Greenville Pain & Spine (A Division of Brier Creek Int. Pain & Spine)

PATIENT INFORMATION FORM

Patient's Name (Last, First, Middle Initial): ______________________ Social Security# ______________

Patient Address ____ CITY STATE ZIP

Home Phone: ______________________ Work Phone: ______________________ Ext#: ________

Cell Phone: ______________ Sex: M or F Date of birth: ________ Employed ☐ FT ☐ PT ☐ Not employed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership EMPLOYER NAME: ______________

Primary Care Physician ______________ **Address** ______________ **Phone #** ______________

Is there another person other than you who is legally responsible for payment? ☐Yes ☐No If yes, name & relationship of person: ______________

1. Name of Primary Insurance: ______________ Subscriber's Name: ______________

Subscriber's sex: ☐M ☐F Subscriber date of birth: ____/____/____ Subscriber's SS#: ______________

Subscriber's relationship to patient: ______________ Policy #: ______________ Group #: ______________

Subscriber's employer name: ______________ Address: ______________ Phone# ______________

2. Name of Primary Insurance: ______________ Subscriber's Name: ______________

Subscriber's sex: ☐M ☐F Subscriber date of birth: ____/____/____ Subscriber's SS#: ______________

Subscriber's relationship to patient: ______________ Policy #: ______________ Group #: ______________

Subscriber's employer name: ______________ Address: ______________ Phone# ______________

Is this visit a result of a **WORK INJURY?** ☐Yes ☐No If yes, **date of injury** ______________ State where injury occurred: ________

Employer name (who you worked for when injury occurred) ______________ Worker's Comp Carrier Name ______________
Claim # ______________ Adjuster Name ______________ Adjuster phone# ______________

PLEASE EXPLAIN THE NATURE OF THE WORK INJURY ______________________________

Is this visit the result of an **AUTO ACCIDENT?** ☐Yes ☐No If yes, **date of injury** ______________ State where accident occurred: ________
Name of insurance company responsible for paying claim ______________
Claim # ______________ Adjuster Name ______________ Adjuster phone# ______________

Are you now, or have you ever been on disability ☐Yes ☐No If yes, date disability began: ______________

Emergency Contact: Name: ______________ Relationship ______________ Ph # ______________

If you were referred by a physician or other professional, please list his or her name, so we may thank them: ______________

If not referred by a healthcare provider, how did you hear about us? ☐Yellow Pages ☐ Newspaper ☐Internet ☐ Family/Friend ☐ Ins.Company ☐Other - ________

ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS NECESSARY, THE PATIENT IS RESPONSIBLE FOR FURNISHING ALL INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AS APPLICABLE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized insurance company benefits be made on my behalf to Brier Creek Integrated Pain & Spine for any services furnished to me by that party who accepts assignment. I authorize any holder of medical or other information about me to release to the Centers for Medicaid/Medicare Services (CMS) and its intermediaries, SSA, DHHS, or commercial insurance companies any information needed to process my insurance claim for benefits. I understand that my signature requests payment be made, and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS- 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In contracted insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the insurance company as the full charge, and the patient is responsible only for any deductible, copay, coinsurance and non-covered services as applicable. Coinsurance and the deductible are based upon the charge determination of the insurance company or payer involved.

Patient/Guardian Signature: ______________________________ Date: ______________

Please read and complete Attachment 1of the Patient Information Sheet. Thank you.

Attachment 1: Patient Information Form

Why do we ask about race and ethnic groups?

We ask for this information to be sure all patients get the best care, regardless of race or ethnic background. Additionally, as part of the Health Insurance Reform Act, questions such as these will be required and also utilized to assist physicians and hospitals in providing the best care possible. For information on how this information will play a major role in the overall goal of Patient Centered Care, please refer to http://www.ahrq.gov/research/iomracereport/reldata1.htm

LANGUAGE(s) SPOKEN: ______________________________

Which of the following race categories best identifies you? Choose one or more.

☐White
☐Black or African American
☐American Indian, Aluet or Alaskan Native
☐Hawaiian or Pacific Islander
☐Asian: Please select one or more as best describes you.
 ☐Chinese ☐Japanese ☐Filipino ☐Korean ☐Vietnamese ☐Laotian
 ☐Hmong ☐Kampuchean/Cambodian ☐Thai ☐Asian Indian
 ☐Other please specify:____________

Are you Hispanic/Latino? Please select one or more.
☐Non-Spanish
☐Mexican
☐Puerto Rican
☐Cuban
☐South or Central American (except Brazil)
☐Other Specified Spanish/Hispanic origin ________________
☐Spanish NOS, Hispanic NOS, Latinos, NOS
☐Spanish surname only
☐Dominican Republic
☐Unknown whether Spanish or not

(Assurance of confidentiality) All personal information will be kept confidential. If general information as race and ethnicity is released, it will not include your name, address, or other information that could identify you. This information is voluntary.

Thank you.

GREENVILLE PAIN & SPINE, PLLC
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name: ______________________________ Date of Birth: __________

I hereby authorize medical providers and personnel of Brier Creek Integrated Pain and Spine, PLLC to discuss my protected health information with:

(Name)____________________ **(Relationship)**___________________

(Name)____________________ **(Relationship)**___________________

(Name)____________________ **(Relationship)**___________________

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initializing the lines below, I authorize the release of the following protected information:

______Information regarding the patient's diagnosis and treatment of HIV/AIDS
______Psychotherapy notes from a Psychiatrist and/or Psychotherapist
______Treatment for alcohol and/or drug abuse reports

____ ___________________
Patient or Legally Authorized Signature Date

____
Relationship to patient if signed by anyone other than the patient (Parent, Legal Guardian, etc)

GREENVILLE PAIN & SPINE, PLLC
FINANCIAL POLICY

Patient's Name: ______________________________ Date of Birth: __________

As a courtesy to our patients, we will file insurance claim forms to your carrier on your behalf. However, your active participation in the insurance claims process may be required. We recommend you confirm your insurance will cover services provided by our practice before your appointment.

All co-pays, deductibles, or co-insurance amounts are due at the time the service is rendered. Please bring your insurance cards and any referral forms with you each time you visit. BCIP&S accepts cash, check, Visa, MasterCard, American Express, and Discover. There is a $35 fee for all returned checks.

Fees for procedures do not include follow-up visits, and will be charged separately.

After payment is received from the insurance carrier, any patient responsibility amounts that remain will be transferred to a patient balance. A statement will be sent to the patient. The balance due amount showing on the statement should be paid in full when the first statement is received.

We are contracted, "participating providers", with most insurance companies. The insurance company reimbursements are based on a negotiated, discounted fee schedule. You are responsible for your co-payment and deductible according to your plan. In most cases, we are obligated to accept these fees as payment in full. However, your insurance company may determine that your service was not a covered benefit or "medically necessary". You may be responsible for payment for these services as appropriate.

Should you have a change in coverage or personal status, we request you contact our Business Office as soon as possible so that we may update this information and avoid payment delays.

If you have any questions regarding our financial policies or your account, call 919-596-3400. Our business office is open Monday through Friday from 8:00 a.m. until 5:00 p.m.

____ ____________________

Patient or Legally Authorized Signature Date

____

Relationship to patient if signed by anyone other than the patient (Parent, Legal Guardian, etc)

GREENVILLE PAIN & SPINE (BRIER CREEK INTEGRATED PAIN & SPINE, PLLC)
PATIENT ACKNOWLEDGEMENT OF UNDERSTANDING OF PRIVACY POLICIES & CONSENT FOR USE/DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ___________

I understand that the patient's health information is private and confidential. I understand that Brier Creek Integrated Pain & Spine, PLLC works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Brier Creek Integrated Pain & Spine, PLLC may use and disclose the patient's personal health information, including mental health information and/or psychological evaluations, to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

Brier Creek Integrated Pain & Spine, PLLC has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have been given a copy of this "Notice" before signing this Acknowledgement.

Within this Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain users; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communication of alternative location.

Under the terms of this consent, I can ask Brier Creek Pain & Spine, PLLC to limit how the patient's health information is used or disclosed to carry out treatment, payment or health care operations. I understand that Brier Creek Integrated Pain & Spine does not have to agree to my request. If Brier Creek Integrated Pain & Spine, PLLC does agree to my request, I understand that Brier Creek Integrated Pain & Spine, PLLC would follow the agreed limits.

I may cancel this consent in writing at any time by doing one of the following:

1. Signing & dating a "Revocation of Consent for Use / Disclosure of Health Care Information" form
2. Writing, signing, & dating a letter to Brier Creek Integrated Pain & Spine, PLLC stating you want to revoke consent to authorize the use and disclosure of the patient's personal health information for treatment, payment and health care operations.

If I revoke this consent, Brier Creek Integrated Pain & Spine, PLLC does not have to provide any further health care services to the patients.

______________________________ ______________

Patient or Legally Authorized Signature — Date

____

Relationship to patient if signed by anyone other than the patient (Parent, Legal Guardian, etc)

GREENVILLE PAIN & SPINE, LLC
WORKERS COMPENSATION/TRAFFIC ACCIDENT INFORMATION

Patient's Name: ________________________________ Date of birth: ________________

Is this a work related injury? ( ) No ( ) Yes (Please fill out the following information)

Was this accident reported to supervisor and/or employer? ( ) No ( ) Yes

Has Workers Compensation Claim been filed? ( ) No ( ) Yes

Date of accident ____

Employer____

Business ____

Describe the accident ____
____
____

Is this a traffic accident injury? ( ) No ( ) Yes (Please fill out the following information)

Were you a: ( ) Driver ( ) Passenger ( ) Pedestrian Date of Accident _______________

If a passenger, where were you sitting? ( ) Right-Front ( ) Right- Rear ( ) Left-Rear

What type was your vehicle? ( ) Car ( ) Truck ( ) Motorcycle ( ) Other _______________

What type was the other vehicle? ( ) Car ( ) Truck ( ) Motorcycle ( ) Other _____________

Did your vehicle hit the other vehicle? ( ) No ( ) Yes Where? ______________________

Did the other vehicle(s) hit your vehicle? ( ) No ( ) Yes Where? ____________________

Were you wearing a seat belt at the time of the accident? ( ) No ( ) Yes

Were traffic citations issued? ( ) No ( ) Yes To Whom? _________________________

Describe the accident including the cause(s) and surrounding circumstance: _______________
____
____

Do you have an attorney? ( ) No ( ) Yes Name: ___________________________________

GREENVILLE PAIN & SPINE, LLC
PATIENT MEDICAL HISTORY and PAIN QUESTIONARE

Patient's Name: ______________________________ Date of Birth: __________

MEDICAL HISTORY: If you have/ have had any of the following, please check the accompanying box:
( ) Cancer ( ) Arthritis ( ) Asthma ( ) Diabetes ( ) HIV ( ) Hepatitis
( ) Muscular Dystrophy ( ) Multiple Sclerosis ( ) High Blood Pressure ( ) Fibromyalgia
( ) Other (Please List) ______________________________

PHARMACY: Name and Location: ______________________________
Telephone Number: ______________________________

Are you currently employed? ( ) YES ( ) NO If no, are you on unemployment, disability, or social security? ______________________________

Are you married? ( ) YES ( ) NO **Do you have children?** ( ) YES ( ) NO
Are your parents living? ( ) YES ( ) NO

SURGERIES: Please list all surgeries with dates if available ______________________________
____
____

ALLERGIES: Please list all allergies and reactions ______________________________
____

EDUCATION: What highest level of education completed ______________________________

PAIN: When and how did your pain originally begin? (Please Circle)
a. injury from automobile accident b. injury obtained at work c. Related to illness
d. Previous Surgery e. an injury obtained from a fall at home or else where
f. appeared randomly for reasons I cannot explain

Please describe the characteristics of your pain. (Please Circle)

A. Stabbing
B. Throbbing
C. Shooting
D. Stinging
E. Itching
F. Burning
G. Numbness
H. Tightening
I. Cramping
J. Aching
K. Other: ______________________

Pain Scale:
Please see attached pain scale and circle the number in which averages the pain you have been experiencing in the last 4 weeks.

1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 /

Little to No Pain **Painful** **Unbearable**

Created by Courtney Housand

GREENVILLE PAIN & SPINE, LLC
PATIENT MEDICAL HISTORY and PAIN QUESTIONARE

Patient's Name: ______________________________ Date of Birth: __________

Previous Treatment:

Have you ever seen a Physical Therapist? ( ) YES ( ) NO
If yes, please explain who, when and where. ______________________________
____

Have you ever been to a pain clinic? ( ) YES ( ) NO
If yes, please explain who, when and where. ______________________________
____

Please circle all previous medications/narcotics you have tried that was prescribed for your pain:

a) **Buprenorphine**, Buprenex
b) **Butorphanol**, Stadol
c) **Codeine**
d) **Fentanyl**, Duragesic patch, Actiqm, Butrans, Fentora
e) **Hydrocodone**, Lorcet, Norco, Vicodin, Vicoprofen, Zydone,
f) **Hydromorphone**, Dilaudid, Exalgo
g) **Levorphanol**, Levo-Dromoran
h) **Meperidine,** Demerol, Mepergan
i) **Methadone**, Dolophine
j) **Morphine**, Astramorph, Duramorph, MS Contin, MS IR, Roxanol, Oramorph, Kadian, Avinza
k) **Nalbuphine**, Nubain
l) **Oxycodone**, Percocet, Roxicet, Roxicodone, Tylox, Percodan, Oxycontin
m) **Oxymorphone,** Opana
n) **Pentazocine**, Talacen, Talwin
o) **Sufentanil,** Sufenta, Sublimaze
p) **OTHER:**

When is your pain at its worst?

a) Morning b) Afternoon c) Evening d) Night
e) No know pattern

What can you do to relieve the pain? And how long before the pain comes back?
____
____
____
____

Created by Courtney Housand

GREENVILLE PAIN & SPINE, LLC
PATIENT MEDICAL HISTORY and PAIN QUESTIONARE

Patient's Name: ______________________________ Date of Birth: __________

MEDICATIONS: Please list all CURRENT medications with strengths and dosage

NAME	STRENGTH	DOSAGE

Please shade where your pain is located

Left Right Right Left

How often do you feel your pain:

- **a.** All the time (75-100% of the time)
- **b.** Most of the time (50-75% of the time)
- **c.** Off and on (25-50% of the time)
- **d.** Sometime (less than 25% of the time)

GREENVILLE PAIN & SPINE, LLC
PATIENT MEDICAL HISTORY and PAIN QUESTIONARE

Patient's Name: ______________________________ Date of Birth: __________

Psychiatry:

Have you ever seen a psychologist, psychiatrist, or any other mental health professional? ( ) YES ( ) NO
If yes, what mental health professional, where, when, and how they treated your diagnosis?__________
____
____

Have you ever experienced suicidal thoughts or thoughts of wanting to die? ( ) YES ( ) NO
If yes, what were your thoughts and how did you handle it? ______________________________
____
____

Have you ever experienced a panic attck? ( ) YES ( ) NO
If yes please describe what you were doing, how it felt, and how you handled it.________________
____
____

Have you ever had serious thoughts of physically harming or injurying someone? ( ) YES ( ) NO
If yes, please explain how you felt and how you handled it.______________________________
____
____

CAGE:

Substance intake per day:

- ☐ Caffeine (coffee, tea, soda, ect.) ______________________________
- ☐ Nicotine (cigarettes, cigar, pipe, chewing tobacco) ______________________
- ☐ Drugs (marijuanna, cocaine, heroin, etc)______________________________

Have you ever felt the need to cut back on your drinking or drug use?

- ☐ Yes
- ☐ No

Have you ever felt guilty for doing something you did while drinking or using drugs?

- ☐ Yes
- ☐ No

Have you ever had an eye opener? (A drink or drug first thing in the morning?)

- ☐ Yes
- ☐ No

Have you recently used any of the following drugs? Choose all that may apply

a. Marijuanna b. Amphetamines c. Cocaine d. Heroin
e. None of these f. Other: ______________________________

Contractual Agreement for Patients Receiving Opioid Treatment from Greenville Pain & Spine (of Brier Creek Integrated Pain & Spine)

I understand that the treatment I received at Greenville Pain & Spine includes opioid and/or sedative medications. I also understand and agree to the following while receiving these drugs:

- ✓ I understand that the goals of prescribing these medications are to increase my activities at home and/or work, decrease the symptoms of pain I experience as well as improve my ability to cope with my discomfort.
- ✓ I understand opioid medications are only one part of my therapy and agree to follow all other parts of my treatment program as prescribed.
- ✓ I will not attempt to obtain any opioid or sedative medications from any source another than Greenville Pain & Spine. If I receive emergency treatment that includes any opioid or sedative medications, I will notify the staff of Greenville Pain and spine, as soon as possible, preferably by the next working day.
- ✓ I agree to provide Greenville Pain & Spine with the name and phone number of the pharmacy I will use.
- ✓ I agree to random urine drug screens to monitor drug usage. If substance abuse is an issue, a referral to a substance abuse counselor will be made.
- ✓ I agree to avoid alcohol on days in which I am taking narcotics. I agree to avoid illicit drugs.
- ✓ I will not share my medications with anyone else.
- ✓ I will bring to every visit all of the unused pain medication I have been prescribed.
- ✓ If I feel tired or mentally foggy when taking these medications, I will not drive, operate heavy machinery, or serve in any capacity related to public safety.
- ✓ I understand that I must discuss any changes in dosage or frequency of my medication with my physician at Greenville Pain & Spine before making any adjustments. If, however, I develop an allergic reaction (hives, rash, shortness of breath, nausea, vomiting or other adverse effects) to an opioid or sedative, I will discontinue the medication and notify Greenville Pain & Spine promptly.
- ✓ I will comply with scheduled appointments, including calling 24 hours prior to any appointments to make changes (reschedule or cancelation); if not, I agree to be billed $25.00.
- ✓ I understand that if I have a problem such as unrelieved pain or if I have a question, I will contact Greenville Pain & Spine.
- ✓ I understand that failure to follow these guidelines may result in cessation of my opioid and/or sedative medication therapy, referral to a substance abuse specialist or possible termination of my patient status at Greenville Pain & Spine.

Created by: D'Reese Barnett

- ✓ **FEMALE PATIENTS: I understand taking opioids and/or sedatives during pregnancy can be harmful to developing babies. I am not currently pregnant.**

Pain Management Center Prescription Policy

- ✓ I understand call-in prescriptions (new or refills) require 24-hour advanced notice. Requests made on Friday will be issued on the following Monday. After notification, we will fill the prescription at the discretion of the physician, as soon as possible.
- ✓ I understand mail-out prescriptions (new or refills) require 5-day advance notice.
- ✓ Prescriptions for refills will only be issued Monday through Friday during business hours.

My signature below confirms that I understand and agree to all of the above requirements to obtain opioid and/or sedative medications at Greenville Pain & Spine.

Patient's signature: ______________________________ **Date:** ____________________

Physician's signature: ______________________________ **Date:** ____________________

Created by: D'Reese Barnett

GREENVILLE PAIN AND SPINE

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED OR DISCLOSED, AND HOW YOU ARE ABLE TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

We understand that your health information is private and confidential. We are committed to protecting that information. This notice of privacy practices describes how we will use and disclose protected information that we receive or create as it is related to your health care. We are required by law to maintain the privacy of your health information, and to give you a copy of this notice describing our privacy practices. We will not use or disclose your health information without your authorization, except in the following situations:

Treatment: We will use and disclose your health information while providing, coordinating or managing your health care. Information obtained by a medical provider will be documented in your record and used to determine your course of treatment. We may also provide other healthcare providers with your information to assist in your treatment.

Payment: We will use and disclose your medical information to obtain or provide compensation or reimbursement for providing your health care.

Health Care Operations: We will use and disclose your health information to deal with administrative aspects of your health care, and to manage our business more efficiently. We may use information in your health record to assess the quality of care and outcomes in your case and others like it. This information will then be used in an effort to improve the quality and effectiveness of the healthcare and services we provide.

Business Associates: There are services provided in our organization through contracts with business associates. We may disclose your health information to our business associate so they can perform the job we've asked them to do. However, we require the business associate to take precautions to protect your health information.

Notification / Communication with Family: We may use or disclose information to notify or assist in notifying a family member, personal representative, or other person responsible for your care of your location and general condition. We may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care.

Research: Consistent with applicable law we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Director, Coroner, and Medical Examiner: Consistent with applicable law we may disclose health information to funeral directors, coroners, and medical examiners to help them carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events, product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including child abuse and neglect.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to appropriate governmental agencies, such as adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect, or domestic violence.

Health Oversight: In order to oversee the health care system, government benefits programs, entities subject to governmental regulation and civil rights laws for which health information is necessary to determine compliance, we may disclose your health information for oversight activities authorized by law, such as audits and civil, administrative, or criminal investigations.

Court Proceeding: We may disclose your health information in response to requests made during judicial and administrative proceedings, such as court orders or subpoenas.

Law Enforcement: Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Threats to Public Health or Safety: We may disclose or use health information when it is our good faith belief, consistent with ethical and legal standards, that it is necessary to prevent or lessen a serious and imminent threat or is necessary to identify or apprehend an individual.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Other Uses: We may also use and disclose your personal health information for the following purposes:

To contact you to remind you of an appointment for treatment;
To describe or recommend treatment alternatives to you;
To furnish information about health-related benefits and services that may be of interest to you; or
For certain charitable fund raising purposes.

Prohibition on Other Uses or Disclosures
We may not make any other use or disclosure of your personal health information without your written authorization. Once given, you may revoke the authorization by writing to the contact person listed below. Understandably, we are unable to take back any disclosure we have already made with your permission.

Individual Rights
You have many rights concerning the confidentiality of your health information including:

The right to request restrictions on the health information we may use and disclose for treatment, payment, and health care operations. We are not required to agree to these requests.

To receive confidential communications of health information about you in a certain manner or at a certain location.

To inspect or copy your health information. If you request a copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies. In certain circumstances we may deny your request to inspect or copy your health information. If you are denied access to your health information, you may request that the denial be reviewed. Another licensed health care

professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if the information was not created by us, unless the person that created the information is no longer available to make the amendment, the information is not part of the health information kept by or for us, is not part of the information you would be permitted to inspect or copy, or is accurate and complete.

To receive an accounting of disclosures of your health information. Not all health information is subject to this request or to receive a copy of this Notice upon request.

All requests to restrict use of your health information for treatment, payment, and health care operations, to inspect and copy health information, to amend your health information, or to receive an accounting of disclosures of health information must be made in writing to the contact person listed below.

Complaints
If you believe that your privacy rights have been violated, a complaint may be made to our privacy officer at the address listed below. You may also submit a complaint to the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Changes to This Notice
We may amend this Notice of Privacy Practices to accordance to applicable law.

Contact Information
Brier Creek Integrated Pain and Spine, PLLC
7780 Brier Creek Parkway Suite 200
Raleigh, NC 27617
Ph. 919.596.3400
Fax 919.596.3499