you will need to sign an authorization form before we can send your health information to your life insurance company. You may revoke an authorization at any time.

- **Marketing:** We must also obtain your written authorization before using your health information to send you any marketing materials. The only exceptions to this requirement are that (1) we can provide you with marketing materials in a face-to-face encounter or a promotional gift of very small value, if we so choose, and (2) we may communicate with you about products or services relating to your treatment, to coordinate or manage your care, or provide you with information about different treatments, providers or care settings.

- **Highly Confidential Information:** Federal and state law requires special privacy protections for certain "Highly Confidential Information" about you, including any part of your health information that is about: 1) child abuse and neglect; 2) domestic abuse of an adult with a disability; 3) mental illness or developmental disability treatment or services; 4) alcohol or drug dependency diagnosis, treatment, or referral;5) HIV/AIDS testing, diagnosis, or treatment; 6) sexually transmitted disease; 7) sexual assault; 8) genetic testing; 9) In Vitro Fertilization (IVF); or 10) maintained in psychotherapy notes. Before we share your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written permission.
- **Sale of PHI:** Disclosures that constitute a sale of PHI require that we must obtain your written permission.

VI. Your Rights Regarding Health Information We Maintain About You

- **Right to Inspect and Copy:** You have the right to inspect and/or to receive a copy of your health information that we maintain in designated records and for which we use to make decisions about your care.

  If you wish to inspect and/or receive a copy of your health information, you must submit your request in writing to **HIPAA Privacy Officer,** Neurospinal Associates, PA, 200 3rd Ave W Ste 200, Bradenton, FL 34205. Your request must state that you want access to your health information and must be signed by you or your personal representative. We may charge you a fee for copying and postage.

  We may deny your request to inspect and/or copy your information in certain limited circumstances. For example, we may deny access if your physician believes it will be harmful to your health, or could cause a threat to others. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Neurospinal Associates, PA will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Request Amendment:** If you believe that any health information we have about you is incorrect or incomplete, you have the right to ask us to change the information. You have the right to request an amendment for as long as the information is kept by or for Neurospinal Associates, PA.

  To request an amendment to your health information, your request must be in writing, signed, and submitted to **HIPAA Privacy Officer,** Neurospinal Associates, PA, 200 3rd Ave W Ste 200, Bradenton, FL 34205. In addition, you must provide a reason for your request.

  We are not obligated to make all requested amendments but we will give each request careful consideration. We may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or location that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for us;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

- **Right to Request Restrictions on Use and Disclosure:** You have the right to request a restriction or limitation on certain uses and disclosures of your health information.

  To request restrictions, you must make your request in writing to **HIPAA Privacy Officer,** Neurospinal Associates, PA , 200 3rd Ave W Ste 200, Bradenton, FL 34205. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, if you want to prohibit disclosures for insurance payment, health care operations, for disaster relief purposes, to persons involved in your care, or to your spouse. It must be signed by you or your personal representative.

  We are not required to agree to your request, but we will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.

- **Right to an Accounting of Disclosures:** You have the right to receive an "accounting of disclosures" made by us of health information about you, as required by law. This accounting will not include any disclosures for treatment, payment, or health care operations; disclosures that you have authorized or that have been made to you; disclosures for national security or intelligence purposes; disclosures to correctional institutions or law enforcement with custody of you; disclosures that took place before April 14, 2003; and certain other disclosures.

  Your accounting request must be in writing and signed by you or your personal representative, and submitted to Neurospinal Associates, PA, HIPAA Privacy Officer, 200 3rd Ave W Ste 200, Bradenton, FL 34205. Your request must state a time-period for which you would like the accounting. The accounting period may not go back further than six years from the date of the request, and it may not include dates before April 14, 2003. You may receive one free accounting in any 12-month period. We will charge you for additional requests.

  Right to Request Confidential Communications: You have the right to request that we communicate with you about health issues by alternative means or at an alternative location. For example, you may request that messages not be left on voice mail or sent to a particular address.

  A request for confidential communications must be in writing, signed by you or your personal representative, and submitted to **HIPAA Privacy Officer,** Neurospinal Associates, PA 200 3rd Ave W Ste 200, Bradenton, FL 34205. Your request must specify how or where you wish to be contacted, and we may require you to provide information about how confidential payments will be managed. We are required to accommodate all reasonable requests.

- **Right to Receive a Copy of this Notice:** You have the right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice any time. This Notice is available at our reception desk and from our website, www.nsadoctors.com.

- **Right to Cancel Authorization to Use or Disclose:** Other uses and disclosures of your health information not covered by this Notice or the laws that govern us will be made only with your written authorization. You have to right to revoke your authorization in writing at any time, and

we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you. You have the right to restrict disclosures of PHI to health plan if you pay out of pocket in full for health care item or service.

- **For further information:** If you have questions, or would like additional information, you may contact Linda Reeves, Controller/HR Manager, 941-794-3118 x1011.
- **To File a Complaint:** If you believe your privacy rights have been violated, you may file a written complaint with us at **HIPAA Privacy Officer,** Neurospinal Associates, PA, 200 3rd Ave W Ste 200, Bradenton, FL 34205. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. ***There will be no retaliation for filing a complaint.*** We cannot, and will not, require you to waive the right to file a complaint as a condition of receiving treatment from us.

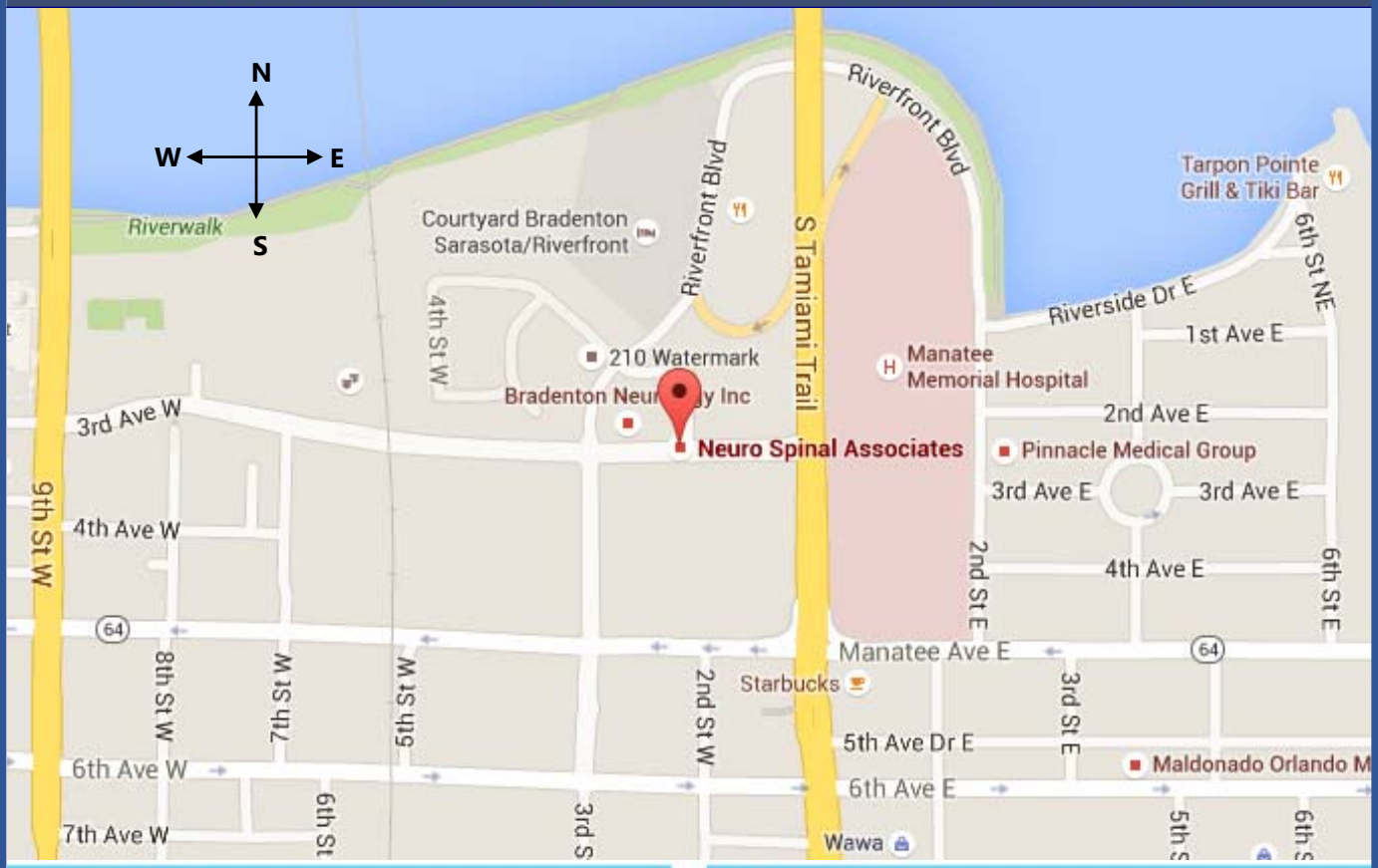
Changes to this Notice: Neurospinal Associates, PA reserves the right to amend, change, or eliminate the terms of this Notice at any time. If we change this Notice, we may make the new Notice's terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new Notice. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our reception desk and picking up a copy, or downloading one from our Web site at www.nsadoctors.com.

Effective Date: This Notice is effective as of September 23, 2013.

NEUROSPINAL
ASSOCIATES, PA

Neurospinal Associates
200 3rd Ave W
Bradenton, FL 34205
(941) 794-3118
nsadoctors.com

DIRECTIONS TO OUR OFFICE



EAST

Head West on Manatee Ave East (SR64)

Pass Manatee Memorial Hospital

crossing the intersection of Manatee Ave E/W and 1st St. Immediately after crossing the intersection get into farthest right hand lane.

Turn right on 3rd St. W.

On right is an empty lot where Bradenton Herald used to be. Bradenton Cardiology is on left

Go to stop sign

you will see two orange and tan building on right with a sign stating Riverwalk Professional Park (intersection of 3rd St. W and 3rd Ave W)

Continue on 3rd St W through stop sign and make first right into parking lot

First Building as you turn into the parking lot

Go to the double doors

Take elevator to second floor

Office is on left when exiting elevator

WEST

Head East on Manatee Ave W

Manatee Ave will turn into 6th Ave W

Turn left onto 3rd St W

School Board Building will be on right and Champs headquarters is on left.

Cross Manatee Ave W, continuing on 3rd St. W

On right is an empty lot where Bradenton Herald used to be. Bradenton Cardiology is on left

Go to stop sign

you will see two orange and tan building on right with a sign stating Riverwalk Professional Park (intersection of 3rd St. W and 3rd Ave W)

Continue on 3rd St W through stop sign and make first right into parking lot

First Building as you turn into the parking lot

Go to the double doors

Take elevator to second floor

Office is on left when exiting elevator

OUR BUILDING ENTRANCE

Arrive 15 minutes before your appointment.

Please call the office if you need to cancel or reschedule your appointment.

Thank you!

01/29/16 JDM