NOTICE OF PRIVACY PRACTICE

We Care About Your Privacy

1. *Our Pledge Regarding Medical Information*

The privacy of your medical records is important to us. We understand that your medical information is personal and we are committed to protect it. We create a record of the care and services you receive at our clinics. We need this record to provide you with quality of care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. *Our Legal Duty*

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy policies, and your rights regarding your medical information
3. Follow the terms of the notice that is now in effect.

We Have The Right To:

1. Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms or our notice effective for all medical information that we keep including information previously created or received before the change.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change the notice and make the new notice available upon request.

3. Use and Disclosure of Your Medical Information

This is how we use and disclose medical information. Note we will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment:

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information with other healthcare providers to assist them in treating you.

For Payment:
We may use and disclose your medical information for payment purposes.
Example: You have had a procedure performed at one of our clinics.

a) We may need to give your health insurance plan information regarding your procedure so that your healthcare plan can make payment to our organization, or make repayment to you.

b) We may also tell your health plan about a treatment you are going to receive to get approval or to determine if your plan will pay for treatment.

For Healthcare Operations:
We may use and disclose your medical information to our healthcare operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation certificates, licenses, and credentials to serve you.

Additional Uses and Disclosures:
Notification:
Funeral Director, Coroner, Medical Examiner:
We may share medical information about a person who has died with a coroner, funeral director, Medical examiner, or an organ procurement to help them carry out their duties.

Specialized Government Functions:
Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for Correctional institutions and other law enforcement custodial situations, and for government programs providing public health.

Court Orders and Judicial and Administrative Proceedings:
We may disclose medical information in response to a court or administrative subpoena, discovery request, or other lawful process under certain circumstances, such as court order, Warrant or grand jury subpoena, we may share your medical information with law enforcement Officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a Law official or correctional institution under certain circumstances.

Public Health Activities:
As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse advents associated with product defects or problems to enable product recalls, repairs, or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence
We may disclose medical information to the appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence, or the possible victim of crime. We may share your medical information if is necessary to prevent a serious threat to your health or the

health and safety of others. We may share medical information when necessary to help the enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation
We may disclose health information when authorized and necessary to comply with laws referring to workers compensation and other similar programs.

Health Oversight Activities:
We may disclose health information to an agency providing health oversight for oversight activities including audits and civil administrative or criminal investigations or proceedings, Inspections, licensure or disciplinary actions or other authorized activities.

Law Enforcement
Under certain circumstances we may disclose health information to the enforcement officials. These circumstances reporting are required by certain laws such as the reporting of certain types of wounds pursuant to certain subpoena or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding victims of crime at the request of the law enforcement officials, reporting crime on our premises and crimes in emergencies.

4. Your Individual Rights

You Have a Right to:

1. View or receive copies of your medical information. You must make your request in writing. You may ask our receptionists for the form to request access. There is a charge for copying and postage. You may ask the receptionist for our structure.

2. Receive a list of the times our business associates or we shared your medical information for purposes other than treatment, payment, and healthcare operations and other specified exceptions.

3. Request that we place additional restrictions on our use or disclosure of your Medical information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency)

4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate by these means or locations must be made in writing to our Privacy Officer.

5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request we will provide you with a written explanation. You may respond with a written disagreement that will be added to the information you want changed. If we accept your request to change your information, we will make reasonable efforts to tell others including people you name, of the change and to include the changes in any future sharing of that information.

6. If you wish to receive a paper copy of this privacy notice you have the right to By making a request in writing to our Privacy Officer.

Questions and Complaints:
If you have any questions about this notice, please ask the receptionist for help or ask to speak to our Privacy Officer.

If you think that we may have violated your privacy rights, contact our Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

These privacy practices are currently in effect and will remain in effect until further notice.
April 14, 2003

I have received a copy of Spine Care Specialists Privacy Practice Policy.

Patient Signature_____

Date_____

Phone Authorization

Due to HIPPA regulations it is the policy of Spine Care Specialists, LLC to obtain authorization to leave voice mail messages regarding confirmation of your appointments and information regarding treatment.

I _____, a patient at Spine Care Specialists I do / do not authorize the personnel to leave information regarding my appointments / treatments on my cell phone and or land line.

I also authorize the person(s) listed below to receive information regarding my appointments or treatments while a patient at Spine Care Specialists.

Name	Relationship
_____	_____
_____	_____
_____	_____

I understand that this authorization will remain in effect while I am a patient at Spine Care Specialists unless otherwise given notice in writing to change the above information.

Patient Signature_____

Date_____

Financial Responsibility Agreement

Below you will find a statement of financial responsibility. Patients with a loss in health insurance coverage are asked to pay at the time of service unless financial arrangements are made in advance. This statement needs to be signed, and a copy must be kept in your patient file. Failure to sign the following statement could result in discharge from the pain management program, or cancellations of set appointments. Please read the statement carefully.

I,_____, as a patient of Spine Care Specialists, LLC, do understand that it is my responsibility to follow the rules and regulations set forth by my health insurance company regarding co-pays and referrals. If a referral or authorization is required for my visit(s), it is my responsibility to make sure that there is one on file with the Doctor's office. I accept that the policy of Spine Care Specialists is to bill the patient if an authorization is not received before appointments are made. Therefore, by signing this agreement, I assume responsibility for my account if my health insurance plan will not cover my visit. In addition, I am aware that if my plan includes office visit co-pays, I shall bring payment to each office visit. If at any time my health insurance coverage should change I will notify Spine Care Specialists of the change immediately. If I have a loss in coverage I understand Spine Care Specialists will continue to treat me for 30 days and I will need to find a new physician that takes self pay patients.

Worker's Compensation Patients:

If you are treated under a Worker's Compensation claim, it is your responsibility to notify Spine Care Specialists if there is any change in your claim, including settlement. If you settle your claim all treatment billed and not paid for by BWC, secondary to your settlement, will become your responsibility.

_____ _____

Patient Signature Date

FORM COMPLETION POLICY

Completing requested paperwork requires time outside your regular office visit. Our policy requires a payment of $75.00 to complete these types of forms.

Examples of these forms include but not limited to:

- Short Term Disability Forms
- Long Term Disability Forms
- Family and Medical Leave Forms

Your forms will be completed within 10 business days from the day of payment.

I acknowledge and understand the above.

Signature: _____

Date:_____