STEPHEN R. NEECE, MD, PA
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REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/referred to clinic by (Please check one box):	☐ Dr.	☐ Insurance plan	☐ Hospital

☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance

		☐ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stephen R. Neece, MD, PA or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Stephen R. Neece, MD PA FACS

Personal Information

Date: _____
Name:_____ DOB:_____ Age: _____
Email Address: _____
Pharmacy: _____ Phone Number: _____
Right Handed Left Handed Referred By:_____

Current Medical History

In your own words, please describe your current complaints and why you are seeing the doctor today.

_____
_____
_____

Past Medical History

Please check if you <u>have ever had</u> any of the following illnesses or medical problems:

- ○ Seizures (Type)
- ○ Tension Headaches
- ○ Neck Injury
- ○ Nervous Breakdown/Panic Attacks
- ○ High Cholesterol/Triglycerides
- ○ Anemia/Bleeding Problems
- ○ Fibromyalgia
- ○ Hay Fever
- ○ Emphysema
- ○ Chronic Cough/Pneumonia
- ○ Hepatitis (A,B or C)
- ○ Diabetes
- ○ Kidney Disease
- ○ Gout
- ○ Migraine Headaches
- ○ Head Injury
- ○ Back Injury
- ○ High Blood Pressure/Heart Attack
- ○ Measles/Mumps/Chicken Pox
- ○ Thyroid Disease
- ○ Cancer (Type)
- ○ Asthma
- ○ Tuberculosis
- ○ Stomach Ulcer/Reflux
- ○ Colon Problems/Ulcers/Chron's
- ○ Rheumatic Fever/Scarlet Fever
- ○ Arthritis Rheumatism
- ○ Lyme Disease

List any Surgeries/Hospitalizations Date:

_____ _____

_____ _____

_____ _____

Current Medications:_____
_____

Medication Allergies:_____

Patient Signature_____Date:_____

Reviewed By:_____Date:_____

Stephen R. Neece, MD PA FACS

Name:_____ DOB:_____

Personal History

Place of Birth (City and State):_____

Current Residence (City):_____ How Long?_____

Education: Highest Level Achieved:_____ High School Grad?_____
College Grad?_____ Post Graduate?_____
Occupation:_____ How Long?_____

Legal Problems, now or in the past?_____

- Product
- Personal Injury
- Comp
- Disability Rating_____

Military Service:_____Branch:_____Years:_____Type of Discharge:_____

Do you smoke?_____amt/frequency:_____
Use alcohol:_____amt/frequency:_____

Family History

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Spouse				
Father				
Mother				
Brother(s)				
Sister(s)				
Children				

Are there any hereditary diseases in your family? ○Yes ○No

If yes, please specify:_____
_____

Patient Signature:_____Date:_____

Stephen R. Neece, MD PA FACS

Name:_____ DOB:_____

Review of Symptoms/Conditions

(Check if you experience any of the following)

General:

○ Tired all the time ○ Weight loss ○ Weight gain

Skin:

○ Rash ○ Itching ○ Psoriasis
○ Poor healing ○ Wounds/Sores ○ Skin cancer

Eyes:

○ Loss of vision in one eye ○ Blurry vision ○Halo around lights
○ Eye pain ○ Double vision ○ Poor night vision
○ Glaucoma ○ Cataracts

Ears/Nose/Throat:

○ Hearing loss ○ Ringing in ears ○ Earache/discharge
○ Nasal Stuffiness ○ Nosebleeds ○ Trouble swallowing
○ Lump in your throat ○ Hoarseness ○ Sore mouth
○ Sore tongue

Respiratory:

○ Constant cough ○ Wheezing ○ Coughing blood
○ Shortness of breath ○ Emphysema ○ Asthma

Cardiovascular:

○ Irregular heartbeat ○ Chest pain ○ Swelling in your feet
○ Heart murmur ○ Enlarged heart ○ Valve problem

Gastrointestinal:

○ Change in eating habits ○ Constipation ○ Diarrhea
○ Irritable bowel ○ Vomiting blood ○ Blood in stool
○ Loss of bowel control

Genitourinary:

○ Loss of bladder control ○ Blood in urine ○ Frequent infection
○ Pain when urinating ○ Prostate problem ○ Trouble passing water
○ Leaky bladder

Musculoskeletal:

○ Joint pain or stiffness ○ Knee pain ○ Hip pain
○ Back pain ○ Neck pain ○ Wrist pain
○ Pain in legs at night ○ Morning stiffness ○ Muscle soreness
○ Jaw pain

Do you:

○ Have trouble sleeping ○ Sleep too much ○ Snore
○ Stop breathing at night ○ Sleep walk ○ Have nightmares
○ Fall asleep at work ○ Fall asleep in the car ○ Have memory lapses

Do you:

○ Feel nervous ○ Feel depressed ○ Cry for no reason
○ Want to commit suicide ○ Hear voices or see objects or people not there ○ Have the feeling that someone is trying to harm you

○ Have any psychiatric hospitalization

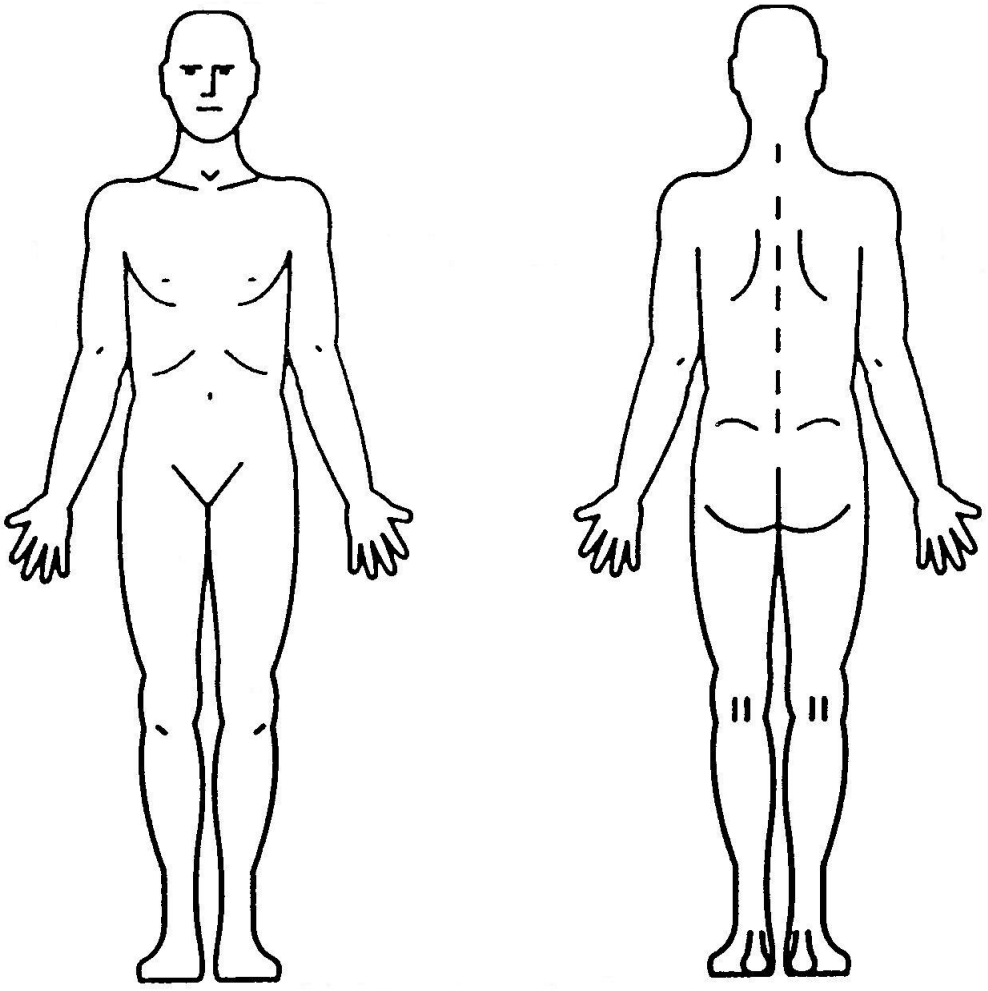
Stephen R. Neece, MD PA FACS

Pain Assessment Form

Name:_____ DOB:_____
Today's Date:_____ Time:_____

On the diagrams below, mark the areas on your body where you feel the sensations described below using the appropriate symbol(s). Mark the areas of radiation, including all affected areas.

Aching	Numbness	Pins & Needles	Burning	Stabbing
++++	====	0000	xxxx	////



Pain Intensity Scale
Circle the area on the scale below that best describes how you rate the intensity of the pain that you are experiencing:
"0" being no pain and "10" being worst possible pain

1	2	3	4	5	6	7	8	9	10
No Pain				Moderate					Worst

Stephen R. Neece, MD PA FACS

Oswestry Low Back Pain Disability Questionnaire

Instructions:
This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking ONE box in each section for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply, but please just check the one that indicates the statement which most clearly describes your problem.

Section 1 – Pain Intensity	**Section 2 – Personal Care (washing, dressing, etc.)**
○ I have no pain at the moment	○ I can look after myself normally without causing extra pain
○ The pain is very mild at the moment	○ I can look after myself normally but it causes extra pain
○ The pain is moderate at the moment	○ It is painful to look after myself and I am slow and careful
○ The pain is fairly severe at the moment	○ I need some help but manage most of my personal care
○ The pain is very severe at the moment	○ I need help every day in most aspects of self-care
○ The pain is the worst imaginable at the moment	○ I do not get dressed, I wash with difficulty and stay in bed

Section 3 – Lifting	**Section 4 – Walking**
○ I can lift heavy weights without extra pain	○ Pain does not prevent me from walking any distance
○ I can lift heavy weights but it gives extra pain	○ Pain prevents me from walking more than 2 kilometers
○ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently placed ex. on a table	○ Pain prevents me from walking more than 1 kilometer
○ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned	○ Pain prevents me from walking more than 500 meters
○ I can lift very light weights	○ I can only walk using a cane or crutches
○ I cannot lift or carry anything at all	○ I am in bed most of the time

Section 5 – Sitting	**Section 6 - Standing**
○ I can sit in any chair as long as I like	○ I can stand as long as I want without extra pain
○ I can only sit in my favorite chair as long as I like	○ I can stand as long as I want but it gives me extra pain
○ Pain prevents me from sitting more than one hour	○ Pain prevents me from standing for more than 1 hour
○ Pain prevents me from sitting more than 30 minutes	○ Pain prevents me from standing for more than 3 minutes
○ Pain prevents me from sitting more than 10 minutes	○ Pain prevents me from standing for more than 10 minutes
○ Pain prevents me from sitting at all	○ Pain prevents me from standing at all

Section 7 – Sleeping	**Section 8 – Sex Life (if applicable)**
○ My sleep is never disturbed by pain	○ My sex life is normal and causes no extra pain
○ My sleep is occasionally disturbed by pain	○ My sex life is normal but causes some extra pain
○ Because of pain I have less than 6 hours of sleep	○ My sex life is nearly normal but is very painful
○ Because of pain I have less than 4 hours of sleep	○ My sex life is severely restricted by pain
○ Because of pain I have less than 2 hours of sleep	○ My sex life is nearly absent because of pain
○ Pain prevents me from sleeping at all	○ Pain prevents any sex life at all

Section 9 – Social Life	**Section 10 – Traveling**
○ My social life is normal and gives me no extra pain	○ I can travel anywhere without pain
○ My social life is normal but increases the degree of pain	○ I can travel anywhere but it gives me extra pain
○ Pain has no significant effect on my social life apart from limiting my more energetic interests ex. sports	○ Pain is bad but I manage journeys over 2 hours
○ Pain has restricted my social life and I do not go out as often	○ Pain restricts me to journeys of less than 1 hour
○ Pain has restricted my social life to my home	○ Pain restricts me to short necessary journeys under 30 minutes
○ I have no social life because of pain	○ Pain prevents me from travelling except to receive treatment

*Note: Distances of 1 mile, ½ mile and 100 yards have been replaced by metric distances in the walking section.

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Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns to the physician or facility named above the following rights, power and authority.

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjuster, for purposes of processing my claims for benefits and payment of services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy including the exclusive irrevocable right to collect payment for such services, make demand in my name for payment and prosecute and receive penalties, interest, court costs or other legally compensable amounts owed by an insurance company in accordance with Article 21:55 of the Texas Insurance Code or other applicable insurance or state statute. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed and appear as needed wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for serviced rendered by the physician/facility named above within 60 days following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amount which I/we personally owe which are not payable under the terms of the policy. This demand specifically conforms with Article 21:55 of the Texas Insurance Code, providing attorney fees, 18% penalty, court costs and interest from judgment upon violation.

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to dispense a separate draft to pay in full all services rendered payable directly to the physician/facility named above.

STATUTE OF LIMITATIONS: I waive my rights to claim statute of limitations regarding claims for services rendered or to be rendered by the facility/physician named above, in addition to reasonable costs of collections, including attorney fees and court costs if incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above the power to endorse my name upon any checks, drafts or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our address upon request in writing to the physician/facility named above.

TERMINATION OF CARE WAIVER: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my doctor at this clinic, he/she has the full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If, during the course of care, my insurance company requires me to take an examination from any other doctor, I will notify this physician/facility immediately. I understand that failure to do so may jeopardize my case.

*A photocopy of this instrument will serve as the original

Signature of Patient and/or Responsible Party

_____ Date:_____

Stephen R. Neece, MD PA FACS

Notice of Privacy Practice
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

Effective September 15, 2013

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("medical information") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Stephen R. Neece, MD PA dba Frisco Neurological Surgery including its providers and employees (the "Practice").

I. OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

- **For Treatment** We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.
- **For Payment** We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.
- **For Health Care Operations** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.
- **Quality Assurance** We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.
- **Utilization Review** We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.
- **Credentialing and Peer Review** We may need to sue or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.
- **Treatment Alternatives** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.
- **Appointment Reminders and Health Related Benefits and Services** We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use

and disclose medical information to tell you about health related benefits or services that we believe may be of interest to you. These reminders may be forwarded either via USPS to your address of record, your email address of record, or phone contact number of record unless you specifically request, in writing, a limited contact protocol.

- **Business Associates** There are some services (such as billing or legal services) that we may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.
- **Individuals Involved In Your Care or Payment For Your Care** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.
- **As Required By Law** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.
- **To Avert an Imminent Threat of Injury to Health or Safety** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such discloser would only be to medical or law enforcement personnel.
- **Organ and Tissue Donation** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Research** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by stat or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."
- **Military and Veterans** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.
- **Workers' Compensation** we may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work related injuries. For example, if you have injuries that resulted from your employment, worker's compensation insurance or a state worker's compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.
- **Public Health Risks** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:
    - To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury)
    - To report births and deaths
    - To report suspected child abuse or neglect
    - To report reactions to medications or problems with medical devices and supplies
    - To notify people of recalls of products they may be using
    - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
    - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law
    - To provide information about certain medical devices
    - To assist in public health investigations, surveillance, or interventions.
- **Health Oversight Activities** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.
- **Legal Matters** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or

authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

- **Law Enforcement National Security and Intelligence Activities** In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials of intelligence, counterintelligence, and other national security activities authorized by law.
- **Coroners, Medical Examiners and Funeral Home Directors** We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.
- **Inmates** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.
- **Marketing of Related Health Services** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face to face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remunerations is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.
- **Fundraising** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have the right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.
- **Electronic Disclosures of Medical Information** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

- **Authorizations** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.
- **Psychotherapy Notes, Marketing and Sale of Medical Information** Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.
- **Right to Revoke Authorization** If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

- **Right to Inspect and Copy** Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law. If your requested medical information is maintained in an electronic format (ex. as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested

medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

- **Right to Amend** If you feel the medical information we have about you is incorrect or incomplete you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.
- **Right to an Accounting of Disclosure** You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or health Care Operations (as described above in this Notice) or disclosures made pursuant to your specific authorization (as described above in this Notice), or certain other disclosures. If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an HER and the effective date, if any, of any additional right to an accounting of disclosures made through an HER for the purposes of Treatment, Payment or Health Care Operations. To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below. Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an HER, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply. As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment of health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as pharmacy filing a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).
- **Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work, or conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below. We will not ask the reason for your request, and we will use our best

efforts to accommodate all reasonable requests, but there are some requests with which we will not be able to comply. Your request must specify how and where you wish to be contacted.

- **Right to Breach Notification** In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE:

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS:

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Stephen R. Neece, MD PA FACS/Frisco Neurological Surgery
Attn: HIPAA Officer
7000 Parkwood Blvd., #F300
Frisco, Texas 75034
Ph: 972-334-0300

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services. In addition, if you have any questions about this Notice, please contact the practice's HIPAA Officer at the address or phone number listed above.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____
_____
_____
_____
_____

Patient Name: _____
(Please Print Name)

Patient Date of Birth:_____

SIGNATURES:

Patient/Legal Representative: _____ Date: _____

If Legal Representative, relationship to Patient:_____

Witness (optional):_____ Date: _____