INSTITUTE FOR NERVE MEDICINE

CENTER FOR ADVANCED SPINAL NEUROSURGERY

2716 OCEAN PARK BLVD., SUITE 3082
SANTA MONICA, CA 90405
310-314-6410
nervemed.com espinehealth.com

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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Aaron Filler, MD, PhD **Sheila Butler, RN, FNP-C**

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 imerative 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:

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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 Hunter / 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 Chagnes
Constipation
Diarrhea
Gas
Hemmorhoids
Indigestion
Nausea
Poor Appetite
Rectal Bleeding
Stomach Pain
Vomiting Blood

HEMATALOGIC / 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
Beast 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

INM
CASN
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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.

active pain	^^^^^ ^^^^^
numb	00000 00000
pins & needles	◆◆◆◆◆ ◆◆◆◆◆
burning	✖✖✖✖✖ ✖✖✖✖✖
radiating pain	///////// /////////

Neck pain:	%
Arm pain:	%
Back pain:	%
Leg pain:	%
Total:	100%

right left left right

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

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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, Coedine, 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 them)
   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, Alternativei 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 anychildren, 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: 1 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

Sherieda Stewart, NP
Aaron Filler, MD, PhD
Privacy Officials
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. I f 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 healthcare 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 of 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 Reauest 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.