HAYNES NEUROSURGICAL GROUP, P.A.

801 Princeton Avenue Southwest
Suite 310
Birmingham, Alabama 35211
(205)787-8676 office (205)785-7944 fax

R. Cem Cezayirli, M.D Phillip Cezayirli, M.D. Robert J. Johnson Jr., M.D.

Pharmacy Information

Patient: ____

DOB: _______________________

Patient E-mail: ____

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone #: _______________________________

I authorize Haynes Neurosurgical Group, PA to download my pharmacy eligibility benefits.

____
Patient Signature

Haynes Neurosurgical Group, P.A.
801 Princeton Avenue Southwest
POB 1 Suite 310
Birmingham, AL. 35211

Patient Information

Patient Name: Last______________ First ______________ Middle ______________

Address____________________ City____________ State____ Zip Code______

Age_____ Date of Birth __________ Sex___ Marital Status _____ SSN#____________

Home Phone____________ Work Phone ____________ Cell Phone____________

Employer ____________________ Address __________________________

Referring Dr.________________________ Referring Dr. Ph. #________________

Primary Care Dr.______________________ Ph.#_________ Fax#:______________

Spouse's Name____________ Employer __________________ Phone____________

Person to notify in case of emergency____________________ Phone __________________
(Outside your home) (Other than your number)

Chief Complaint____________________________________

Were you injured at work ☐ YES ☐ NO If so how ________________________

Date of Injury ___/___/___

If you were injured at work, please complete the following:

Claim # __________________________ Contact Person______________________

W/C Company __________________________ Phone______________________

Address____________________________________ Fax __________________

Insurance Policy Information

Insurance (**Primary**)_________________Contract ___________Group ____________

Does your insurance require a referral to see a specialist? ☐ Yes ☐ No

Policy holder's name____________________ Date of Birth___/___/___ SSN#____________

Employer________________________ Relationship to policyholder__________________

Insurance (**Secondary**)_________________Contract ___________Group ____________

Does your insurance require a referral to see a specialist? ☐ Yes ☐ No

Policy holder's name____________________ Date of Birth___/___/___ SSN#____________

Employer________________________ Relationship to policyholder__________________

Consent for Treatment- I consent to necessary treatment, including drugs, medicine, performance of operation and conduct of x-rays, or other studies that may be used by the attending physician, his nurse or staff.

Authorization for Release of Information- I authorize Haynes Neurosurgical Group, P.A. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

Assignment of Benefits- I hereby authorize payment directly to Haynes Neurosurgical Group, P.A., to benefit otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the Haynes Neurosurgical Group, P.A. charges for these services. I understand that I am financially responsible to Haynes Neurosurgical Group, P.A. for charges not covered by this assignment the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

Guarantee Account- For services furnished by Haynes Neurosurgical Group, P.A., I hereby guarantee the payment of all account for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all cost of collection, including attorney fees.

SIGNATURE______________________________ DATE__________________

I have received and read a copy of MY HIPPA PRIVACY NOTICE

Signature______________________________ DATE__________________

Physicians List

Specialty:	Name:	Phone#:	Fax#:
Primary Care Doctor (PCP)			

Patient:________________ **New Patient Info. Form** Ht: ______ Wt: ______ Temp:________

Date: ____________ BP: ______ / ______ Pulse:________

HISTORY

CHIEF COMPLAINT:______________________________

HISTORY OF PRESENT ILLNESS:
- For an "Extended" history, document at least 4 of these elements

- Location________________ (Where is the pain/problem?)
- Quality________________ (Example of color of sputum)
- Severity________________ (How severe is the pain/problem?)
- Duration________________ (How long have you had this pain/problem? or When did it start?)
- Timing ________________ (Does this pain/problem occur at a specific time?)
- Context________________ (Where were you at the onset of this pian/problem?)
- Associated signs/symptoms________________ (What other associated problems have you been having?)
- Modifying factors________________ (What makes the pain/problem worse or better? Or Have you had any previous episodes?)

MEDICAL HISTORY:
- For a "Pertinent" history-at least 1 specific item for ANY ONE of the 3 histories
- For a "Complete" history-at least 1 specific item for EACH ONE of the 3 histories

- Patient medical history

Diabetes………………………… No Yes
Hypertension…………………… No Yes
Cancer………………………… No Yes
Stroke………………………… No Yes
Heart trouble…………………… No Yes
Arthritis/gout…………………… No Yes
Convulsions…………………… No Yes
Bleeding tendency……………… No Yes
Acute infections………………… No Yes
Venereal disease………………… No Yes
Hereditary defects……………… No Yes

Previous Hospitalizations/Surgeries/Serious Injuries When?

____
____
____
____

Medications

____
____
____
____

- Patient social history

Marital Status: Single ______ Married______ Separated______ Divorced ______ Widowed ______
Use of alcohol: Never ______ Rarely______ Moderate ______ Daily ______
Use of tobacco: Never ______ Previously, but quit ______ Current packs/day ______
Use of drugs: Never ______ Type/Frequency______________________________
Excessive exposure at home or work to: Fumes ______ Dust ______ Solvents ______ Air-borne particles______ Noise ______

- Family medical history

	Age	Diseases	If Deceased, Cause of Death
Father	______	______________________	______________________
Mother	______	______________________	______________________
Siblings	______	______________________	______________________
	______	______________________	______________________
Spouse	______	______________________	______________________
Children	______	______________________	______________________
	______	______________________	______________________
	______	______________________	______________________

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SYSTEM REVIEW:

Document the positive & pertinent negative responses
- For an "EXTENDED" system review - at least 2 systems
- For a "COMPLETE" system review - at least 10 systems (Dictate responses to pertinent systems, then state "All other systems negative")

- CONSTITUTIONAL SYMPTOMS
  - Good general health lately..... No Yes
  - Recent weight change..... No Yes
  - Fever..... No Yes
  - Fatigue..... No Yes
  - Headaches..... No Yes

- EYES
  - Eye disease or injury..... No Yes
  - Wear glasses/contact lenses..... No Yes
  - Blurred or double vision..... No Yes
  - Glaucoma..... No Yes

- EARS/NOSE/MOUTH/THROAT
  - Hearing loss or ringing..... No Yes
  - Earaches or drainage..... No Yes
  - Chronic sinus problem or rhitnitis..... No Yes
  - Nose bleeds..... No Yes
  - Mouth sores..... No Yes
  - Bleeding gums..... No Yes
  - Bad breath or bad taste..... No Yes
  - Sore throat or voice change..... No Yes
  - Swollen glands in neck..... No Yes

- CARDIOVASCULAR
  - Heart trouble..... No Yes
  - Chest pain or angina pectoris..... No Yes
  - Palpitation..... No Yes
  - Shortness of breath with walking or lying flat... No Yes
  - Swelling of feet, ankles or hands..... No Yes

- RESPIRATORY
  - Chronic or frequent coughs..... No Yes
  - Spitting up blood..... No Yes
  - Shortness of breath..... No Yes
  - Asthma or wheezing..... No Yes

- GASTROINTESTINAL
  - Loss of apetite..... No Yes
  - Change in bowel movements..... No Yes
  - Nausea or vomiting..... No Yes
  - Frequent diarrhea..... No Yes
  - Painful bowel movements or constipation..... No Yes
  - Rectal bleeding or blood in stool..... No Yes
  - Abdominal pain or heartburn..... No Yes
  - Peptic ulcer (stomach or duodenal)..... No Yes

- GENITOURINARY
  - Frequent urination..... No Yes
  - Burning or painful urination..... No Yes
  - Blood in urine..... No Yes
  - Change in force of strain when urinating..... No Yes
  - Incontinence or dribbling..... No Yes
  - Kidney stones..... No Yes
  - Sexual difficulty..... No Yes
  - Male- testicle pain..... No Yes
  - Female- pain with periods..... No Yes
  - Female- irregular periods..... No Yes
  - Female- vaginal discharge..... No Yes
  - Female- # Pregnancies______ # Miscarriages ______
  - Female- date of last pap smear__________________

- MUSCULOSKELETAL
  - Joint Pain..... No Yes
  - Joint stiffness or swelling..... No Yes
  - Weakness of muscles or joints..... No Yes
  - Muscle pain or cramps..... No Yes
  - Back Pain..... No Yes
  - Cold extremities..... No Yes
  - Difficulty in walking..... No Yes

- INTEGUMENTARY (skin,breast)
  - Rash or itching..... No Yes
  - Change in skin color..... No Yes
  - Change in hair or nails..... No Yes
  - Varicose veins..... No Yes
  - Breast pain..... No Yes
  - Breast lump..... No Yes
  - Breast discharge..... No Yes

- NEUROLOGICAL
  - Frequent or recurring headaches..... No Yes
  - Light headed or dizzy..... No Yes
  - Convulsions or seizures..... No Yes
  - Numbness or tingling sensations..... No Yes
  - Tremors..... No Yes
  - Paralysis..... No Yes
  - Stroke..... No Yes
  - Head injury..... No Yes

- PSYCHIATRIC
  - Memory loss or confusion..... No Yes
  - Nervousness..... No Yes
  - Depression..... No Yes
  - Insomnia..... No Yes

- ENDOCRINE
  - Glandular or hormone problem..... No Yes
  - Thyroid disease..... No Yes
  - Diabetes..... No Yes
  - Excessive thirst or urination..... No Yes
  - Heat or cold intolerance..... No Yes
  - Skin becoming dryer..... No Yes
  - Change in hat or glove size..... No Yes

- HEMATOLOGIC/LYMPHATIC
  - Slow to heal after cuts..... No Yes
  - Bleeding or bruising tendency..... No Yes
  - Anemia..... No Yes
  - Phlebitis..... No Yes
  - Past transfusion..... No Yes
  - Enlarged glands..... No Yes

- ALLERGIC/IMMUNOLOGIC
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics..... No Yes
    - Morphine, Demerol, or other narcotics.. No Yes
    - Novocaine or other anesthetics..... No Yes
    - Aspirin or other pain remedies..... No Yes
    - Tetanus antitoxin or other serums..... No Yes
    - Iodine, methiolate or other antiseptic.... No Yes
  - Other drugs/medications__________________
  - Known food allergies __________________

Pain Drawing and Pain Scale

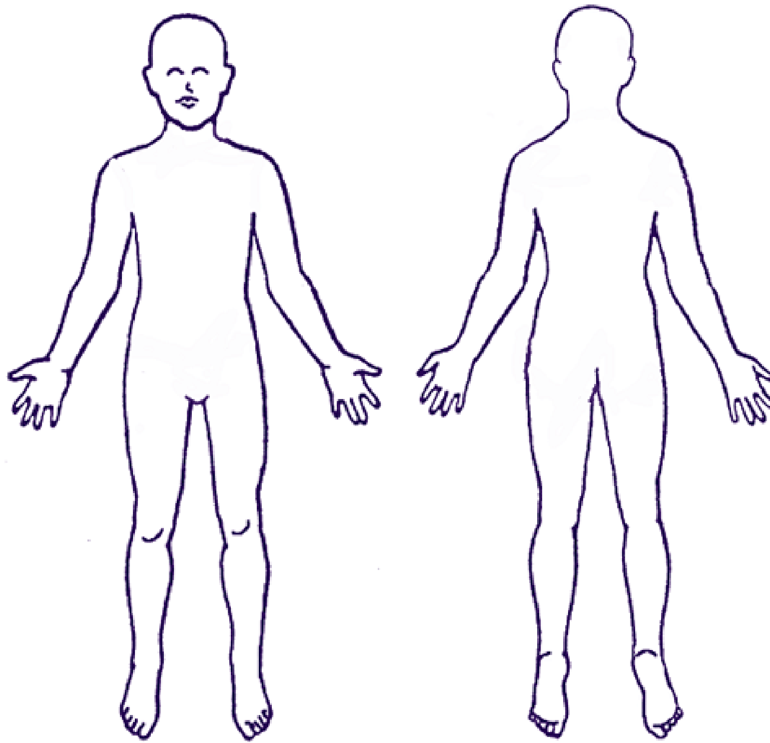
Patient Name____Date_________________

Pain Location

Draw the location of your pain on the body below using these symbols:

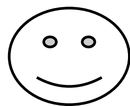
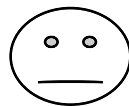
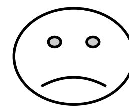
000 – Pins and needles XXX – Burning ··· - Numbness

/// - Stabbing +++ - Dull Ache



Rate your Pain

Circle the number on the scale below that best describes your pain today.

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

Moderate Pain

Oswestry

Name______________________ Date ____________ Patient Number __________

How long have you had back pain? ______ years ______ weeks ______ months

How long have you had leg pain? ______ years ______ weeks ______ months

Please Read:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage every day life. Please answer every section and mark in each section only the **one** box which applies to you, but please just mark the one box which most closely describes your problem.

Section 1-Pain Intensity

- ☐ I can tolerate the pain without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain and I do not use them.

Section 2-Personal Care-(washing, dressing, etc)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myslef normally but it causes extra pain.
- ☐ It is painful to look after myself and I and slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

Section 3-Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavyweights off the floor, but I can manage if they are conveniently positioned on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4-Walking

- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me from walking more than a mile.
- ☐ Pain prevents me from walking more than $1/2$ mile.
- ☐ Pain prevents me from walking more than $1/4$ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5-Sitting

- ☐ I can sit in any chair for as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than an hour.
- ☐ Pain prevents me from sitting more than $1/2$ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6-Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7-Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours.
- ☐ Even when I take tablets I have less than 4 hours.
- ☐ Even when I take tablets I have less than 2 hours.
- ☐ Pain prevents me from sleeping at all.

Section 8-Sex Life

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severly restricted by pain.
- ☐ My sex life is nearly absent because of my pain.
- ☐ Pain prevents any sex life at all.

Section 9-Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest.
- ☐ Pain has restricted my social life and I do not go out often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10-Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than an hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to doctor or Hospital.

Comments: ____

____

____

The Neck Disability Index

Patient name: ______________________________ File #____________ Date: ____________

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

SECTION 1-PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2-PERSONAL CARE (washing, dressing, etc)

- ☐ I can look after myself normally, without extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3-LIFTING

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4-READING

- ☐ I can read as much as I want to, with no pain in my neck.
- ☐ I can read as much as I want to, with slight pain in my neck.
- ☐ I can read as much as I want to, with moderate pain in neck.
- ☐ I can't read as much as I want, because of moderate pain in my neck.
- ☐ I can hardly read at all, because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5-HEADACHES

- ☐ I have no headaches at all
- ☐ I have slight headaches that come infrequently
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6-CONCENTRATION

- ☐ I can concentrate fully when I want to, with no difficulty.
- ☐ I can concentrate fully when I want to, with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7-WORK

- ☐ I can do as much work as I want to.
- ☐ I can do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8-DRIVING

- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want, with slight pain in my neck.
- ☐ I can drive my car as long as I want, with moderate pain in my neck.
- ☐ I can't drive my car as long as I want, because of moderate pain in my neck.
- ☐ I can hardly drive at all, because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9-SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed(1-2 hours sleepless).
- ☐ My sleep is moderately disturbed (2-3 hours sleepless).
- ☐ My sleep is greatly disturbed (3-5 hours sleepless).
- ☐ My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10-RECREATION

- ☐ I am able to engage in all my recreation activities, with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some neck pain.
- ☐ I am able to engage in most, but not all, of my usual recreation activities, because of pain in my neck.
- ☐ I am able to engage in a few of my recreation activities, because of pain in my neck.
- ☐ I can hardly do any recreation activities, because of pain in my neck.
- ☐ I can't do any recreation activities as all.

Haynes Neurosurgical Group, P.A.
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(205)787-8676 office *(205)785-7944 fax*
R. Cem Cezayirli, M.D. **Robert J. Johnson Jr., M.D.**

Statement of Patient Financial Responsibility

PATIENT NAME:____________________________________ DOB: _______________________
(Printed)

Haynes Neurosurgical Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of out fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

In the event that your balance is not paid in full within the allotted time, you understand that collection procedures will begin. Collection procedures include, but are not limited to, a series of collection letters, being turned to a collection agency, 2.5% monthly interest dated back to the date of services performed, and having your account turned over to a lawyer. You waive all claims of exemption under the State of Alabama and agree to pay if necessary, all cost of collection, including attorney fees.

I have read the above policy regarding my financial responsibilty to Haynes Neurosurgical Group, P.A., for providing medical/rehabilitative services to me or to the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Haynes Neurosurgical Group, P.A., the full and entire amount of the bill incurred by me or the above named patient; or, if applicable any amoount of due after payment has been made by my insurance carrier is my responsibility.

PATIENT SIGNATURE:__________________________________ DATE:_________________

GUARANTOR SIGNATURE:______________________________ DATE:_________________
(If guarantor is not patient)

HAYNES NEUROSURGICAL GROUP, P.A.
801 PRINCETON AVENUE SOUTHWEST
POB 1 SUITE 310
BIRMINGHAM, ALABAMA 35211

Phone: (205) 787-8676 Fax: (205) 785-7944

Receipt for HIPPA Privacy Notice and Authorization to Obtain or Release Medical Information

Name:______________________ Date of Birth:______________
SSN:______________________ Date of Request:______________

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained or released may be subject to re-disclosure by the recipient of the health information and no longer protected by the federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Haynes Neurosurgical Group, P.A. in writing, but if I do, it will not have effect on the uses of disclosures prior to the receipt of the revocation.

I hereby authorize Haynes Neurosurgical Group, P.A. to use, disclose health information as follows:

Release to:______________________ Relation to patient:______________
(name)

Address:______________________ Phone number:______________

Release to:______________________ Relation to patient:______________
(name)

Address:______________________ Phone number:______________

PLEASE NOTE THAT BY CHECKING ANY BOX BELOW MAY RESULT IN THE STAFF OF HNS LEAVING YOUR PROTECTED HEALTH INFORMATION ON AN ANSWERING MACHINE AT THE NUMBER REQUESTED BY YOU.

YES NO The physicians and staff of Haynes Neurosurgical Group may confirm appointments to my answering machine at the number provided on my Patient Information Sheet.

YES NO The physicians and staff of Haynes Neurosurgical Group may release information to my pharmacy without prior authorization in order to allow call-in of prescription.

SPECIAL INSTRUCTIONS:

____
____
____

My signature below is acknowledgement that I have received a copy of the Haynes Neurosurgical Privacy Notice and that I agree to the conditions stated in the notice:

Patient Signature:______________________ **Date:**______________

Haynes Neurosurgical Group, P.A.
Notice of Privacy Practices

Haynes Neurosurgical Group, P.A. is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information:

- We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment, or health care operations.
- We may disclose your health care information to your insurance provider for the purpose of payment or health care operations.
- We may disclose your health care information as necessary to comply with State Workers' Compensation Laws.
- We may disclose your health care information to notify, or assist in notifying, a family member or another person responsible for your care about your medical condition in the event of an emergency or of your death.
- As required by law, we may disclose your health information to public authorities for purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting the Food and Drug Administration problems with products and reactions to medication, and reporting disease or infection exposure.
- We may disclose your health care information in the course of any administrative or judicial proceeding.
- We may disclose your health care information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose your health care information to coroners or medical examiners.
- We may disclose your health care information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose your health care information to researchers conducting research that has been approved by an Institutional Revenue Board.
- It may be necessary to disclose your health care information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
- We may disclose your health care information for military, national security, prisoner and government benefits purposes.

In the event that Haynes Neurosurgical Group, P.A. is sold or mergred with another organization, your health information/records will become property of the new owner.

Your Health Care Information Rights:

- You have the right to request restrictions on certain uses and disclosures of your health care information. Please be advised however, that Haynes Neurosurgical Group, P.A. is not required to agree to the restriction that you requested.
- You have the right to have your health care information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.
- You have the right to inspect and copy your health care information.
- You have the right to request that Haynes Neurosurgical Group, P.A. amend your protected health care information. Please be advised, however, that Haynes Neurosurgical Group, P.A. is not required to agree to amend your protected health information. If your request to amend is denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

Haynes Neurosurgical Group, P.A. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Haynes Neurosurgical Group, P.A. is required by law to comply with this notice.

If you are not satisfied with the manner in which this office handles your information, you may contact:

DHHS, Office of Civil Rights
200 Independence Ave. S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Haynes Neurosurgical Group, P.A. with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice, effective as of the date signed below.

____
Patient's Name (print)

______________________________________ ______________________
Patient's Signature Date

______________________________________ ______________________
Authorized Facility Signature Date

Haynes Neurosurgical Group, P.A.

801 Princeton Avenue, Southwest
POB I, Suite 310
Birmingham, AL 35211

Phone: (205) 787-8676 Fax: (205) 785-7944

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ____

Address: ____

Date of Birth: ________________________ Date of Request: ______________________

As required by the Privacy Regulations, Haynes Neurosurgical Group, PA, may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:
Patient Health Information authorization to be disclosed:

____

For the specific purpose of (describe in detail)

____

Effective dates for this authorization: ___/____/___ through ____/___/____. This authorization will expire at the end of the above period

I understand that the information disclose above may be re-disclosed to additional parties and no longer protected for reasons beyond out control.

I understand I have the right to:

1. Revoke this authorization by sending a written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

____ ____________
Signature of Patient or Patient's Authorized Representative *Date*

____ ____________
Authorized Signature of Facility *Date*