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

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._____ Primary Care Dr. Ph. #_____

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-ray's, 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 _____

Name _____ Date _____

CHIEF COMPLAINT

_____
_____

HISTORY OF PRESENT ILLNESS

- **Location** – Where is the pain/problem?
  _____
  _____

- **Severity** – How severe is the pain/problem?
  _____
  _____

- **Timing** – When does this pain occur?
  _____
  _____

- **Associated signs/symptoms** – What other associated problems have you been having?
  _____
  _____

- **Quality** – What is the quality of your pain/problem?
  _____
  _____

- **Duration** – How long have you had this pain/problems? Or, when did it start?
  _____
  _____

- **Context** – Where were you at the onset of this pain/problem?
  _____
  _____

- **Modifying factors** – What makes the pain/problem worse? What makes the pain/problem better?
  _____
  _____

MEDICAL HISTORY
(Check all that apply)

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusions
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Cataract
- ☐ Chronic bronchitis
- ☐ COPD
- ☐ Congestive heart failure
- ☐ Deep vein thrombosis
- ☐ Depression
- ☐ Diabetes
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Fibromyalgia
- ☐ Gastro esophageal reflux disease
- ☐ Glaucoma
- ☐ Gout
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Restless leg syndrome
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stroke

SURGICAL HISTORY
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____
Surgery_____Date_____

FAMILY HISTORY
☐ Adopted

Father	Mother	Siblings
__alive	__alive	__alive
__deceased	__deceased	__deceased
__Alzheimer's	__Alzheimer's	__Alzheimer's
__Cancer	__Cancer	__Cancer
__Diabetes	__Diabetes	__Diabetes
__Heart disease	__Heart disease	__Heart disease
__Hypertension	__Hypertension	__Hypertension
__Stroke	__Stroke	__Stroke
__Other	__Other	__Other

SOCIAL HISTORY
Employment Employed Unemployed Retired Student
Alcohol Never Moderate Rarely Past only
Illegal Drugs Never Currently Past only
Tobacco Never Currently Past only
Marital Status Single Married Divorced Separated Widowed
Number of Children_____

MEDICATIONS
NAME DOSAGE DIRECTIONS
_____
_____
_____
_____
_____
_____
_____
_____
_____

FOOD REACTIONS
____ No known food allergies
____ Eggs headache hives rash other
____ Milk headache hives rash other
____ Shellfish headache hives rash other
____ Other (please list)
_____ headache hives rash other
_____ headache hives rash other

DRUG ALLERGIES

____ No known drug allergies
____ Aspirin/
other pain remedies headache hives rash other
____ Iodine headache hives rash other
____ Morphine headache hives rash other
____ Novocaine/
other anesthetics headache hives rash other
____ NSAIDS headache hives rash other
____ Penicillins headache hives rash other
____ Tetanus headache hives rash other
____ Other (please list)
_____ headache hives rash other
_____ headache hives rash other

ENVIRONMENTAL ALLERGIES
____ No known environmental allergies
____ Latex headache hives rash other
____ Tape headache hives rash other
____ Topical Iodine headache hives rash other

SPECIALTY QUESTIONS
Who is your family doctor_____
Who referred you to this clinic_____
What other doctors do you see_____
_____
Do you have a pacemaker_____
Do you have a stent_____
Is your pain related to a work injury? YES NO
If so, when were you injured_____
If so, how were you injured_____
_____

CONSTITUTIONAL

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	NO	YES
Wear contacts	NO	YES
Blurred or double vision	NO	YES
Glaucoma	NO	YES

EARS/NOSE/THROAT/NECK

Hearing loss or ringing	NO	YES
Earaches	NO	YES
Chronic sinus problem or rhinitis	NO	YES
Nosebleeds	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 pressure	NO	YES
Palpitations	NO	YES
Shortness of breath	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
Wheezing	NO	YES

GASTROINTESTINAL

Loss of appetite	NO	YES
Change in bowel movements	NO	YES
Nausea	NO	YES
Vomiting	NO	YES
Frequent diarrhea	NO	YES
Painful bowel movements	NO	YES
Rectal bleeding or blood in stool	NO	YES
Abdominal pain	NO	YES
Heartburn	NO	YES
Peptic ulcer (stomach or duodenal)	NO	YES

GENITOURINARY/NEPHROLOGY

Frequent urination	NO	YES
Burning or painful urination	NO	YES
Blood in urine	NO	YES
Change in force of stream when urinating	NO	YES
Incontinence or dribbling	NO	YES
Kidney stones	NO	YES
Sexual difficulty	NO	YES

GENITOURINARY/NEPHROLOGY (CONT.)

MALE-Testicular pain	NO	YES
FEMALE-Menstrual pain	NO	YES
FEMALE-Menstrual irregularity	NO	YES
FEMALE-Vaginal discharge	NO	YES

FEMALE-Number of pregnancies_____
FEMALE-Number of miscarriages_____

MUSCULOSKELETAL

Joint pain	NO	YES
Joint stiffness	NO	YES
Joint swelling	NO	YES
Muscle weakness	NO	YES
Muscle pain or cramps	NO	YES
Back pain	NO	YES
Difficulty in walking	NO	YES

DERMATOLOGIC

Rash	NO	YES
Itching	NO	YES
Change in skin color	NO	YES
Change in hair or nails	NO	YES
Varicose veins	NO	YES

NEUROLOGIC

Frequent or recurring headaches	NO	YES
Lightheaded or dizziness	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 problems	NO	YES
Thyroid disease	NO	YES
Diabetes	NO	YES
Excessive thirst or urination	NO	YES
Heat or cold intolerance	NO	YES

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	NO	YES
Bleeding or bruising tendency	NO	YES
Anemia	NO	YES
Phlebitis (clot in leg vein)	NO	YES
Past transfusion	NO	YES

ALLERGIES

Penicillin or other antibiotics	NO	YES
Morphine, Demerol or other narcotics	NO	YES
Novocaine or other anesthetics	NO	YES
Aspirin or NSAIDS	NO	YES
Tetanus or other serums	NO	YES
Iodine or other antiseptics	NO	YES

Other drugs_____
Food Allergies_____

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. often.
- ☐ 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
- ☐ 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.

Pain Drawing and Pain Scale

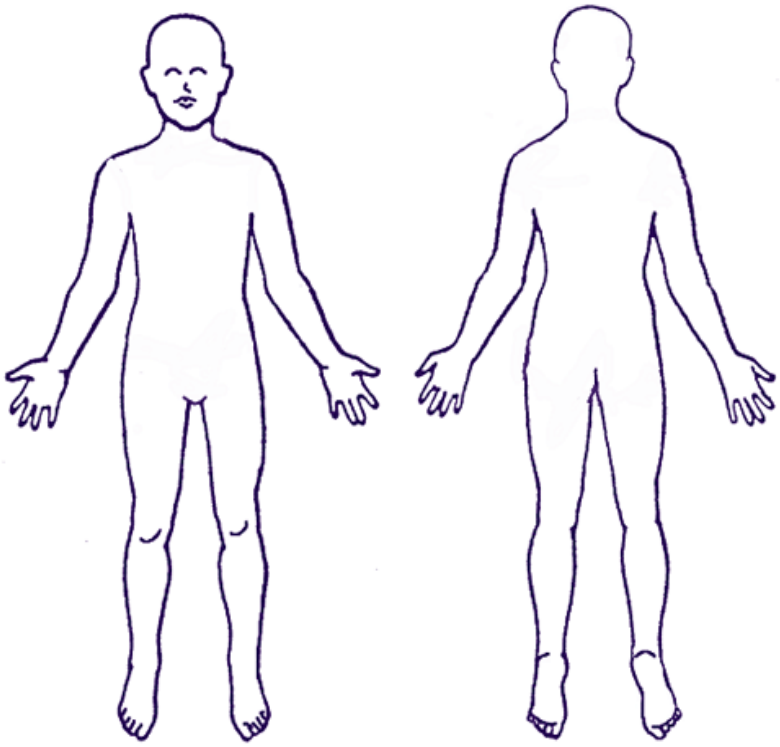
Patient Name_____Date_____

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

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. **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 our 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*