New Patient Information

Please answer **every** question below as concisely and accurately as possible.

The form may seem lengthy, but it is very important to help us understand your pain complaints. This will help us provide you with the highest level of care.

Primary Care Provider **City & State** **Phone Number**

____

Referring Provider **City & State** **Phone Number**

____

Have you ever been seen or are you currently seeing a Pain Management doctor? Yes No
If Yes please provide the following:

Pain Doctor's Name Phone Number

____

List areas of Pain:

1. ______________________________
2. ______________________________
3. ______________________________

When did your pain begin? _____weeks _____months ______years

How did your pain start? ______________________________

Does your pain radiate anywhere? (Examples: into arm, leg, chest, and abdomen)

Is the pain: □ Intermittent or □ Constant

Circle the words which best describe your pain:

Aching	Sharp	Gnawing	Dull
Throbbing	Shooting	Cramping	Tightness
Stabbing	Tearing	Deep	Searing
Burning	Other:____________		

Circle the numbers between 0-10 that represents the intensity of your pain:

Key: ***0= No pain***

5= Interferes with activities

10= Worse pain imaginable

Average pain= 0 1 2 3 4 5 6 7 8 9 10

Worse pain= 0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse? (please circle all that apply)

Sitting Standing Walking Lifting Lying Flat Other: ______________________________

What makes your pain better? (please circle all that apply)

Nothing Sitting Standing Walking Rest Other: ______________________________

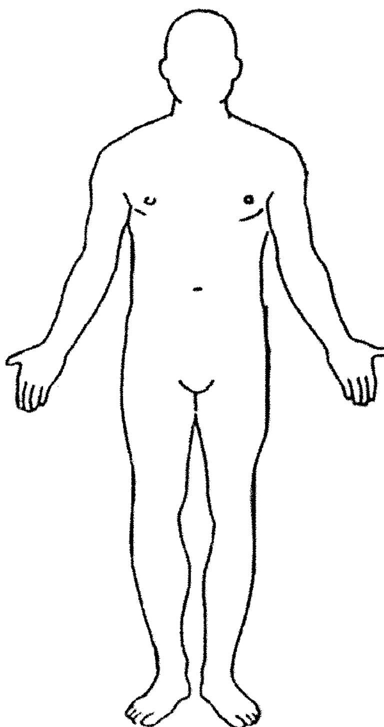
Pain Diagram:

Key: **Stabbing=**//////// **Burning=** XXXXX **Pins and needles=** 0000 **Numbness=** ========

Aching/Throbbing= ^^^^^ **Other:** ....

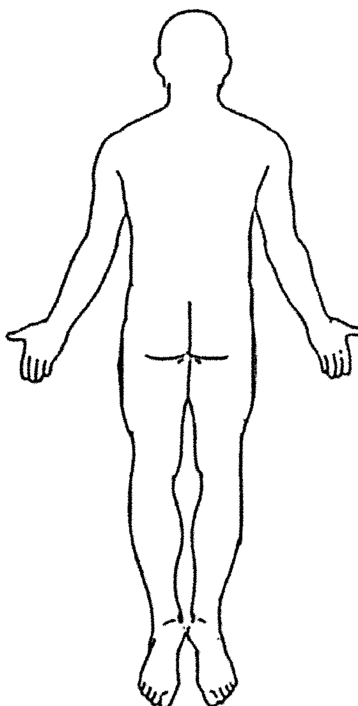
Front

Right ***Left***



Back

Left ***Right***



What Pain Medication Have you tried?

Medication	Still Using	Stopped Because
Tylenol	☐	☐__________
Aspirin	☐	☐__________
Ibuprofen (Motrin/Advil)	☐	☐__________
Naprosyn (Aleve)	☐	☐__________
Toradol (Ketorlac)	☐	☐__________
Diclofenac (Arthotec)	☐	☐__________
Flector Patches	☐	☐__________
Mobic/Meloxicam	☐	☐__________
Celebrex	☐	☐__________
Valium	☐	☐__________
Flexeril/Cyclobenzaprine	☐	☐__________
Zanaflex	☐	☐__________
Soma	☐	☐__________
Neurontin/Gabapentin	☐	☐__________
Lyrica	☐	☐__________
Cymbalta	☐	☐__________
Savella	☐	☐__________
Effexor	☐	☐__________
Lexapro	☐	☐__________
Amitriptyline (Elavil)	☐	☐__________
Nortriptyline (Pamelor)	☐	☐__________
Lidoderm Patches	☐	☐__________
Ultram/Tramadol	☐	☐__________
Ultracet	☐	☐__________
Darvocet N50 N100	☐	☐__________
Codeine	☐	☐__________
Tylenol #2, 3 or 4	☐	☐__________
Hydrocodone 5/ 7.5/ 10	☐	☐__________
Vicoden 5/ 7.5/ 10	☐	☐__________
Percocet 2.5/ 5/ 7.5/ 10	☐	☐__________
Methadone	☐	☐__________
Morphine	☐	☐__________
Kadian	☐	☐__________
Aviza	☐	☐__________
Embeda	☐	☐__________
Opana IR	☐	☐__________
Opana ER	☐	☐__________
Fentanyl Patches	☐	☐__________
Actiq Lollipops	☐	☐__________
Fentora	☐	☐__________
Oxycodone	☐	☐__________
Oxycotin	☐	☐__________
Hydromorphone (Dilaudid)	☐	☐__________

Please list other pain medications you have tried.

Medications	**Still using**	**Stopped Because**
______________	☐	☐______________
______________	☐	☐______________
______________	☐	☐______________

What Treatments have you tried:

Procedure	***How long ago***	***Effective***
Trigger Points	______________	☐Yes ☐ No
Epidural Steroids	______________	☐Yes ☐ No
Nerve Blocks	______________	☐Yes ☐ No
Facet Blocks	______________	☐Yes ☐No
Sacro-iliac injections	______________	☐Yes ☐No
Spinal Cord Stimulator	______________	☐Yes ☐ No
Intrathecal Pumps	______________	☐Yes ☐No
Physical Therapy	______________	☐Yes ☐No
Chiropractor	______________	☐Yes ☐ No
Aqua therapy	______________	☐Yes ☐ No
Acupuncture	______________	☐Yes ☐ No
Traction	______________	☐Yes ☐No
Surgery	______________	☐Yes ☐No
Durable Medical Equipment	______________	☐Yes ☐No
Other	______________	☐Yes ☐ No

Do you have any allergies to medications? ☐**Yes** ☐**No Known Drug Allergies**

If yes, please list your allergies below:

Drug **Reaction**

1.____

2. ____

3. ____

4. ____

5. ____

Are you allergic to iodine or x-ray contrast? ☐Yes ☐ No

List ALL Medications you are taking:

Medication **Dose** **Frequency**

1.____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

List ALL Surgeries:

Surgery **Date** **Doctor** **Hospital**

1.____
2. ____
3. ____
4. ____
5. ____

List ALL Medical Problems: (Including any diagnosis of anxiety or depression)

Medical Problem **Treating Doctor** **Phone Number**

1.____
2. ____
3. ____
4. ____
5. ____

Family & Social History

Is your mother Alive List major illness____________________
Deceased Age and cause of Death____________________

Is your father Alive List major illness____________________
Deceased Age and cause of Death____________________

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children? ☐Yes ☐ No

Son/Daughter **Age** **Medical Problems**

1.____
2. ____
3. ____
4. ____

Activities and your Pain:

List your hobbies and interest:

1.____

2. ____

3. ____

4. ____

Does your pain stop you from doing the things you enjoy? ☐Yes ☐No

To assist in walking I use a: ☐ Cane ☐ Walker ☐Wheelchair ☐ No assistance devices used

Smoking Status

☐ Never ☐Former ☐Current Everyday Smoker ☐Current Occasional Smoker

Alcohol Intake ☐None ☐Occasional ☐Moderate ☐Heavy

Have you ever felt you should cut down on drinking alcohol?	☐Yes	☐No
Have people annoyed you by criticizing your drinking?	☐Yes	☐No
Have you ever felt bad or guilty about your drinking?	☐Yes	☐No
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of your hangover?	☐Yes	☐No

Do you use any illegal drugs? ☐Yes ☐No If yes, how much:_______________________

Are you employed? Yes No

If yes what is your job? ______________________________________

If No: are you ☐Disabled ☐Retired How Long: ____________________

Do you have any of the following symptoms:

			If yes, explain
General/Constitutional:			
Fever	☐Yes	☐No	____________
Chills	☐Yes	☐No	____________
Fatigue	☐Yes	☐No	____________
Skin/Allergy:			
Rash	☐Yes	☐No	____________
Itching	☐Yes	☐No	____________
Sweating	☐Yes	☐No	____________
Musculoskeletal:			
Joint Stiffness	☐Yes	☐No	____________
Joint/Bone Pain	☐Yes	☐No	____________
Joint swelling	☐Yes	☐No	____________

Muscle cramps/pain	☐ Yes	☐ No	________
Back Pain	☐ Yes	☐ No	________

HEENT:

Headaches	☐ Yes	☐ No	________
Dizziness/Vertigo	☐ Yes	☐ No	________
Fainting	☐ Yes	☐ No	________
Sensitivity to light	☐ Yes	☐ No	________
Sinus congestion	☐ Yes	☐ No	________
Nose Bleeds	☐ Yes	☐ No	________
Facial Pain	☐ Yes	☐ No	________

Endocrine:

Jaundice	☐ Yes	☐ No	________
Neck swelling	☐ Yes	☐ No	________
Heat/Cold intolerance	☐ Yes	☐ No	________
Weight loss/gain	☐ Yes	☐ No	________
Appetite change	☐ Yes	☐ No	________
Male :			
Erectile problem	☐ Yes	☐ No	________
Female:			
Abdominal bleeding/ discharge pain	☐ Yes	☐ No	________

Respiratory:

Wheezing	☐ Yes	☐ No	________
Cough	☐ Yes	☐ No	________
Shortness of Breath	☐ Yes	☐ No	________

Cardiovascular:

Chest Pain	☐ Yes	☐ No	________
Palpitations	☐ Yes	☐ No	________
Leg/Feet swelling	☐ Yes	☐ No	________

Hematological:

Easy bruising	☐ Yes	☐ No	________
Easy bleeding	☐ Yes	☐ No	________
Abnormal clotting	☐ Yes	☐ No	________

Lymph Nodes:

Enlargement	☐ Yes	☐ No	________
Tenderness	☐ Yes	☐ No	________

Gastrointestinal:

Difficulty Swallowing	☐ Yes	☐ No	______
Heartburn	☐ Yes	☐ No	______
Constipation	☐ Yes	☐ No	______
Diarrhea	☐ Yes	☐ No	______
Change in stool	☐ Yes	☐ No	______
Nausea	☐ Yes	☐ No	______
Vomiting	☐ Yes	☐ No	______

Genitourinary:

Painful urination	☐ Yes	☐ No	______
Difficult urination	☐ Yes	☐ No	______
Urgency/frequency	☐ Yes	☐ No	______
Incontinence	☐ Yes	☐ No	______
Blood in urine	☐ Yes	☐ No	______

Neurological:

Fainting	☐ Yes	☐ No	______
Weakness/paralysis	☐ Yes	☐ No	______
Tremors	☐ Yes	☐ No	______
Weakness/paralysis	☐ Yes	☐ No	______
Incoordination	☐ Yes	☐ No	______
Headaches	☐ Yes	☐ No	______
Migraines	☐ Yes	☐ No	______

Psychiatric:

Depression	☐ Yes	☐ No	______
Suicidal thoughts	☐ Yes	☐ No	______
Anxiety	☐ Yes	☐ No	______
Sleep disturbance	☐ Yes	☐ No	______
Seizures	☐ Yes	☐ No	______
Memory Loss	☐ Yes	☐ No	______

Patient Signature:______________________________

Person filling in form if different from the patient______________________________

Provider signature:______________________________

CONSENT TO BILL, TREAT, RELEASE INFORMATION
AND FINANCIAL RESPONSIBILITY GUARANTEE
Please read carefully before signing

CONSENT TO MEDICAL CARE: By my signature and or electronic signature below, I hereby request and authorize the physician and other health care providers of KureSmart Pain Management (the Practice), KureSmart Pain Management, Smart Pain Surgery Center at Owings Mills, Smart Pain Surgery Center at White Marsh, Smart Pain Surgery Center at Germantown & Bay Surgery Centers, LLC (Practices) does each entity have similar forms? Necessary to put them all here? Probably makes sense....:)and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions that have brought about my seeking medical care services at the offices of the Practices. I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of the Practices.

INSURANCE ASSIGNMENT: If I have an insurance with which the Practices participate, a claim for reimbursement for services rendered will be submitted based on the information I provide to KureSmart Pain Management, Smart Pain Surgery Center at Owings Mills, Smart Pain Surgery Center at White Marsh, Smart Pain Surgery Center at Germantown & Bay Surgery Centers, LLC (Practices). If due to incomplete or incorrect information, payment has not been received by the Practices with 48 days from the date of services, all charges become my responsibility and are immediately payable by me.

FINANCIAL AGREEMENT AND GUARANTEE: I accept full and complete financial responsibility for all charges of the Practices for its provision of medical services, items and supplies to me. I agree to pay any and all copayment, deductible, and coinsurance amounts at time of service comment?. Provided that the Practices advise me in advance if my health benefit plan does not cover a specific service and I still elect to receive that service, I also agree to be solely financially responsible for payment for the Practice's provision of the "non-covered" service.

PATIENT RESPONSIBILITY FOR NON-CONTRACTED PLANS: My signature below acknowledges that the Practices has informed me if they are not contracted with my insurance plan that as a courtesy, they will provide me with a form listing the services (procedures) and the reasons for the services (diagnoses) for me to submit for possible reimbursement by my insurance company.

REFERRALS/AUTHORIZATIONS: If required, I understand that without a referral/authorization from my insurance carrier, I am financially responsible for all charges I incur.

SELF-PAY: If on the day services are rendered I: 1) do not have health insurance or am uncertain as to which insurance I have 2) do not want my insurance to be billed, 3) do not comply with the terms of the insurance policy (including, but not limited to, falling to supply adequate insurance information or bring authorization/referral forms). I agree to be financially responsible for all charges incurred, will pay in full for services rendered at the time of the visit and will pursue reimbursement from third parties myself.

Self-Pay will be limited to 120? days after which patients must provide the Practices with proof of insurance.

WORKER'S COMPENSATION: I understand that if my workers compensation insurance carrier or the Workers' Commission denies my claim and I failed to supply adequate health insurance information. I will be financially responsible for any unpaid balances. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain it, even though your worker's compensation insurance carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once Worker's Compensation denies the claim. In such a situation, I agree that I am financially responsible for the unpaid balance.

MVA/PERSONAL INJURY: We will file claims with your PIP carrier with the necessary documentation from your physician. In the event your PIP becomes exhausted, your health insurance will be billed and you will become responsible for any co-payment or deductible. PLEASE NOTE: If your health insurance requires a referral/authorization to be seen, your health insurance company still requires you to obtain it, even though the PIP carrier is being billed as the primary insurance. I understand that failure to obtain the referral/authorization can result in my health insurance denying payment once PIP has been exhausted. In such a situation, I agree that I am financially responsible for the unpaid balance.

MISSED APPOINTMENTS: If you fail to provide a least 24 hours' notice to cancel or fail to show up for an appointment, we will charge $25.00. Due to facility scheduling requirements, procedures scheduled in Bay Surgery Center, LLC, Smart Pain Surgery Center at Owings Mills, Smart Pain Surgery Center at White Marsh and Smart Pain Surgery Center at Germantown must be cancelled with 48 hours' notice or a fee of $100.00 will be charged. Missed new patient appointments for our physical therapy office will result in a $100 fee. KureSmart Pain Management reserves the right to discharge a patient in the event of 3 no-shows or late cancellations. All missed appointment fee must be paid in full before future care is rendered.

RETURNED CHECKS: There will be a returned check fee of $35.00 assessed for any check returned for insufficient funds.

MEDICAL RECORDS: Any information from the medical record must have the patient's signed consent to release. Please allow 2 weeks for the copying of medical records. I understand that I must pre-pay the copying fee based upon allowed charges under current Maryland law for copying medical records. Patients or other parties authorized by the patient to request medical records for legal issues, insurance, disability (not worker's compensation), physician change or relocation from the area are subject to a processing charge in addition to the copying charge. There will be no charge for copying records for a referral to another physician made by a Practice physician, or workers' compensation issue or any other solutions covered under Maryland law.

I also hereby authorize the Practice to disclose all or any part of the medical record of protected health information relating to my care to such insurance companies, or third-party payers that require the information for the payment of medical services rendered to me, consistent with Federal HIPAA

regulations or applicable laws. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of benefits or payment.

This agreement is valid for all episodes of care rendered by physicians associated with the Practices. I permit a copy of this authorization and agreement to be used in place of the original. By signing below, the patient, parent, legal guardian or responsible party agrees to make all required payments as provided above.

NOTICE OF BENEFICIAL INTEREST: Physicians within the Practice may refer me to an ambulatory surgery center ("ASC") in which they have an ownership interest or with which they have a compensation arrangement. Physicians in the Practice have ownership interests in various ASC's including: Bay Surgery Centers LLC, Westminster Surgery Center located in Westminster, and, SMART Pain Management Surgery Center at Owings Mills, Maryland, SMART Pain Management Surgery Center at Germantown, Maryland and Smart Pain Surgery Center at White Marsh. I understand that I may choose to have the surgical procedure done at any other health care entity. By signing below, I acknowledge receipt of this Notice, a copy of which will be placed by the Practice in my medical record.

CORRECT INFORMATION: The undersigned represents and warrants that: (i) he/she is 18 years or older, (ii) is either the patient or the legal representative of the patient; (iii) has provided the Practices fully accurate information and understand that any false statements or concealment of material fact may be prosecuted under applicable law (iv) has read, fully understands accepts the information, terms and conditions set forth above and has had the opportunity to ask any questions duly regarding this form, prior to voluntarily signing below.

Signature: ______________________________________ Date:______________________

Printed Name:__________________________________

HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED BY KURESMART PAIN MANAGEMENT AND HOW TO ACCESS THIS INFORMATION

Effective Date of This Notice: May 1, 2018

If you have any questions about this notice, please contact the Privacy Official for KureSmart Pain Management at 443-693-7246.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

We will create a record of the care and services you receive from us to provide you with quality care and to comply with legal or regulatory requirements.

We are committed to protecting your health information. This Notice applies to all of the records generated or received by KureSmart Pain Management whether we documented the health information, or another doctor forwarded it to us. This Notice describes how we may use or disclose your health information, your rights to access your health information, and describe certain obligations we have regarding the use and disclosure of your health information.

The federal government has issued a regulation to provide safeguards for privacy and security of health information that may identify you. This rule was issued under a law called the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This document, called an "Authorization," describes your rights and explains how your health information will be used and disclosed.

The privacy and security provisions of the Health Insurance Portability and Accountability Act ("HIPAA") require us to:

- Make sure that health information that identifies you is kept private;
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and follow the terms of the notice that is currently in effect.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record--?
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition--?
- Provide disaster relief--?
- Include you in a hospital directory--?
- Provide mental health care--?
- Market our services and sell your information--?
- Raise funds--?

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Participate in the Chesapeake Regional Information System for Patients ("CRISP")

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee. What is a cost-based fee?

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days. Let's discuss.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. Let's discuss.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Let's discuss.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Officer for KureSmart Pain Management at 443-693-7246.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission for:

- Marketing purposes
- Sale of your information--?

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.--?

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following way to:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Participate in CRISP

CRISP is a statewide health information exchange established to foster better coordination of care. You may choose to opt out of CRISP by contacting CRISP at www.crisphealth.org or calling 1-877-952-7477.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

This notice also applies to Bay Surgery Centers and Smart Pain Surgery Centers.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Signature: ______________________________ Date:________________