Brain & Spine of Texas

Rebecca Stachniak, MD

1200 Brooklyn Ave Ste. 305
San Antonio, Texas 78212

Welcome to Brain & Spine of Texas and the office of Rebecca E. Stachniak, M.D.

Our staff and physicians understand that your problem needs careful attention. In order to provide you with the best care we have designed the attached forms for you to complete. It is very important that you answer all questions on the forms to the best of your ability.

Please bring the following to all appointments:

- New Patient Information Packet- Completed attached forms (initial visit only)
- Driver's License
- Insurance Cards
- All spine/head x-rays, MRI, CT/Myelogram films and copies of the reports
- All medical records pertaining to your current condition

Please arrive 30 minutes early to your first appointment. *Please feel free to call our staff for directions. We can send them via e-mail, fax them to you or give them to you over the phone.

Payment is due at the time of service. Your portion (including deductible, co-pay, or patient percentage) is determined by your insurance company. Please contact your insurance company if you have any questions regarding your financial responsibility as outlined in your policy.

Thank you,

Rebecca E. Stachniak, M.D. and Staff

Brain & Spine of Texas

Rebecca Stachniak, MD

NEW PATIENT OFFICE INFORMATION

Patient's Name _____ **Date of Birth** _____/_____/_____

Address _____

City _____ State _____ Zip _____ M_____ F_____

Home Phone (_____) _____ - _____ **Cell Phone** (_____) _____ - _____

Can leave message: _____Home Phone and/or _____ Cell Phone

Employer _____ Phone Number (_____) _____ - _____ xt. _____

Occupation _____ City _____

Emergency Contact/Relation _____ Phone (_____) _____ - _____

Drug Allergies _____

INSURANCE INFORMATION: (Please provide us with your cards)

Primary Insurance Co. Name _____ Phone Number (_____) _____ - _____

ID # _____ Group # _____

Insurance Policy Holder (if different than patient) _____

Date of Birth _____/_____/_____ Policy Holder's SS# _____-_____-_____

Do you have secondary insurance coverage? **Y / N** If yes, please list _____

How were you referred?

Referring Doctor _____ **Phone Number/ City** _____

Primary Care Doctor _____ **Phone Number/ City** _____

- All professional services rendered are charged to the patient, necessary forms will be completed to expedite insurance payments. However, the patient is responsible for all fees, regardless of insurance coverage.
- The afore mentioned patient requests that payment of authorized medicare/other insurance company benefits be made on my behalf to one of the following physicians that treated my condition: Rebecca E. Stachniak, M.D.. For any services furnished to me by that party who accepts assignment regulations pertaining to medicare/other insurance company benefits apply.
- I authorize any holder of medical or other information about me, be released to the social security administration, healthcare financing administration, intermediaries, any other insurance company or carrier of any information needed for this or a related medicare/other insurance company claim.
- I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim if item 9 of hcfa-1500 form is completed, my signature authorizes releasing of the information to the insurer or agency shown in medicare/other insurance company assigned cases, physician or supplier agrees to accept the charge determination of the medicare/other insurance company as the full charge and the patient is responsible only for deductible coinsurance and noncovered services. Coinsuranced and the deductible are based upon the charge determination for the medicare/other insurance company.

_____ _____ _____

SIGNATURE PRINTED NAME DATE

Brain & Spine of Texas

Rebecca Stachniak, MD

Thank you in advance for taking the time to complete the detailed confidential questionnaire

Name _____ **Referring Physician** _____

Date _____ **Height** _____ **Weight** _____ **Age** _____ Handedness: Right Left

Chief Complaint (reason for visit) _____

_____

PAST MEDICAL HISTORY (Circle all previous or current medical problems)

Diabetes Heart Cancer Arthritis Liver Lung High blood pressure

Stroke Seizure Blood clot Kidney Stomach ulcer Thyroid problem

Previous Surgeries [List Date(s) and Type (s)] _____

_____

FAMILY HISTORY

Has anyone in your immediate family (parents, grandparents, and siblings) had or have any of the following diseases? If deceased, at what age and of what disease (Place X in the blank)

Family Member	Diabetes	High BP	Heart Disease	Stroke	Cancer	Deceased
Mother						
Father						
Sibling						
Sibling						
Grandmother						
Grandfather						

Current Medications: **Name** **Amount/Dose** **Frequency** **Reason**

_____

_____

_____

_____

_____

_____

_____

MEDICATION ALLERGIES _____

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed Stresses: Home Relationship Work

Do you live in a: House Apartment Other _____ **Are there stairs?** _____

Do you smoke? Y / N IF YES, **How many packs/day?** _____ Date Quit _____

Do you chew or dip tobacco? _____ **Do you drink alcohol?** Y / N if yes, how much a day _____

Recreational drug use: Y / N if yes, last date of use_____ Type _____

Employed? Y/N **Type of Occupation:** _____

Brain & Spine of Texas

Rebecca Stachniak, MD

Health Questionnaire for Brain and Spine Center of Texas, L.L.P.
Circle items that you have had, if unknown leave blank
For common illnesses, circle only if you consider it to be abnormal for you

Childhood Diseases

Measles	yes	no	Mumps	yes	no	Rubella	yes	no
Diphtheria	yes	no	Tetanus	yes	no	Polio	yes	no
Small Pox	yes	no	Rheumatic Fever	yes	no	Whopping Cough	yes	no
Tuberculosis	yes	no	Scarlet Fever	yes	no	Chicken Pox	yes	no

Neurological

Blackouts	yes	no	Seizures	yes	no	Migraine headaches	yes	no
Concussions	yes	no	Hit in Head	yes	no	Lymes Disease	yes	no
Brain Surgery	yes	no	Unconscious	yes	no	Epilepsy	yes	no
Dizziness	yes	no	Stroke	yes	no	Difficulty Walking	yes	no
Blurred Vision	yes	no	Double Vision	yes	no			

Cardiovascular

Angina	yes	no	Palpitations	yes	no	Arrhythmia	yes	no
Lightheaded	yes	no	Fainting	yes	no	Bypass Surgery	yes	no
Hypertension	yes	no	Low BP	yes	no	Anemia	yes	no
Heart Disease	yes	no	Pacemaker	yes	no	Implanted Defibrillator	yes	no
Mononucleosis	yes	no	Bleeding Tendency	yes	no	Mitral Valve Prolapse	yes	no

Respiratory

Hayfever	yes	no	Bronchitis	yes	no	Lung Surgery	yes	no
Allergies	yes	no	Emphysema	yes	no	Pulmonary Edema	yes	no
Asthma	yes	no	Wheezing	yes	no	Pneumonia	yes	no
Short of Breath	yes	no						
Tuberculosis	yes	no	If yes, date of +ppd _____ or date of last chest x-ray					

Gastro-intestinal

Reflux	yes	no	Nausea	yes	no	Persistent Vomiting	yes	no
Diarrhea	yes	no	Hiatal Hernia	yes	no	Lactose Intolerance	yes	no
Constipation	yes	no	Ulcer	yes	no	Vomiting Blood	yes	no

Genito-Urinary

Incontinence	yes	no	Discharge	yes	no	Painful Urination	yes	no
Frequency	yes	no	Bladder infection	yes	no	Venereal Disease	yes	no
Kidney Disease	yes	no	Blood in urine	yes	no			

Other

Difficulty hearing	yes	no	Thyroid	yes	no	Glaucoma	yes	no
Cataracts	yes	no	Atherosclerosis	yes	no	Poor blood circulation	yes	no
Arthritis	yes	no	Cancer	yes	no	Organ Transplant	yes	no
Sinus Trouble	yes	no	Hernia R or L	yes	no	Hemorrhoids	yes	no
Blood Transfusion	yes	no	Weight loss unexplained	yes	no	Back trouble	yes	no
Hives or Eczema	yes	no	Hepatitis A B C D E	yes	no	Weight gain unexplained	yes	no
AIDS	yes	no				Unexplained rash	yes	no
Diabetes	yes	no						

Birth Control? Yes No **Are you claustrophobic? Yes No**

Explain YES answers

_____

_____

_____

Brain & Spine of Texas

Rebecca Stachniak, MD

HISTORY OF PRESENT ILLNESS

What caused your illness/pain? Disease Accident Surgery Other _____

Describe what happened _____

_____

Pain onset: Sudden Gradual The pain is: Constant Intermittent Occasional

Pain radiates/shoots: Yes No Where? _____

How many hours per day do you have pain? _____

Is the pain disturbing your sleep? Yes No How many hours per night do you sleep? _____

What relieves your pain? _____

What aggravates your pain? _____

What activities are most affected by the pain? _____

Rate your pain: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Today _____ Average day _____ Good day _____ Bad day_____

What diagnostic test have you had? Xray CAT Scan MRI EMG Other _____

What treatments have you received? Physical Therapy TENS Surgery Acupuncture

Steroid Injections Manipulation Other _____

Have you had any previous work related injuries? No Yes Explain _____

Is there a lawyer involved in your case? No Yes Name _____

PLEASE COMPLETE THE FOLLOWING SECTION ONLY IF YOU WERE INJURED ON THE JOB OR IN AN ACCIDENT

Is this a work related injury? No Yes Is this an accident injury? No Yes

Date of injury/accident _____ When did you first notice pain? _____

When did you first seek medical help? _____ Where? _____

Are you currently working? No Yes Full duty _____ Light duty _____

IF YES, how many hours/day _____ Describe your job duties _____

_____

Sitting _____ hours Standing _____ hours Lifting _____ hours Overhead work? _____

Climbing? No Yes Repetitive upper extremity use? No Yes

IF NO, how long have you been out of work? _____ Why did you stop? _____

Job satisfaction? No Yes Why? _____ Have you tried to return to work? No Yes

How long did you work at this job before this injury? _____

If you were injured in a car accident, were you? Driver Passenger

Rear-ended Side-swiped Broad-sided Was seat belt on? No Yes

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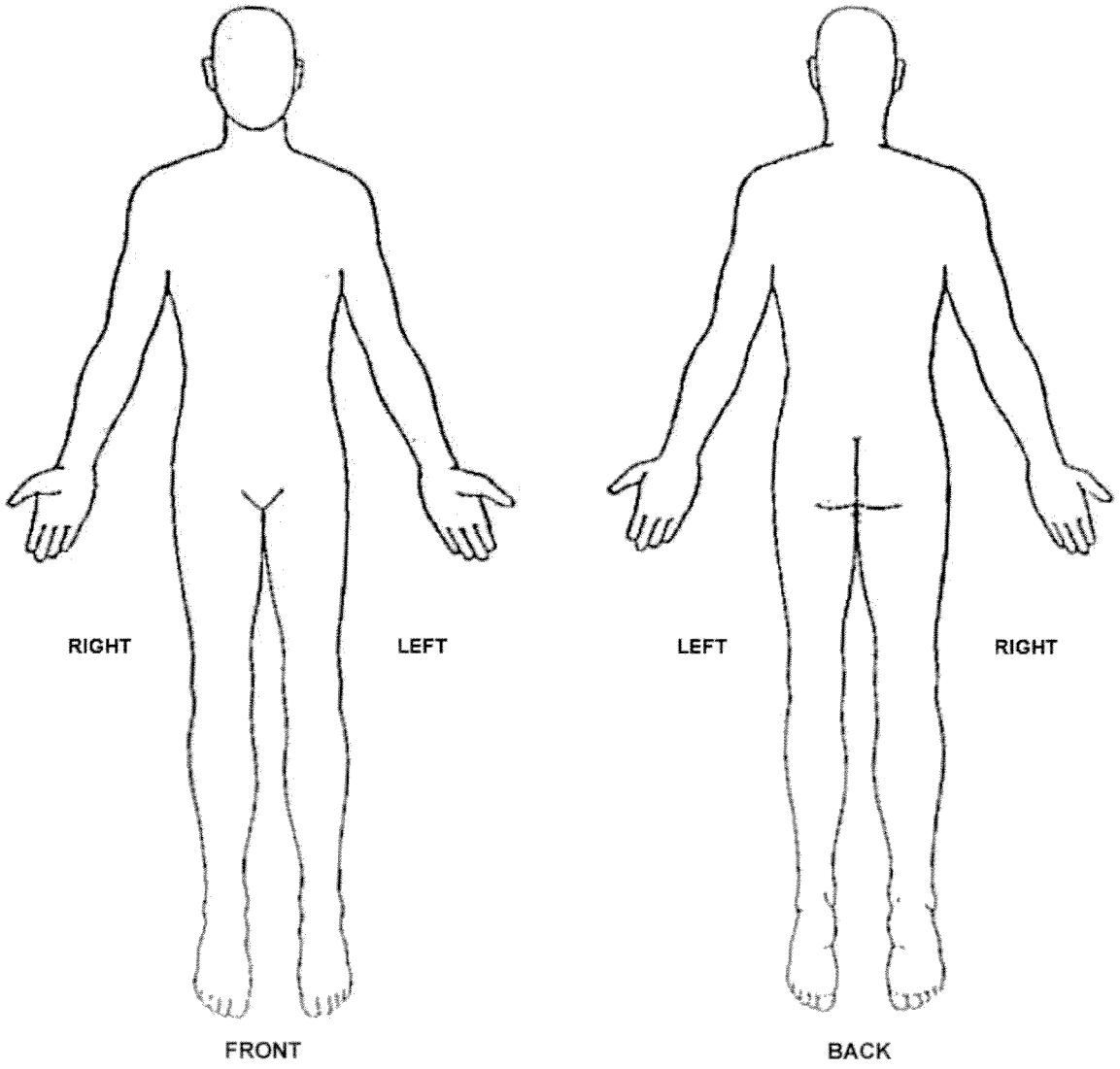
WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Please use the appropriate symbols. Include all affected areas.

ACHES	^^^^^ ^^^^^ ^^^^^	**NUMBNESS**	00000 00000 00000	**PINS & NEEDLES**	- - - - - - - - - - - - - - -	**BURNING**	XXXXX XXXXX XXXXX	**STABBING**	/ / / / / / / / / / / / / / /



Brain & Spine of Texas

Rebecca Stachniak, MD

Consent to Use and Disclose Protected Health Information

THE NOTICE OF PRIVACY PRACTICES

Brain and Spine Center of Texas, LLP and Rebecca E. Stachniak, M.D. understand that your private health information is personal and private. We are committed to the protection of your medical information and required to provide to you a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the "Notice of Privacy Policies and Practices" provided on our website or if you would like a paper copy we will provide it promptly.

PLEASE REVIEW IT CAREFULLY

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Your protected health information will be used by the **Brain and Spine Center of Texas, LLP** or disclosed to others for the purposes of treatment, obtaining payment, supporting the day-to-day health care operations of the practice or appointment reminders. Please see the notice for more details.

YOU MAY PLACE RESTRICTIONS ON THE USE OR DISCLOSURE OF YOUR HEALTH INFORMATION

You may request a restriction on the use or disclosure of your protected health information. However, the **Brain and Spine Center of Texas, LLP** may or may not agree to your request to restrict the use or disclosure of your protected health information. You may be asked to complete an authorization to activate this request. Please consult with a practice representative or **Office Administrator** if you would like additional information or clarification. It is a violation of the federal privacy standards if we agree and fail to comply with your request. The restrictions requested will not affect use and disclosure of your information before the date of your request. If you still have questions after reviewing the Notice of Privacy Practices, please consult with a practice representative or **Office Administrator.**

YOU MAY REVOKE THIS CONSENT AT ANYTIME

You may revoke this consent at anytime; however, the **Brain and Spine Center of Texas, LLP** requires that you must revoke this consent in writing. If you choose to revoke this consent, the revocation will not affect use and disclosure of your information before the date of your request.

CHANGES TO PRIVACY PRACTICES

WE reserve the right to change or modify the privacy practices outlined in the Notice of Privacy Practices. The **Brain and Spine Center of Texas, LLP** will notify you of any changes of privacy practices either by mail, at your next appointment, or any other pre-approved method at your request.

SIGNATURE

I have reviewed this consent form, and received the "Notice of Privacy Policies and Practices" and give my permission to the **Brain and Spine Center of Texas, LLP** to use and disclose my health information in accordance with this consent and the notice provided.

Name of Patient (Print or Type)	Signature of Patient	Date

Brain & Spine of Texas

Rebecca Stachniak, MD

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless either you or your health insurance carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience we accept cash, check, Visa, MasterCard, Discover, and American Express.

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment and/or deductible at the time of service. This office has the policy to collect this co-payment and/or deductible when you arrive for your appointment.

- If your insurance plan requires a referral, it is your responsibility to obtain that referral from your primary care physician prior to your first date of service. It is also your responsibility to maintain the referral for all upcoming visits.

- If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.

- In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

- We will bill your health plan for all service provided in the hospital Rebecca E. Stachniak, M.D. Any balance due is your responsibility and is due upon receipt of a statement from our office.

- In the event that your insurance company has not paid their balance in 45 days, it will be automatically billed directly to you. All debts that exhausted collection and are greater than 120 days old will be turned over to a collection agency unless you have made prior arrangements with our office.

- We will bill your health plan for assistant surgeon services if you require surgery. Any balance due, other than deductibles, related to assistant surgeon fees will **NOT** be your responsibility.

I have read and understand the financial policies above and agree to adhere to these policies.
I also understand that I may have a copy of this at my request.

Name of Patient (Print or Type)	Signature of Patient	Date

Brain & Spine of Texas

Rebecca Stachniak, MD

Office Policies and Procedures

We are delighted you have chosen our team to provide your neurosurgical care. Please take a moment to read the information below:

Staff:
Our clinical staff includes Rebecca Stachniak, M.D. a Board Certified Neurosurgeon and a Physician Assistant and/or Nurse Practitioner. During your appointment, you may see either one or both of these clinicians.

Office Hours:
Our office hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. Dr. Stachniak is in the operating room 2 ½ days a week. **Please understand that as a Neurosurgeon, Dr. Stachniak, must attend to emergencies occasionally and schedules are subject to change.**

Contacting the Office:
If you have an emergency please call 911 or immediately go to the nearest emergency room. For urgent matters during business hours, please choose option 1 to speak to a staff member. For non-emergency calls after hours, please call 972-943-9779 and leave a message with the answering service who will notify the physician on call. NOTE: Please be aware that if your phone is set to reject calls from anonymous callers, the physician will not be able to return your call. Please remove this feature from your phone.

Appointments:
Please arrive at least 30 minutes early to your first appointment (with your Driver's License and insurance card) and 15 minutes early to all consecutive appointments so that we may gather any new or updated information from you. We make every effort to see our patients in a timely matter. If you are late for your appointment, rescheduling MAY be necessary. Please understand that neurosurgical emergencies arise at times, which may require some waiting to see the physician or physician assistant. Effective September 1st, 2005, there will be a $35 charge if you do not give a 24hr notice for cancellations (by speaking directly to the staff) or if you do not show up for an appointment.

Films:
It is VERY IMPORTANT that you bring any relevant x-rays or films with you to your clinic appointments. We prefer you bring the actual films rather than a compact disk of the films. These films are NOT automatically sent to us and cannot under any circumstances be faxed. If we are unable to evaluate your films, we may have to reschedule your appointment. Please bring your current films with you to every appointment unless otherwise instructed by the staff.

Forms / Release of Medical Records:
Our records are released through AMRAS. Feel free to contact them at 972-272-4335. Our office will gladly fill out forms for insurance companies, employers or FMLA. A $35 fee will apply for completion of these forms. Please allow at least 10 days for all completion of forms requested.

Brain & Spine of Texas

Rebecca Stachniak, MD

Please sign and date form so that a copy may be placed in your medical file.
If you have any questions regarding the office policies that you were given, please feel free to discuss them with our administrative staff.

Please make sure that you have reviewed all of the policies pertaining to:

- Staff
- Office Hours
- Contacting the office
- Appointments
- Films
- Forms/Medical Records

I _____ have read and understand all office policies.

_____ _____

Signature Date

Brain & Spine of Texas

Rebecca Stachniak, MD

MEDICATION POLICY

Our goal at the Brain and Spine Center of Texas, LLP is to provide you with the best treatment possible in a pleasant and caring manner. We are sensitive to the pain you may be experiencing, and for that reason, you may be given medication to help your pain. The following medication policy is intended for the safety of our patients and to limit the chance of drug interactions.

- Medications should be taken only as prescribed.
- Patients must use one pharmacy for their medications and refills obtained through our office.
- **THE BRAIN AND SPINE CENTER OF TEXAS, LLP IS AVAILABLE TO REFILL PRESCRIPTION MEDICATIONS MONDAY THROUGH THURSDAY 8:00AM-3:00PM AND FRIDAY 8:00AM-12NOON.**
- Please allow 48 hours for all medication refills.
- Patients must contact their pharmacy for refills; they will fax the request to us.
- **Medications will not be filled on the weekend or after office hours.**
- Pain Medications will not be refilled early except in extreme circumstances and will be at the discretion of the physician and/or the physician assistant.
- **Failure to keep/schedule follow up appointments prevents us from being able to prescribe pain medications.** You will be asked to make appointments on a regular basis in order to receive prescriptions for medications.
- The Brain and Spine Center of Texas, LLP does not prescribe long-term narcotic pain medications. Patients requiring long-term pain medications will be referred to a pain management specialist for all medication needs.

DUE TO THE NEW DPS GUIDELINES REGARDING HYDROCODONE COMBINATION PRODUCTS (HCP'S), THE BRAIN & SPINE CENTER OF TEXAS WILL NOW REQUIRE ALL PATIENTS TO SCHEDULE AN APPOINTMENT FOR ALL REFILLS OF THIS TYPE OF MEDICATION. PLEASE UNDERSTAND IT WILL BE NECESSARY FOR YOU TO MONITOR YOUR MEDICATIONS CLOSELY AS HCP'S CAN NOT BE REFILLED OVER THE PHONE OR FAX. PLEASE CALL THE OFFICE 7 DAYS PRIOR TO YOUR NEXT REFILL.

I fully understand and agree to the medication policy. In addition, I understand that failure to comply with this policy will result in delayed or denied medication refills.

Name of Patient (Print or Type)	Signature of Patient	Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

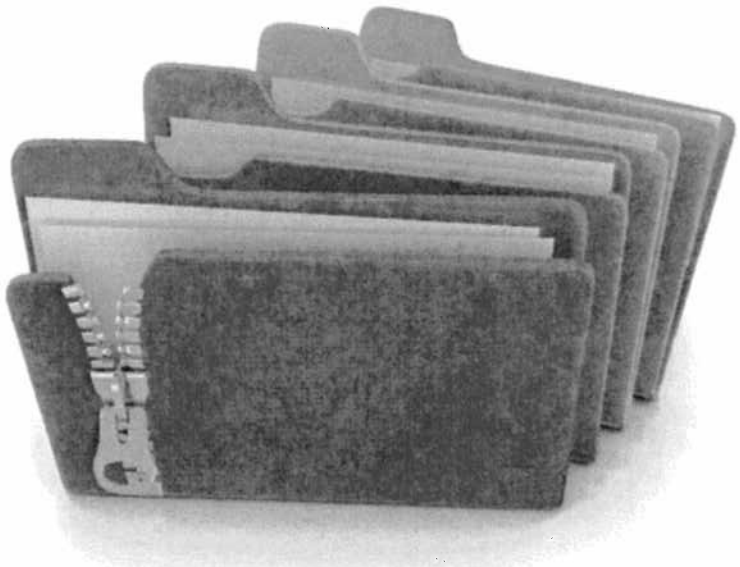
Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.



Your Information.
Your Rights.
Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on the back page. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

Our Uses and Disclosures

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

Brain & Spine of Texas

Rebecca Stachniak, MD

1200 Brooklyn, Ave Ste. 305
San Antonio, Texas 78212

Office 210-757-3217
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