



**PATIENT APPOINTMENT CHECKLIST** complete everything & fax to us/bring with you

Welcome to the Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery. Our staff looks forward to providing you with exceptional medical care and excellent customer service. In order to serve you best, we have assembled all your preliminary forms into this convenient package. Please complete them either by printing them out and filling them in by hand, or by filling in the PDF's fields in Adobe Reader and then printing out the results, which you can then fax to us at 310-314-2414 or bring to your appointment. Either way, please have your forms complete by the time of your appointment. If you have any questions regarding these forms, please contact us at 310-314-6410 between 9AM-5PM weekdays.

Please arrive on time for your scheduled appointment. If you are more than 20 minutes late, your appointment will be cancelled and rescheduled for a later date.

Our office requires a credit card or debit card to be on file in order to confirm your appointment. Unless you have provided this guarantee, please do not consider your appointment time to be reserved. If you need to cancel your appointment, please contact our office within 48 hours of your scheduled appointment time or you will be charged a \$100 cancellation fee.

**Please note you will be in the office at least TWO HOURS. Incomplete paperwork will delay your appointment.**

1. **IDENTIFICATION:** Bring ALL insurance cards, referral forms, and authorizations. In addition, bring the name of the physician currently treating you and their contact information.

2. **DIAGNOSTIC IMAGES: BRING ALL DIAGNOSTIC IMAGES AND REPORTS**

While reviewing all imaging is sometimes beneficial, ONLY, reports and images conducted within the current year are necessary. Requests for extensive review for testing over one year old will incur additional charges. Please utilize the subsequent list to ensure that you have all of the images needed for a comprehensive examination. **IF YOU DO NOT HAVE ALL OF YOUR IMAGES AND REPORTS, YOU WILL DELAY THE START OF YOUR TREATMENT PLAN,** as an additional appointment will be necessary to complete your initial procedure plans.

- MRN
- MRI
- C.T.
- X-ray
- Ultrasound
- Nuclear Medicine
- Dexa
- DOS \_\_\_\_\_ (month / day / year)

3. **OPERATIVE REPORTS AND INJECTION PROCEDURE REPORTS:** Bring ALL treatment reports and referring physician tests pertaining to body regions involved in your reason for consultation. Please refer to the following list to ensure that you have all reports needed for a complete evaluation.

- Outpatient surgery report
- Inpatient surgery report
- Spinal Nerve Blocks
- Epidural Blocks
- RF and Fluro guided injections
- DOS \_\_\_\_\_ (month / day / year)

**LOCATION AND PARKING:** The Institute for Nerve Medicine and The Center for Advanced Spinal Neurosurgery is located at 2716 Ocean Park Blvd., Suite 3082, Santa Monica, California, on the south side of Ocean Park Boulevard, just west of 28th Street. Parking is in the back of the building entering off 28th Street. We do not offer parking validation, so please be prepared to pay for your parking fees. As there is a long waiting list for appointments, if you are unable to keep your appointment, please call our office (310-314-6410) to reschedule as soon as possible. Thank you for choosing our medical office to provide your care. We look forward to seeing you in our office soon.



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CENTER FOR ADVANCED SPINAL NEUROSURGERY

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SANTA MONICA, CA 90405
310-314-6410
nervemed.com espinehealth.com

Aaron Filler, MD, PhD

PATIENT INFORMATION

Date: Home Phone:
Patient: Soc.Sec.:
Address:
City: State: Zip:
Sex: M F Age: Birthdate: Single Married Widowed Divorced
Patient Employer: Occupation:
Business Address: Bus. Phone:
Referring Physician: Phone:
Address: Fax:
Primary Care Physician: Phone:
Address: Fax:
Pain Management Doctor: Phone:
Address: Fax:
Reason for visit:

OTHER INFORMATION

Person Responsible for Account: Phone:
Relationship to Patient: Soc.Sec.: Date of Birth:
Address (if different from patient):
Person Responsible Employed By: Phone:
Is this a work-related injury? Yes No If Yes, please fill out Workers Compensation Information below
Is this case under litigation? Yes No Attorney's Name:
Attorney Address: Phone:
In case of emergency who should we notify?: Phone:

PRIMARY / SECONDARY INSURANCE INFORMATION

Primary Insurance: Phone:
Claims Address:
Insured Name: Date of Birth:
Contract #: Group #: Subscriber #:
Is the patient covered by additional insurance? Yes No
Secondary Insurance: Phone:
Claims Address:
Insured Name: Date of Birth:
Contract #: Group #: Subscriber #:

WORKERS COMPENSATION INSURANCE

Employer's Name: Phone:
Date of Injury: Claim #:
Worker Compensation Carrier:
Carrier Address:
Adjuster's Name: Carrier Phone:
Coverage Verified By: (Office Use Only) Carrier Fax:

Please continue to the second page of this form



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**ASSIGNMENT AND RELEASE**

I, the undersigned, certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assigned directly to The Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that Dr. Aaron Filler is not a provider of services with my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OPT-OUT PROVIDER MEDICARE ADVISORY**

I, the undersigned, gives up all Medicare payment for services furnished by the "opt out" physician; agrees not to bill Medicare or ask the physician to bill Medicare; is liable for all of the physician's charges, without any Medicare balance billing limits; acknowledges that Medigap or any other supplemental insurance will not pay toward the services; and acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SPECIAL NOTICE TO GOVERNMENT EMPLOYEES, MILITARY  
& ARMED FORCES PERSONNEL (ACTIVE & RETIRED)**

Insurances like TriWes Care may require contracting for your reimbursement. Please be advised that this provider does not contract with any insurance carrier. This medical practice has opted out of Medicare; the provider has a deactivated UPIN number. Your signature acknowledges that we will not sign a contract for your insurance payment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**FINANCIAL WARRANTY**

Attention Patients:

Our staff looks forward to providing you with excellent customer service and our providers look forward to providing exceptional medical care. Our practice offers technological advances in pain management such as open MRI-guided Injections. Dr. Aaron G. Filler is a neurosurgeon with specialized expertise in peripheral nerve surgery and complex spine and cranial cases.

This practice is a non-contracted and non-participating provider. By choosing to obtain service with this provider, you acknowledge that you are seeking treatment outside of your insurance plan network. It is the responsibility of each patient to be aware of their individual plan benefits for out of network services, this includes any restrictions in payment and non-covered medical services.

By signing below you are accepting full financial responsibility for the payment of professional services rendered while under our care. Please be advised that all services must be paid in full, no exceptions and no deductions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_



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## **FEES & FINANCING**

As patients consider care from Aaron G. Filler, MD, they frequently ask for information about the various payment options. We hope the following information and fee estimates are helpful and informative.

As a Non-Contracted Provider, please be advised that we do not share an insurance contract with your insurance carrier. Some insurance plans do not allow you to go out of network and those that do may have a lower reimbursement rate, meaning a greater out-of-pocket expense to you. Moreover, the usual and customary percentage rate that is set by your carrier does not apply to a non-contracted provider.

After your calendar-year deductible is met, your carrier will reimburse you according to their fee schedule which we are not bound to. We cannot provide insurance appeals or participate in any insurance grievance that you may initiate with your insurance carrier. It is imperative that you contact the 800 numbers on the back of your insurance card(s) for the correct percentage reimbursement for all surgeries and injections. We provide live internet connectivity for online insurance inquiries to your insurance carrier from within our offices.

Since you have made the decision to go out of network, you have the responsibility for being informed about your insurance policy and its payment benefits. Our office is not responsible for any payment denials or reduction in fee payments that your plan may apply. Any insurance appeals or grievances that you may have with your carrier does not preclude prompt payment to our office.

### **ESTIMATED FEE SCHEDULE**

Super bill Estimates with CPT codes and charges for your procedure are provided at the time of procedure order. Please be advised that these are estimates ONLY and that medical service charges can only be confirmed upon conclusion of the procedure. Any hospital, surgi-center facility and radiological or anesthesia services are separate from these professional fee estimates.

The following represents a summary of some of our most frequently ordered procedures, and their estimates costs:

Open MR-guided Injection Piriformis / Pudendal: \$2900 to \$3900

Open MR-guided Injection TOS or Scalene: \$3500 to \$5000

Open MR-guided Injection Spine: \$1900 to \$3250

Piriformis Surgery: \$8000 to \$12,000

Brachial Plexus Surgery: \$15,750 to \$20,000

Re-Operative Spine Surgery: \$20,000 to \$35,000



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**PAYMENT & FINANCING**

Payment for injections and surgery are due in full at the time of scheduling for your procedure. In order to confirm your appointment for injection or surgery, payment must be received by our billing office. We provide a number of payment options which may be used individually or combined, according to your wishes.

Our financial coordinators are readily available to meet with you personally to provide the specific information you desire.

Cash or Check: Personal check, cashier’s check or cash

Financing Applications: Detailed information and applications for these companies are available from our patient coordinators. They can assist you in the process of obtaining your preferred financing option by calling us at 866-41-NERVE.



The Institute for Nerve Medicine and the  
Center for Advanced Spinal Neurosurgery  
accept these as methods of payment

Optional Patient Financing Plans: We will be happy to assist you with applying for financing should you so desire. We do not handle any financing “in house,” but we do have financing available through American Express.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Thank you for choosing the Institute for Nerve Medicine and Center for Advanced Spinal Neurosurgery. We look forward to seeing you.

Aaron Filler, MD, PhD  
Director, Institute for Nerve Medicine  
Director, Center for Advanced Spinal Neurosurgery



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**MEDICAL QUESTIONNAIRE FOR PATIENTS OF AARON FILLER, MD, PhD**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:    M    F    Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Are You?:    Working    Disabled    Retired

Are You?:    Married    Single    Separated    Widowed    Are You?:    Right-Handed    Left-Handed

**CURRENT PROBLEM**

Symptoms: \_\_\_\_\_ Duration: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Previous Operations: \_\_\_\_\_ Dates: \_\_\_\_\_

Implants?:    Yes    No    Type: \_\_\_\_\_ Location: \_\_\_\_\_

Other Past and Current Medical Problems (examples: hypertension, diabetes, stroke, cancer, etc.)

Family History - Parents, Grandparents, Siblings (alive; if deceased, list cause)

**MEDICATIONS**

List all Current Medications (including aspirin and herbal supplements):

Allergies to Medications: \_\_\_\_\_ Other Allergies: \_\_\_\_\_

Smoke \_\_\_\_\_ packs per day    Alcohol Usage: \_\_\_\_\_

Recent X-rays, CTs, MRIs, etc. (include dates):

Are you claustrophobic?    Yes    No    Do you need sedation?    Yes    No

Other:



GENERAL REVIEW OF SYSTEMS

Patient's Name: Date:

Last Dental Visit: Last Eye Exam: Last Physical:

Please check the items that pertain to you during your lifetime

ALLERGIES

Asthma
Hay Fever
Skin Eruption

CARDIOVASCULAR

Chest Pain
Irregular Heart Beat
High / Low Blood Pressure
Poor Circulation
Rapid Heartbeat
Swelling of Ankles
Varicose Veins
Cold Hands or Feet
Heart Murmur

CONSTITUTIONAL

Chills / Sweats / Fever
Fainting
Forgetfulness
Headaches
Loss of Sleep
Weight Loss
Nervousness

EENT

Bleeding Gums
Difficulty Swallowing
Earache
Ear Discharge
Hearing Loss
Sinus Problems
Nosebleeds
Persistent Cough
Ringing in Ears

ENDOCRINE

Rapid Weight Loss / Gain
Intolerance to Warm Room
Multiple Broken Bones
Cessation of Menstrual Periods
Excessive Hunger / Thirst
Loss of Libido
Spontaneous Nipple Discharge

EYES

Blurred Vision
Crossed Eyes
Double Vision
Vision Flashes or Halos

GENITOURINARY

Blood in Urine
Lack of Bladder Control
Painful Urination
Urinary Retention

GASTROINTESTINAL

Bloating
Bowel Changes
Constipation
Diarrhea
Gas
Hemorrhoids
Indigestion
Nausea
Poor Appetite
Rectal Bleeding
Stomach Pain
Vomiting Blood

HEMATOLOGIC / LYMPH

Swollen Lymph Nodes
Easy Skin Bruising
Prolonged Bleeding from Tooth
Extraction

INTEGUMENTARY

Skin Rashes or Eruptions
Chronic Skin Itching
Unusual Moles
Poor Scaring

MEN

Breast Lump
Lump in Testicle
Penile Discharge
Sore on Penis/Genitals

MUSCULOSKELETAL

Pain, Weakness, Numbness or swelling in:
Hands, Wrists, Hips, Knees or Joints
Pain in Arms or Legs

NEUROLOGICAL

Fainting
Headache
Numbness of Arms or Legs
Seizures
Tingling of Hands, Feet, Arms or Legs
Problems with Memory

PSYCHIATRIC

Anxiety
Depression
Panic Attack
Restlessness

PULMONARY

Coughing up blood
TB
Chronic Cough
Dizziness
Shortness of Breath
Smoker - How much / how long

WOMEN

Abnormal PAP
Bleeding Between Periods
Breast Lump
Extreme Menstrual Pain
Hot Flashes
Menopause
Painful Intercourse
Date of Last Period:
Date of Last PAP:
Last Mammogram:
Are you Pregnant? Y N
If Yes, how long?
# of Pregnancies:
# of Miscarriages:
# of Children:
Ages:

COMMENTS



PAIN-FUNCTIONAL QUESTIONNAIRE

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ How long have you been in pain? Years \_\_\_\_ Months \_\_\_\_ Weeks \_\_\_\_

Please do not complete this form if your medical problem does not involve pain or disability. Note: you may be asked to complete this form on subsequent visits during your treatment.

Please read prior to filling out questionnaire: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box which mostly closely describes your problem.

Section 1 - Pain Intensity

- I can tolerate the pain I have without having to use pain killers
The pain is bad but I manage without taking pain killers
Pain killers give complete relief from pain
Pain killers give moderate relief from pain
Pain killers give very little relief from pain
Pain killers have no effect on the pain and I don't use them

Section 6 - Standing

- I can stand as long as I want without extra pain
I can stand as long as I want with a little pain
Pain prevents me from standing for more than one hour
Pain prevents me from standing for more than 30 minutes
Pain prevents me from standing for more than 10 minutes
Pain prevents me from standing at all

Section 2 - Personal Care (washing, dressing, etc.)

- I can look after myself normally without causing extra pain
I can look after myself normally but it causes extra pain
It is painful to look after myself and I am slow and careful
I need some help but manage most of my personal care
I need help every day in most aspects of self care
I do not get dressed, wash with difficulty and stay in bed

Section 7 - Sleeping

- Pain does not prevent me from sleeping well
I can sleep well only by using tablets
Even when I take tablets, I have less than six hours of sleep
Even when I take tablets, I have less than four hours of sleep
Even when I take tablets, I have less than two hours of sleep
Pain prevents me from sleeping at all

Section 3 - Lifting

- I can lift heavy weights without extra pain
I can lift heavy weights but it gives extra pain
Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g. on the table
Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
I can lift only very light weights
I cannot lift or carry anything at all

Section 8 - Sex Life

- My sex life is normal and causes no pain
My sex life is normal but increased on the degree of pain
My sex life is nearly normal but it is very painful
My sex life is nearly absent because of pain
Pain prevents me from any sex life at all

Section 4 - Walking

- Pain does not prevent me from walking any distance
Pain prevents me from walking more than 1 mile
Pain prevents me from walking more than one-half mile
Pain prevents me from walking more than one-quarter mile

Section 9 - Social Life

- My social life is normal and give me no extra pain
My social life is normal but increases the degree of pain
Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, sports, etc.
Pain has restricted my social life and I do not go out as often
Pain has restricted my social life to my home
I have no social life because of pain

Section 5 - Sitting

- I can sit in any chair as long as I like
I can only sit in my favorite chair as long as I like
Pain prevents me from sitting for more than one hour
Pain prevents me from sitting for more than 30 minutes
Pain prevents me from sitting for more than 10 minutes
Pain prevents me from sitting at all

Section 10 - Traveling

- I can travel anywhere without extra pain
I can travel anywhere but it give me extra pain
Pain is bad but I manage journeys over two hours
Pain restricts me to journeys of less than one hour
Pain restricts me to short, necessary journeys under 30 minutes
Pain prevents me from traveling except to the doctor or hospital

**PAIN LOCATIONS**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_

**Where is your pain now?** Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation using the symbols indicated below. Include all affected areas. Just to complete the picture, please draw in your face.

<b>active pain</b>	^^^^ ^^^^	<b>numb</b>	0000 0000	<b>pins &amp; needles</b>	◆◆◆◆ ◆◆◆◆	<b>burning</b>	XXXXX XXXXX	<b>radiating pain</b>	////// //////
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	Neck pain:	%	
	Arm pain:	%	
	Back pain:	%	
	Leg pain:	%	
	Total:	100%	

**How bad is your pain now? (1=no pain 10=worst pain)**

1      2      3      4      5      6      7      8      9      10

**How consistent is your pain now?**

Continuous

Positional

Intermittent (on/off)

Unable to rate



### TREATMENT INTENSITY SCORE

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please answer the questions below**, choosing the answer that most closely describes your situation at the present time. We understand there may be one or more alternatives that may apply to you. Please choose the one you feel is most descriptive of your problem.

1. What medications are you taking for your pain?
  - a. None
  - b. Tylenol, Aspirin, Motrin, Aleve or other non-prescription pain medication
  - c. Vicodin, Codeine, Darvocet, Ultram
  - d. Medrol Dose Pack Morphine Analogs (Oxycontin, MS Contin, Percocet, etc.)
  
2. How long is the pain relieved before you need medication again?
  - a. 24 hours or more (rarely take medication)
  - b. 12 hours
  - c. 8 hours
  - d. 6 hours
  - e. 4 hours
  - f. Less than 4 hours
  
3. How long have you taken these medications?
  - a. Use them occasionally only (i.e. do not need them every day)
  - b. 6 weeks
  - c. 3 months
  - d. 6 months
  - e. 1 year
  - f. 2 years or more
  
4. Have you needed to seek other treatment options, specifically because of the pain in your neck, shoulder, arms, buttocks, legs or back?
  - a. None
  - b. Massage therapy, Shiatsu, Acupressure, etc.
  - c. Supervised Physiotherapy and/or Chiropractor
  - d. Acupuncture, Acupressure, Alternative Medicine Therapies
  - e. Injections such as Nerve Root Blocks or Epidural Steroids
  - f. Spinal Cord Stimulator, Morphine Pump
  
5. How often have you had to see a Doctor, Therapist, or gone to the Emergency Room, specifically because of unbearable pain (please don't include/disregard any routine follow-up visit)?
  - a. Never
  - b. Once in 6 months or less
  - c. Once in 3 months
  - d. Every 6 weeks
  - e. Every week or 2-3 times a week
  - f. Needed admission to the hospital for severe pain



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**PATIENT-PHYSICIAN ARBITRATION AGREEMENT**

**ARTICLE 1:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**ARTICLE 2:** I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

**ARTICLE 3:** I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

**ARTICLE 4:** I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

**ARTICLE 5:** On behalf of myself and all others bound by this agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Healthcare Association (CHA) and the California Medical Association (CMA), as they may be amended from time to time, which are hereby incorporated into this agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the California Medical Association, P.O. Box 7690, San Francisco, Ca, 94120-7690, Attention: Arbitration Rules, I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

**ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT** If I intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), I have indicated the earlier date I intend this agreement to be effective from and initialed below.

Earlier effective date: \_\_\_\_\_ Patient's Initials: \_\_\_\_\_

**ARTICLE 7:** I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_  
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship: \_\_\_\_\_

**PHYSICIAN'S AGREEMENT TO ARBITRATE**

In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 4 above.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_  
(Physician or Duly-Authorized Representative)

Title: \_\_\_\_\_ Print Name: \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY ISSUES**

**Aaron Filler, MD, PhD  
Privacy Official  
310-314-6410**

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by email at:

\_\_\_\_\_

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_



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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS TRACKING INFORMATION**

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

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City / State / Zip: \_\_\_\_\_

**FOR OFFICE USE ONLY**

Date received:		Processed by:	
Practice Follow-up:	Yes	No	Date of Practice Follow-up:

Complete the following only if the Patient refuses to sign the Acknowledgement:

Efforts to Obtain:

\_\_\_\_\_  
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## NOTICE OF PRIVACY PRACTICES

Effective Date: April 12, 2006

**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.**

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed at the end of this document.

### **A. How this Medical Practice May Use or Disclose Your Health Information**

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

**1. Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

**2. Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

**3. Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another health-care provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

**4. Appointment Reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

**5. Sign in sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

**6. Notification and communication with family.** We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

**7. Marketing.** We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We will not use or disclose your medical information without your written authorization.

**8. Required by law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

**9. Public health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

**10. Health oversight activities.** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

**11. Judicial and administrative proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

**12. Law enforcement.** We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

**13. Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

**14. Organ or tissue donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

**15. Public safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

**16. Specialized government functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

**17. Worker's compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

**18. Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**19. Research.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

**20. Fundraising.** We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices.

## **B. When This Medical Practice May Not Use or Disclose Your Health Information**

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

## **C. Your Health Information Rights**

**1. Right to Request Special Privacy Protections.** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

**2. Right to Request Confidential Communications.** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

**3. Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

**4. Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

**5. Right to an Accounting of Disclosures.** You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

**6. You have a right to a paper copy of this Notice of Privacy Practices,** even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

## **D. Changes to this Notice of Privacy Practices**

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment. We will also post the current notice on our website.

## **E. Complaints**

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed below.

Institute for Nerve Medicine, Inc.  
Privacy Official  
310-314-6410  
310-314-2414 FAX

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services  
Office of Civil Rights  
Hubert H. Humphrey Bldg.  
200 Independence Avenue, S.W.  
Room 509F HHH Building  
Washington, DC 20201

You will not be penalized for filing a complaint.