THE SPINE INSTITUTE OF SOUTHERN NEW JERSEY

Office Phone: 856-797-9161
Office Fax: 856-797-3637

The Spine Institute of Southern NJ Registration

Please present driver's license / photo ID and health insurance cards to the front desk

Date: ____/____/_____ Account#_____ (for internal use only)

Patient Information		
Last Name:	First Name:	MI:
Address: _____ Street City State Zip		
Date of Birth:	Social Security: - -	Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Divorced	Driver's License # & State:	
Home #:	Cell #:	Work #: Ext:
Your Email Address:	Employed: ☐ Yes ☐ No ☐ Retired	
Employer Name:	Employer Address:	
Family Physician Name and Phone #:		
Referring Physician Name and Phone #:		
Emergency Contact Name:	Relationship to Patient:	
Emergency Contact Phone #:		

Accident Insurance Information		
Is this a **motor vehicle accident**? ☐ Yes ☐ No	A **work injury**? ☐ Yes ☐ No	**Other:** ☐ _____
Date of Accident or Injury:	State Accident Occurred In:	
Insured's Last Name:	First Name:	MI:
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Claim #:	
Liability Insurance Name & Address: _____ Name Street City State Zip		
Adjustor Name:	Phone #:	Liability Policy #:
Nurse Case Manager Name:		Phone #:
Attorney Name:		Phone #:

Primary Health Insurance Information			
Insurance Company Name & Address: _____ Name Street City State Zip			
Effective Date:	ID #:		Group #:
Co Pay: $	Insured Party Last Name:	First Name:	MI:
Sex: ☐ Male ☐ Female	Date of Birth:	Social Security: - -	
Insured's Address (If Different): _____ Street City State Zip			
Home #:	Work #: Ext:		Cell #:
Insured's ID #:	Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other		
Employer Plan? ☐ Yes ☐ No	Employer Name:		

Assignment of Benefits /Authorization/Notice of Collection Practices

I request payment of insurance benefits for all services rendered to me to be made on my behalf to The Spine Institute of Southern NJ, PC. I authorize The Spine Institute of Southern NJ, PC to release medical information to my insurance carrier and its entities to determine payment for services rendered. I further understand I am responsible to pay certain amounts due. These amounts may include annual deductibles, copayments, co-insurances and charges denied by my insurance company as not covered or not medically necessary. I am responsible for any fees incurred should my account require collection action. (E.G. late fees, collection agency, court or attorney costs). I agree this authorization shall remain valid unless/until I rescind in writing.

Print Name of Person Completing this form:	
Signature:	**Date:**

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COMMERCIAL ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to The Spine Institute of Southern NJ, PC for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making the assignment, I understand and agree that I am financially responsible to the above party for charges not paid under the insurance policy. I permit a copy of this authorization to be used in place of the original.

GENERAL RELEASE OF INFORMATION

The Spine Institute of Southern NJ, PC may disclose any part of my clinical record to any insurance company or companies, or, in the case of Worker's Compensation claims, to my past or present employer (s), for purposes of satisfying charges billed by The Spine Institute of Southern NJ, PC and/or its physicians. This authorization does not cover requests from other parties seeking information regarding my account. If my insurance company refuses to make payment to The Spine Institute of Southern NJ, PC on my behalf I give my consent to The Spine Institute of Southern NJ, PC to appeal the denial of payment.

GUARANTEE OF ACCOUNT

For and in consideration of services rendered by The Spine Institute of Southern NJ, PC to the below and named patient, the undersigned (jointly and verbally if more than one) guarantees payment of all charges and collection fees incurred by said patient in accordance with the policy of payment of such bills.

THE UNDERSIGNED CERTIFIES THAT EACH HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS

Patient Signature Date

Patient's Representative or Guarantor Signature Date

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FINANCIAL POLICY

The Spine Institute believes that an important part of good healthcare practice is to establish and communicate our financial policy to our patients

Thank you for choosing **The Spine Institute of SNJ** as your specialty care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask business office personnel. We ask that all patients please take a moment to read and sign our Financial Policy.

The patient's portion of the payment (i.e., copay, deductible, coinsurance) as well as any past due balances are due at the time services are rendered unless prior payment arrangements have been made with the billing department. We accept cash, personal check, money orders, travelers' checks and most major credit cards. *Please note: if you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.*

We accept assignment with most major insurance companies and participating provider plans. However, please understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with YOU, not your insurance carrier.
2. All charges are your responsibility whether or not your insurance company pays.
3. Fees for services, unpaid deductibles, and co-payments are due at the time of treatment.
4. Returned checks will be subject to a $30.00 insufficient fund fee. We will notify you by mail and you will be asked to cover the payment and service fee.
5. Should you receive a payment for services rendered, please contact the Practice Administrator or Billing Manager immediately, then mail the payment or bring the payment to the office to keep your account from becoming delinquent. The practice is notified if a check was sent to a patient when claim status is called on.
6. Personal payments and credits will be applied to the oldest date of service first.
7. Unpaid balances over 90 days are subject to collection via small claims court, attorney, and/or collections agency with applicable collection fees.
8. Failure to cancel an appointment in a timely manner may result in a cancellation fee/no show fee charge of $25.00 for each time you fail to notify the office.
9. If an attorney is utilized for collection of an outstanding balance, you will be responsible for attorney and court costs incurred.
10. Completing insurance forms, completing disability forms, and copying medical records require the office staff's and the doctors' time. The charge for completing forms is $15.00 prepaid per form (with the exception of the NJ State Disability form). The charge for copying medical records is $1.00 per page copied up to a maximum charge of $100.

We understand that temporary financial problems may affect timely payments of your balance and encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize the release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to **The Spine Institute of SNJ** the medical benefits I am entitled from my insurance company and/or Medicare.

This authorization is in effect for all future claims until I choose to revoke it in writing.

I, the undersigned, understand and agree to the above Financial Policy and understand that I am financially responsible for all charges incurred for my medical treatment.

Patient/Guardian Signature	Date
Printed Name of Patient	Relationship to patient if not patient

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NO SHOW POLICY

WE UNDERSTAND THERE ARE OFTEN REASONS TO HAVE TO CANCEL AN APPOINTMENT, BUT WE ASK YOU TO PLEASE CALL IN ADVANCE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT IN ORDER FOR US TO OFFER IT TO ANOTHER PATIENT WHO NEEDS TO BE SEEN.

THIS LETTER IS TO NOTIFY YOU THAT FAILURE TO PROVIDE A 24 HOUR NOTICE OF CANCELLATION WILL RESULT IN A $25 NO SHOW FEE.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS POLICY.

PATIENT SIGNATURE

PRINTED NAME DATE

DISABILITY FORM POLICY

THERE IS A $15.00 CHARGE FOR EACH DISABILITY INSURANCE FORM IN NEED OF COMPLETION BY OUR OFFICE.

ALL FORMS REQUIRE 5-7 DAYS NOTICE. THE FEE IS PAYABLE WHEN THE FORMS ARE DROPPED OFF TO THE OFFICE.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS POLICY.

PATIENT SIGNATURE

PRINTED NAME DATE

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Privacy Notice – Acknowledgement of Receipt

Patient Name: _____ ACCT #: _____

I, _____, acknowledge that I have received
Patient's Name

a copy of "Notice of Privacy Practices" from this office.

_____ _____
Patient's Signature Date

_____ _____
Witness Signature Date

For Office Use Only:

- ☐ Patient refused to sign
- ☐ Patient unable to sign due to communication/language barrier
- ☐ Patient unable to sign to due emergency situation
- ☐ Other (please explain):

_____

_____

_____ _____
Office Representative Signature Date

The signed form is placed in the patient's medical record

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FAMILY DOCTOR/INTERNIST:

Name: _____

Address: _____

_____

_____

Send them a letter? Yes ☐ No ☐

WHO REFERRED YOU TO US?

Name: _____

Address: _____

_____

_____

Send them a letter? Yes ☐ No ☐

CHECK ALL THAT APPLY:

☐ Injury on the job ☐ Auto accident ☐ Receiving disability income
☐ Receiving workers comp ☐ Legal proceedings pending ☐ Working with rehab nurse

Do you experience?

☐ Neck pain ☐ Arm pain ☐ Headaches ☐ Back pain ☐ Leg pain (left or right) ☐ Weakness of extremity
☐ Numbness in extremities ☐ Feeling of pins and needles in extremities ☐ Bowel or bladder incontinence ☐ Blackouts
☐ Memory difficulties ☐ Vision changes ☐ Speech difficulties ☐ Difficulty walking ☐ Other_____

Does this problem keep you from working? Yes ☐ No ☐ **(If yes; date last worked:** _____)

How long have you had the pain? _____ Years _____ Months _____ Weeks

How far can you walk? ☐ Blocks (number of times _____) ☐ Around the house
☐ Unlimited ☐ Other _____

Have you ever had pain like this before? Yes ☐ No ☐

Explain: _____

How did you treat the pain or problem? _____

_____

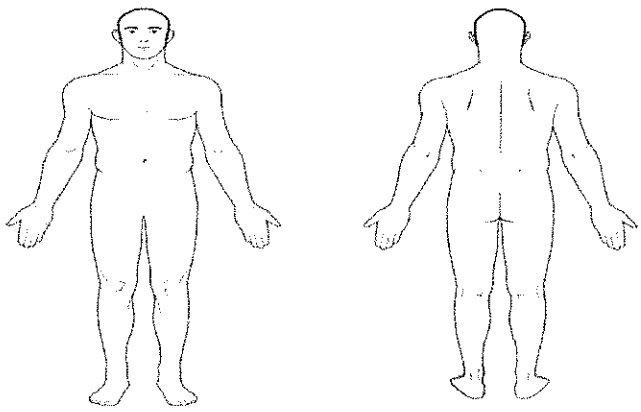
How often does your pain occur?

☐ Hourly ☐ Daily ☐ Weekly ☐ Occasionally ☐ Constant

Has this pain changed over time? Yes ☐ No ☐ Explain: _____

_____

Please indicate the location of your pain:



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Past Medical History/Family History (Check all that apply)

You	Family	History of...	You	Family	History of...
☐	☐	Heart attack	☐	☐	Bleeding Problem
☐	☐	High blood pressure	☐	☐	Stress test
☐	☐	Stroke	☐	☐	Cancer
☐	☐	Kidney Disease	☐	☐	Hepatitis
☐	☐	Heart catheterization	☐	☐	Pulmonary embolus
☐	☐	Diabetes	☐	☐	Blood clotting
☐	☐	High cholesterol	☐	☐	Reflux
☐	☐	Stomach problems	☐	☐	Osteoporosis
☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Anxiety	☐	☐	Depression
☐	☐	Pulmonary Disease	☐	☐	Thyroid problems
☐	☐	Psychiatric problems	☐	☐	Heart murmur
☐	☐	Sleep Apnea			

List ALL past surgeries (include dates if known):

_____

_____

_____

_____

Are you employed: Yes ☐ No ☐ **Occupation:** _____

Are you married? Yes ☐ No ☐ Number of children & Ages: _____

FEMALES Are you pregnant? Yes ☐ No ☐ Unsure ☐

Are you or have you ever been a smoker? Yes ☐ No ☐ (No. of packs _____ a day for _____ years)

Do you currently use or have you ever used other forms of tobacco? Yes ☐ No ☐ (What kind? _____)

Do you drink alcohol? Yes ☐ No ☐ (No. of drinks weekly: _____)

Do you use illicit drugs? Yes ☐ No ☐

Please list your allergies to any medications and the reactions you have (include tape and latex allergies):

_____

_____

_____

Please list all current medications, supplements, vitamins, and herbs you take:

Drug/Supplements	Dose	Taken how many times daily?

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Please circle which medicines you have tried for pain relief:

NSAIDS	Celebrex, Vioxx, Bextra, Motrin/Ibuprofen, Aleve/Naprosyn. Tylenol, Asprin
Narcotics	Morphine, Oxycontin, Methadone, Duragestic, Patchm Vicodin, Lorcet, Norco, Hydrocodone, Darvocet, Percocet, Oxycodone, Ultram, Dilaudid
Antidepressants	Paxil, Prozac, Celexa, Elavil/Amitriptyline, Zoloft, Lexapro, Effexor, Desyrel.Trazadone, Pamelor/Nortrptyline, Sinequan/Doxepin
Anticonvulsants	Neurotin, Lamotrigine, Dilantin, Tegretol
Muscle Relaxants	Soma, Flexeril Skelaxin, Diazepam/Valium, Klonopin/Clonazepam, Robaxin, Lanaflex, Baclofen
Other	Lidoderm Patch, Capsicin, Catapress Patch, Tramadol

Describe the character/quality of the pain (circle all that apply):

☐ Cold ☐ Hot ☐ Aching ☐ Throbbing ☐ Burning ☐ Dull ☐ Sharp ☐ Cramping
☐ Electric ☐ Spasms ☐ Sharp ☐ Pinching ☐ Squeezing ☐ Punishing ☐ Shooting ☐ Exhausting

Do you have any of the following physical changes associated with your pain/symptoms (check all that apply):

☐ Swelling ☐ Visions Changes ☐ Sweating ☐ Loss of consciousness ☐ Muscles spasms
☐ Weakness ☐ Skin color changes ☐ Temperature changes ☐ Loss of bladder/bowel control
☐ Inability to do fine movements with hands ☐ Changes in the way you walk

What makes your pain better?

☐ Lying down ☐ Manipulation ☐ Physical Therapy ☐ Sitting ☐ Exercise ☐ Aspirin ☐ Standing
☐ Prescription pain medication ☐ Tylenol ☐ Walking ☐ Over the counter medications
☐ Other: _____

What makes your pain worse?

☐ Lying down ☐ Sneezing ☐ Coughing ☐ Sitting ☐ Standing ☐ Walking ☐ Exercise
☐ Bending forward ☐ Bending backward
☐ Other: _____

Have you had any of the follow (check all that apply):

☐ X-Rays ☐ MR ☐ CAT scan ☐ Bone Scan ☐ EMG ☐ Myelogram ☐ MMPI-2 ☐ Discogram

What treatments have you had for pain relief (check all that apply):

	Did it help?			Did it help?	
☐ Physical Therapy	Yes	No	☐ Taken time off work	Yes	No
☐ Aqua Therapy	Yes	No	☐ Altered daily activities	Yes	No
☐ Traction	Yes	No	☐ Rested	Yes	No
☐ Massage	Yes	No	☐ Used ice	Yes	No
☐ TENS	Yes	No	☐ Used heat	Yes	No
☐ Acupuncture	Yes	No	☐ Nerve block	Yes	No
☐ Facet block	Yes	No	☐ Anti-inflammatory meds	Yes	No
☐ Oral Steroids	Yes	No	☐ Pain medications	Yes	No
☐ Epidural Steroid Injections	Yes	No	☐ Worn a brace	Yes	No
☐ Trigger point injections	Yes	No	☐ Chiropractic treatment	Yes	No

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Who have you seen for treatment of your pain/symptoms in the past? Please list names:

	Name of Doctor
☐ Primary Care	
☐ Orthopaedic Spine Surgeon	
☐ Neurosurgeon	
☐ Rehab doctor	
☐ Neurologist	
☐ Emergency Room How many times? _____	
☐ Pain Clinic	
☐ Chiropractor Adjustments done? Yes ☐ No ☐	
☐ Psychologist	
☐ Psychiatrist	
☐ Naturopath	
☐ Other	

Please note if you are taking any of the following medications (please notify your doctor):

☐ Coumadin (warfarin) ☐ Trental (pentoxifylline) ☐ Plavix (clopidogrel) ☐ Aggrenox ☐ Aspirin
☐ Ticlid (ticlodipine) ☐ NSAIDS ☐ Lovenox (enoxaparin) ☐ Pletal (cilostazol)
☐ Innohep (tinzaparin) ☐ Fragmin (dalteparin)

Review of Systems (please check any that apply):

GENERAL
☐ fever
☐ chills
☐ weight gain
☐ weight loss
☐ sexual dysfunction
☐ cancer
☐ HIV

EARS, NOSE, THROAT
☐ cold symptoms
☐ headache
☐ nasal drainage
☐ sore throat
☐ hearing loss

EYES
☐ sharp vision
☐ glaucoma
☐ cataracts
☐ blindness

HEART
☐ chest pain (angina)
☐ palpitations
☐ irregular heart beat
☐ poor circulation
☐ valve disease

LUNGS
☐ shortness of breath
☐ cough
☐ home oxygen use

HORMONAL
☐ diabetes
☐ thyroid disease
☐ calcium imbalance

STOMACH (GI)
☐ abdominal pain
☐ diarrhea
☐ constipation
☐ nausea/vomiting
☐ reflux
☐ liver cirrhosis
☐ loss of bowel control

RENAL (Urinary)
☐ renal failure
☐ difficulty urinating
☐ urgency
☐ frequency
☐ UTI
☐ kidney stones
☐ loss of bladder control

MUSCLE/BONE
☐ arthritis
☐ osteoporosis
☐ lupus
☐ rheumatoid arthritis
☐ spinal stenosis
☐ disc disease
☐ neck pain
☐ back pain
☐ sciatica
☐ radiculopathy

SKIN
☐ rash
☐ cancer
☐ infection
(also any history in the past or after surgery)
☐ blisters
☐ psoriasis
☐ eczema
☐ ulcers

LYMPH NODES
☐ enlarged lymph nodes in neck, armpits, or groin

SLEEP/PSYCHOLOGICAL
☐ insomnia
☐ anxiety
☐ excessive tiredness
☐ depression
☐ manic depression

RAIN/NERVES
☐ seizures
☐ memory loss
☐ paralysis
☐ TIA
☐ mini stroke
☐ facial drooping
☐ slurred speech
☐ neuropathy
☐ loss of sensation

BLOOD DISORDERS
☐ sickle cell anemia
☐ VonWillebrands disease
☐ hemophilia
☐ excessive bleeding
☐ easy bruising

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information

Please read this notice carefully!

All of the facilities and health care practitioners affiliated with The Spine Institute of Southern NJ believe that your health information is personal and private. We keep records of care and services that you receive that participate with The Spine Institute of Southern NJ and we are committed to keeping your health information private. In addition, we are required by law to respect your confidentiality. This Notice of Privacy Practices ("Notice") describes the privacy practices of all the TSISNJ Providers and applies to all of the health records that identify you and the care you receive at the TSISNJ facility. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of our Notice of Privacy Practices that is currently in effect.

I. SPINE INSTITUTE OF SNJ PROVIDER

All of the TSISNJ Providers – employed physicians, allied health care practitioners, doctors' offices, entities, facilities, and other affiliated programs, services, and health care practitioners – follow the terms of this Notice. The doctors and caregivers of other facilities who are not employed by or affiliated with TSISNJ Providers may exchange information about you as a patient with TSISNJ Providers for reasons of treatment, payment, and health care operations as discussed below. These health care practitioners may give you other privacy notices that describe their own privacy practices.

When you become a patient of TSISNJ, we will use your health information within the facility and disclose your health information outside the facility for the reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

II. PERMITTED USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Treatment. We use your health information to provide you with health care services. We may disclose your health information to TSISNJ Providers – doctors, nurses, technicians, medical or nursing students, or other persons at TSISNJ Facilities – who need that information to take care of you. We also may disclose your health information to people outside TSISNJ who may be involved in your health care, such as treating doctors, home care providers, pharmacies, drug or medical device experts, and family members. For example, a TSISNJ Provider treating you at TSISNJ may need to ask another doctor if you have diabetes because diabetes may complicate your treatment.

Payment. We may use and disclose your health information so that the health care you receive may be billed and paid by you, your insurance company, or a third party. For example, we may give information about surgery you had at a TSISNJ Facility to your health plan so it will pay us or reimburse you for the surgery. We also may tell your health plan about a treatment you are going to receive so we can get prior approval if your plan will pay for the treatment.

Health Care Operations. We may use your health information and disclose it outside a TSISNJ Facility for our health care operations. These uses and disclosures help us operate our facilities to maintain and improve patient care. For example, we may use your health information to review the care you received and to evaluate the performance of our staff in caring for you. We also may combine the health information of many patients to identify new services to offer, what services are not needed, and whether certain therapies are effective. We also may disclose information to doctors, nurses, technicians, medical students, and other persons at TSISNJ who are not directly involved in your care for learning and quality improvement purposes. We may remove information that identifies you so people outside TSISNJ may study your health data without knowing who you are. Moreover, we may use and disclose your health information to our business associates and us involves the use or disclosure of your health information, that business associate is required to keep your information confidential.

More Stringent State and Federal Laws: The information in this Notice complies with the requirements of the Health Insurance Portability and Accountability Act (HIPPA) regulations. In some cases, other state or federal laws may be more stringent than the HIPPA regulations. TSISNJ Providers will continue to abide by these more stringent state and federal laws. State law is more stringent when the individual is entitled to greater access to records than under HIPPA and when under state law, the records are more protected from disclosure than under HIPPA.

Contacting You. We may use and disclose your health information to contact you by mail, telephone, or email about appointments and other matters. We may leave voice messages at the telephone number with which you provide us, and we may respond to your e-mail messages to us.

Health-Related Services. We may use and disclose health information about you to send you mailings about health related products and services available at TSISNJ.

III. PERMITTED USE AND DISCLOSURE WHERE YOU HAVE AN OPPURTUNITY TO AGREE OR OBJECT

Patient Information. Our facility maintains limited information about you in their patient directories, such as your name and possibly your location and general condition (for example: good, fair, serious, critical, or undetermined). We usually give this information to people who ask for you by name. We may also include your religious affiliation in the directories and give your name to members of the clergy. Releasing directory information about you enables your family and others (such as friends, clergy, and delivery persons) to visit you in the hospital and generally know how you are doing. We will not release any of this information if you tell the hospital's admitting department or hospital's administration not to do so.

Promotional Communication. We do not share or sell your health information to companies that market health care products or services directly to consumers, including drug companies. We do maintain a list of individuals to whom we may have sent health improvement information or health promotion materials and news about the TSISNJ program, and you may be included in this list. If you do not wish to be contacted for promotional communications, please notify us in writing to the TSISNJ Privacy Officer at **The Spine Institute of Southern NJ ATTN: Privacy Officer 512 Lippincott Drive, Marlton, NJ 08053**

Other Uses. As described above, we will use your health information and disclose it outside TSISNJ Facilities for treatment, payment health care operations, and when permitted or required by law. We will not use or disclose your health information for other reasons without your written authorization. You may revoke authorization, in writing, at any time, but we cannot take back any uses or disclosures of your health information already made with your authorization.

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IV. USES AND DISCLOSURES PERMITTED BY PUBLIC POLICY OR LAW WITHOUT YOUR AUTHORIZATION

Organ and Tissue Donation. We may release health information about organ, tissue and eye donor transplant recipients to organizations that manage organ, tissue, and eye donations and transplantation.

Coroners, Medical Examiners, and Funeral Directors. We will disclose your health information to a coroner, medical examiner or funeral director if it becomes necessary to identify a deceased person, to determine a cause of a death, or to carry out their duties.

Public Health and Legal Matters. We will disclose health information about you outside TSISNJ Facilities when required to do so by federal, state, and local law or by a court. We may disclose health information about you for public health reasons, including reactions to medications, problems with medical products, or death. We may release health information to help control the spread of disease or to notify a person whose health or safety may be threatened. We may disclose health information to a health oversight agency for activities authorized by law, such as for audits, investigations, inspections, and licensure.

V. YOUR RIGHTS REGARDING HEALTH INFORMATION

Right to Inspect and Obtain Copy. You have the right to inspect and obtain a copy of your completed health records unless your doctor believes the disclosure of that information could harm you. You may not see or receive a copy of information that has been gathered for a legal proceeding or that otherwise may be protected or prohibited by law. Your request to inspect or obtain a copy of your medical records must be submitted in writing to the Medical Records Department at the TSISNJ Facility that maintains your records. If denied, you may appeal it to the TSISNJ Privacy Officer at **The Spine Institute of Southern NJ ATTN: Privacy Officer 512 Lippincott Drive, Marlton, NJ 08053.** We will respond to you within 60 days. We may deny your request and if we do, we will tell you why and explain your options.

Right to Accounting. You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom a TSISNJ Provider or TSISNJ Facility has disclosed your health information without your written authorization. The accounting would not include disclosures for treatment, payment, health care operations, and certain other disclosures exempt by law. Your request for an accounting of disclosures must be in writing, signed, and dated. It must identify the time period of the disclosures and the TSISNJ Facility that maintains the records about which you want the accounting. We will not list disclosures made 6 years before your request. Your request should indicate the form in which you want the list (for example, on paper or electronically). You must submit your written request to the Medical Records Department of the TSISNJ Facility that maintains the records. We will respond to you within 60 days. We will give you the first listing you request within any 12-month period free, but we will charge you for all other accountings requested within the same 12 months.

Right to Request Restrictions. You have the right to ask us to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree. You also may ask us to limit the health information that we use or disclose about you to someone who is involved in the payment for your care, such as a family member or friend. Again, we do not have to agree. A request for a restriction must be signed and dated and must identify the TSISNJ Facility that maintains the information. The request should also describe the information you want restricted, state whether you want to limit the use and/or the disclosure of the information, and tell us who it is you do not wish to receive the restricted information. You must submit your request in writing to the Medical Records Department of the TSISNJ Facility that maintains the information you want restricted. We will notify you regarding whether or not we agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

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Office Fax: 856-797-3637

Right to Request Confidential Communications. You have the right to request that we communicate with you about your health in a certain way or at a certain location (for example, you can request that we only contact you at work or by mail). Your request for confidential communications must be in writing, signed, and dated and it must identify the TSISNJ Facility making the confidential communications and specify how or where you wish to be contacted. You need not tell us the reason for your request. You must send your written request to the TSISNJ Privacy Officer at **The Spine Institute of Southern NJ ATTN: Privacy 512 Lippincott Drive, Marlton, NJ 08053**

Right to a Paper Copy of this Notice. You have the right to a paper copy of this Notice and may ask us to give you a copy at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper. You may obtain a paper copy of this notice at any TSISNJ facility.

VI. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the TSISNJ Privacy Officer or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the TSISNJ Privacy Officer, please submit your complaint in writing to the Privacy Official at the TSISNJ Facility where you believe your rights have been violated. You will not be penalized for filing a complaint.

VII. CHANGES TO THIS NOTICE

We may change this Notice at any time. Any change in this Notice could apply to medical information we already have about you, as well as any information we should receive in the future. We will post a copy of the current Notice at each TSISNJ Facility and on our website, **www.sjspine.com**

If you have any questions about this Notice, you may contact the TSISNJ Privacy Officer at the following address: 512 Lippincott Drive, Marlton, NJ 08053.