

NOTICE OF PRIVACY PRACTICES (HIPAA): Please Complete **Front** and **Back** of This Form

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

We are dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. We are required by law to abide by the terms of this Notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and by administrative personnel reviewing the quality of the care you receive. We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders: We may contact you to provide appointment reminders	Legal Proceedings. We may disclose your medical information in the course of certain judicial or administrative proceedings.
Disclosure to Department of Health and Human Services. We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.	Law Enforcement. We may disclose your medical information for law enforcement purposes or other specialized governmental functions.
Disaster Release. We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.	Coroners, Medical Examiners and Funeral Directors. We may disclose your medical information to a coroner, medical examiner or funeral director.
Health Oversight Activities. We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspection, licensure or disciplinary actions, administrative and/or legal proceedings.	Organ Donation. If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.
Abuse or Neglect. We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.	Research. We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.
Business Associates. We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.	Public Safety. We may use or disclose your medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.
	Workers' Compensation. We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.
	Notification. Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

AUTHORIZATIONS:

We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

Bay Area Neurosurgery, P.A. – (813) 681-4404, Office Manager

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of the disclosures of your medical information made by us following April 14, 2003, except for disclosure for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, or if you would like further information regarding your rights regarding the uses and disclosures of your medical information, you may contact:

Bay Area Neurosurgery, P.A. – (813) 681-4404, Office Manager

THIS NOTICE IS EFFECTIVE AS OF April 14, 2003.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change the terms of this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at Bay Area Neurosurgery, P.A. and will make paper copies of the revised Notice of Privacy Practices available upon request.

ACKNOWLEDGMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning this Notice of Privacy Practices.

Print Patient Name

Patient Signature

Date

Print Legally Authorized Rep Name

Legally Authorized Rep Signature

Relationship to Patient

Date

*The Proposed rule issued 3/02 eliminated the consent requirement for uses and disclosures for treatment, payment and health care operations and replaced it with a requirement that health care providers with a direct treatment relationship with the patient make a good faith effort to obtain an acknowledgment that that patient received the provider's Notice of Privacy Practices.

PATIENT INFORMATION: Please Complete **Front** and **Back** of This Form

PATIENT'S NAME: _____
Last First MI

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

Email address: _____

Caution: Bay Area Neurosurgery is unable to guarantee the security of information passed via e-mail

Home Phone#: _____ Work Phone#: _____ Cell#: _____

Social Security#: _____ Date of Birth: _____ Age: _____ Male ___ Female ___

Whom may we thank for referring you today? _____ Phone #: _____

Primary Care Doctor: _____ Phone #: _____

SPOUSE/NEXT OF KIN/NOTIFY IN CASE OF EMERGENCY

Last Name: _____ First Name: _____

Relationship: _____ Phone Number: _____

INSURANCE INFORMATION

Medical

Primary Insurance: _____ HMO or PPO

Subscriber ID# _____ GROUP#: _____

Subscriber (If different from patient): _____ DOB: _____ SSN: _____

Secondary or Auto/WC Insurance: _____

Subscriber (If different from patient): _____ DOB: _____ SSN: _____

Subscriber ID#: _____ GROUP#: _____

Other Claim: Workers Comp Claim: Yes ___ No ___ Auto Accident: Yes ___ No ___

Adjustor: _____ Phone #: _____ Date of Injury: _____

Address for claims: _____

Claim # _____

Authorization and Release:

I authorize the release of any information by BAN including the diagnosis and the records of any treatment or examination rendered to me during the period of such care to the third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group BAN, insurance benefits otherwise payable to me. If payment is made to me, I agree to pay BAN the amount paid to me. I understand that my insurance carrier may pay less than the contracted rate for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents at the allowable rate. If I am not effective on my insurance at the time of service, I agree to pay the BAN rate at the time of service. Should it become necessary to turn my account over to an outside agency, I will be responsible for collection cost, attorney fees, litigation fees, and court costs.

SIGNATURE: _____ DATE: _____

Bay Area Neurosurgery, P.A. 813 S. Parsons Avenue Brandon, FL 33511