

25150 HANCOCK AVE.

STE 210 MURRIETA, CA

Temecula Valley

92562

Neurosurgery, INC.

TEL: 951-587-3739 FAX: 951-698-5213

BRET B. ABSHIRE, M.D.
DANIEL L. FRIEDLICH, M.D.

PERSONAL INFORMATION

Date _____ Family Physician _____ Phone # _____

Birthdate _____ Social Security # _____

NAME _____ Wish to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State / Prov. _____ Zip/P.C. _____

Occupation _____ Employer _____

Referred by _____

Contact Information

Home Phone _____ Cell Phone _____ Pharmacy Phone# _____

Work Phone _____ Ext.# _____ E-Mail _____

Preferred to receive call? ☐ Home ☐ Work ☐ Cell Phone Best time to reach you ? Time _____ Days _____

INSURANCE INFORMATION

Primary Insurance

Name of Insured _____

Relationship to patient _____

Insured's Birthdate _____

SS #/SIN _____

Employer _____

Date Employed _____

Occupation _____

Insurance Company _____

Group # _____

Insurance Co. Address _____

Deductible _____

Max. annual benefit _____

Additional Insurance

Name of Insured _____

Relationship to patient _____

Insured's Birthdate _____

SS #/ SIN _____

Employer _____

Date Employer _____

Occupation _____

Insurance Company _____

Group # _____

Insurance Co. Address _____

Deductible _____

Max. annual benefit _____

AUTHORIZATION AND RELEASE

I hereby assign the insurance benefits to which I am entitled, directly to TEMECULA VALLEY NEUROSURGERY, INC., a medical group. I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility, I authorize release of medical records and information regarding medical history that is requested by the insurance company. I hereby authorize treatment by TEMECULA VALLEY NEUROSURGERY, INC.. A Photostat of this authorization is accepted with the same authority as original.

SIGNATURE OF PATIENT / GUARDIAN

DATE

This agreement will remain valid from this day forward to include all future services relating to the above patient, or until changes in the above information are required. It is the patient's responsibility to notify Temecula Valley Neurosurgery, INC. of any changes in information .

Temecula Valley Neurosurgery, Inc.
25150 Hancock Ave Suite 210
Murrieta, CA 92562
(951) 587-3739

OUR POLICIES AND PROCEDURES

OFFICE TELEPHONE HOURS ARE MONDAY, TUESDAY, WEDNESDAY AND THURSDAY FROM 8:00 A.M. – 4:00 P.M., FRIDAYS FROM 8:00 A.M. – 12:00 PM. PLEASE BE ADVISED THAT OUR PHONES ARE TURNED OVER TO VOICEMAIL FROM THE HOURS OF 12:00 P.M. - 2:00 P.M. AND AFTER 4:00 P.M. MONDAY, TUESDAY, WEDNESDAY AND THURSDAY. HOWEVER WE ARE FREQUENTLY SEEING PATIENTS DURING THESE TIMES.

PLEASE BE AWARE THAT OUR PHYSICIANS DO TAKE TRAUMA CALL AND CAN BE CALLED OUT TO AN EMERGENCY AT ANY GIVEN TIME. IF YOUR APPOINTMENT IS RESCHEDULED DUE TO THE PHYSICIANS TRAUMA CALL WE WILL MAKE EVERY EFFORT TO ACCOMMODATE YOU ON OUR SCHEDULE.

DUE TO THE COMPLEX NATURE OF MANY OF OUR PATIENT'S MEDICAL PROBLEMS WAIT TIMES CAN EXCEED UP TO 1 HOUR OR MORE OF YOUR SCHEDULED APPOINTMENT. WE APPRECIATE YOUR PATIENCE AND UNDERSTANDING IN THIS MATTER.

APPOINTMENTS: IF YOU ARE MORE THAN 15 MINUTES LATE TO YOUR APPOINTMENT WE WILL HAVE TO RESCHEDULE YOUR APPOINTMENT FOR THE NEXT AVAILABLE DATE. IF YOU MISS TWO OR MORE APPOINTMENTS, WE WILL ASSUME ANOTHER PHYSICIAN IS TREATING YOU AND YOU WILL BE DISCHARGED FROM OUR CARE. IF YOU HAVE HAD ANY X-RAYS TAKEN, (MRI, CT SCAN, PLAIN X-RAYS, etc...), PLEASE MAKE SURE THAT YOU BRING EITHER YOUR ACTUAL FILMS OR A CD OF THEM WITH YOU TO YOUR APPOINTMENT. PLEASE BE ADVISED THAT ALL IMAGING STUDIES NEED TO BE NO MORE THAN 1 YEAR OLD. NEW PATIENTS MUST ALSO COMPLETE NEW PATIENT DOCUMENTS VIA OUR PATIENT PORTAL. PATIENTS MUST PROVIDE THEIR EMAIL ADDRESS TO OUR OFFICE STAFF SO WE MAY SEND AN INVITE WITH INSTRUCTIONS. A PAPER VERSION OF THE DOCUMENTS CAN BE RETRIEVED FROM OUR WEBSITE, WWW.TVNEUROSURGERY.COM. PLEASE CHECK IN 30 MINUTES EARLIER THAN YOUR SCHEDULED TIME TO COMPLETE THE NECESSARY PAPERWORK.

HANDICAPPED PATIENTS: THERE IS ELEVATOR ACCESS IN THE BUILDING FOR OUR PATIENTS AS OUR OFFICE IS LOCATED ON THE SECOND FLOOR.

REFERRALS: IF YOUR INSURANCE REQUIRES A REFERRAL OR PRIOR AUTHORIZATION, PLEASE BE SURE ONE HAS BEEN OBTAINED PRIOR TO SCHEDULING YOUR APPOINTMENT. WE WILL BE UNABLE TO SCHEDULE AN APPOINTMENT WITHOUT AN AUTHORIZATION. PLEASE HAND CARRY A COPY OF YOUR AUTHORIZATION TO YOUR APPOINTMENT OR MAKE ARRANGEMENTS TO HAVE YOUR REFERRING PHYSICIAN FAX A COPY TO OUR OFFICE WITH ANY MEDICAL RECORDS PERTAINING TO THE REASON FOR YOUR VISIT.

WORKMAN'S COMPENSATION: IF YOU ARE UNDER WORKMAN'S COMPENSATION IT IS NECESSARY FOR YOUR ADJUSTER TO FAX AN AUTHORIZATION AND ANY MEDICAL RECORDS IN ADVANCE PRIOR TO SCHEDULING YOUR APPOINTMENT. PLEASE BE AWARE THAT IT IS THE RESPONSIBILITY OF THE PATIENT TO COORDINATE THE AUTHORIZATION PROCESS WITH THEIR ADJUSTER.

HOSPITALS: OUR PHYSICIANS PERFORM SURGERY AT INLAND VALLEY MEDICAL CENTER, LOMA LINDA-MURRIETA AND TEMECULA VALLEY HOSPITAL

X-RAYS/RECORDS:. MEDICAL RECORDS WILL BE KEPT FOR 7 YEARS. COPIES OF MEDICAL RECORDS CAN BE FAXED TO OTHER PHYSICIANS UPON RECEIPT OF A SIGNED MEDICAL RECORDS RELEASE FORM FROM THE PATIENT AT NO CHARGE. IF THE PATIENT WOULD LIKE A COPY OF THEIR OWN MEDICAL RECORDS, A RECORD RELEASE FORM WILL NEED TO BE SIGNED STATING WHAT SPECIFIC PART OF THE CHART THE PATIENT WOULD LIKE COPIES OF. PLEASE NOTE, THERE IS A \$0.25 FEE FOR EACH PAGE REQUESTED. WE REQUIRE A 3 DAY NOTICE FOR COPYING OF MEDICAL RECORDS OR PICK UP OF X-RAYS THAT HAVE BEEN LEFT IN OUR OFFICE.

BILLING/INSURANCE: CO-PAYS ARE DUE AT THE TIME OF SERVICE, WE WILL ONLY ACCEPT CASH OR CREDIT/DEBIT CARDS. WE MUST EMPHASIZE THAT AS MEDICAL CARE PROVIDERS, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY. PLEASE MAKE SURE TO BRING YOUR INSURANCE CARD(S) AND PICTURE IDENTIFICATION WITH YOU TO YOUR APPOINTMENT SO THAT WE MAY MAKE COPIES. THE FILING OF INSURANCE CLAIMS IS A COURTESY THAT WE EXTEND TO OUR PATIENTS; ALL CHARGES ARE THE PATIENTS RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. WE REALIZE THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT, IF SUCH A PROBLEM SHOULD ARISE WE ASK YOU TO CONTACT CRISTY IN OUR BILLING OFFICE AT (951)587-3739.

MEDICATIONS: OUR PHYSICIANS DO NOT PRESCRIBE NARCOTIC MEDICATIONS FOR PATIENTS THAT THEY HAVE NOT PERFORMED SURGERY ON. YOU WILL NEED TO CONTACT YOUR PRIMARY CARE PHYSICIAN FOR THIS.

MEDICATION REFILLS WILL BE CONSIDERED DURING OFFICE HOURS ONLY. PATIENTS NEED TO CONTACT THEIR PHARMACY 3 DAYS PRIOR TO NEEDING A REFILL.

NOTE: NO REFILLS WILL BE GRANTED TO ANY PATIENT WHO HAS NOT BEEN SEEN IN THIS OFFICE FOR 6 MONTHS OR MORE. NO MEDICATIONS WILL BE REFILLED AFTER 4PM FRIDAY UNTIL 8AM MONDAY.

I HAVE READ THE ABOVE POLICIES & PROCEDURES AND I UNDERSTAND THAT IF FOR ANY REASON I DISAGREE WITH THE ABOVE, I DO HAVE THE RIGHT TO CANCEL MY APPOINTMENT AND SEEK TREATMENT ELSEWHERE

X _____ **DATE:**_____

I hereby assign the insurance benefits to which I am entitled, directly to TEMECULA VALLEY NEUROSURGERY, INC. , a medical group . I understand that I am financially responsible for all charges regardless of insurance verification benefits and eligibility, I authorize release of medical records and information regarding medical history that is requested by the insurance company . I hereby authorize treatment by TEMECULA VALLEY NEUROSURGERY, INC.. A Photostat of this authorization is accepted with the same authority as original .

x _____
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DATE

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25150 HANCOCK AVE.

STE 210 MURRIETA,

BRET B. ABSHIRE , M.D.
DANIEL L. FRIEDLICH, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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

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

Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality and security of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses

or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts.

We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our

health professionals will use their best judgment in communication with your family and others.

Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. If you are currently an enrollee of a health plan, we may receive payment for communications to you in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of your covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any payment for other marketing communications without your prior written authorization unless you have a chronic and seriously debilitating or life-threatening condition, we will tell you who is paying us, and we will also tell you how to stop these communications if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for any marketing activity you authorize.

Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

Public Health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Health Oversight Activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any

administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

Fundraising. We may use or disclose your demographic information and the dates that you received treatment in order to contact you for fundraising activities. If you do not want to receive these materials, notify the Privacy Officer listed at the top of this Notice of Privacy Practices and we will stop any further fundraising communications.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California and federal law. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional. If your written request clearly, conspicuously and specifically asks us to send you or some other person or entity an electronic copy of your medical record, and we do not deny the request as discussed above, we will send a copy of the electronic health record as you requested, and will charge you no more than what it cost us to respond to your request.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously received one.

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

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

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

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

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

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized for filing a complaint.

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DANIEL L. FRIEDLICH, M.D.

Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of the current Notice of Privacy Practice and understand a current Notice of Privacy Practice is available at my appointments and at the office website .

Patient Name: _____ Date of Birth: _____

Signature: _____

Relationship to Patient if not "Self": _____

Date: _____

Instructions for Communicating Personal Health Information (PHI)

Please indicate which of the following numbers and/or email address we should use to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers, you want us to call. Please specify if a message can be left on voicemail or with a designated person.

Home _____ Message: *Yes / No*

Work _____ Message: *Yes / No*

Cell _____ Message: *Yes / No*

Other _____ Message: *Yes / No*

Email _____ Message: *Yes / No*

My PHI may be communicated to:

Do not communicate my PHI to:

Initials: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of receipt of Notice of Privacy Practices but was unable to do so as documented below:

Date: _____

Reason: _____

Employee Initials: _____