SPINE & BRAIN SURGERY, LLC
RISHI N. SHETH, MD
5341 W. ATLANTIC AVENUE, STE #302
DELRAY BEACH, FL 33484

SPINE & BRAIN SURGERY
RISHI N. SHETH, MD

DEMOGRAPHIC INFORMATION:

DATE: _____

LAST NAME: _____ FIRST NAME: _____

DOB: _____ AGE: _____ GENDER: M/F

HEIGHT: _____WEIGHT: _____LBS. MARITAL STATUS: SINGLE/MARRIED/WIDOWED/DIVORCED

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____ ALT PHONE: _____

ARE YOU CURRENTLY EMPLOYED? YES/NO/RETIRED OCCUPATION: _____

REASON FOR VISIT - CHIEF COMPLAINT

(PLEASE DESCRIBE THE MAIN PROBLEM THAT BRINGS YOU IN TODAY):

_____

PAIN ASSEMENT

RATE YOUR PAIN ON A SCALE OF 0-10 (10 BEING THE WORST PAIN)

HEADACHES: _____

NECK PAIN: _____

LOW BACK PAIN: _____

OTHER AREA: _____

DOES YOUR PAIN INTERFERE WITH ANY OF THE FOLLOWING?

WORK SLEEP WALKING BATHING DRESSING SEX HOBBIES OTHER: _____

LEGAL ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL PLAN/DOCUMENTS

NAME_____

IN CONSIDERING THE AMOUNT OF MEDICAL EXPENSES TO BE INCURRED, I THE UNDERSIGNED, HAVE INSURANCE AND/OR EMPLOYEE HEALTH CARE BENEFITS COVERAGE WITH THE PREVIOUSLY LISTED COMPANY, AND HEREBY ASSIGN AND CONVEY DIRECTLY TO SPINE AND BRAIN SURGERY, LLC ALL MEDICAL BENEFITS AND/OR INSURANCE REIMBURSEMENT, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED FROM SUCH DOCTOR AND CLINIC. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL THE CHARGES REGARDLESS OF ANY APPLICABLE INSURANCE OR BENEFIT PAYMENTS. I AUTHORIZE THE DOCTOR TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I HEREBY AUTHORIZE ANY PLAN ADMINISTRATOR OR FIDUCIARY, INSURER TO RELEASE TO SUCH DOCTOR AND CLINIC ALL PLAN DOCUMENTS, INSURANCE POLICY INFORMATION UPON WRITTEN REQUEST FROM SUCH DOCTOR AND CLINIC IN ORDER TO CLAIM SUCH MEDICAL BENEFITS, REIMBURSEMENT OR ANY APPLICABLE REMEDIES. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE AND/OR EMPLOYEE HEALTH BENEFITS CLAIM SUBMISSIONS.

I HEREBY CONVEY TO THE ABOVE NAMED PROVIDER TO THE FULL EXTENT PERMISSIBLE UNDER THE LAW AND UNDER ANY APPLICABLE INSURANCE POLICIES AND/OR EMPLOYEE HEALTH CARE PLAN ANY CLAIM, CHOOSE IN ACTION, OR OTHER RIGHT I MAY HAVE TO SUCH INSURANCE AND/OR EMPLOYEE HEALTH CARE BENEFITS COVERAGE UNDER ANY APPLICABLE INSURANCE POLICIES RECEIVED FROM THE ABOVE NAMED DOCTOR AND CLINIC AND TO THE EXTENT PERMISSIBLE UNDER THE LAW TO CLAIM SUCH MEDICAL BENEFITS, INSURANCES REIMBURSEMENT AND ANY APPLICABLE REMEDIES. FUTHER, IN RESPONSE TO ANY REASONABLE REQUEST FOR COOPERATION, I AGREE TO COOPERATE WITH SUCH DOCTOR AND CLINIC IN ANY ATTEMPTS BY SUCH DOCTOR AND CLINIC TO PERSUE SUCH CLAIM, CHOOSE IN ACTION OR RIGHT AGAINST MY INSURERS AND/OR EMPLOYEE HEALTH CARE PLAN IN MY NAME BUT AT THE SUCH DOCTOR'S EXPENSE.

THE LIFETIME ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING, A PHOTOCOPY OF THIS ASSIGNMENT IS NOT TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

SIGNATURE: _____ DATE: _____

I UNDERSTAND THAT I AM ENTERING A CONTRACTUAL RELATIONSHIP WITH SPINE AND BRAIN SURGERY, LLC FOR PROFESSIONAL CARE. I UNDERSTAND THAT MERITLESS AND FRIVOLOUS CLAIMS FOR MEDICAL MALPRACTICE HAVE AN ADVERSE EFFECT UPON THE COST AND AVAILABILITY OF MEDICAL CARE, AND MAY RESULT IN IRREPARABLE HARM TO A MEDICAL PROVIDER. AS ADDITIONAL CONSIDERATION FOR PROFESSIONAL CARE PROVIDED TO ME BY SPINE AND BRAIN SURGERY, LLC, I (THE PATIENT) AND/OR MY REPRESENTATIVE AGREE NOT TO ADVANCE, DIRECTLY OR INDIRECTLY, ANY FALSE MERITLESS, AND/OR FRIVOLOUS CLAIM(S) OF MEDICAL MALPRACTICE.

FURTHERMORE, SHOULD A MERITORIOUS MEDICAL MALPRACTICE CLAIM OR CAUSE OF ACTION BE INITIATED OR PURSUED, (THE PATIENT AND/OR MY REPRESENTATIVE), AGREE TO USE AN ABMS BOARD CERTIFIED EXPERT WITNESS IN THE SAME OR SIMILAR SPECIALTY. I AGREE THAT THESE EXPERT WITNESSES WILL ADHERE TO THE GUIDELINES AND/OR CODE OF CONDUCT DEFINED BY THE SPECIALTY SOCIETIES FOR EXPERT WITNESSES IN MEDICINE THAT WOULD TYPICALLY HAVE THE BACKGROUND AND EXPERIENCE TO OPINE ON SUCH CASE. IN FURTHER CONSIDERATION FOR THIS, I (THE PHYSICIAN), AGREE TO THE SAME STIPULATIONS.

SIGNATURE: _____ DATE:_____

HIPPA PRIVACY NOTICE

- YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY BE RELEASED TO OTHER HEALTHCARE PROFESSIONALS WITHIN THE ORGANIZATION FOR THE PURPOSE OF PROVIDING YOU WITH QUALITY HEALTHCARE.
- YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY BE RELEASED TO YOUR INSURANCE PROVIDER FOR THE PURPOSE OF THE ORGANIZATION RECEIVING PAYMENT FOR PROVIDING YOU WITH NEEDED HEALTHCARE SERVICES.
- YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY BE RELEASED TO THE PUBLIC OR LAW ENFORCEMENT OFFICIALS IN THE EVENT OF AN INVESTIGATION IN WHICH YOU ARE THE VICTIM OF ABUSE, A CRIME OR DOMESTIC VIOLENCE.
- YOUR CONFIDENTIAL HEALTHCARE MAY BE RELEASED TO OTHER HEALTHCARE PROVIDERS IN THE EVENT YOU NEED EMERGENCY CARE.
- YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY BE RELEASED TO A PUBLIC HEALTH ORGANIZATION OR FEDERAL ORGANIZATION IN THE EVENT OF A
  COMMUNICABLE DISEASE OR TO REPORT A DEFECTIVE DEVICE OR UNTOWARD EVENT TO A BIOLOGICAL PRODUCT (FOOD OR MEDICATION).
- YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY NOT BE RELEASED FOR ANY PURPOSE THAN THAT WHICH IS IDENTIFIED IN THIS NOTICE.
- YOUR CONFIDENTIAL HEALTHCARE INFORMATION MAY BE RELEASED ONLY AFTER RECEIVING WRITTEN AUTHORIZATION FROM YOU. THIS PROVISION INCLUDES BUT IS NOT LIMITED TO ANY PSYCHOTHERAPY NOTES, FOR MARKETING PURPOSES AND ANY DISCLOSURES THAT MAY CONSTITUTE A SALE OF YOUR PROTECTED HEALTHCARE INFORMATION. ANY OTHER USE OR DISCLOSURES NOT DESCRIBED IN THIS NOTICE CAN ONLY BE MADE WITH YOUR EXPRESS AUTHORIZATION. YOU MAY REVOKE YOUR PERMISSION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION AT ANY TIME.
- YOU MAY RESTRICT THE DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION FOR ANY SERVICES PROVIDED WHEREBY YOU SOMEBODY ELSE PAYS "OUT OF POCKET", IN FULL, FOR THE SERVICES.
- YOU MAY BE CONTACTED BY THE ORGANIZATION TO REMIND YOU OF ANY APPOINTMENTS.
- YOU HAVE THE RIGHT TO OPT OUT OF NOTIFICATIONS REGARDING HEALTHCARE TREATMENT OPTIONS, MARKETING AND FUNDRAISING, OR OTHER HEALTH SERVICES THAT MIGHT BE OF INTEREST TO YOU.
- YOU MAY BE CONTACTED BY THE ORGANIZATION FOR THE PURPOSE OF RASING FUNDS TO SUPPORT THE ORGANIZATION'S OPERATIONS. IT IS YOUR EXPRESS RIGHT TO OPT OUT OF ANY FUND-RASING COMMUNICATIONS.
- YOU HAVE THE RIGHT TO RESTRICT THE USE OF YOUR CONFIDENTIAL HEALTHCARE INFORMATION. HOWEVER, THE ORGANIZATION MAY CHOOSE TO REFUSE YOUR RESTRICTION IF IT IS IN CONFLICT OF PROVIDING YOU WITH THE QUALITY HEALTHCARE OR IN THE EVENT OF AN EMERGENCY SITUATION.
- YOU HAVE THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATION ABOUT YOUR HEALTH STATUS.
- YOU HAVE THE RIGHT TO REVIEW AND PHOTOCOPY AND/ALL PORTIONS OF YOUR HEALTHCARE INFORMATION.
- YOU HAVE THE RIGHT TO MAKE CHANGES TO YOUR HEALTHCARE INFORMATION
- YOU HAVE THE RIGHT TO KNOW WHO HAS ACCESSED YOUR CONFIDENTIAL HEALTHCARE INFORMATION AND FOR WHAT PUPOSE.
- YOU HAVE THE RIGHT TO POSSESS A COPY OF THIS PRIVACY NOTE UPON REQUEST. THIS COPY CAN BE IN THE FORM OF AN ELECTRONIC TRANSMISSION OR ON PAPER.
- THE ORGANIZATION IS REQUIRED BY LAW TO PROTECT THE PRIVACY OF ITS PATIENTS. IT WILL KEEP CONFIDENTIAL ANY AND ALL PATIENT'S HEALTHCARE INFORMATION.
- THE ORGANIZATION WILL PROMPTLY CONTACT YOU SHOULD THERE BE A BREACH OF YOUR PROTECTED HEALTH INFORMATION.
- THE ORGANIZATION WILL ABIDE BY THE TERM OF THIS NOTICE. THE ORGANIZATION RESERVES THE RIGHTS TO MAKE CHANGES TO THIS NOTICE AND CONTINUE TO MAINTAIN THE CONFIDENTIALITY OF ALL HEALTHCARE INFORMATION.
- YOU HAVE THE RIGHT TO COMPLAIN TO THE ORGANIZATION IF YOU BELIEVE YOUR RIGHT TO PRIVACY HAS BEEN VIOLATED. IF YOU FEEL YOUR PRIVACY RIGHT HAS BEEN VIOLATED, PLEASE MAIL YOUR COMPLIANT TO THE ORGANIZATION:

SPINE & BRAIN SURGERY, LLC
RISHI N. SHETH, MD
5341 W. ATLANTIC AVENUE, SUITE 302
DELRAY BEACH, FL 33484

- ALL THE COMPLAINTS WILL BE INVESTIGATED. NO PERSONAL ISSUE WILL BE RAISED FOR FILING A COMPLAINT WITH THE ORGANIZATION.

- FOR FURTHER INFORMATION ABOUT THIS PRIVACY NOTICE, PLEASE CONTACT 561-403-5175.

- THIS NOTICE IS EFFECTIVE AS OF 1/1/16. THIS DATE MUST NOT BE EARLIER THAN THE DATE ON WHICH THE NOTICE IS PRINTED OR PUBLISHED.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

SPINE & BRAIN SURGERY, LLC WOULD UKE TO SECURE YOUR ACKNOWLEDGEMENT OF RECIPT OF THIS NOTICE OF PRIVACY PRACTICES("NOTICE"). YOUR ACKNOWLEDGMENT OR LACK OF ACKNOWLEDGEMENT OF THIS NOTICE WILL NOT AFFECT YOUR MEDICAL BENEFITS. YOU WILL CONTINUE TO RECEIVE THE SAME SERVICE AS USUAL.

PLEASE NOTE THAT THIS ACKNOWLEDGMENT APPLIES ONLY TO YOU. OTHER MEMBERS OF YOUR FAMILY WHO ARE ON YOUR MEDICAL BENEFITS PLAN SHOULD MAKE A SEPARATE ACKNOWLEDGEMENT THAT THEY HAVE READ THE NOTICE OF PRIVACY PRACTICES.

SIGNED _____ DATE _____

PRINT NAME _____

WITNESS _____ DATE _____

PRINT NAME _____

MEDICAL INFORMATION RELEASE FORM

HIPPA RELEASE FORM

NAME: _____ **DATE OF BIRTH** _____/_____/_____

RELEASE OF INFORMATION

[ ] I AUTHORIZE THE RELEASE OF INFORMATION, INCLUDING THE DIAGNOSIS, RECORDS, PRESCRIPTIONS, EXAMINATION RENDERED TO ME AND CLAIMS INFORMATION. THIS INFORMATION MAY BE RELEASED TO:

[ ] SPOUSE

[ ] CHILD[REN]

[ ] OTHER

[ ] INFORMATION IS NOT TO RELEASED TO ANYONE.

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

MESSAGES

PLEASE CALL: [ ] MY HOME [ ] MY WORK [ ] MY CELL NUMBER: _____

IF UNABLE TO REACH ME:

[ ] YOU MAY LEAVE A DETAILED MESSAGE

[ ] PLEASE LEAVE A MESSAGE ASKING ME TO RETURN YOUR CALL

[ ] _____.

THE BEST TIME TO REACH ME IS (DAY) _____ BETWEEN (TIME) _____

SIGNED: _____ **DATE:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING PROTECTED HEALTH INFORMATION:

[ ] OFFICE NOTES/NAME OF PHYSICIAN:_____

[ ] PATHOLOGY REPORTS [ ] RADIOLOGY REPORTS [ ] LAB REPORTS DATE(S): _____

[ ] OTHER _____ [ ] PAPER COPY [ ] ELECTRONIC COPY

THE PURPOSE FOR THIS REQUEST TO RELEASE MEDICAL INFORMATION IS

[ ] MEDICAL CARE/TREATMENT [ ] INSURANCE [ ] OTHER (SPECIFY)

SEND MY MEDICAL INFORMATION TO:

SPINE & BRAIN SURGERY, LLC
RISHI N. SHETH, MD
5341 W. ATLANTIC AVE, STE #302
DELRAY BEACH, FL 33484

I UNDERSTAND THAT:

- BY SIGNING THIS FORM, I AM AUTHORIZING THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AS INDICATED ABOVE.
- I MAY REFUSE TO SIGN THIS AUTHORIZATION, WHICH WILL NOT AFFECT MY TREATMENT OR PAYMENT FOR HEALTHCARE.
- I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BEFORE THE INFORMATION I HAVE REQUESTED BE RELEASED BY PROVIDING WRITTEN NOTICE OF REVOCATION AS SPECIFIED IN THE NOTICE OF PRIVACY PRACTICES.
- IF THE RECEIVING PARTY IS NOT SUBJECT TO MEDICAL RECORD POLICY LAWS, THE INFORMATION MAY BE RE-DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL/STATE LAW. SPINE AND BRAIN SURGERY, LLC SHALL NOT BE HELD LIABLE FOR ANY CONSEQUENCES RESULTING FROM RE-DISCLOSURE.
- IF THE INFORMATION TO BE RELEASED CONTAINS ANY INFORMATION ABOUT HIV/AIDS AN ADDITIONAL HIPAA RELEASE OF MEDICAL INFORMATION WILL BE REQUESTED.
- ALCOHOL OR SUBSTANCE ABUSE, MENTAL HEALTH OR PHYSIC NOTES MAY HAVE ADDITIONAL COMPLIANCES REQUIREMENTS THAT MUST BE MET BEFORE THE INFORMATION CAN BE RELEASED.

SIGNATURE: _____ DATE: _____

IF THE PATIENT LISTED ABOVE IS A MINOR OR IS UNABLE TO SIGN AND YOU ARE THE LEGAL GUARDIAN/REPRESENTATIVE PLEASE SIGN BELOW.

SIGNATURE: _____ RELATIONSHIP: _____ DATE: _____

RETAIN THIS FORM IN THE PATIENT MEDICAL RECORD AND PROVIDE A COPY TO THE PATIENT