Jonathan T. Paine M.D., P.A. Neurosurgery
1305 Valentine St.
Melbourne FL, 32901
(321)-727-2468

To better assist you, it is essential that you arrange for the following items to be available in our office at least two days prior to your appointment:

* Office hours: Mon-Fri. 9am to 5:00pm.

_____ All films or CDs (i.e. MRIs, X-rays, CTs, etc.) you have had relevant to your condition.

_____ The enclosed forms, completed in full.

_____ Your insurance cards.

_____ The reports of any and all labs, images, or studies you have had relevant to your condition.

_____ A list of all medications you are taking (please include dosage, time of day taken and condition for which medication is being taken.)

_____ A list of ***all*** food, drug and substance allergies or sensitivities.

_____ If you have an appointment for a ***neck*** or ***back*** problem, we will need your records of any prior treatment related to this condition. (i.e., medications, epidural or other injections, physical therapy, chiropractic care, etc.)

If you have any questions or need assistance in completing the forms, feel free to contact our office.

Jonathan T. Paine M.D., P.A.

PATIENT INFORMATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address (Include City, Zip):	Social Security no.:	Home Phone No: ( )

Cell Phone No: ( )	Email:	Referring Physician:

Occupation:	Employer Name & Address:	Employer Phone No: ( )

Language Spoken:

(Circle One) Patient Ethnicity: Hispanic or Latino, Non-Hispanic or Latino

(Circle One) Patient Race: Caucasian, Black or African, Asian, American Indian, Alaska Native, Chinese, Filipino, Japanese, Native Hawaiian, Multiracial, Pacific Islander.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate Primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable): (If Medicare is Secondary, Please Indicate why):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

On the Job Injury: ❑ Yes ❑No	Auto Injury: ❑ Yes ❑No	Date of Accident:	Attorney Involved: ❑ Yes ❑No

Please Notify Receptionist if YES to any of the above.

Brief Description of Accident:

If on the job injury, name of Adjuster:

If Attorney is involved, name of Attorney:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

PAIN LEVEL CHART

PATIENT NAME: _____

Describe Your Pain: Use this chart to help you describe your particular level of pain to your health care provider.

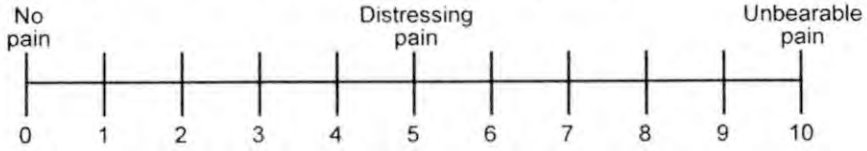
My pain is:

☐ Throbbing	☐ Aching	☐ Steady	☐ Persistent
☐ Stabbing	☐ Pinching	☐ Localized	☐ Comes & Goes
☐ Dull	☐ Burning	☐ Generalized	

☐ Other (please describe) _____

_____

Use the scale below to better estimate the level of the pain you are experiencing: Remember that pain affects everyone differently and only you know what you are feeling. The following scale can help you define the intensity of your pain and describe your discomfort to caregivers so they can provide the best treatment.



0 - 1: Very little or barely noticeable pain.

2 - 3: Pain is present, but you may have to stop and think about it to really tell if it is there or gone. You seem just fairly comfortable.

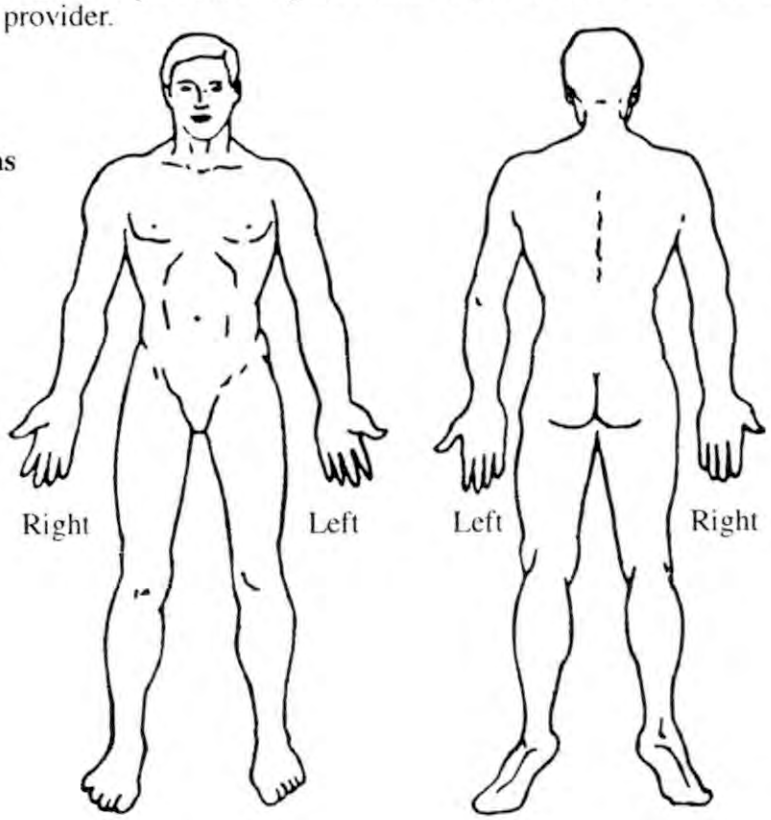
4 - 5: You now notice your pain, perhaps at rest or during activity. It may interfere with your activities. Level "4" is the level at which it is a good idea to start introducing some avenues of relief.

6 - 7: Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be "gritting your teeth" to carry out activities.

8 - 9: Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else but your pain at this level. You may be uncomfortable even during rest or quiet times.

10: Your pain is now the worst you can imagine. Do not wait for Level "10" before your discuss options with your health care provider.

Please shade areas where you are experiencing pain.



Patient's Name: _____

Medical Surrogate or Advance Care Plan (Living Will)

Do you have a medical surrogate (person you have designated to make medical decisions for you if you are incapacitated)? If so, please list surrogate's name and contact information

_____ _____

Name Relationship

_____

Address Line 1

_____ _____

Address Line 2 Phone

Do you have an advance care plan (living will)? If so, please provide a copy to this office.

Assignment of Benefits

I assign the right to payment for all medical benefits directly to Jonathan T. Paine, M.D., P.A. in consideration for medical services and supplies provided pursuant to my health insurance plan.

In the event my health insurance plan refuses to pay for provided, medically necessary services, I also assign all my ERISA* rights to Jonathan T. Paine, M.D., P.A. for a full and fair review of any and all denied claims, including any penalties that may be assessed against the insurance company for faulty claims processing. This ERISA assignment is in consideration for the unpaid services provided and in consideration for the continued willingness of Jonathan T. Paine, M.D., P.A. to see patients, including myself on an insurance assignment basis. I understand that if my treating doctor prevails in any such payment dispute, I may be liable for co-payment for the contested services.

I give consent to release medical information to Jonathan T. Paine, M.D. I give consent to Jonathan T. Paine, M.D., P.A. to release medical information to other healthcare providers for the purpose of treatment, when necessary for my care. I give consent to Jonathan T. Paine, M.D. to send medical information as necessary, to my insurance plan.

_____ _____

Date Signature

*ERISA is an acronym for the Employee Retirement Income Security Act. The Employee Retirement Income Security Act includes federal laws requiring insurance companies to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations. The failure to process submitted insurance claims and appealed (denied) insurance claims according to ERISA regulations may result in fines charged to the insurance company in amounts up to $110 a day for each infraction.

LIFETIME SIGNATURE AUTHORIZATION:

This authorization and assignment is to be a continuing one, remaining in force until revoked in writing by the undersigned for services beginning:

_____ _____

Date Signature

Jonathan T. Paine M.D., P.A.
1305 Valentine St.
Melbourne Fl, 32901

NEW PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____, understand that as part of my health care, Jonathan T. Paine M.D., P.A. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any place for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and procedural information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Healthcare Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges.

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Jonathan T. Paine M.D., P.A. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken actions in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me, as permitted by Section 164.506 of the Code of Federal Regulations.
I further understand that Jonathan T. Paine M.D., P.A. reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Jonathan T. Paine M.D., P.A. change their notice, they will make the notice available upon request on/or after the effective date of the revision.

I wish to have the following restrictions to the use or disclosure of my health information:
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
Consent Received by _____ on _____
Consent refused by patient, and treatment refused as permitted.
Consent added to the patient's medical record on _____

PATIENT NAME _____ **DATE** _____

PATIENT HEALTH QUESTIONNAIRE – 9 (PHQ – 9)

Over the last 2 weeks, how often have you been bothered By any of the following problems? *(Use "✔ to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + _____ + _____ + _____

= TOTAL SCORE: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Jonathan T. Paine, M.D.
Health History Questionnaire

Patient Name: _____ Date of Birth: _____ Ht.: _____ Wt.:_____ (Lbs.)
Today's Date: _____
Dominant Hand (Circle One): Right Left Both

Current Medications: (When listing medications include all over-the-counter medications and naturopathic supplements)

Medication Name (Including Strength)	Dosage/Frequency	Route of Administration (Oral, injection, etc.)	Reason Taking Medication

Pharmacy(s) Name(s) and Address(es): Include phone number if possible:
_____
_____

List Allergies to Medications and Foods (Include Reaction)
_____
_____
_____

When was your last flu vaccine? Month_____ Year _____

Habits:

Do you smoke? (Circle one)		Yes	No
If yes,	Cigarettes?	Yes	No
	Cigars?	Yes	No
	Pipes?	Yes	No
If cigarette smoker:	How many packs per day?		_____
	Year started		_____
	Number of years smoked?		_____
If cigar smoker:	How many per week?		_____
	Year started		_____
	Number of years smoked?		_____
If pipe smoker:	How many pipes per week?		_____
	Year started		_____
	Number of years smoked?		_____

If former cigarette smoker, how many packs per day? _____ Year started: _____ Number of years smoked _____
Year quit: _____ Number of years since last quit: _____
If former cigar smoker, how many per week? _____ Year started: _____ Number of years smoked _____
Year quit: _____ Number of years since last quit: _____
If former pipe smoker, how many per week? _____ Year started: _____ Number of years smoked _____
Year quit: _____ Number of years since last quit: _____
Do you currently use smokeless tobacco? (Circle one) Yes No. If yes, how many times per day _____
Year started _____ Number of years used _____
Did you formerly use smokeless tobacco? (Circle one) Yes No. If yes, how many times per day _____
Year started _____ Year quit _____ Number of years since last quit _____ Number of years used _____

Are you exposed to passive smoke (Circle one) Yes No

Do you use recreational drugs? (Circle one) Yes No
If yes, list substance(s) _____

Average number of caffeinated beverages per day: _____

Do you drink alcoholic beverages (Circle one) Yes No
If yes, type: (i.e. beer, wine, liquor) _____
Number of drinks per day: _____
If yes, have you ever:

Felt the need to cut down?	Yes	No
Felt annoyed by complaints about your drinking?	Yes	No
Felt guilty about drinking?	Yes	No
Felt the need for an "eye opener" in the morning?	Yes	No
Been counseled to quit or cut down	Yes	No

Do you exercise? Yes No
If yes, how many times per week? _____
Type of exercise _____

What percent of the time do you wear a seatbelt:
Circle one: 100% 75% 50% 25%

Sun exposure: Circle one Frequent Occasional Rare Remote

Women only: Number of pregnancies _____ Number of Children _____ Date of last menstrual period _____

Do you have a family history (immediate family only) of heart attack? Yes No

If yes, Female under age 65? Yes No _____ Relationship
If yes, Male under age 55? Yes No _____ Relationship

Patient Name (Print)_____
Date: _____

Major Illnesses:

- High blood pressure Yes No
- Diabetes Yes No
- Heart problems Yes No
  If yes, what type? _____
  Name of cardiologist: _____
  Pacemaker? Yes No
- Have you been diagnosed with sleep apnea? Yes No
  (If yes, please provide this office with the most recent sleep study)
  Do you use a CPAP machine? Yes No

- Have you had a stroke or new onset seizure
  within the last 3 months? Yes No
  (If yes, please provide this office with the most recent exam note from your neurologist)
- Are you undergoing renal dialysis? Yes No
  Name of treating physician _____
  Name of dialysis center _____

List types of surgeries and approximate date:

_____
_____
_____
_____
_____

List major accidents/injuries or trauma and approximate date. (Please include concussive injuries)

_____
_____
_____
_____
_____

Family History

	Major Health Problems	Age at Death	Cause of death if known
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Patient Name (Print)_____
Date: _____

Health History Systems Review
Please place an "x" on all conditions that apply

GENERAL
□ fever
□ chills
□ sweats
□ anorexia
□ fatigue
□ weakness
□ malaise
□ weight loss
□ sleep disorder
Comments:

EYES
□ blurring
□ double vision
□ irritation
□ discharge
□ vision loss
□ eye pain
□ light sensitivity
Comments:

EARS/NOSE/THROAT
□ earache
□ ear discharge
□ ringing in ears
□ decreased hearing
□ nasal congestion
□ nosebleeds
□ sore throat
□ hoarseness
Comments:

CARDIOVASCULAR
□ chest pain
□ palpitations
□ fainting episodes
□ difficulty breathing
□ shortness of breath when lying flat
□ waking from sleep unable to breath
□ swelling of lower legs/feet
Comments:

RESPIRATORY
□ cough
□ difficulty breathing
□ excessive sputum
□ coughing up blood
□ wheezing
□ chest pain with breathing/coughing
Comments:

GASTROINTESTINAL
□ nausea
□ vomiting
□ diarrhea
□ constipation
□ change in bowel habits
□ abdominal pain
□ black, tarry stool
□ rectal bleeding
□ yellow skin discoloration
□ gas/bloating
□ indigestion/heartburn
□ difficulty swallowing
□ painful swallowing
Comments:

GENITOURINARY
□ painful urination
□ blood in urine
□ discharge
□ urinary frequency
□ urinary hesitancy
□ nighttime urination
□ incontinence
□ genital sores
□ decreased libido
□ erectile dysfunction
□ vaginal discharge
□ absence of menstruation
□ heavy or prolonged menstrual periods
□ abnormal vaginal bleeding
□ pelvic pain
Comments:

MUSCULOSKELETAL
□ back pain
□ joint pain
□ joint swelling
□ muscle cramps
□ muscle weakness
□ stiffness
□ arthritis
□ sciatica
□ restless legs
□ leg pain at night
□ leg pain with exertion
Comments:

DERMATOLOGICAL
□ rash
□ itching
□ dryness
□ suspicious lesions
Comments:

NEUROLOGICAL
□ paralysis
□ tingling, numbness or burning in extremities
□ seizures
□ tremors
□ sensation of room spinning
□ transient blindness
□ frequent falls
□ frequent headaches
□ difficulty walking
Comments:

PSYCHOLOGICAL
□ depression
□ anxiety
□ memory loss
□ thoughts of suicide
□ hallucinations
□ paranoia
□ phobia
□ confusion
Comments:

ENDOCRINE
□ cold intolerance
□ heat intolerance
□ excessive thirst
□ excessive hunger
□ excessive urination
□ unusual weight change
Comments:

HEMATOLOGICAL
□ abnormal bruising
□ bleeding
□ enlarged lymph nodes
Comments:

ALLERGY
□ hives
□ allergic rash
□ hay fever
□ recurrent infections
Comments:

_____
Patient Name (Print)

_____
Patient Signature

_____
Date

_____
Parent, guardian or legal representative signature

_____
Relationship
Date

Notice of Privacy Practices

Jonathan T. Paine, M.D., P.A.

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

Jonathan T. Paine, M.D., P.A. and all associates at all locations are required by law to maintain the privacy of patient's Protected Health Information (PHI) and to provide individuals with the following Notice of the legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and these new terms will affect all PHI that we maintain at that time.

In certain circumstances we may use and disclose PHI about you without your written consent:

For Treatment: We will use health information about you to provide you with medical treatment or services. We will disclose PHI about you to doctors, nurses, technicians, students in health care training programs, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes might slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of Jonathan T. Paine, M.D., P.A. may share health information about you in order to coordinate the services you need, such as prescriptions, lab work and x-rays. We may disclose health information about you to people outside Jonathan T. Paine, M.D., P.A. who provide your medical care like nursing homes or other doctors.

For Payment: We will use and disclose information to other health care providers to assist in the payment of your bills. We will use it to send bills and collect payment from you, your insurance company, or other payers, such as Medicare, for the care, treatment and other related services you receive. We may tell your health insurer about a treatment your doctor has recommended to obtain prior approval to determine whether your plan will cover the cost of the treatment.

For Health Care Operations: We may use and disclose PHI about you for the purpose of our business operations. These business uses and disclosures are necessary to make sure that our patients receive quality care and cost effective services. For example, we may use PHI to review the quality of our treatment and services, and to evaluate the performance of our staff, contracted employees and students in caring for you.

Business Associates: We may use or disclose your PHI to an outside company that assists us in operating our health system. They perform various services for us. This includes, but is not limited to, auditing, accreditation, legal services, and consulting services. These outside companies are called "business associates" and they contract with us to keep any PHI received from us confidential in the same way we do. These companies may create or receive PHI on our behalf.

Family Members and Friends: If you agree, do not object, or we reasonably infer that there is no objection, we may disclose PHI about you to a family member, relative or another person identified by you who is involved in your health care or payment for your health care. If you are not present or are incapacitated or it is an emergency or disaster relief situation,

we will use our professional judgment to determine whether disclosing limited PHI is in your best interest under the circumstances. We may disclose PHI to a family member, relative or another person who was involved in the health care or payment for health care of a deceased individual if not inconsistent with the prior expressed

preferences of the individual that are known to Jonathan T. Paine, M.D., P.A. But, you also have the right to request a restriction on our disclosure of your PHI to someone who is involved in your care.

Appointments: We may use and disclose PHI to contact you for appointment reminders and to communicate necessary information about your appointment.

Contacting You: We may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

Hospital Directory: When you are an inpatient admitted to the hospital, the hospital may list certain information about you, such as your name, your location in the hospital, a general description of your condition that does not communicate specific medical information, and your religious affiliation, in a hospital directory. The hospitals can disclose this information, except for your religious affiliation, to people who ask for you by name. Your religious affiliation may be given to members of the clergy, even if they do not ask for you by name. You may request that no information contained in the directory be disclosed. To restrict use of information listed in the directory, please inform the admitting staff or your nurse. They will assist you in this request. In emergency circumstances, if you are unable to communicate your preference, you will be listed in the directory.

Required or Permitted by Law: We may use or disclose your PHI for public health activities that are permitted or required by law.

Public Health Activities: We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may disclose your PHI in certain circumstances to control or prevent a communicable disease, injury or disability; to report births and deaths; and for public health oversight activities or interventions. We may disclose your PHI to the Food and Drug Administration (FDA) to report adverse events or product defects, to track products, to enable product recalls, or to conduct post-market surveillance as required by law or to a state or federal government agency to facilitate their functions. We also may disclose protected health information, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and Other Legal Proceedings: We may disclose your PHI in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). If certain conditions are met, we may also disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect: We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if we believe you have been a victim of abuse, neglect, or domestic violence, we may

disclose your protected health information to a governmental entity authorized to receive such information.

Law Enforcement: Under certain conditions, we also may disclose your PHI to law enforcement officials for law enforcement purposes. These law enforcement purposes include, by way of example, (1) responding to a court order or similar process: (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; (3) reporting suspicious wounds, burns or other physical injuries; or (4) as relating to the victim of a crime.

To Prevent a Serious Threat to Health or Safety: Consistent with applicable laws, we may disclose your PHI if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Coroners, Medical Examiners and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. We may also release your PHI to a funeral director, as necessary, to carry out his/her duties.

Organ, Eye, and Tissue Donation: We will disclose PHI to organizations that obtain, bank or transplant organs or tissues.

Research: Jonathan T. Paine, M.D., P.A. may use and share your health information for certain kinds of research. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. In some instances, the law allows us to do some research using your PHI without your approval.

Workers' Compensation: We will disclose your health information that is reasonably related to a worker's compensation illness or injury following written request by your employer, worker's compensation insurer, or their representative.

Shared Medical Record/Health Information Exchanges: We maintain PHI about our patients in shared electronic medical records that allow the Jonathan T. Paine, M.D., P.A. associates to share PHI. We may also participate in various electronic health information exchanges that facilitate access to PHI by other health care providers who provide your care. For example, if you are admitted on an emergency basis to another hospital that participates in the health information exchange, the exchange will allow us to make your PHI available electronically to those who need it to treat you.

Other Uses and Disclosures of PHI

Most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes and disclosures that constitute the sale of PHI require your written authorization.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide Jonathan T. Paine, M.D., P.A. with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we have used or disclosed in reliance on the authorization.

Your Rights Regarding Your PHI:

The Right to Access to Your Own Health Information: You have the right to inspect and copy most of your protected health information for as long as we maintain it as required by law. All requests for access must be made in writing. We may charge you a nominal fee for each page copied and postage if applicable. You also have the right to ask for a summary of this information. If you request a summary, we may charge you a nominal fee. Please contact Jonathan T. Paine, M.D., P.A. Health Information/Medical Records Department with any questions or requests.

Right to Request Restrictions: You have the right to request certain restrictions of our use or disclosure of your PHI. We are not required to agree to your request in most cases. But if Jonathan T. Paine, M.D., P.A. agrees to the restriction, we will comply with your request unless the information is needed to provide you emergency treatment. Jonathan T. Paine, M.D., P.A. will agree to restrict disclosure of PHI about an individual to a health plan if the purpose of the disclosure is to carry out payment or health care operations and the PHI pertains solely to a service for which the individual, or a person other than the health plan, has paid Jonathan T. Paine, M.D., P.A. for in full. For example, if a patient pays for a service completely out of pocket and asks Jonathan T. Paine, M.D., P.A. not to tell his/her insurance company about it, we will abide by this request. A request for restriction should be made in writing. To request a restriction you must contact Health Information/Medical Records

Department. We reserve the right to terminate any previously agreed-to restrictions (other than a restriction we are required to agree to by law). We will inform you of the termination of the agreed-to restriction and such termination will only be effective with respect to PHI created after we inform you of the termination.

Right to Request Confidential Communications: If you believe that a disclosure of all or part of your PHI may endanger you, you may request in writing that we communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger. We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your protected health information could endanger you.

Right to be Notified of a Breach: You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of unsecured protected health information involving your medical information.

Right to Inspect and Copy: You have the right to inspect and receive a copy of PHI about you that may be used to make decisions about your health. A request to inspect your records may be made to your nurse or doctor while you are an inpatient or to the Health Information/Medical Records Department while an outpatient. For copies of your PHI, requests must go to the Health Information/Medical Records Department. For PHI in a designated record set that is maintained in an electronic format, you can request an electronic copy of such information. There may be a charge for these copies.

Right to Amend: If you feel that PHI we have about you is incorrect or incomplete, you may ask us to amend the information, for as long as Jonathan T. Paine, M.D., P.A. maintains the information. Requests for amending your PHI should be made to the Health Information/Medical Records Department. The personnel who maintain the information will respond to your request within 60 days after you submit the written amendment request form. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to

inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to an Accounting: With some exceptions, you have the right to receive an accounting of certain disclosures of your PHI. A nominal fee will be charged for the record search.

Complaints: You may submit any complaints with respect to violations of your privacy rights to the Jonathan T. Paine, M.D., P.A. Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from Jonathan T. Paine, M.D., P.A. for making a complaint.

Changes to this Notice: If we make material change to this Notice, we will provide a revised Notice available at www.jonathanpainemd.com. A copy will also be available in our office at 1305 S. Valentine Street, Melbourne, Florida, 32901.

Contact Information: Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact the Privacy Officer at 321-727-2468.

Revised May 2013

JONATHAN T. PAINE, M.D .. F.A.C.S.
NEUROSURGERY

1305 South Valentine
Street Melbourne. FL
32901
Telephone (321) 727-2468
Fax (321) 952·0163

HIPAA CONTACT INFORMATION FORM

In order to assist you in receiving your health information from Jonathan T. Paine M.D., P.A., please complete this form:

_____ (Initial) Jonathan T. Paine M.D., P.A. is permitted to share **any and all** medical information with the following individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

_____ (Initial) Jonathan T. Paine M.D., P.A. is permitted to share **any** medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

Except: _____

Persons authorized to receive my medical information:
(Include: Full name, relationship, and phone number.)

NAME: **RELATIONSHIP:** **PHONE NUMBER:**

_____
_____
_____
_____

You may notify me with test results, appointment reminders and other information regarding my health information as follows:

___ Message on answering machine (Phone # _____)

___ Message on work voicemail (Phone # _____)

___ Message on cell phone (Phone # _____)

___ Email Address _____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Printed Name Signature

DOB:_____ Date:_____

This authorization is **not** valid for the request of printed copies of your medical records. You and only you (or your legal personal representative) must sign a Health information Release form to obtain copies of your medical records.

Jonathan T. Paine M.D., P.A.
1305 Valentine St.
Melbourne, Fl 32901

JONATHAN T. PAINE, M.D., P.A. F.A.C.S.
NEUROSURGERY

1305 South Valentine Street
Melbourne. FL 32901
Telephone (321) 727-2468
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Financial Policy

As your physician, we are committed to providing you with the best possible medical care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

PAYMENT FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED – We accept cash, personal checks, Master Card, Visa, and Discover. Returned checks are subject to a service charge of $20.00, and you will lose your privilege to write checks in our office.

CANCELLED APPOINTMENTS – If you need to cancel an appointment, please make every effort to let us know ***AT LEAST 24 HOURS IN ADVANCE.*** Patients will be charged for the office visit after the third missed appointment without notification to the office.

HMO/PPO/MANAGED CARE – Co-payment and deductible must be paid at the time of service. We will file your insurance.

MEDICARE – Your deductible and 20% of the allowable charges are due at the time of service if you do not have a secondary insurance. Since we are Medicare providers, we will file your Medicare.

WORKER'S COMPENSATION – Please have your worker's compensation insurance carrier call us to authorize your appointment. We will file your company's insurance. In the event you fail to execute the claim for Worker's Compensation for this illness or condition, or it is determined by the Worker's Compensation carrier that the illness or condition is not a result of a Worker's Compensation case, you agree to pay our usual and customary fees for services rendered to you.

FINANCIAL AGREEMENT – We will gladly discuss your proposed treatment and do our best to answer any questions relating to your insurance. Please realize however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to all insurance contracts.
2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover (e.g., yearly physicals). Please familiarize yourself with your insurance carrier's benefits and exclusions.
3. Interest is assessed at the rate of 1% per month on balances owing from the patient for more than thirty days.

If it becomes necessary to collect any sum due through an attorney, the patient agrees to pay all reasonable costs of collection, including attorney's fee.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy.

_____ _____
Signature Date

Continued on next page

Jonathan T. Paine M.D., P.A.
1305 Valentine St.
Melbourne, Fl 32901

PATIENT STATEMENT FOR NON-HMO PATIENTS

I certify that ***I am not a member*** of any Health Maintenance Organization (HMO). If I am enrolled in an HMO and fail to get proper authorization prior to treatment, I agree to take full responsibility for the entire amount of any charge that I may incur.

_____ _____
Signature of Patient or Responsible Party Date

_____

PATIENT STATEMENT FOR HMO PATIENTS

I certify that I am a member of the Health Maintenance Organization (HMO) listed below. ***I am aware that it is my responsibility*** to make sure that I have proper authorization in order for services to be covered. I will take full responsibility of any charges which are not covered due to lack of proper authorization or which are considered non-covered services by my HMO.

Name of HMO of which I am currently a member: _____

_____ _____
Signature of Patient or Responsible Party Date

I certify that ***I am*** enrolled in a Health Maintenance Organization (HMO) with which this office may or may not have a participating provider agreement. I prefer to be seen without waiting for the necessary authorization. ***I will take full responsibility*** for the entire amount of any charges that I may incur.

_____ _____
Signature of Patient or Responsible Party Date

PATIENT QUESTIONNAIRE FOR CERVICAL SPINAL CONDITIONS

It is important that each question be answered as fully as possible. Incomplete answers may result in denial of some of your treatment options by your insurance company.

SYMPTOMS:

1. How long have you experienced neck pain? _____

2. Does your pain radiate into one or more of your upper extremities? (arms, hands, fingers) ___yes ___no
   If yes, right, left or both? _____

3. Are you experiencing weakness in your upper extremities? ___yes___no
   If yes, please indicate right, left, or both _____

4. Are you experiencing any lack of bladder control? ___yes___no

5. Are you experiencing any change in your ability to walk? ___yes___no

6. Does your neck pain come and go or is it constant?_____

HISTORY:

1. Is your pain level affecting your lifestyle / ability to perform daily living activities? ___yes___no
   If yes, please explain:_____
   _____

2. What lifestyle adjustments / therapies have you undertaken to help you in the performance of your daily living activities? Please check each that you have tried and indicate how long:

   _____ Anti-inflammatory medications: ___3___6___12 months___longer
   _____ Pain medications: ___3___6___12 months___longer
   _____ Daily exercise (specifically for neck problem: ___3___6___12 months___longer
   _____ Activity / lifestyle modification (such as rest, avoiding activities that aggravate your symptoms, etc.): ___3___6___12 months___longer
   _____ Weight reduction: ___yes___no___not significantly overweight
   _____ Supervised Physical Therapy program completed: ___yes___no If yes, how long? ___3___6___12 months___longer
   _____ Localized injections, such as trigger-point or epidural injections: ___yes___no If yes, for how long? ___3___6___12 months___longer
   _____ Other; please describe: _____
   _____

3. Do you currently smoke cigarettes? ___yes___no
   ***NOTE* Patients who smoke are hereby advised to stop at least 6 weeks before a planned surgery involving spinal fusions. Studies have demonstrated that the rate of non-fusion in smokers is as much as twice that of non-smokers due to the negative effects of nicotine on bone growth.**

_____ _____
PATIENT NAME DATE COMPLETED

4. Have you had a prior neck surgery? ___yes___no If yes, when? _____
   If yes, did you have some relief of symptoms following surgery? ___yes___no

5. Have you previously been under the care of a physician for your cervical condition? ___yes___no If yes, Please summarize approximately when, for how long, and what type of treatment you received: _____
   _____
   _____
   _____
   _____
   _____

6. If you have undergone conservative (non-surgical) treatment for your neck condition (such as physical therapy, treatment by pain management specialist, injections, chiropractic, etc.), by whom were you treated and when?

_____	From: _____ To: _____
_____	From: _____ To: _____
_____	From: _____ To: _____
_____	From: _____ To: _____
_____	From: _____ To: _____
_____	From: _____ To: _____

_____ _____
PATIENT NAME DATE COMPLETED