SPINE & NEUROSURGERY ASSOCIATES
A Medical Corporation
B. Barry Chehrazi, M.D., F.A.C.S.
Kavian Shahi, M.D., Ph.D., F.A.A.N.S.
Hamid Aliabadi, M.D.

IMPORTANT:

Please note the following to facilitate your initial consult with us:

1. **Hand carry your X-Rays, MRI's, CT scans and any other radiological studies with you. Films couriered or mailed to our office, may not arrive in time for your appointment. These studies are necessary for your initial consult. Without them we may have to reschedule your appointment.**
2. **Completely fill out the attached Health Information Questionnaire. PLEASE DO NOT FORGET to bring it with you to our office.**
3. **Due to the high cost of billing, we expect co-payments and/or deductibles to be paid at the time services are rendered.**

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Dear:

We hope this letter will answer questions you may have about receiving medical care from our office. Our medical staff and medical personnel operate as a team. We take great pride in our training, knowledge, and capabilities, and we want you to know that we are dedicated to giving you quality health care.

OFFICE HOURS:

Regular office hours are 9:00 a.m. to 4:00 p.m. Monday through Thursday and 9:00 a.m. to 12:00 p.m. on Friday. We would appreciate 24 hours notice if you find it necessary to cancel your appointment.

DIRECTIONS:

- Our **Roseville** office is located at 1301 Secret Ravine Parkway, Suite 200, near Sutter Roseville Medical Center. From I-80 west take the Eureka Road exit, go straight through the light and make a right on East Roseville Parkway. From I-80 east take the Eureka Road exit, make a left on N. Sunrise, then make a right on East Roseville Parkway. Turn left turn on Secret Ravine Parkway. We are located on the left-hand side.

MEDICATION:

Your doctor may prescribe medication as part of your treatment. Please note that your doctor must authorize all refills. Please telephone your pharmacy and ask that they fax a refill request to our office. **Please allow 3 days for this process.**

INSURANCE AND PAYMENT:

We must emphasize that as a medical care provider, our relationship is with you, not your insurance company. Due to the Health Care Reform, insurance requirements vary with each insurance. Therefore, prior to your visit, we recommend that you contact your insurance carrier to find out their particular requirements to eliminate any misunderstandings. While filing of claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If we do not receive payment from your insurance company within 60 days, we will expect payment from you. **We do ask for your deductible and any co-payment at the time services are rendered to help defray our costs**. We are a member of certain PPO's and HMO's. Please notify this office immediately if ANY changes have occurred during on-going treatment to avoid any problems. Changes we are concerned about are changes in your primary care provider, your insurance has been terminated, or that you have signed up with a new insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us for assistance in the management of your account. Our office accepts personal checks, cash, MasterCard, and Visa.

Our office is based on a friendly mutual understanding among staff, doctor, and patient. If you have any questions, please do not hesitate to bring them to our attention. We're looking forward to getting to know you.

Sincerely,

Staff of Spine & Neurosurgery Associates

Appointment_____

Physician_____

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ABOUT YOUR NEUROSURGEON

B. Barry Chehrazi, M.D., F.A.C.S.

Dr. Chehrazi graduated with a B.S. degree, cum laude, in psychology from the University of Wisconsin, Madison, in 1969. He received his medical degree from the University of California, San Francisco (UCSF) in 1973 and completed his residency training in surgery and neurological surgery at Yale University in 1979. Dr. Chehrazi served on the faculty of Yale University and held the position of Chief of the Section of Neurosurgery at West Haven V.A. Hospital. In 1981, he joined the faculty of the University of California, Los Angeles (UCLA), and served as the Chief of Section of Neurosurgery at Wadsworth Hospital. Dr. Chehrazi joined the faculty of the University of California, Davis (UCD), in 1983 where he served as Director of the Cerebral Vascular Surgery and Vice-Chair of the Department of Neurological Surgery prior to establishing private practice in the greater Sacramento area. Presently he is a clinical professor of Neurological surgery at UCD.

Dr. Chehrazi has been awarded a number of honors including Phi Eta Sigma, Phi Beta Kappa, Phi Kappa Phi, and the Outstanding Professor of the Year in Neurosurgery in 1988 and 1993.

While at Yale Dr. Chehrazi embarked on basic science and clinical research programs in the area of spine and spinal cord injury. During his tenure at UCD, he established basic science and clinical research in cerebral vascular disease, and developed a large clinical referral practice in cerebral aneurysms and vascular malformations as well as other intra cranial, spinal, and peripheral nerve disorders.

Dr. Chehrazi is Board Certified by The American Board of Neurological Surgery. He is a member of the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, Joint Sections on Tumors, Trauma, and Cerebral Vascular Surgery, the Western Neurosurgical Society, the California Association of Neurological Surgeons, and the American College of Surgeons. He has served on the Board of Directors of the Sacramento-El Dorado Medical Society, the California Association of Neurological Surgeons, and The Golden Empire Chapter of The American Heart Association. He has served as a commissioner and Expert Medical Reviewer for the Medical Board of California. Dr. Chehrazi has more than fifty publications in scientific journals and made more than seventy scientific presentations.

Dr. Chehrazi is committed to providing an exceptional quality of neurosurgical care with an efficient, knowledgeable, and caring staff in a pleasant and relaxing environment. The staff will assist you with all phases of scheduling, record keeping, insurance questions, and billing.

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ABOUT YOUR NEUROSURGEON

Kavian Shahi, M.D., Ph.D.

Dr. Shahi graduated with a B.S. degree in chemistry and a B.S. degree in biology from the University of California at Irvine. He then received his doctorate of philosophy (Ph.D.) and doctorate of medicine (M.D.) degrees with highest distinction from the University of Southern California. He completed his residency training in surgery and neurological surgery at the University of Utah where he was involved in over 1000 surgical procedures.

Dr Shahi has numerous publications and oral presentations to his name and has done extensive basic science research looking at the mechanisms of synaptic plasticity in the mammalian nervous system. His clinical research involved utilizing the latest molecular biological techniques to elucidate genetic variations of malignant brain tumors in hopes of better understanding the vulnerabilities of these devastating cancers.

Dr Shahi has experience with a wide variety of neurosurgical problems. He is licensed to practice neurological surgery in the states of California and Utah and is Board Certified with the American Board of Neurological Surgery. He is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

Dr Shahi is committed to providing an exceptional quality of neurosurgical care with an efficient, knowledgeable, and caring staff in a pleasant and relaxing environment. The staff will assist you with all phases of scheduling, record keeping, insurance questions and billing.

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ABOUT YOUR NEUROSURGEON

Hamid Aliabadi, M.D.

Dr. Aliabadi graduated with a B.S. degree in Neurobiology and a B.S. degree in Nutritional Science from the University of Maryland where he was elected to Phi Beta Kappa Honor Society. He received his medical degree from the Medical College of Virginia where he was elected to Alpha Omega Alpha and completed a post-doctoral research fellowship in neuro-oncology. He completed his neurosurgical training at Duke University where he was involved in over 2000 surgical procedures.

Dr. Aliabadi has numerous publications and oral presentations to his name and has been one of the primary investigators on a clinical study of post-operative stereotactic radiosurgery for brain metastases at Duke University.

Dr. Aliabadi has experience with a wide variety of neurosurgical problems. He is licensed to practice neurological surgery in California and is Board Eligible with the American Board of Neurological Surgery. He is a member of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

Dr. Aliabadi has extensive experience in brain tumor surgery. He also has an interest in the surgical treatment of spine disease, including: minimally invasive spine surgery, surgery for spinal tumors, cervical artificial disc replacement, and treatment of degenerative scoliosis. His neurosurgery training included a multi-disciplinary approach using neuronavigation, micro-neurosurgical techniques, and neuroendoscopy. He is a clinical faculty at the University of California, San Francisco Department of Neurological Surgery.

Dr. Aliabadi is committed to providing an exceptional quality of neurological care with an efficient, knowledgeable, and caring staff in a pleasant and relaxing environment. The staff will assist you will all phases of scheduling, record keeping, insurance questions and billing.

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Patient Information

Patient's name: _____ Date of birth:_____

Home address: _____ City:_____ State:_____ Zip code:_____

Home phone: _____ Work phone:_____

Cell phone: _____

Social Security number: _____ Drivers License number: _____

Occupation: _____ Employer: _____ How long employed: _____

Work address: _____ City:_____ State:_____ Zip code:_____

Spouse's name: _____ Date of birth:_____

Social Security number: _____

Emergency contact: _____ Relationship:_____ Phone:_____

Address: _____ City:_____ State: _____ Zip code:_____

****

Referring Physician _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____

Primary Care Physician _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____

****

Insurance Information

Primary carrier: _____ Identification # _____

Secondary carrier: _____ Identification # _____

If work related, date of injury: _____ **Claim#**:_____

****

Workman's Compensation and/or Attorney's Information

Adjuster's Name: _____ Phone: _____

R.N. Case Mgr: _____ Phone: _____

Attorney's Name: _____ Phone: _____

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Health Information Questionnaire

Patient's Name: _____ Date: _____

DOB: _____ Age: _____ Handedness: (L / R / Both) Gender: (M / F)

History of Present Illness:

1. What is the main purpose of your visit today?

_____

_____

1a. Are you referred for surgery? 1. Yes 2. No

2. Please list and describe the symptoms that are bothering you in order of their importance:

(Please specify which side)

1. _____
2. _____
3. _____
4. _____

3. When did you first note your present symptoms: _____

_____

4. In your opinion what caused your present complaint:

_____

4a. Is your complaint related to a personal injury case? (i.e. Motor Vehicle Accident) 1. Yes 2. No

4b. Is your complaint due to a work related injury? (i.e. Worker's Compensation Case) 1. Yes 2. No

If yes, please give date and description: _____

5. Have you received treatment for this problem before? 1. Yes 2. No

If yes, please describe the type of treatment please include name of provider/facility and date:

_____

_____

Reviewer: _____

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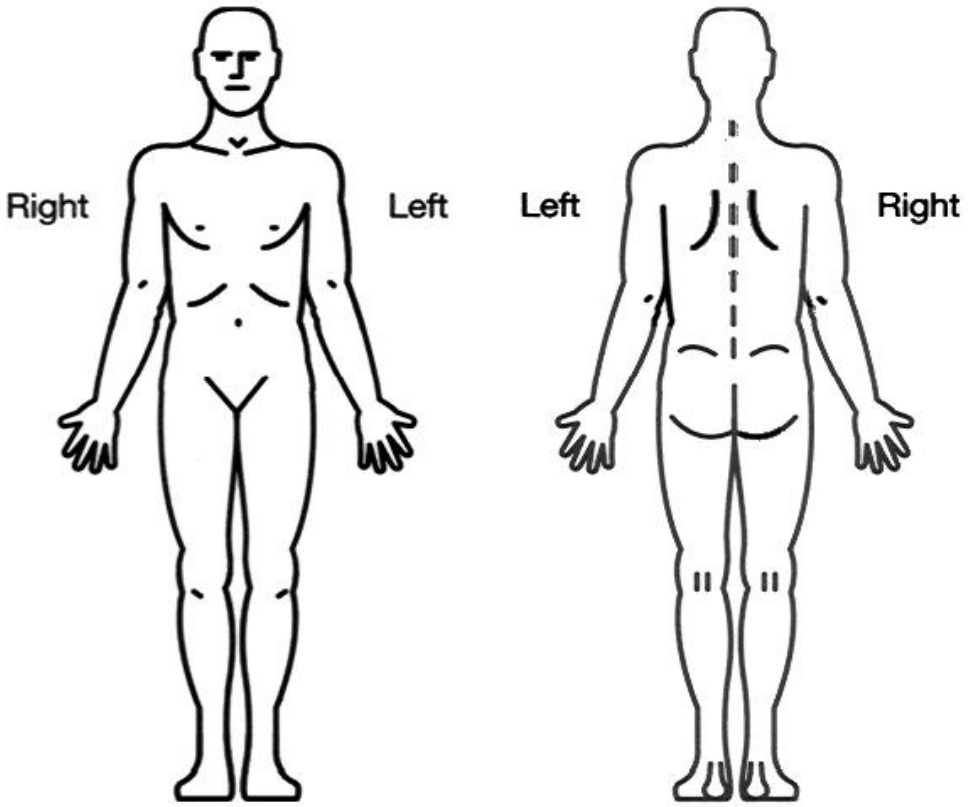
Patient's Name: _____ **Date:** _____

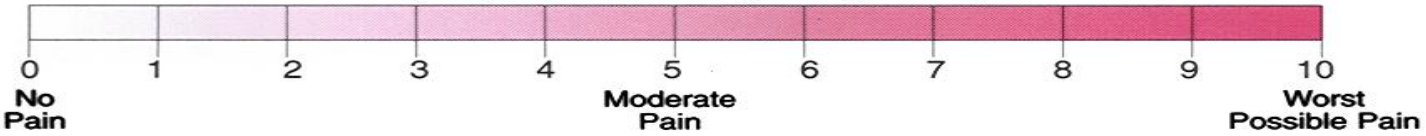
Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol.

Aching	Numbness	Pins & Needles	Burning	Stabbing	Other
ΔΔΔΔ	====	000	xxx	///	••••



Pain Intensity Scale

Circle the area on the scale below that best describes how the patient rates the intensity of the pain that they are experiencing: "0" being no pain and "10" being worst possible pain.



How would you describe your pain?

1. Sharp 2. Dull 3. Cold 4. Hot 5. Grabbing 6. Pulling 7. Other

Reviewer: _____

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6. How often have you had pain (over the past month)?

_____ **Intermittent -** less than one fourth of the time when you are awake *(up to 25%)*
_____ **Occasional -** between one fourth and half of the time when you are awake *(25-50%)*
_____ **Frequent -** between one half and three fourths of the time when you are awake *(50-75%)*
_____ **Constant -** between three fourths and all of the time when you are awake *(75-100%)*

7. When you are experiencing pain, is it generally (check one):

_____ **Annoying -** does not interfere with daily activities or sleep
_____ **Tolerable -** may interfere with some daily activities and sleep. Aspirin/Motrin may be taken regularly.
_____ **Limiting -** severely interferes with daily activities and sleep. Prescription/Narcotic medication taken.
_____ **Disruptive -** Inhibits daily actives, social/recreational activities and disrupts sleep. Narcotic medications may not relieve pain

8. Describe the effect of the following activities on your symptoms:

	Better	Worse	No effect		Better	Worse	No effect
Bending				**Twisting**			
Standing				**Sitting**			
Walking				**Sneezing**			
Reaching				**Driving**			
Stretching				**Lifting**			
Pulling				**Pushing**			
Grasping				**Hot Shower**			
Limiting Activity				**Changing position**			
Heat				**Resting**			

9. If you had to continue the rest of your life with your <u>condition as it is right now</u>, how would you feel about it?

1. Extremely dissatisfied
2. Very dissatisfied
3. Somewhat dissatisfied
5. Somewhat satisfied
6. Very satisfied
7. Extremely satisfied

<u>Past Medical History:</u>

10. Have your ever been treated for any of the following medical problems? If yes, circle the appropriate one.

1. Diabetes	2. Arthritis	3. Cancer	4. Epilepsy	5. Hypertension
6. Stroke	7. Migraine	8. Heart Disease	9. Kidney Disease	10. Bowel Disease
11. Bladder Disease	12. Lung Disease	13. Pneumonia	14. Asthma	15. Emphysema
16. Headaches	17. Liver Disease	18. Hepatitis	19. Blood Disorders	20. Anemia
21. Excessive Bleeding	22. AIDS	23. Psychological difficulties		

11. Please list any/all major illnesses:

_____

_____

Reviewer: _____

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12. Have you had any operations? 1. Yes 2. No *If yes, please list below and indicate the year.*

_____

_____

13. Have you had any serious trauma? 1. Yes 2. No I*f yes please explain* _____

_____

14. Are you allergic to any medication, anesthetic, or x-ray dye? 1. Yes 2. No I*f yes please list:*

_____

15. Current Medications and dosage:

Medication	**Dosage**	**Frequency (i.e. twice a day, etc.)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Do you drink alcoholic beverages?
1. Never 2. Rarely 3. Daily 4._____

17. Have you ever smoked? 1. Yes 2. No If Yes: ____ pack(s) per day for ____ year(s)

18. Do you currently smoke? 1. Yes 2. No If Yes: ____ pack(s) per day

19. Have you abused drugs? 1. Yes 2. No (*Cocaine, Crack, LSD, Marijuana, Heroin, Prescription)*

Family History:

20. Are there any diseases that run in your family? 1. Yes 2. No

If yes, please explain. _____

_____

21. Please complete the following:

	Age	**Chronic Medical conditions**	**if deceased – age at death & cause**
Father			
Mother			

Reviewer: _____

21. Please complete the following:

	# of	Age	Chronic Medical conditions	if deceased – age at death & cause
Brothers				
Sisters				
Children				

22. Please indicate if any members of your family have any of the following diseases:

1. Diabetes 2. Heart Disease 3.Migraine Headaches
4. Cancer 5. Stroke 6. Hypertension
7. Epilepsy 8. Arthritis 9. Bleeding disorder

Social History:

23. Marital Status: 1. Single 2. Married 3. Widowed 4. Separated 5. Divorced

24. Are you currently working? 1. Yes 2. No *If yes, please describe provide us with a brief job description:*

_____

25. If you are not working now, when was the last time you worked? _____

What type of work were you doing? _____

26. What is the highest level of your education?

1. High School 1 2 3 4 Location/Name:
2. College 1 2 3 4 Location/Name:
3. Graduate school 1 2 3 4 Location/Name:

27. How do you spend your free time? (Hobbies, interests, sports, etc.)

_____

28. What effects have your present medical problem(s) had on your social life?

_____

Reviewer: _____

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Review of Systems: Please circle the symptoms that best describe your condition:

29. Height: _____ Weight: _____

30. Have you had a recent weight change? 1. Yes 2. No

If your answer to number 30 is yes: You have gained/lost _____ lbs over the past 3/6 months.

31. Have you had a recent change in your appetite? 1. Yes 2. No

32. Head, Eyes, Ears, Nose, Throat and Neck:

Change in vision	1.Yes 2. No	**Dizziness**	1.Yes 2. No
Double vision	1.Yes 2. No	**Hard of hearing**	1.Yes 2. No
Jaw pain	1.Yes 2. No	**Loss sense of smell**	1.Yes 2. No

Please explain:_____
_____

33. Hematological:

Bleeding Problems	1. Yes 2. No	**Anemia**	1. Yes 2. No
Blood Disease	1. Yes 2. No	**Bruise easily**	1. Yes 2. No

please explain:_____
_____

34. Locomotor-Musculoskeletal:

Varicose Veins	1. Yes 2. No	**Phlebitis**	1. Yes 2. No
Swelling at joints	1. Yes 2. No	**Pain in arms**	1. Yes 2. No
Numbness in arms	1. Yes 2. No	**Pain in feet**	1. Yes 2. No
Numbness in feet	1. Yes 2. No		

Please explain: _____
_____

35. Respiratory:

Coughing	1. Yes 2. No	**Spitting up blood**	1. Yes 2. No
Difficulty with Breathing	1. Yes 2. No		

Please explain:_____
_____

36. Cardiovascular:

Heart attack	1. Yes 2. No	**High blood pressure**	1. Yes 2. No
Heart Murmur	1. Yes 2. No	**Chest pain at rest**	1. Yes 2. No
Chest pain with activity	1. Yes 2. No	**Swelling of hands/feet**	1. Yes 2. No
Shortness of breath	1. Yes 2. No		

Please explain: _____
_____

Reviewer: _____

37. Gastrointestinal:

Change in ability to taste food	1. Yes 2. No	**Difficulty swallowing**	1. Yes 2. No
Vomiting blood/food	1. Yes 2. No	**Jaundice**	1. Yes 2. No
Painful bowel movements	1. Yes 2. No	**Bleeding w/ bowel movements**	1. Yes 2. No
Recent change in bowel habits	1. Yes 2. No	**Cramping/pain in abdomen**	1. Yes 2. No

Please explain:_____
_____

38. Neuropsychiatric:

Convulsions	1. Yes 2. No	**Loss of Consciousness**	1. Yes 2. No
Fainting Spells	1. Yes 2. No	**Prior Psychiatric history**	1. Yes 2. No

please explain: _____
_____

39. Gynecologic (women only):

Are you still menstruating?	1. Yes 2. No
Are your periods regular?	1. Yes 2. No
Do you have pain with your periods?	1. Yes 2. No
Is there a chance you may be pregnant?	1. Yes 2. No

Please explain: _____
_____

Reviewer: _____

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OSWESTRY DISABILITY QUESTIONNAIRE

Please Read: This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only the one box that applies to you. We realize you may consider two of the statements in any one section relate to you, but **please mark one box that most closely describes your problem.**

Section 1 – Pain Intensity (check only one)

- ☐ I can tolerate the pain without having to use painkillers
- ☐ The pain is bad but I manage without painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on pain and I don't use them.

Section 2 – Personal Care (check only one)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes me extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty, and stay in bed.

Section 3 – Lifting (check only one)

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights, but I can manage if they are coneniently positioned e.g. on a table.
- ☐ Pain prevents me from lifting heavy objects, but I can manage light to medium weights if they are conveniently positioned (i.e. on a table)
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Sitting (check only one)

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour
- ☐ Pain prevents me from sitting for more than ½ hour
- ☐ Pain prevents me from sitting for more then 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 5 – Walking (check only one)

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking for more than 1 mile.
- ☐ Pain prevents me from walking for more than ½ mile.
- ☐ Pain prevents me from walking for more than ¼ mile.
- ☐ I can only walk using a cane or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 6 – Standing (check only one)

- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want, but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

Section 7 – Sleeping (check only one)

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets, I have less than 6 hours of sleep.
- ☐ Even when I take tablets, I have less than 4 hours of sleep.
- ☐ Even when I take tablets, I have less than 2 hours of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life (check only one)

- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal, but causes some extra pain.
- ☐ My sex life is nearly normal, but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 – Social Life (check only one)

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling (check only one)

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere, but it gives me extra pain.
- ☐ Pain is bad, but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than I hour.
- ☐ Pain restricts me to journeys of less than ½ hour.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

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MEDICAL RECORDS RELEASE

Date: _____

I authorize any physician, hospital, clinic, or any medically related facility to furnish to Spine & Neurosurgery Associates, A Medical Corporation, any medical information, including copies of all my medical records and diagnostic tests/films. A copy of this authorization shall be considered as effective and valid as the original.

Signature: _____

Name (please print):_____

Date of birth: _____

FINANCIAL AGREEMENT

Spine & Neurosurgery Associates, A Medical Corporation, will bill your insurance company for services provided by your doctor. If you wish us to do so, we will need your consent.

I acknowledge and agree that I am personally financially responsible for payment of services that are performed by Spine & Neurosurgery Associates, A Medical Corporation. I understand that my insurance company may not pay for services in full. I understand that I am responsible for any deductible or co-payments which are required by my insurance company and are payable at the time of my visit.

Name: _____ Date: _____

Signature: _____

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Kavian Shahi, M.D., Ph.D., F.A.A.N.S.
Hamid Aliabadi, M.D.

ASSIGNMENT OF BENEFITS

I hereby assign to Spine & Neurosurgery Associates, A Medical Corporation., my right, title, and interest in and to any and all health care and/or surgical benefits, otherwise payable to me for medical treatment.

Signed: _____ Date: _____

If not signed by the patient, please indicate relationship:
____ Parent or guardian of minor patient.
____ Guardian or conservator of patient.
____ Beneficiary or personal representative of deceased patient.
____ Spouse or person financially responsible.

This form should be completed and signed by the patient, and if the patient is a minor, or the policy otherwise required another signature, by the appropriate patient representative. Also, a copy of the assignment should be attached to the claim form when it is submitted to the payer. A third-party payer has no obligation to physician to pay them absent notice of the assignment - this form serves as notice.

FAILURE TO PAY DESPITE ASSIGNMENT

The "assignment of benefits" does not ensure the physician will receive payment from the third-party payer. If a payer refuses to make a partial or total payment to physician, they may seek full payment directly from the patient or the financially responsible person. By merely assigning benefits to the physician the patient cannot escape the burden of the obligation to pay physician for services rendered if the payer fails to pay. Patients still remain liable to physicians (unless they formally release the patient of such obligation). Therefore, when the payer is not paying the physician for any apparent reason, despite the physician's repeated attempts to obtain payment, the physician may bill the patient.

"SIGNATURE ON FILE" CLAIM AUTHORIZATION

I request that payment of all medical benefits be made directly to Spine & Neurosurgery Associates, A Medical Corporation. If the payment from my insurance comes directly to me, I understand that I am fully responsible for the balance. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits, of the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. Coinsurance and deductible are based upon the charge determination of the insurance carrier.

1301 Secret Ravine Parkway, Suite 200
Roseville, CA 95661
(916) 771-3300 (916) 771-3443 Fax

SPINE & NEUROSURGERY ASSOCIATES
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Spine and Neurosurgery Associates

Summary of Notice of Privacy Practice

The Health Insurance Portability and Accountability act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. *We are required to ask you to sign a one-time acknowledgement that you have received this summary. A copy of the full Notice is available upon request.*

Your Rights as a Patient
You have rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information
We are permitted to use your protected health information for treatment purposes, payment, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be very difficult to avoid entirely, and considers them permissible.

Disclosures of Protected Health Information Requiring your Authorization
For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures of Protected Health Information Not Requiring your Authorization
We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Restrictions to Use and Disclosure
You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, only the minimum amount of such information will be used to accomplish the intended goal.

Access to Protected Health Information
You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments to Medical Records
You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

Accounting of Disclosures of Protected Health Information
You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures make in the course of treatment, payment, or operations.

Complaints Related to Perceived Violations of your Privacy Rights
You may register a complaint about any of our privacy practices with our Privacy Officer or with the Secretary of Health and Human Services.

Faxed Medical Records
Your medical records will be provided to primary care physicians, referring doctors, and adjusters, etc., via fax.

Therefore, I _____, acknowledge that **Spine and Neurosurgery Associates has provided a**
(printed name of patient or personal representative)

written copy of their summary Notice of Privacy Practices to (check one) Myself _____ or Specify _____.

_____ _____
Signature of Patient or Personal Representative Date

_____
Relationship to Patient

Spine and Neurosurgery Associates has made a good faith attempt to provide the above named patient with a copy of our summary Notice of Privacy Practices, but we were not successful for the following reason:

_____
_____

_____ _____
Signature of Representative Date

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DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to Spine & Neurosurgery Associates (SNA) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). SNA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SNA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Spine & Neurosurgery Associates, HIPAA Officer at 1301 Secret Ravine Parkway, Suite 200, Roseville, CA 95661.

With this consent, SNA may call my home or other alternative locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, SNA may mail to my home or other alternative location any items to assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, SNA may e-mail to my home or other alternative locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that SNA restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to SNA's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, SNA may decline to provide treatment to me.

Signature of Patient or Legal Guardian: _____

Patient Name: _____

Date: _____

RELEASE OF MEDICAL INFORMATION TO FAMILY MEMBERS

I authorize Spine & Neurosurgery Associates to discuss and release all medical information to those persons named below, including medical records, x-rays, history, findings and prognosis pertaining to the medical condition, services rendered, or treatment given to me. This authorization complies with the Confidentiality of Medical Information Act, Section 56 et seq. of the California Civil Code.

Name: _____**Relationship:**_____

Name: _____**Relationship:**_____

Name: _____**Relationship:**_____

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Map to 1301 Secret Ravine Pkwy

Directions:

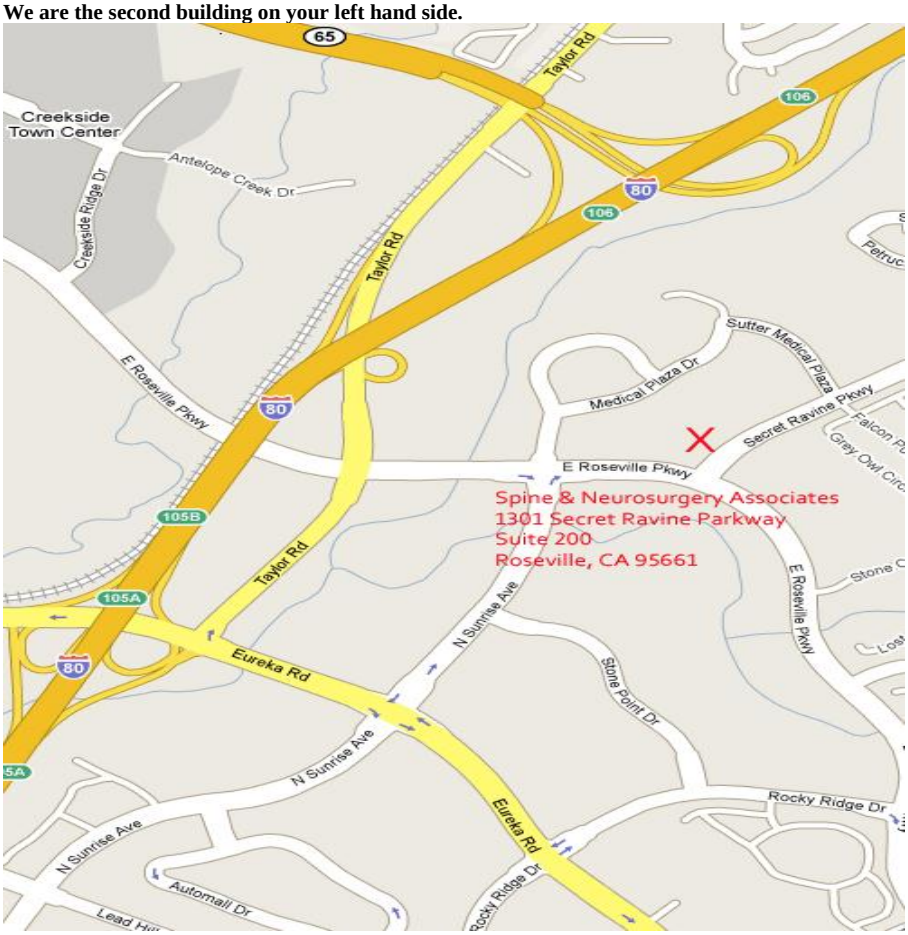
Coming from:

1-80 East toward Reno

Take Eureka Road and turn right
Left on N. Sunrise Blvd
Right on E. Roseville Pkwy
Left on Secret Ravine Pkwy
We are the second building on your left hand side.

I-80 West towards Sacramento

Take Eureka Road and continue over the overpass
Left on N. Sunrise Blvd
Right on E. Roseville Pkwy
Left on Secret Ravine Pkwy
We are the second building on your left hand side.



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