

**Palm Beach Spine & Diagnostic Institute**

2290 Tenth Avenue North, Suite 600

Lake Worth, FL 33461-6618

561.649.8770

Patient Registration Form and Financial Responsibility Agreement

PLEASE PRINT

**Patient Name** \_\_\_\_\_ Jr, Sr, II, III **S.S.#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(Last) (First) (Middle)

**Drivers License#** \_\_\_\_\_ **State Registered** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_ **Age** \_\_\_\_\_

Florida  
**Address** \_\_\_\_\_ **City/State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Home #**(\_\_\_\_) \_\_\_\_\_ **Cell #**(\_\_\_\_) \_\_\_\_\_ **Email** \_\_\_\_\_ @ \_\_\_\_\_ **Marital Stat:** S M W D Sep

**Employer Name** \_\_\_\_\_ **Work #** (\_\_\_\_) \_\_\_\_\_ **Ext** \_\_\_\_\_

*Out of State Address* \_\_\_\_\_ *City/State* \_\_\_\_\_ *Zip Code* \_\_\_\_\_ *Phone* (\_\_\_\_) \_\_\_\_\_  
(If Applicable)

**Emergency Contact: Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone**(\_\_\_\_) \_\_\_\_\_

**Preferred Hospital: Name:** \_\_\_\_\_ **Phone**(\_\_\_\_) \_\_\_\_\_

**Who may we release your medical records to: Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Phone** (\_\_\_\_) \_\_\_\_\_

**Insurance Information:**

**Automobile Ins Name:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_ **Date of Accident:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Adjustor Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Health Ins Name** \_\_\_\_\_ (PPO/HMO) **I.D.#** \_\_\_\_\_ **Grp#** \_\_\_\_\_

**Ins Phone**(\_\_\_\_) \_\_\_\_\_ **Card Holders Name** \_\_\_\_\_  
(ONLY IF DIFFERENT THAN ABOVE)

**Card Holder's SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Policy Holder's D.O.B. (VERY IMPORTANT)** \_\_\_\_\_ **Relation** \_\_\_\_\_

**ATTORNEY:** (If Applicable)

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Please Initial:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# Financial Policy

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1. Patients who have insurance are expected to pay their coinsurance or co-pay responsibility on the day of service. If a deductible has not been met, payment in full to the amount of the deductible is required at the time of service. **HMO patients must have any required referral authorization before service can be provided.** If a valid referral is not documented at the time of service, a new appointment will be rescheduled.
2. Patients who are insured by plans and insurance companies not contracted with PBS&DI may not receive insurance benefits. These patients are expected to **pay a deposit** for office visits, office procedures and any routine services at the time they are seen. If acceptable payments are made to PBS&DI from the insurance carrier, refunds will be sent to the patient.
3. Established patients with outstanding balances are expected to pay the balance before further services are provided. In the event of special circumstances or hardships, special payment arrangements may be discussed.
4. Patients with pending litigation may be required to provide a Letter of Protection.
5. Patients, who were originally seen by one of our physicians in the hospital and who come to our office for follow up services, are expected to provide accurate insurance information at the time of service. Co-payment or other coinsurance responsibilities are also required time of the office appointment.
6. Patients may pay by **CASH, CHECK or MONEY ORDER or CREDIT CARD (VISA, MASTERCARD or AMERICAN EXPRESS)**. Patients whose checks are returned to us for non-sufficient funds will be fined a \$35 returned check fee and will be required to pay the balance due by cash, money order or credit card.
7. Patients, who do not pay bills within 60days of the billed date, or after the receipt of two additional statements, will be referred to a collection agency, **and will be discharged from the practice.**
8. Special needs patients or patients with financial hardships may contact our billing department to discuss unique circumstances and arrange a payment plan if applicable.
9. Patients, who cancel or miss an appointment without prior 48-hour notice, will be charged a fee. Extenuating circumstances will be considered on an individual basis. The charge for a missed consultation is \$100.00. Missed follow-up appointments are \$50, and the charge for a missed procedure is \$250. These fees must be paid before the next office visit or procedure will be rescheduled.

Notice to All Workers' Compensation Patients: Patients who miss two or more appointments without canceling 24 hours in advance, will be discharged from the care of Palm Beach Spine & Diagnostic Institute. Furthermore, we are **required** to note in the medical record that the patient is non-compliant. A notation of non-compliance may jeopardize the patient's ability to received full benefits from Worker's Compensation.

10. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or any other insurance agencies, any information needed for any commercial or manager care claim or related Medicare claim. I permit a copy of this authorization to be used in place of original, and request payments of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment. (Section 1128B of Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare benefits also apply.
11. I hereby authorize PALM BEACH SPINE & DIAGNOSTIC INSTITUTE, P.A., to apply for benefits on my behalf for covered services rendered by them, or by their order. I request that payment from my insurance company be made directly to PALM BEACH SPINE & DIAGNOSTIC INSTITUTE, P.A., Dr. Gorfine and/or Dr. MacLear. I permit a copy of this authorization to be used in place of original.

**Patient:** \_\_\_\_\_  
**Signature**

**Date:** \_\_\_\_\_

**Name printed:** \_\_\_\_\_

**Patient/Guardian:** \_\_\_\_\_

# Palm Beach Spine & Diagnostic Institute

## Prescription Policy

New prescriptions and refill prescriptions will only be written **Monday through Thursday, 9:00am – 4:00pm**. Prescriptions will not be written or refilled at night, on weekends, or on holidays.

Please make sure prescription needs are addressed during your visit with the doctor. Requests for prescriptions or refills made via telephone, unless directed by the physician may result in a significant delay in filling the prescription.

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## Telephone Calls Policy

Emergency return telephone calls will not be made if Caller ID Blocking is not permitted. If you do not allow the physician to block his personal telephone number, he will be unable to return your call. **If it is an emergency and you do not de-activate your caller ID, Call 911.**

*To de-activate caller ID, simply lift your telephone handset, and **press \*87**. Thank you very much for your understanding and cooperation.*

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## Medigap Authorization Statement (Medicare Patients Only)

A Medigap policy is a health insurance policy or other health benefit plan offered by a private company to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered to an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

Patients Name: \_\_\_\_\_

Patients Policy #: \_\_\_\_\_

I request that payment or authorized MEDIGAP benefits be made to PALM BEACH SPINE & DIAGNOSTIC INSTITUTE for any services furnished by the physician. I understand that I am financially responsible for all charges whether or not paid by my insurance, including any deductibles and co-pays, and that payments are due at the time services are rendered. I authorize any holder of hospital or medical information, including any information needed to determine benefits or benefits payable for related services, to be released to:

Medigap Insurance Co. \_\_\_\_\_

I permit a copy of this authorization to be used in place on the original. This authorization is in force until it is either cancelled or changed by me.

.....

**Patient:** \_\_\_\_\_  
Signature

**Date:** \_\_\_\_\_

PATIENT QUESTIONNAIRE

NAME \_\_\_\_\_ DATE \_\_\_\_\_ AGE \_\_\_\_\_

SEX: M F WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ DOB \_\_\_\_\_

PLEASE STATE PAIN COMPLAINT: \_\_\_\_\_  
\_\_\_\_\_

PAIN FREQUENCY (CHECK):

\_\_\_\_\_ RARELY PRESENT \_\_\_\_\_ OCCAS. PRESENT \_\_\_\_\_ FREQUENTLY PRESENT

\_\_\_\_\_ ALWAYS PRESENT \_\_\_\_\_ ONLY UNDER CERTAIN CONDITIONS (EXPLAIN):  
\_\_\_\_\_

WHAT ACTIVITIES WORSENS THE PAIN? \_\_\_\_\_

WHAT RELIEVES THE PAIN? \_\_\_\_\_

HAVE YOU BEEN TREATED IN A PAIN PROGRAM BEFORE? YES NO

IF YES, WHERE? \_\_\_\_\_

HAVE YOU HAD AN MRI/CT SCAN OR XRAY'S? YES NO WHERE/WHEN? \_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY PROBLEMS WITH THE FOLLOWING:

\_\_\_\_\_ EYES \_\_\_\_\_ STOMACH \_\_\_\_\_ MUSCLE/BONE

\_\_\_\_\_ EARS/THROAT \_\_\_\_\_ BOWEL \_\_\_\_\_ NERVE DISORDER

\_\_\_\_\_ THYROID \_\_\_\_\_ BLADDER \_\_\_\_\_ BLOOD DISORDERS

\_\_\_\_\_ HEART \_\_\_\_\_ KIDNEY \_\_\_\_\_ BLEEDING

\_\_\_\_\_ LUNGS \_\_\_\_\_ LIVER \_\_\_\_\_ CANCER

\_\_\_\_\_ DIABETES: INSULIN YES NO

\_\_\_\_\_ OTHER: \_\_\_\_\_

LIST ANY ALLERGIES TO MEDICATIONS: \_\_\_\_\_

PLEASE CIRCLE ONE: **RIGHT** OR **LEFT** HAND DOMINANT

LIST ALL CURRENT MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

LIST ALL PAST SURGERIES:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLEASE CHECK IF YOU TAKE ANY OF THE FOLLOWING MEDICATIONS:

\_\_\_\_ ASPIRIN                      \_\_\_\_ ANTI-INFLAMMATORIES  
\_\_\_\_ COUMADIN                    \_\_\_\_ TICLID  
\_\_\_\_ NONE OF THE ABOVE

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING TYPES OF MEDICAL TREATMENT OR SEEN ANY OF THE FOLLOWING SPECIALISTS FOR YOUR PAIN PROBLEM:

\_\_\_\_ CHIROPRACTOR    \_\_\_\_ PSYCHIATRIST    \_\_\_\_ PSYCHOLOGIST  
\_\_\_\_ NERVE BLOCKS    \_\_\_\_ PAIN MEDICATION    \_\_\_\_ TRIGGER POINT INJECTIONS  
\_\_\_\_ ACUPUNCTURE    \_\_\_\_ SURGERY            \_\_\_\_ PHYSICAL THERAPY  
\_\_\_\_ TENS                \_\_\_\_ BIOFEEDBACK        \_\_\_\_ HYPNOSIS        \_\_\_\_ GROUP THERAPY

ARE YOU PREGNANT OR PLANNING TO BECOME PREGNANT?    \_\_\_\_ YES    \_\_\_\_ NO

DO YOU SMOKE? \_\_\_\_ YES    \_\_\_\_ NO    IF YES, HOW MUCH? \_\_\_\_\_

DO YOU DRINK ALCOHOLIC BEVERAGES? \_\_\_\_ YES    \_\_\_\_ NO    IF YES, HOW MUCH? \_\_\_\_\_

HAVE YOU EVER HAD A CHEMICAL DEPENDENCY PROBLEM?    \_\_\_\_ YES    \_\_\_\_ NO  
IF YES, WHEN? \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_ RELATION TO PATIENT \_\_\_\_\_

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Palm Beach Spine & Diagnostic Institute**

2290 Tenth Avenue North, Suite 600

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T: 561.649.8770 F: 561.649.0570

Past Injuries

1) Have you ever had a previous injury?  YES  NO

\* If you answer **NO** to this question, please do **NOT** complete this form. See 'Current Injury' form.

2) What type of past accident was it?  Work  Automobile  Other: \_\_\_\_\_

3) When did the accident occur? \_\_\_\_\_

4) Did you go to the hospital for the past injury?  YES  NO If yes, where? \_\_\_\_\_

5) Were x-rays, MRI's or other studies done?  YES  NO If yes, where? \_\_\_\_\_

6) What part of your body was injured? \_\_\_\_\_

7) Were you off work for a previous injury at any time?  YES  NO If yes, how long? \_\_\_\_\_

8) Have you ever had any legal settlements from a previous injury?  YES  NO

9) Do you have any old records regarding a previous injury?  YES  NO

10) Do you have any problems from past injuries in any part of your body?  YES  NO

If so, please explain? \_\_\_\_\_

11) Do you have any permanent or temporary disabilities from previous injury?  YES  NO

If so, please explain? \_\_\_\_\_

12) Were you given a permanent impairment rating?  YES  NO If yes, what was it? \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Palm Beach Spine & Diagnostic Institute**

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Current Injury

- 1) Date of accident: \_\_\_\_\_
- 2) Describe your injury: \_\_\_\_\_
- 3) How did the accident happen? \_\_\_\_\_
- 4) Did the airbags deploy?  YES  NO
- 5) Did the back of your head hit the head rest?  YES  NO
- 6) Were you wearing a seat belt?  YES  NO
- 7) Where is the pain? \_\_\_\_\_
- 8) When did the pain start? \_\_\_\_\_
- 9) Did you ever have pain or an injury in the same area?  YES  NO Describe: \_\_\_\_\_  
\_\_\_\_\_
- 10) Did you lose consciousness?  YES  NO
- 11) Did you go to the emergency room?  YES  NO If so, where? \_\_\_\_\_
- 12) Did your injuries require in-patient hospitalization?  YES  NO If so, where? \_\_\_\_\_
- 13) Have you ever had any MRI's or other studies before you had your accident?  YES  NO  
If yes, where? \_\_\_\_\_
- 14) Were you employed at the time of the accident?  YES  NO
- 15) If so, what was your profession? \_\_\_\_\_
- 16) Have you been able to work since the accident?  YES  NO
- 17) How long was it before you were able to return to work? \_\_\_\_\_
- 18) Do you have any restrictions?  YES  NO If yes, what? \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Palm Beach Spine and Diagnostic Institute, P.A.  
2290 Tenth Avenue North, Suite 600  
Lake Worth, Florida 33461

**Authorization To Use And Disclose Health Information**

Patient Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Information To Be Disclosed:**

My entire medical record, all medical information and all payment information.

Other in which case specify: \_\_\_\_\_  
\_\_\_\_\_

**Sensitive Health Information:**

By checking any of the boxes below, I specifically authorize the use and/or disclosure of the type of Protected Health Information indicated next to the box, if any such information will be used or disclosed pursuant to this Authorization:

- Information about a Mental Illness or Developmental Disability
- Psychotherapy Notes
- Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative)
- Information about Venereal Disease(s)
- Information about Alcohol/Drug Abuse Treatment
- Information about Abuse/Neglect of an Adult with a Disability
- Information about Sexual Assault
- Information about Child Abuse/Neglect
- Information about Genetic Testing

**Authorized Recipient:** I authorize the Practice to use and disclose my health information for the term of this Authorization to the following person(s) at the following address(es): \_\_\_\_\_  
\_\_\_\_\_

**Expiration Date of Authorization** This Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation.

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s):

- At the request of the patient, if the patient is initiating this Authorization.
- If other, then specify: \_\_\_\_\_

I understand that once the Practice discloses my health information to the recipient, the Practice cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that the Practice may, directly or indirectly, receive remuneration from a third party in connection with the use or disclosure of my health information.

I understand that I may cancel or revoke this Authorization at any time and for any reason and that such cancellation or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me, except, however, if my treatment at the Practice is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice's Privacy Officer at the address listed below. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization prior to receiving my written notice of cancellation or revocation.

I may contact the Practice's Privacy Officer by mail at: 2290 Tenth Ave North, Suite 600 Lake Worth, FL 33461.  
I may contact the Privacy Officer by telephone at: (561) 649-8770.

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

If someone else is signing this Authorization on behalf of the Patient, please provide the following information:

\_\_\_\_\_  
Legal Representative \*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to the Patient

**Note:** \* Please provide written documentation to support your status as a legal representative and/or guardian.

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**PALM BEACH SPINE AND DIAGNOSTIC INSTITUTE, P.A.**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices of Palm Beach Spine and Diagnostic Institute, P.A. which I have read and understand. I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

\_\_\_\_\_  
**Signature of Patient** (or Personal Representative)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name of Patient** (or Personal Representative)

\_\_\_\_\_  
Relationship to Patient (or Legal Authority)

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**PALM BEACH SPINE AND DIAGNOSTIC INSTITUTE, P.A.**

**NOTICE OF PRIVACY PRACTICES**

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

**I. What This Is.** This Notice describes the privacy practices of Palm Beach Spine and Diagnostic Institute, P.A.

**II. Our Privacy Obligations.** We are required by law to maintain the privacy of medical and health information about you (“**Protected Health Information**” or “**PHI**”) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

**III. Permissible Uses and Disclosures Without Your Written Authorization.** In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need your authorization for the following uses and disclosures:

**A. Use and Disclosure for Treatment, Payment and Health Care Operations.** We may use and disclose PHI, but not your “Highly Confidential Information” (defined in Section IV. C below), in order to treat you, obtain payment for services provided to you and conduct our health care operations (e.g., internal administration, quality improvement and customer service) as detailed below:

- **Treatment.** We use and disclose PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.
- **Payment.** We may use and disclose PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“**Your Payer**”), or to verify that Your Payer will pay for health care. While federal law does not require your consent or authorization for payment purposes, Florida law does. By signing the Acknowledgement to this Notice, you are authorizing us to disclose PHI to your private health insurer, HMO or other private payer in accordance with Florida law as well.
- **Health Care Operations.** We may use and disclose PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our office manager in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

**B. Disclosure to Relatives, Close Friends and Other Caregivers.** We may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the privacy officer.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person’s involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

C. Special Consent. Confidential HIV related information (for example, information regarding whether you have ever been the subject of an HIV test, have HIV infection, HIV related illness or AIDS, or any information which could indicate that you have ever been potentially exposed to HIV) and other sensitive information such as psychotherapy notes, treatment for substance abuse or sexually transmitted diseases information will never be used or disclosed to any person without your specific written consent regarding sensitive information, except to certain other persons who need to know such information in connection with your medical care, and, in certain limited circumstances, to public health or other government officials (as required by law), to insurers as necessary for payment for your care or treatment, or to certain persons with whom you have had sexual contact or have shared needles or syringes (in accordance with a specified process set forth under Florida law). This special written consent (“**Your Special Consent**”) is a separate document from this Notice and the authorization form discussed below.

D. Public Health Activities. We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

E. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

F. Other. We may disclose PHI: (i) to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid; (ii) in the course of a judicial or administrative proceeding in response to a legal order or other lawful process; (iii) to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena; (iv) to a coroner or medical examiner as authorized by law; (v) to organizations that facilitate organ, eye or tissue procurement, banking or transplantation; (vi) without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure; (vii) to prevent or lessen a serious and imminent threat to a person’s or the public’s health or safety; (viii) to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law; (ix) the extent necessary to comply with laws relating to workers' compensation or other similar programs; (ix) when required to do so by any other law not already referred to in the preceding categories.

#### IV. Use and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our authorization form (“**Your Authorization**”). For instance, you will need to execute an authorization form before we can send PHI to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

B. Marketing Communications. We must also obtain Your Authorization prior to using PHI to send you any marketing materials. We can, however, provide you with marketing materials in a face-to-face encounter, without obtaining Your Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Authorization. In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

C. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you (“**Highly Confidential Information**”). In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

Patient Copy

## V. Your Individual Rights

A. For Further Information; Complaints. If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our privacy officer. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the privacy officer will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our privacy officer and submit the completed form to the privacy officer. We will send you a written response.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

D. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the privacy officer and submit the completed form to the privacy officer. If you request copies, we will charge you a fee of \$1.00 for the first 25 pages, \$0.25 for each additional page thereafter, and the actual costs for reproducing X-rays and such other special kinds of records, as permitted under Florida law.

E. Right to Revoke Your Authorization. You may revoke Your Authorization or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the privacy officer identified below. A form of Written Revocation is available upon request from the privacy officer.

F. Right to Amend Your Records. You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the privacy officer and submit the completed form to the privacy officer. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive an Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, we will charge you a reasonable cost based fee.

H. Right to Receive Paper Copy of this Notice. Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

Patient Copy

**VI. Effective Date and Duration of This Notice**

A. Effective Date. This Notice is effective as of February 24, 2006.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of Palm Beach Spine and Diagnostic Institute, P.A. You may also obtain any revised notice by contacting the privacy officer.

**VII. Privacy Officer**

You may contact the privacy officer at:

Palm Beach Spine and Diagnostic Institute, P.A.  
2290 Tenth Avenue North, Suite 600  
Lake Worth, Florida 33461  
Attention: Privacy Officer