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. THE PRIVACE OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your protected health information ('PHI'). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We are required to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 23, 2013, and will remain in effect until we replace it.

We reserve the right make the changes in our privacy practices provided that such changes are permitted by applicable law and the new terms are effective for all protected health information that we maintain, including medical information we created or received before we made the changes. We will provide you with a revised notice in person during your next office visit. You may also request a copy of our notice (or any subsequent revised notice) at any time. You may request a copy of our notice (or any subsequent revised notice) at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures of your protected health care information that may occur. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your dental and health care and any related services. This includes the coordination or management of your dental care with a third party or to other physicians who may be treating you. For example, we would disclose your PHI to other dentists or physicians in order to diagnose or treat you.

Payment: Your PHI may be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as: making a determination of eligibility or coverage for insurance benefits.

Health Care Operations: We may use or disclose, as needed, your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to quality assessments, reviewing the competence or qualifications of health care professionals, and conducting training programs. For example, Coast may use or disclose your health information in order to conduct an internal assessment of the quality of care we provide.

Business Associates: We will share your PHI with third party "business associates" that perform various activities (e.g. billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclose of your PHI, we will have a written contact that contains terms that will protect the privacy of your PHI.

Other Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your care or payment related to your health care or needed for notification purposes. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. We may disclose your PHI following your death to a family member or close personal friend who was involved in your care or payment prior to your death, however, we will not disclose any information if we are aware that you would not have wanted disclosure of your PHI.

Marketing: We may use or disclose your PHI, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. In order to receive this information, we are required to obtain an authorization from you. Should you not wish to receive these marketing materials, you may opt out on the authorization or by advising us using the contact information listed at the end of this notice.

Uses and Disclosures for which an authorization or an opportunity to agree or object is not required:

a. **Research; Death; Organ Donation**: We may use or disclose your PHI for research purposes in limited circumstances. We may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director, or organ procurement organization for certain purposes.

b. **Public Health and Safety**: We may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose your PHI to a government health agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public heath purposes.

c. **Health Oversight**:. We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

d. **Abuse or Neglect**: We may disclose your PHI to a governmental agency that is authorized by law to receive reports of abuse, neglect, or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

e. **Food and Drug Administration**: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

f. **Criminal Activity**:, We may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend and individual.

g. **Required by Law**: We may use or disclose your PHI when we are required to do so by law. For example, we must disclose your PHI to the U.S Department of Health and Human Services upon request for purposes of determining whether we are in compliance with privacy laws. We may disclose your PHI when authorized by workers' compensation or similar laws. We may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your PHI to law enforcement officials.

h. **Fugitive, material witness, crime victim, or missing person**. We may disclose PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

i. **Specialized Government activities**: We may disclose your PHI for military, national security, and prisoner purposes.

Your Protected Health Information Rights:

a. **Access**: You have the right to look at or get copies of your PHI, with limited exceptions. You may request electronic copies of your PHI contained in electronic health records or you may request in writing or electronically that another person receive an electronic copy of your records. If you request a copy of your electronic records, it will be provided in the format requested or in a mutually agreed-upon format. You may also request access by sending us a letter to the address at the end of this notice. We may charge you for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI or a reasonable cost-based fee to locate and copy your PHI that is not electronic and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or explanation of your PHI for a fee.

b. **Accounting of Disclosures**: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for the purpose other than treatment, payment, health care operations and certain other activities after April 14, 2003. After April 14, 2003, the accounting will be provided for the past six (6) years, if applicable. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

c. **Restriction Requests**: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make a request for additional restrictions must be in writing signed by a person

authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. You also have the right to restrict that we not share your PHI with a health plan for payment or operations purposes if the PHI relates to services for which you paid in full. For example, rather than allow us to file a claim with your dental insurance carrier for treatment of a specific dental condition, you chose to pay for the treatment in full, then you can restrict us from sharing your PHI related to that specific service with your dental insurance plan.

d. **Confidential Communication**: You have the right to request that we communicate with you in confidence about your PHI by alternative means or to an alternative location. You must make your request in writing. We must accommodate your request if it is reasonable, specifies the alternative means or locations, and continue to permit us to bill and collect payment from you.

e. **Amendment**: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reason. If we deny your request, we will provide you a written explanation. You may respond with a written disagreement of the denial. We will make reasonable efforts to inform others, including people or entities you name, of the amendment (if applicable) and to include the changes in any future disclosures of the information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information below. If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S Department of Health and Human Services.

Name of Privacy Officer: John Cassidy

Telephone: (941) 484-3404

E-Mail: theresa@cassidyguerin.com

PATIENT INFORMATION – PLEASE PRINT

PATIENT NAME: _____ SOCIAL SECURITY #: _____

LOCAL ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: _____ CELL: _____

EMAIL: _____ COMMUNICATION PREFERENCE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____

HAND DOMINANCE: LEFT or RIGHT RACE: _____ ETHNICITY: _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

PERSON RESPONSIBLE FOR BILL: _____

RELATIONSHIP: _____ D/O/B: _____ OWN OR RENT: _____

NORTHERN OR ALTERNATE ADDRESS: _____

PRIMARY DOCTOR: _____ REFERRING DOCTOR: _____

PHARMACY: _____ LOCATION (*Cross Street*): _____

CITY: _____ PHONE: _____

DO YOU HAVE AN ADVANCE DIRECTIVE?

_____ YES _____ NO NAME: _____

ARE WE SEEING YOU BECAUSE OF THE FOLLOWING?

AUTO ACCIDENT? _____ DATE: _____ WHERE OCCURRED: _____
WRITE YES OR NO

WORKERS COMPENSATION: _____ DATE: _____ REPORTED TO EMPLOYER: _____
WRITE YES OR NO WRITE YES OR NO

NAME OF YOUR ATTORNEY: _____ PHONE: _____

EMPLOYMENT INFORMATION

PATIENT EMPLOYER: _____ YOUR POSITION: _____

ADDRESS: _____ WORK PHONE: _____

PLEASE READ

PLEASE GIVE OUR RECEPTIONIST YOUR INSURANCE CARDS SO THAT WE MAY PHOTOCOPY THEM. WE HAVE REQUESTED YOUR INSURANCE INFORMATION FOR OUR RECORDS ONLY. PAYMENT IS EXPECTED AT THE TIME AF SERVICE, UNLESS WE PARTICIPATE WITH YOUR INSURANCE, OR YOU HAVE PREVIOUSLY SET UP A PAYMENT LAY WITH OUR OFFICE. **CO-PAYS AND DEDUCTABLES ARE DUE AT TIME OF SERVICE**. DR. CASSIDY AND DR. GUERIN DO PARTICIPATE WITH MEDICARE. PLEASE DO NOT HESITATE TO DISCUSS ANY QUESTIONS REGARDING INSURANCE OR PAYMENT WITH US.

PAST MEDICAL HISTORY:

Do you have or have you EVER had any of the following:

Self		
	Acid Reflux	
	Anesthesia problem	
	Angina	
	***Any* breathing problem**	
	***ANY* Heart problem**	
	Arthritis	
	Asthma	
	Bleeding problem	
	Bladder	
	Blood clots	
	Blood pressure	
	Blood Transfusion	
	Bowel	
	Cancer	
	Chest pain	
	Claustrophobia	
	COPD	
	Diabetes	
	Emphysema	
	Hearing Loss	
	Heart Fibrillation	
	Hepatitis	
	HIV or AIDS	
	Kidney problems	
	Pacemaker	
	Psychiatry evaluation	
	Recent fever	
	Seizures	
	Skin rash/Blisters	
	Sleep Apnea	
	Stroke	
	Tumor	
	Ulcers	
	Visual problems	
	Weight Change	
	****Other Medical Conditions:**	

FAMILY MEDICAL HISTORY: _____

_____

Neurosurgical Associates, Cassidy & Guerin, MD., P.A.

Name: _____ Date of Visit: _____

Date of Birth: _____ Gender: _____ Age: _____ Dr. You are seeing: _____

Family Physician: _____ Referring Physician: _____

TO BE COMPLETED BY OFFICE

Height: _____ Weight: _____ B/P: _____ Pulse: _____

MEDICAL HISTORY

WHAT MEDICAL PROBLEM BRINGS YOU HERE TODAY? _____

ALLERGIES

Yes: _____ No: _____

Latex Allergy: _____

List all allergies below:

ALL CURRENT MEDICATIONS

List drug names, dose, number of times per day

Do you take Aspirin? _____ Do you drink alcohol? _____ Smoker: Yes or No Amt: _____

RECENT FLU /PNEUMONIA VACCINE: YES or NO DATE: _____

OPERATIONS (Include Year)

MEDICAL ILLNESSES or HOSPITAL ADMINISSIONS (Include Year)

NEUROSURGICAL ASSOCIATES, CASSIDY & GUERIN, M.D., P.A.
AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT:

Name of Patient: _____ Patients Date of Birth: _____

Street Address: _____ City, State, Zip: _____

I AUTHORIZE:

Name: _____

Street Address: _____

City, ST, Zip: _____

RELEASE OF PROTECTED HEALTH INFORMATION FROM:

Neurosurgical Associates Dr Cassidy & Dr Guerin
842 Sunset Lake Blvd, Venice, FL 342923

INFORMATION TO BE RELEASED:

I hereby authorize you to release all of my medical records for any treatment and laboratory/diagnostic test performed except for information pertaining to:

_____ Testing or treatment of HIV/AIDS

_____ Treatment of alcohol or substance abuse

_____ Records from other facilities/providers

_____ Communications between patient and psychotherapist for mental health treatment

For the Following Date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Please check one)

_____ Further Medical Care

_____ Insurance/Eligibility

_____ Other (Specify): _____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

I understand I must be provided with a signed copy of this authorization and written notification is necessary to cancel this authorization. I understand I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Neurosurgical Assoc. Cassidy and Guerin, M.D., P.A will not be able to release my records to someone else without a signed authorization. If I decide not to sign this form, Neurosurgical Assoc. will not refuse to continue treatment. By signing this form, I do expressly and voluntarily consent to disclosure of the information checked above to the privacy person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by federal standards, the health information disclosure as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for copying these medical records.

_____ _____

SIGNATURE OF PATIENT/LEGAL REP: **TODAY'S DATE:**

If signed by other than patient, state relation and authority to do so

EXPIRATION DATE: This authorization is good until the following date(s): 1 year from date of signature