

HIPAA 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 review it carefully. Effective date of this notice is November 1, 2020 and will remain in effect until it is amended or replaced by us.

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 a copy of health and claims records

- You can ask to see or get a copy of your health and claims records 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are 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.

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 consider all reasonable requests and must say “yes” if you tell us you would be in danger if we do not. **Ask us to limit what we use or share**

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.
- 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.

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 us using the information on page 1. 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.

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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 ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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 situation such as:

- Preventing Disease
- Helping with product recalls
- Reporting adverse reactions to medication
- 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 and work with a medical examiner or funeral director

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

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.

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, on our website, and we will mail a copy to you.
- Effective date of this notice is November 1, 2020 and will remain in effect until it is amended or replaced by us.

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Consent to Medical Treatment

Excel Pain and Spine maintains personnel and facilities in order to assist my physicians in providing me with medical care, and I authorize Excel Pain and Spine providers and personnel to perform on me the care ordered by my physicians. I consent to received services by telemedicine (using interactive audio, video, or data communications to carry out consultations, evaluation, screenings, diagnosis, treatment, monitoring or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so, I choose to receive services even if my insurance plan may not cover or continue to cover specific services, including the specific services rendered during the admission. I understand that I have the right to be informed by my providers of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to the recognized standards of medical practice, and I acknowledge that Excel Pain and Spine and its personnel are not responsible for providing me this information. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of examinations and or treatments provided by Excel Pain and Spine.

Consent to Recording or Filming

I authorize Excel Pain and Spine, the attending physician, or other Excel Pain and Spine authorized persons to record, photograph or film me for treatment, quality improvement or education purposes. Such recording, filming or photographs will be released only as permitted by law or authorized by me.

Authorization to Disclose information and Privacy Act

I authorize Excel Pain and Spine, and its affiliates to use or disclose my protected health information for the purposes of treatment, payment or healthcare operations. This consent shall cover any of my protected health information that Excel Pain and Spine may maintain or receive. I authorize the release of medical and related information about my treatment to the Professional Standards Review Organization responsible for reviewing the medical care furnished to me. This authorization will expire six years from the date shown below, however, I reserve the right to revoke this authorization at any time by contacting Excel Pain and Spine at 813-701-5804.

For Underinsured Patients or Uninsured Patients

I authorize Excel Pain and Spine and its affiliates, to use or disclose my protected healthcare information for the purpose of helping me find a healthcare provider and/or locate a payment source for my visit.

Release of Responsibility/Liability For Valuables

I understand that Excel Pain and Spine has a policy for safekeeping of patient valuables requiring all money, credit cards and/or items of value including jewelry to be given to a family member to hold or leave at home. If I choose not to deposit such items of value with my family member, I absolve Excel Pain and Spine Florida from responsibility for their loss, damage or disappearance.

I have read the request and authorization in its entirety and agree to be bound by all the terms and conditions herein. Witness my (our) hand(s) and seal(s) below,

Patient

Responsible Party(ies)

Witness

Relationship to Patient

I have been provided access to Excel Pain and Spine of Privacy Practices

Patient Signature (or authorized representative)

Date :
D D M M Y Y

Excel Pain and Spine Representative

Date :
D D M M Y Y

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PATIENT SELF-DETERMINATION QUESTIONNAIRE - YOUR RIGHT TO DECIDE

While you cannot remove all uncertainty about your future health care needs, having an ADVANCE DIRECTIVE in place can give you the peace of mind that comes from making your wishes known in advance. Please let us know if you have any of the following:

1. Declaration to Decline Life Prolonging Procedures (such as do not resuscitate of "DNR")

I have I have NOT made a Living Will

2. Durable Power of Attorney

I have I have NOT made a Living Will

3. Health Care Surrogate

I have I have NOT made a Living Will

If you have a living will and/or an assigned health care surrogate, we will gladly make a copy of your documents/will and place it in your chart if you desire.

PATIENT PRIVACY QUESTIONNAIRE

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name :

Address :

Phone Number:

Relationship :

Please list the family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:

Name :

Phone Number :

Name :

Phone Number :

Patient Name

Date of Birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

Legal Representative

Relationship to patient

Signature of Patient or Legal Representative

Date :

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

MEDICAL RELEASE FORM



Patient Name :

Date Of Birth : Phone Number :
D D M M Y Y

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that, by initializing this form, I am specifically authorizing the releasr of this information.

Initials: _____ Date :
D D M M Y Y

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the person(s) or entity listed below:

EXCEL Pain and Spine

Phone Number: (813) 701-5804

Fax: (813) 291-7615

Email: documents@excelpainandspine.com or hello@excelpainandspine.com

LOCATIONS:

BRANDON: 414 W Robertson Street Brandon, FL 33511

CLEARWATER: 28050 US HWY 19N Suite 100. Clearwater, FL 33761

DAVENPORT: 2310 North Blvd W Suite A Davenport, FL 33837

ELLENTON: 7032 US-301 North Ellenton, FL 34222

LAKELAND: 1611 Harden Blvd, Lakeland, FL 33803

PORT CHARLOTTE: 18501 Murdock Cir, Suite 101 B, Port Charlotte, FL 33948

SARASOTA: 3333 Clark Rd, Sarasota, FL 34231

ST. PETERSBURG: 2100 1st Ave S. Suite 100 B, St. Petersburg, FL 33712

SUN CITY CENTER: 771 Cypress Village Blvd. Sun City Center, FL 33573

TAMPA: 3218 W Azeele Street, Tampa, FL 33609

WAUCHULA: 326 South 6th Ave Wauchula, FL 33873

WESLEY CHAPEL: 26851 Tanic Drive, Suite 102, Wesley Chapel, FL 33544

WINTER HAVEN: 1749 6th Street NW, Winter Haven, FL 33881

Patient's Signature

Date :
D D M M Y Y

NEW PATIENT QUESTIONNAIRE



PERSONAL INFORMATION

Last Name : First Name : Middle Name :

Sex : Date Of Birth :
M M D D Y Y

Referring Physician : Family Physician :

PAST MEDICAL HISTORY

Diabetes (High Blood Sugar) : YES NO Cancer : YES NO

Bleeding Disorder : YES NO Type :

Other Medical Conditions :

Medication Allergies & Reaction :

Current Medications (Dose & How often taken) :

Are you on blood thinners ? YES NO

If yes, which one ?

When did your pain begin ?

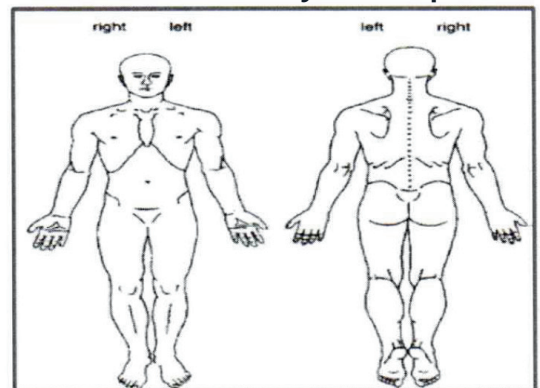
Was there an inciting event ?

How do you rate your pain ? 1 2 3 4 5 6 7 8 9 10
worst pain imaginable

What makes your pain better ? (i.e. sitting, lying down, heat, cold, standing, etc)

What makes your pain worse ? (i.e. movement, walking, bending over, weather, etc)

Shade the locations you have pain:



Other Symptoms or Concerns:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)



ID Number: _____

Date:
M M D D Y Y

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "check" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying little energy	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed or the opposite - being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself	0	1	2	3

(Healthcare professional: For interpretation of TOTAL, please refer to accompany scoring card)

TOTAL :

<p>10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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NEW PATIENT DEMOGRAPHICS



Please Provide the Following Information:

Date :
M M D D Y Y

PATIENTS:

Last Name : First Name : Middle Name :

Social Security Number : Date Of Birth :
M M D D Y Y

Street Address :

City : State : Zip Code :

Home Phone : Cell Phone :

Work Phone : Email :

Gender : Age : Height : ' " Weight : lbs
M F

Marital Status : SINGLE MARRIED WIDOWED SEPARATED DIVORCED

Spouse's Name : Spouse's Phone Number :

PHARMACY

Name :

Address :

Referring Physician Name : Phone Number :

EMPLOYMENT

EMPLOYED DISABLED RETIRED FULL-TIME STUDENT PART-TIME STUDENT UNEMPLOYED

Patient's Employer :

Business Address and Phone Number :

INSURANCE:

Do you have medical insurance?
Y N

Primary Insurance Name : ID # :

Subscriber : Group # :

Secondary Insurance Name : ID # :

Subscriber : Group # :

Worker's Compensation:
Y N

Claim # : Adjuster :

Phone # : Fax # : Date of Injury :

Claim Mailing Address :

NEW PATIENT QUESTIONNAIRE



PATIENTS:

Last Name : First Name : Middle Name : Date:

M M D D Y Y

Please answer each question as honestly as possible by putting the corresponding number in the box to the right (ie, if "Seldom" write "1", if "Sometimes" write "2", etc). There are no right or wrong answers.

SCORE	COLOR	Initials of the reviewer	SOAPP®-R				
			NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
			0	1	2	3	4
1. How often do you have mood swings?							
2. How often have you felt a need for higher doses of medication to treat your pain?							
3. How often have you felt impatient with your doctors?							
4. How often have you felt that things are just too overwhelming that you can't handle them?							
5. How often is there tension in your home?							
6. How often have you counted pain pills to see how many are remaining?							
7. How often have you been concerned that people will judge you for taking pain medication?							
8. How often do you feel bored?							
9. How often have you taken more pain medication than you were supposed to?							
10. How often have you worried about being left alone?							
11. How often have you felt a craving for medication?							
12. How often have others expressed concern over your use of medication?							
13. How often have any of your close friends had a problem with alcohol or drugs?							
14. How often have others told you that you had a bad temper?							
15. How often have you felt consumed by the need to get pain medication?							
16. How often have you run out of pain medication early?							
17. How often have others kept you from getting what you deserve?							
18. How often, in your lifetime, have you had legal problems or been arrested?							
19. How often have you attended an AA or NA meeting?							
20. How often have you been in an argument that was so out of control that someone got hurt?							
21. How often have you been sexually abused?							
22. How often have others suggested that you have a drug or alcohol problem?							
23. How often have you had to borrow pain medications from your family or friends?							
24. How often have you been treated for an alcohol or drug problem?							
Has any relative had a problem with: (Please circle Y/N for each item below)							
Alcohol: Y/N Addiction: Y/N Mental Illness: Y/N							
Green = less than 9		Yellow = 10-21	Red = 22 and over				

Please include any additional information you wish about the above answers. Thank you.
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OSWESTRY PATIENT QUESTIONNAIRE



Name :

Date Of Birth :
M M D D Y Y

Instructions: this questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1. PAIN INTENSITY

- I can tolerate the pain I have without having to use pain killers
- The pain is bad but I manage without taking pain killers
- Pain killers give complete relief from pain
- Pain killers give moderate relief from pain
- Pain killers give very little relief from pain
- Pain killers have no effect on the pain and I do not use them

2. PERSONAL CARE (e.g. Washing, Dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes 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 don't get dressed, I was with difficulty and stay in bed

3. LIFTING

- 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 off the floor, but I can manage if they are conveniently positioned, i.e. on a table
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- I can lift very light weights
- I cannot lift or carry anything at all

4. WALKING

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

5. SITTING

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than ½ hour
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

6. STANDING

- 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 one hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

7. SLEEPING

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

8. SOCIAL LIFE

- 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, i.e. 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

9. TRAVELLING

- 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 1 hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOME MAKING

- My normal homemaking/ job activities do not cause pain.
- My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
- Pain prevents me from doing anything but light duties.
- Pain prevents me from doing even light duties.
- Pain prevents me from performing any job or homemaking chores.