THE BRAIN & SPINE CENTER

hoag
Pickup Family Neurosciences Institute

You may print and complete these forms, or complete the forms and then print and sign.

To allow a thorough review please be sure you have included:

A copy of your insurance card, front and back.
A copy of your **Imaging or Diagnostic Reports**
A copy of any relevant medical records you may have.

A copy and list of up to date medication list

Please **BRING ALL FILMS/CDs** with you for your appointment. Thank you for your patience.

Office Location (map):
THE Brain & Spine Center
3900 West Coast Highway Suite 300
Newport Beach, CA 92663
Phone: (949) 383-4185

Please fax this document to (949)438-3835 or scan and email to mlazaro@thebsc.net Thank You.

The Brain & Spine Center
Robert G. Louis, MD

PRELIMINARY PATIENT APPOINTMENT/HISTORY/REGISTRATION SHEET

Physician: **Robert G. Louis, MD**

PATIENT NAME: _____
LAST FIRST DOB

HOME ADDRESS: _____
STREET CITY STATE ZIPCODE

HOME PHONE: ( )_____-_____ **OK TO LEAVE VOICEMAIL:** YES / NO
WORK PHONE: ( )_____-_____ **EMAIL:** _____
CELL PHONE: ( )_____-_____ **SSN#:** _____

SEX: ☐ **MALE** ☐ **FEMALE**

EMERGENCY CONTACT: _____ **PHONE: (_____)** _____-_____
NAME RELATION

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Separated** ☐ **Widowed** ☐ **Partner**

PHYSICIAN INFORMATION

REFERRING PHYSICIAN

PHYSICIAN NAME: _____ **SPECIALTY:** _____
LAST FIRST

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: ( ) _____ - _____ **FAX:** ( ) _____ - _____

INTERNIST/PRIMARY CARE PHYSICIAN

PHYSICIAN NAME: _____
LAST FIRST

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

PHONE: ( ) _____ - _____ * **FAX:** ( ) _____ - _____

OTHER PHYSICIAN

PHYSICIAN NAME: _____ **SPECIALTY:** _____
LAST FIRST

PHYSICIAN ADDRESS: _____
STREET CITY STATE ZIPCODE

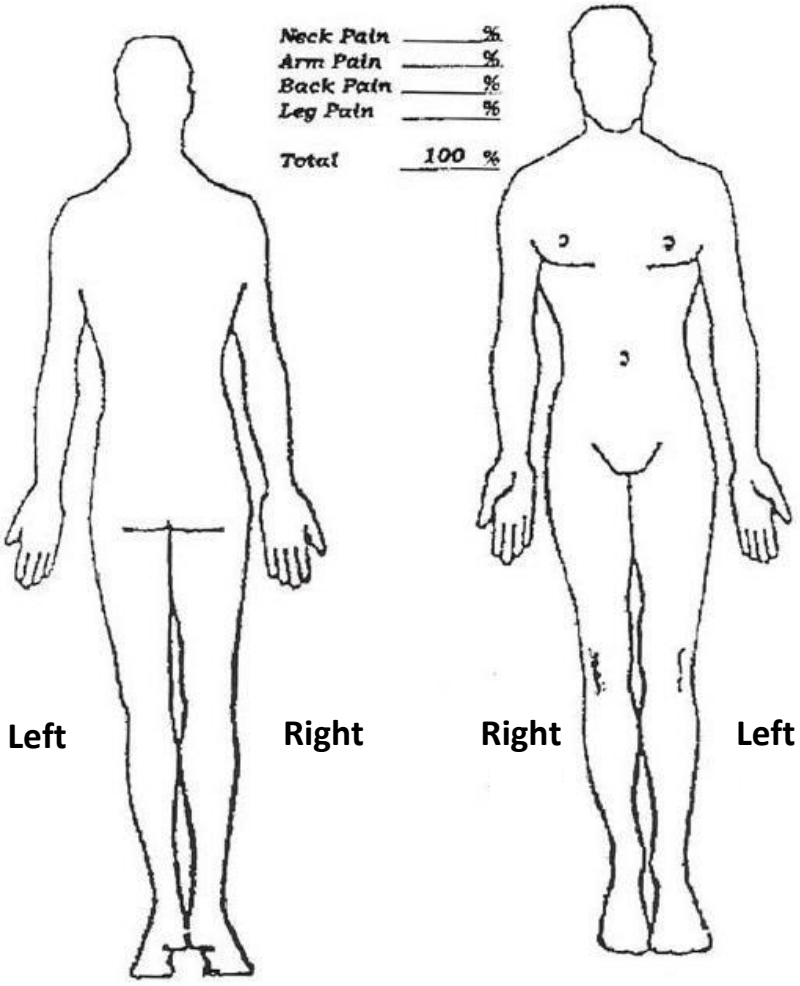
PHONE: ( ) _____ - _____ **FAX:** ( ) _____ - _____

The Brain & Spine Center
Robert G. Louis, MD

PAIN DESCRIPTION

Where is your pain right now?

Mark the areas on the body below where you feel the described sensations, using the appropriate symbols.
Mark the areas of radiation, including all affected areas.



Ache ^^^^^ ^^^^^

Numbness OOOO OOOO

Pins & Needles ■■■■

Burning XXXX XXXX

Radiating Pain ////// //////

HOW BAD IS YOUR PAIN RIGHT NOW? (PLEASE CIRCLE)

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

NO PAIN **INTERMEDIATE PAIN** **WORST PAIN**

HEIGHT:_____ WEIGHT:_____ BLOOD PRESSURE (Last Known):_____/_____

THE Brain & Spine Center
3900 West Coast Highway Suite 300, Newport Beach CA 92663
949-383-4185 phone / 949-438-3828 fax www.brainspinemd.com

The Brain & Spine Center
Robert G. Louis, MD

PATIENT HISTORY

PATIENT NAME: _____ **AGE:** _____ **DATE:** _____

REFERRED BY: _____ **OCCUPATION:** _____

1. **WHEN DID SYMPTOMS FIRST START?** _____ **ARE THEY GETTING:** ☐ WORSE ☐ BETTER ☐ STABLE

2. **PLEASE DESCRIBE PRESENT SYMPTOMS:** _____

3. **WHAT POSITION/ ACTIVITY IMPROVES YOUR PAIN?** _____

4. **WHAT POSITION/ ACTIVITY WORSENS YOUR PAIN?** _____

5. **PLEASE SELECT ALL PRIOR TREATMENTS:**

   ☐ PHYSICAL THERAPY ☐ CHIROPRACTOR ☐ INJECTIONS ☐ MEDICATIONS ☐ ACUPUNCTURE

   ☐ PAIN MANAGEMENT ☐ MASSAGE ☐ OTHER: _____

6. **HAVE YOU HAD ANY INJECTIONS? PLEASE LIST TYPE(S), DATE(S) AND RESULTS:** _____

7. **HAVE YOU HAD PRIOR SPINE SURGERY OR PROCEDURE?** ☐**YES** ☐**NO**
   PLEASE LIST TYPE(S) AND DATE(S): _____

8. **PLEASE LIST ANY <u>RECENT</u> TESTS RELATED TO YOUR PROBLEM AND DATE (MRI, X-RAY, EMG, ETC.):** _____

9. **PLEASE LIST PREVIOUS DIAGNOSIS AND TREATMENTS/SURGERY RECOMMENDED:** _____

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3900 West Coast Highway Suite 300, Newport Beach CA 92663
949-383-4185 phone / 949-438-3828 fax www.brainspinemd.com

10. PAST MEDICAL HISTORY: (PLEASE CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD):

HYPTERTENSION	HIGH CHOLESTEROL	ASTHMA
DIABETES	DRUG/ALCOHOL ABUSE	GOUT
HEART DISEASE	BLEEDING/CLOTTING DISORDER	HIV
ATRIAL FIBRILATION	CANCER (TYPE :_____)	DEMENTIA
STROKE	HEPATITIS	CHRONIC INFECTIONS
SEIZURES	RADIATION/CHEMOTHERAPY	RESPIRATORY PROBLEMS
MULTIPLE SCLEROSIS	DEPRESSION OR	PARKINSON'S DISEASE
ULCERS	PSYCHOLOGICAL PROBLEMS	

11. PLEASE LIST ALL CURRENT MEDICAL PROBLEMS/CONDITIONS NOT LISTED:_____

_____

12. PLEASE LIST ANY OTHER PRIOR SURGERIES AND DATES:_____

_____

13. FAMILY MEDICAL HISTORY:

a. PLEASE DESCRIBE ANY FAMILY HISTORY OF SPINE PROBLEMS:_____

b. PLEASE DESCRIBE FAMILY HISTORY OF OTHER MEDICAL PROBLEMS : _____

_____

14. SOCIAL HISTORY:

a. DO YOU USE TOBACCO/SMOKE/VAPE? Yes / Quit / Never

b. Yes , HOW MUCH: _____

c. If QUIT - DATE: _____

d. ALCOHOL INTAKE?_____**PLEASE LIST AMOUNT/FREQUENCY/TYPE**: _____

e. DESCRIBE PHYSICAL ACTIVITY/EXERCISE TYPE AND FREQUENCY:_____

_____

f. VACCINES: WHICH HAVE YOU RECEIVED?
INFLUENZA (YES/NO) Date: _____ **PNEUMONIA (YEST/NO) Date:** _____ **COVID (YES/NO) Date:** _____

15. HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? (PLEASE CIRCLE ALL THAT APPLY):

FATIGUE	SHORTNESS OF BREATH	URINARY INCONTINENCE	DEPRESSION
FEVER	CHEST PAIN	WEAKNESS	ANXIETY
HEADACHE	CONSTIPATION	RASH	SUBSTANCE ABUSE
SLEEP DISTURBANCE	DIARRHEA	TINGLING/NUMBNESS	ALCOHOL ABUSE
ITCHING	NAUSEA	MEMORY LOSS	STRESS
BLURRED VISION	HEARTBURN	SEIZURES	NERVOUSNESS
HOT/COLD INTOLERANCE	VOMITING	BALANCE DIFFICULTY	MENTAL ILLNESS

OTHER (PLEASE DESCRIBE): _____

The Brain & Spine Center
Robert G. Louis, MD

16. MEDICATIONS: PLEASE LIST ALL MEDICATIONS AND VITAMINS YOU ARE CURRENTLY TAKING AND THE DAILY DOSAGE :

MEDICATION	DOSAGE	FREQUENCY

Allergies

Pharmacy Info

Name:	Phone:
Address:	

PATIENT CONSENT AND AUTHORIZATION

1. **Consent to Treatment**. I hereby authorize Robert G. Louis, M.D., Inc., through its physicians and health care staff, to provide medical services to me, and I hereby consent to the performance of laboratory tests, diagnostic procedures, and other medical treatment as discussed with my health care provider. I also authorize Robert G. Louis, M.D., Inc. to obtain outside medical and medication histories.

2. **Release of Information**. I hereby authorize Robert G. Louis, M.D., Inc. to release and disclose all or any portion of my patient records to any person or entity which is or may be responsible for all or part of the charges for services rendered to me (including, but not limited to, insurers, employers and health care service plans) for the purposes of obtaining payment. I also authorize the release of patient information to other health care providers for purposes of diagnosis or treatment, and as may be required by law.

3. **Assignment of Benefits**. I hereby assign to Robert G. Louis, M.D., Inc. and authorize payment directly to it of any and all health insurance or health plan benefits otherwise payable on my behalf or to me for services rendered. I understand and agree that I am financially responsible for any charges not paid by insurance benefits or otherwise not covered by this assignment and agree to pay the full cost of all such charges for services rendered.

4. **Health Care Service Plan Obligation**. I understand that Robert G. Louis, M.D., Inc. participates on the panels of various health care service plans with which it contracts. If services rendered are found to be noncovered by a contracted health care service plan, or if I am not eligible to receive services by a contracted health care service plan, I agree to be individually obligated to pay the full cost of the services rendered to me by Robert G. Louis M.D., Inc.

5. **Financial Agreement**. I hereby agree that I am individually obligated to pay all charges for services rendered to me that are not paid by insurance benefits or covered by a health care service plan (including, but not limited to, coinsurance, copayments and deductibles). I accept full financial responsibility for all such charges billed and guarantee to pay all such charges. All accounts are due and payable upon presentation of a statement. I understand that if any bill remains unpaid thirty (30) days after the statement date, interest will accrue at a rate of one percent (1%) per month on the unpaid balance. In the event that my account must be place with an attorney or collection agency to obtain payment, I further agree to pay all reasonable fees and collection expenses. I also agree that if my insurance plan pays my benefits directly to me, I will immediately send a check in the amount of the benefits paid to Robert G. Louis, M.D., Inc.

I hereby certify that I have read, understand and accept the above terms and conditions.

_____	_____	_____
Patient Name (Print)	Patient Signature	Date

If patient is a minor or unable to consent

_____	_____	_____	_____
Name of Legal Representative	Signature of Legal Representative	Relationship to Patient	Date:

Notice of Privacy Practices Acknowledgment

We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law professional accreditation standards and our internal policies and procedures.

Attached is your personal copy of your Notice of Privacy Practice. This notice explains your rights, our legal duties and our privacy practices. It also describes how much medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice:

- Our Pledge
- Your personal information
- Our Privacy Practices
- Your written permission
- Other restrictions
- Your rights
- Changes
- Questions or Complaints

We may use your information for:

- Treatment
- Health Information Exchange
- Payment
- Health Care Operations
- Notifications
- Marketing Research
- Special circumstance & the law

Please understand that this summary is not our Notice of Privacy Policies, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, please contact our office manager at the address or phone number above to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining this signed acknowledgment. If, after reviewing the notice, you decide that you do not want to retain your copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices and the office policies & procedures and do with to receive treatment:

_____ _____ _____

Signature Printed Name Date

Robert G. Louis, MD
3900 West Coast Hwy
Newport Beach, CA 92663
P (949) 383-4185 | F (949) 438-3828

Privacy Officer:

Effective Date: August 15, 2018

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected

health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. **Treatment.** We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. **Health Information Exchange:** This practice is participating in the Hoag Health Information Exchange (HIE), an electronic system through which it and other participating healthcare providers can share patient information according to nationally recognized standards and in compliance with federal and state law that protects your privacy. Through the HIE, your participating providers will be able to access information about you that is necessary for your treatment, unless you choose to have your information withheld from the HIE by personally opting out from participation.
   If you choose to opt out of the HIE (that is, if you feel that your medical information should not be shared through the HIE), We will continue to use your medical information in accordance with this Notice of Privacy Practices and the law, but will not make it available to others through the HIE. To opt out of the HIE, please contact the Hoag Director of Health Information Exchange in writing at One Hoag Drive, Newport Beach, CA 92663, or by telephone at 949/764-8722.
3. **Payment.** We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
4. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan, healthcare clearinghouse, or one of their business associates, California law prohibits all recipients of healthcare information from further disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population- based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.
5. **Appointment Reminders**. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
6. **Sign In Sheet.** We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
7. **Notification and Communication with Family**. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you have instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
8. **Marketing**. Provided we do not receive any payment for making these communications, we may contact you to encourage you to purchase or use products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans we participate in,
   We may receive financial compensation to talk with you face-to-face, to provide you with small promotional gifts, or to cover our cost of reminding you to take and refill your medication or otherwise communicate about a drug or biologic that is currently prescribed for you, but only if you either: (1) have a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise you about treatment options and otherwise maintain adherence to a prescribed course of treatment, or (2) you are a current health plan enrollee and the communication is limited to the availability of more cost-effective pharmaceuticals. If we make these communications while you have a chronic and seriously debilitating or life threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2)

your right to opt-out of future remunerated communications by calling the communicator's toll-free number. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

9. **Sale of Health Information**. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.
10. **Required by Law**. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
11. **Public Health.** We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
12. **Health Oversight Activities**. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
13. **Judicial and Administrative Proceedings**. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
14. **Law Enforcement**. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
15. **Coroners**. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
16. **Organ or Tissue Donation**. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
17. **Public Safety**. We may, and are sometimes required by law, to disclose your health 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 the general public.
18. **Proof of Immunization**. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if you have agree to the disclosure on behalf of yourself or your dependent.
19. **Specialized Government Functions**. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
20. **Worker's Compensation**. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
21. **Change of Ownership**. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
22. **Breach Notification**. In the case of a breach of unsecured protected health information, we will notify you as required by law. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate
23. **Psychotherapy Notes**. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: (1) your treatment, (2) for training our staff, students and other trainees, (3) to defend ourselves if you sue us or bring some other legal proceeding, (4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, (5) in response to health oversight activities concerning your psychotherapist, (6) to avert a serious threat to health or safety, or (7) to the coroner or medical examiner after you die. To the extent you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.
24. **Research**. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.
25. **Fundraising**. We may use or disclose your demographic information, the dates that you received treatment, the department of service, your treating physician, outcome information and health insurance status in order to contact you for our fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications. Similarly, you should notify the Privacy Office if you decide you want to start receiving these solicitations again.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to another person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. You also have the right to request that we add to your record a statement of up to 250 words concerning anything in the record you believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by email.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice.

After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX
OCRMail@hhs.gov

ROBERT G. LOUIS, MD, INC

A MEDICAL CORPORATION

Office Policy for Cancellations and Paperwork / Disability Processing

Cancellation Policy: For clinical appointments, I understand that a 24-hour cancellation notice is necessary to avoid charges.

- $75 fee charged for cancellations made with less than 24-hour notice/and or no show

For surgery cancellations and or change date charges.

- $200 fee to change dates of surgery with less than 2 weeks' notice from the tentatively agreed upon surgical date
- $500 fee for cancellation of surgery within 2 weeks of tentatively agreed upon surgical date

I also understand that my tentative agreed upon surgical date may be moved or cancelled by the office or hospital at any time, in which circumstances, I would not incur a rescheduling or cancellation fee.

Disability Form Processing: Due to the very high volume of patients who require disability paperwork completion we have adopted the following guidelines for ***all disability related paperwork***.

Please take note all paperwork has a two week turnaround time once submitted to the office. If you would like us to fax paperwork directly to your Employer/Insurance company/Outside Agency, please provide fax numbers.

Paperwork will not be processed unless all portions of the documentation requiring patient completion is filled out. NO EXCEPTIONS.

A copy of all paperwork will be placed in patient chart after doctor's signature and completion and will remain as part of the patient's permanent medical record.

Please take note of for completion and processing fee below:

- $60 fee for any forms (including but not limited to: Disability forms, EDD forms, DMV placard, letters, etc.)
    - Please take note office only accepts online EDD submission (no written forms will be accepted)

All fees are due at the time forms are submitted to our office. Paper work WILL NOT be processed without payment in advance. We accept cash, checks and credit cards. Please make checks payable to: Robert G. Louis, MD, INC

I hereby certify that I have read, understand and accept the above terms and conditions.

_____ _____ _____

Patient Name (Print) Patient Signature Date