



Name: \_\_\_\_\_

**\*\*\*Your appointment will be rescheduled if you are late.\*\*\***

Your Appointment has been scheduled with: **CHRISTOPHER S. KENT, MD**

Appointment Date: \_\_\_\_\_ Arrival Time: \_\_\_\_\_  
Appointment Time: \_\_\_\_\_

305 Memorial Medical Parkway, Suite 206 Daytona Beach, FL 32117

Welcome to Our Office

Welcome to Florida Hospital Memorial Medical Center, HealthCare Partners.

Dr. Kent, Dr. Martin, Dr. Murphy and staff are pleased to welcome you to our facility. We appreciate the confidence your doctor has in referring you to our office. We believe that you will find that we strive to provide the utmost in quality and personal neurosurgical care. Ours is a general neurosurgical practice encompassing in the treatment of spine, intracranial, and peripheral nerve disorders.

When you come to the office for the first time please go to the reception desk. Please bring your completed history form. Our registrar will ask you for information needed for our records and she will be happy to assist you in becoming familiar with the office and its procedures.

Following registration a medical office assistant will take you to an examining room, check and update your history, and may take your pulse, blood pressure, height, and weight. The office medical assistant will be glad to answer any questions about the examination. If you have tests or medical information from another hospital please give them to the staff.

The doctor will see you, may take an in-depth history regarding your complaint and perform a physical examination directed at the musculoskeletal or neurological systems. He will review pertinent x-ray studies, often having done so before your visit. He will speak to you about his findings, diagnosis, and treatment or diagnostic recommendations following exam. Additional studies may be scheduled at your convenience. It will not be necessary for you to pick up radiographic studies done. The office staff will gather them and the doctor will review them before your next visit. If a personal physician has referred you, a report will be forwarded to that doctor quickly.



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If the doctor determines that x-ray studies are necessary, they will be scheduled at your convenience and reviewed before you return.

X-ray tests are typically performed at Florida Hospital Memorial Medical Center.

Your Doctor will discuss your diagnosis with you in detail. He will be pleased to answer any questions you might have either at the time of appointment or afterwards if you leave a message with an assistant. The diagnosis will be explained and options and treatment reviewed. Surgery if necessary will be explained in detail.

The doctors reserve surgery as a last resort for patients who have failed conservative treatment. Typically operations are performed at Florida Hospital Memorial Medical Center. Surgery is often done on an outpatient basis with preoperative laboratory testing done several days before and admission scheduled the morning of the procedure. Other diagnostic studies such as electrophysiological testing are scheduled at your convenience with a neurologist who will provide a report to the doctor.

We are interested in your opinion regarding care offered here.

You may call our office with questions and concerns regarding your care. At times the doctors may be with a patient and unavailable to speak with you. The receptionist may give you the option of using the voice-mail system. An office assistant will return your call as soon as possible. Often, messages will be left for the doctor and he will review your chart and instruct his assistant to call you expeditiously. It often takes 2-3 weeks for you to be seen back in follow up after a test is ordered. After having the test, such as an x-ray or electrical study, precerted and approved it then has to be scheduled at the appropriate facility or other doctor's office. Your Doctor personally review all x-ray studies and may dictate a note regarding the findings. After it comes back from the transcription office the doctor will be ready to see you and review with you the results. Our office typically waits until follow up appointments to review with the patients the results of laboratory or radiographic studies, etc. at which time decisions are made regarding treatment.

Our new patient information packet includes the policy regarding prescriptions and refills. They are issued only during regular office hours. During the evening and on weekends it is impossible for the doctor on call to determine if such is indicated as he does not have access to your medical record. There will be no narcotic prescriptions or refills authorized after office hours (8 AM – 5 PM, Monday thru Thursday & 8 AM – 3 PM Friday).

Our facility participates with the majority of all insurance programs on an assigned basis. Please contact the office prior to your appointment for determination of whether Drs Martin and Murphy are allowed to participate with your particular insurance program.

We file all unpaid charges with your insurance company on an assigned basis. Some companies pay fixed allowables for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or other balance not paid for by your insurance company. We file an assigned claim to your insurance company and it is your responsibility to pay any deductible amount, coinsurance, or other balance not paid for by your insurance company. After payment has been made by your insurance company you will receive a bill for any non-covered balances for services and payment is due at the time.

For nonassigned claims charges can be filed by you personally with our Fee Ticket Encounter that we will provide you with. Or as a courtesy we would be happy to file a nonassigned claim for you to your insurance company. Any refund would come to you.

Our doctors participate under the Medicare program. We will file all claims with Medicare on your behalf. We also accept the Medicare Allowable as our fee for service provided. We will also file as a courtesy for you a claim to your Secondary Insurance. Any portion of the Medicare deductible or 20% that is not paid by your Secondary will be your responsibility.

Charges for medical services provided at the office are due and payable at the time of service. You will receive a statement for any service provided at the hospital after your insurance has paid and full payment of the balance is expected. If circumstances should make it impossible for you to pay the balance billed, we invite you to call or personally discuss the matter with our financial coordinator. Such will avoid misunderstandings and enable you to keep your account in good standing. Except when hardship warrants, accounts past due are referred to a collection agency. Accounts placed for collection are considered for legal action which may result in additional expense to you.

It is our goal to provide optimal care to you. We believe in thoughtful and careful analysis of each patient's problem and spend much time that you do not see reviewing radiographic studies and test results discussing your case with colleagues, and reviewing reports from other healthcare professionals. We believe in very close attention to detail and hope that if you have questions you will feel free to ask him at the time of your visit.

We hope that you find your medical care unequalled at Brain & Spine Surgery Associates  
*A Service Of Florida Hospital Memorial Medical Center/HealthCare Partners.*

## **Neurological Surgery/HCP**

**Christopher S. Kent, MD. Robert J. Martin, MD & D. Mark Murphy, MD**

From north: Take I-95 south to exit 268 (Rt 40/Granada Avenue). Go east on Rt 40 to traffic light at Williamson. Turn right onto Williamson. Go about 1 mile to traffic light at Memorial Medical Parkway and turn right into Hospital.

From south: Take I-95 north to exit 265 (LPGA), veer to the right onto LPGA and get in left lane. At traffic light, turn left onto Williamson. At next light, turn left into Hospital.

Go past ER, past Main entrance to back of the hospital to Medical Office building 305 Memorial Medical Parkway. Take elevator to the second floor, Suite 206.



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CWCC618  
Exhibit A

*Florida Hospital Memorial Medical Center, Medical Staff of Florida Hospital Memorial Medical Center, Florida Hospital Oceanside, Medical Staff of Florida Hospital Oceanside, (referred to as FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O)*

**HIPAA NOTICE OF PATIENT PRIVACY PRACTICES**

*Effective Date: November 10, 2011*

**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.**

Florida Hospital Memorial Medical Center is a facility affiliated with Adventist Health System (AHS). Except for state law changes and personalizing this Notice for each AHS facility, all AHS facilities generally follow this same Notice. This Notice applies to all of the health records that identify you and the care you receive at AHS facilities. <http://www.adventisthealthsystem.com/AboutUs/WebsitePrivacyPolicy/AffiliatedEntities.aspx>

If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you.

If you have any questions about this notice, please contact the local Compliance and Privacy Officer at Florida Hospital Memorial Medical Center at 386-231-3064.

***Section A: Who Will Follow This Notice?***

This notice describes FH-MMC, Medical Staff of FH-MMC, FH-O, Medical Staff of FH-O practices and that of:

- Any health care professional authorized to enter information into your medical chart.
- All departments and units of FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O.

Any member of a volunteer group we allow to help you while you are in FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O.

- All employees, staff and other personnel of FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O.

FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or hospital operations purposes described in this notice. This list may not reflect recent acquisitions or sales of entities, sites, or locations.

***Section B: Our Pledge Regarding Medical Information.***

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O, whether made by FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- ♦ Use our best efforts to keep medical information that identifies you private;
- ♦ Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- ♦ Follow the terms of the notice that is currently in effect.

**Section C: How We May Use and Disclose Medical Information About You.**

We may share your medical information in any format we determine is appropriate to efficiently coordinate the treatment, payment, and health care operation aspects of your care. For example, we may share your information orally, via fax, on paper, or through electronic exchange.

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O who may be involved in your medical care after you leave FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O, such as family members, clergy or others we use to provide services that are part of your care.
- **Payment.** We may use and disclose medical information about you so that the treatment and services you receive at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about surgery you received at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O so your health plan will pay us or reimburse you for the surgery. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **Health Care Operations.** We may use and disclose medical information about you for FH-MMC, Medical Staff of FH-MMC, FH-O, Medical Staff of FH-O and FH-MMC HCP operations. These uses and disclosures are necessary to run FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may give out your medical information to our business associates that help us with our administrative and other functions. These business associates may re-disclose your medical information as necessary for our health care operations functions. We may also combine medical information about many patients to decide what additional services FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O personnel for review and learning purposes. We may also combine the medical information we have with medical information from other entities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.
- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Fundraising Activities.** We may use information about you to contact you in an effort to raise money for FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O and its operations. We may disclose information to a foundation related to FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O so that the foundation may contact you to raise money for FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O. We would release only contact information, such as your name, address, phone number, gender, age, insurance status, and the dates you received treatment or services at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O. If you do not want FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O to contact you for fundraising efforts, you must notify us in writing.
- **Patient Directory.** We may include certain limited information about you in FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O patient directory while you are a patient at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O. This information may include your name, location in FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. This is so your family, friends and clergy can visit you in FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O and generally know how you are doing.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and that you are in FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital. We will generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

#### **Section D: Special Situations**

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
  - ◆ To prevent or control disease, injury or disability;
  - ◆ To report births and deaths;

- ♦ To report child abuse or neglect;
  - ♦ To report reactions to medications or problems with products;
  - ♦ To notify people of recalls of products they may be using;
  - ♦ To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - ♦ To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you or we are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
- ♦ In response to a court order, subpoena, warrant, summons or similar process;
  - ♦ To identify or locate a suspect, fugitive, material witness, or missing person;
  - ♦ About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - ♦ About a death we believe may be the result of criminal conduct;
  - ♦ About criminal conduct at FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O; and
  - ♦ In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O to funeral directors as necessary to carry out their duties.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

#### **Section E: Your Rights Regarding Medical Information About You**

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy some of the medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. When your medical information is contained in an electronic health record, as that term is defined in federal laws and rules, you have the right to obtain a copy of such information in an electronic format and you may request that we transmit such copy directly to an entity or person designated by you, provided that any such choice is clear, conspicuous and specific. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy medical information in certain circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed

health care professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of certain disclosures we made of medical information about you. The accounting will exclude certain disclosures as provided in applicable laws and rules such as disclosures made directly to you, disclosures you authorize, disclosures to friends or family members involved in your care, disclosures for notification purposes and certain other types of disclosures made to correctional institutions or law enforcement agencies. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

*We are not required to agree to your request, except in limited circumstances where you have paid for medical services out-of-pocket in full and have requested that we not disclose your medical information to a health plan. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.*

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Notice of Breach.** You have the right to receive written notification of a breach if your unsecured medical information has been accessed, used, acquired or disclosed to an unauthorized person as a result of such breach, and if the breach compromises the security or privacy of your medical information. Unless specified in writing by you to receive the notification by electronic mail, we will provide such written notification by first-class mail or, if necessary, by such other substituted forms of communication allowable under the law.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, [www.floridahospitalmemorial.org](http://www.floridahospitalmemorial.org) or [www.hcpphysicians.org](http://www.hcpphysicians.org).

- **Right to Decline Participation in Health Information Exchange.** AHS has electronically connected the medical information each AHS facility has in your medical record through a series of interfaces, named iNetwork. iNetwork contains a summary of your most relevant medical information that includes at a minimum, available information regarding your demographics, insurance, problem list, medication list, radiology reports, and lab reports. Making your medical information available through iNetwork promotes efficiency and quality of care. You may choose not to allow your medical information to be shared through iNetwork. It is not a condition of receiving care. If you do not want your medical information shared through iNetwork, please contact the Privacy Officer at the phone number below. Once we process your request, your health care providers will no longer be

able to view your medical information in iNetwork. This means that it may take longer for your health care providers to get medical information they may need to treat you.

AHS and its affiliated facilities may also choose to share medical information electronically with other health care providers located near or in the same state as an AHS affiliated facility through regional or state health information exchanges. You may choose not to allow your medical information to be shared through regional or state health information exchanges by either refusing to sign an authorization form or contacting the Privacy Officer at the number below, depending on the consent process of the regional or state health information exchange. This means that it may take longer for your health care providers to get information they may need to treat you. However, even if you do not want to participate in a state health information exchange, certain state law reporting requirements, such as the immunization registry, will still be fulfilled through health information exchange, and some states still allow health care providers to access your medical information through a regional or state health information exchange if needed to treat you in an emergency.

To exercise the above rights, please contact the following individual to obtain a copy of the relevant form you will need to complete to make your request:

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***Section F: Changes To This Notice.***

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to the hospital for treatment or health care services as an inpatient or outpatient, we will make available a copy of the current notice in effect.

***Section G: Complaints***

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O contact the local Compliance and Privacy Officer at 386-231-3064. All complaints must be submitted in writing.

**You will not be penalized for filing a complaint.**

***Section H: Other Uses of Medical Information***

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

***Section I: Organized Health Care Arrangement***

The FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O, the independent contractor members of its Medical Staff (including your physician), and other health care providers affiliated with the FH-MMC, Medical Staff of FH-MMC, FH-O, and Medical Staff of FH-O have agreed, as permitted by law, to share your medical information among themselves for purposes of your treatment, payment or health care operations. This enables us to better address your health care needs.

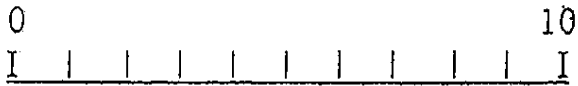
# Neurological Surgery/HCP

Christopher S. Kent, MD. Robert J. Martin, MD & D. Mark Murphy, MD

DATE: \_\_\_\_\_ NAME: \_\_\_\_\_

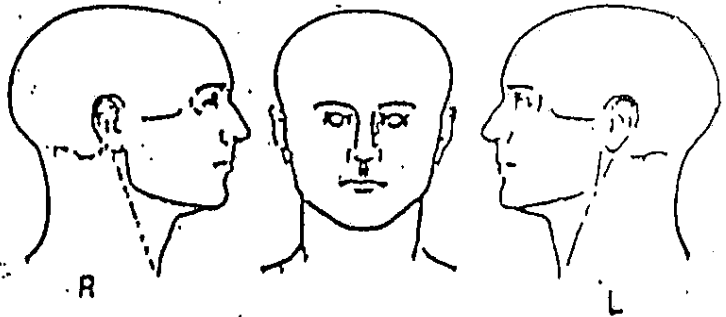
TIME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

1. State on a scale of 0 to 10 your pain level.

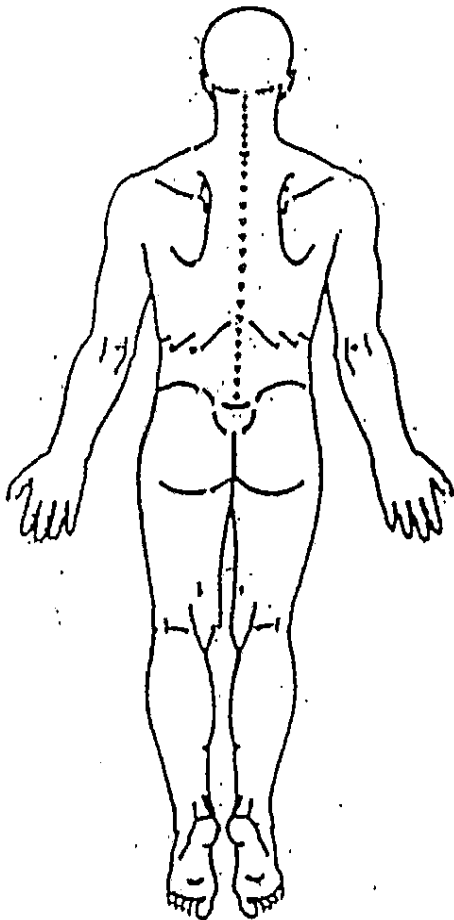


Where is your pain? What type of pain?

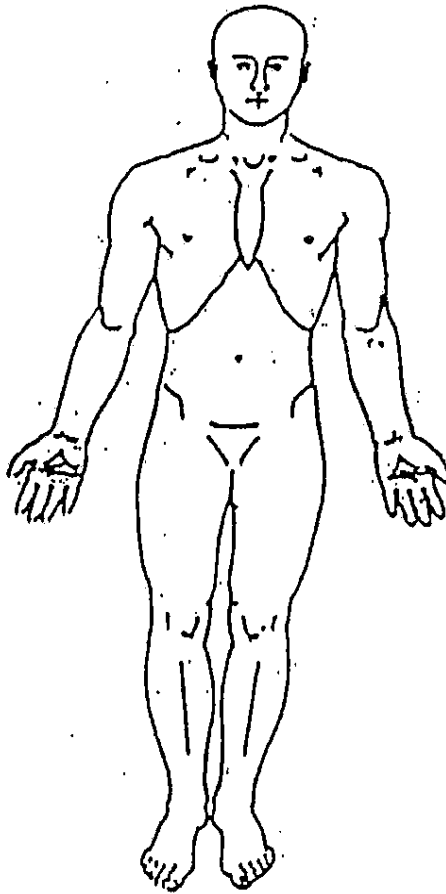
- 000 Pins and Needle
- UUU Numbness
- XXX Burning
- VVV Aching
- ///// Stabbing
- ~~~~~ Tingling



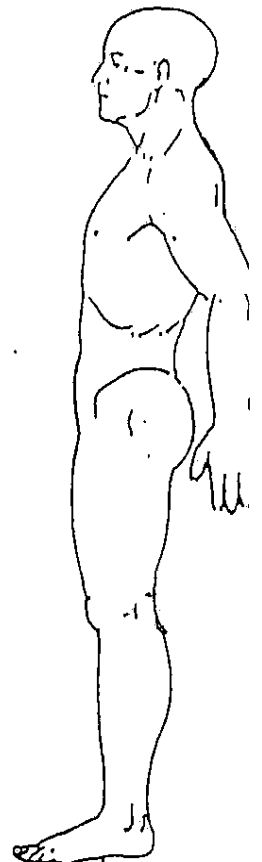
Right Side



Back



Front



Left Side

**Neurological Surgery/HCP**  
**Christopher S. Kent MD Robert J. Martin MD & D. Mark Murphy MD**  
**386-231-3540**

**NEW PATIENT INFORMATION FORM**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred by: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ Your occupation: \_\_\_\_\_

Your Pharmacy Name & Telephone Number: \_\_\_\_\_

Do you have a Living Will/Advanced Directive: No or Yes - Where is it on file: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

Reason for visit: \_\_\_\_\_

X-rays: \_\_\_\_\_

**History of Illness or Injury:**

- ▶ Location \_\_\_\_\_ Severity \_\_\_\_\_  
 Where is the pain or problem? How severe is the pain or problem?
- ▶ Duration \_\_\_\_\_ Is this an Auto Accident injury? \_\_\_\_\_  
 Date of injury or onset of symptoms? Is this an on the job injury? \_\_\_\_\_
- ▶ Associated Signs/Symptoms \_\_\_\_\_  
 Other pains, numbness, weakness? \_\_\_\_\_

**VITAL SIGNS** (Vitals only to be filled out at office)

Blood Pressure: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Cardiac (Heart)

- None
- Heart Attach
- Chest Pain
- Hypertension/High Blood Pressure
- Shortness of Breath
- Irregular Heart Rate
- High Cholesterol
- Valve Problems: Prolapsed  
Murmurs
- Other \_\_\_\_\_

Hematologic (Blood)

- None
- Anemia
- Clotting Problems
- Easy Bruising
- Other \_\_\_\_\_

Other Medical Problems

- None
- Diabetes Type I\_\_ Type II\_\_
- Thyroid Problems
- HIV/AIDS
- Depression
- Mental Illness
- Skin Problems
- Gout
- Eye Problems
- Ear, Nose, Throat Problems
- Transfusion
- Other \_\_\_\_\_

Pulmonary (Lung)

- None
- Asthma
- Emphysema
- COPD
- Bronchitis
- Chronic Cough
- Pneumonia
- Other \_\_\_\_\_

Gastrointestinal/Hepatic

- None
- Ulcers
- Gallbladder Problems
- Hepatitis A, B, or C
- Liver Disease
- Diarrhea
- IBS
- GERD
- Other \_\_\_\_\_

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**PAST MEDICAL HISTORY CONTINUED:**

Renal (Kidney/Bladder)

- None
- Kidney Stone
- Chronic Infections
- Dialysis
- Kidney Failure
- Prostate Problems
- Other

Neurological Disease

- None
- Epilepsy
- Seizures
- Stroke/TIA
- Parkinson's
- MS
- Dizzy/Fainting Spells
- Headaches
- Other

Cancer

- Type \_\_\_\_\_
- Treatment \_\_\_\_\_
- Physician \_\_\_\_\_
- Remission (Status) \_\_\_\_\_

**PAST SURGICAL HISTORY:**

_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____
_____	Year _____

**List any medications you are taking and the dosage:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Are you allergic to any medications? If so, please list:** \_\_\_\_\_  
\_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Cancer..... Yes No      Diabetes..... Yes No      Heart Disease ..... Yes No      (circle one for each question)

**SOCIAL HISTORY**

Marital Status  
 Single       Married       Divorced       Widowed

Number of Children \_\_\_\_\_

Do You Use Nicotine Products?

- No, Never Have
- No, I stopped in \_\_\_\_\_  
How much did you use? \_\_\_\_\_ packs/cans/cigars per day for \_\_\_\_\_ years.
- Yes, I do  
\_\_\_\_\_ packs/cans/cigars per day for \_\_\_\_\_ years.

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**SOCIAL HISTORY CONTINUED:**

**Alcohol Use**

- None
- Stopped in \_\_\_\_\_
- Yes, I do..... Amount per day \_\_\_\_\_

**Drug use**

- Never
- Only in the past
- Any history of IV Drug Use  Yes  No
- Yes, I do
- Any IV Drug Use
- Types of drugs used \_\_\_\_\_

**Do you exercise?**

- No
- Yes If so, type \_\_\_\_\_ How often \_\_\_\_\_

**REVIEW OF SYSTEMS**

▶ **Constitutional Symptoms**

- Good general health lately..... Yes No
- Recent Weight Change..... Yes No
- Fever..... Yes No
- Headaches..... Yes No

▶ **Cardiovascular**

- Heart trouble..... Yes No
- Chest pain..... Yes No
- Shortness of breath..... Yes No
- Swelling of feet, ankles, hands..... Yes No

▶ **Respiratory**

- Chronic or frequent coughs..... Yes No
- Spitting up blood..... Yes No
- Shortness of breath..... Yes No
- Asthma or wheezing..... Yes No

▶ **Gastrointestinal**

- Change in bowel habits..... Yes No
- Nausea or vomiting..... Yes No
- Painful bowel movements..... Yes No
- Rectal bleeding..... Yes No
- Abdominal pain or heartburn..... Yes No
- Peptic ulcer..... Yes No

▶

- Thyroid disease..... Yes No
- Diabetes..... Yes No
- Heat or Cold Intolerance..... Yes No
- Skin becoming dryer..... Yes No
- Glandular or hormone problems..... Yes No

Physician's Initials: \_\_\_\_\_

▶ **Genitourinary**

- Frequent urination..... Yes No
- Burning or painful urination..... Yes No
- Blood in urine..... Yes No
- Kidney stones..... Yes No

▶ **Hematologic/Lymphatic**

- Anemia..... Yes No
- Phlebitis..... Yes No
- Depression..... Yes No
- Bleeding or bruising tendency..... Yes No

▶ **Psychiatric**

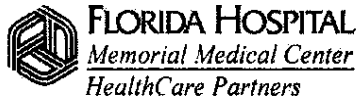
- Memory loss or confusion..... Yes No
- Nervousness..... Yes No
- Depression..... Yes No
- Insomnia..... Yes No

▶ **Musculoskeletal**

- Joint pain..... Yes No
- Joint Stiffness or swelling..... Yes No
- Weakness or muscles or joints..... Yes No
- Muscle pain or cramps..... Yes No

▶ **Neurological**

- Frequent headaches..... Yes No
- Dizziness..... Yes No
- Convulsions or seizures..... Yes No
- Numbness or tingling..... Yes No
- Tremors..... Yes No
- Paralysis..... Yes No
- Stroke..... Yes No
- Head injury..... Yes No
- Difficulty walking..... Yes No



**Neurological Surgery/HCP**  
**Christopher S. Kent, MD, Robert J. Martin, MD, & D. Mark Murphy, MD**

***Patient Registration***

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First MI

Street Address \_\_\_\_\_ Age \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Home Telephone # ( ) \_\_\_\_\_ Cellular # ( ) \_\_\_\_\_

SS# \_\_\_\_\_ Marital Status: S M W Sep. D (Circle One)

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Telephone # ( ) \_\_\_\_\_ Occupation \_\_\_\_\_

Insurance Coverage \_\_\_ Yes \_\_\_ No Name of Insurance \_\_\_\_\_

Insured Name \_\_\_\_\_ Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_

Spouse Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Telephone # ( ) \_\_\_\_\_ SS # \_\_\_\_\_

Insurance Coverage \_\_\_ Yes \_\_\_ No Name of Insurance \_\_\_\_\_

Person Responsible for Bill: \_\_\_ Patient \_\_\_ Spouse \_\_\_ Other  
Nearest Relative or Friend to Notify if Unable to Contact Patient:

Name \_\_\_\_\_ Telephone # ( ) \_\_\_\_\_

I hereby authorize Neurological Surgery to release or receive any information regarding my medical condition and medical history to my insurance company, hospital, or other physician participating in my health care. I permit a copy of this authorization to be used in place of the original. This shall remain in effect until revoked by me in writing and will not be done without prior approval from patient.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



CO-INSURANCE NOTICE TO MEDICARE PATIENTS

Dear Medicare Patient:

We would like to take this opportunity to inform you that this physician practice is a provider-based clinic. This provides increased continuity of care and improved reimbursements, thus allowing Florida Hospital Memorial Medical Center to continue to provide quality medical care and services.

Your visits to this office are billed by a Central Billing Office(CBO), which is a service of Florida Hospital Memorial Medical Center. You will be registered in this office as an outpatient of Florida Hospital Memorial Medical Center. Any services you receive will still be billed by Florida Hospital Memorial Medical Center to Medicare and any secondary insurance companies. If you have any questions regarding your service provided at this office, please call 386-671-4500 to speak to a Billing Representative.

In accordance with Medicare's laws and regulations, you will incur a co-insurance liability to Florida Hospital Memorial Medical Center that you would not have incurred if this office were not provider-based. Your actual co-insurance liability will depend upon the actual services furnished by this office. For example, co-insurance balances for an average follow up visit for an established patient (99213) would be approximately \$13.02 for the hospital charge and \$ 8.97 for the physician charge.

After the hospital and physician have been reimbursed by Medicare, co-insurance balances will be billed to secondary insurers. If co-insurance is still owed to Florida Hospital Memorial Medical Center and/or physician, you will be billed. If you have no secondary insurance you will be required to pay your portion at time of service. You may request an estimate of this amount of co-insurance liability by contacting your physician's office.

As required by policy, for this physician's office, you will be required to read and sign this letter at every visit.

I have read and understand that I will incur a liability to Florida Hospital Memorial Medical Center for Medicare coinsurance as permitted by law.

Signature of Patient or Authorized Representative Date
Signature of Patient or Authorized Representative Date
Signature of Patient or Authorized Representative Date
Signature of Patient or Authorized Representative Date

**MEDICARE SECONDARY  
PAYOR (MSP) QUESTIONNAIRE**

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_\_\_

Physician: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

I AM ENTITLED TO MEDICARE BENEFITS:

NO - RETURN FORM TO THE FRONT DESK

YES - PROCEED TO SECTION I.

**SECTION I**

Select the ONE statement that is true for you:

I am over 65 and married... **Proceed to section II**

I am over 65 and not married (includes widowed)... **Proceed to section III**

I am under 65, Disabled and currently employed... **Proceed to section IV**

I am under 65, Disabled and unemployed...

Disability Date: \_\_\_\_\_ **IV Proceed to section**

**SECTION II**

Select the one statement that is true for you:

My spouse and I are both fully retired

The date of my retirement: \_\_\_\_\_

The date of my spouse's retirement: \_\_\_\_\_ ...**Proceed to section V**

I work full or part-time (my spouse is retired) for a company with:

LESS than 20 employees... **Proceed to section V**

MORE than 20 employees... **Proceed to section IV**

My spouse works full or part-time (I am retired) for a company with:

LESS than 20 employees... **Proceed to section V**

MORE than 20 employees... **Proceed to section IV**

**SECTION III**

Select the one statement that is true for you:

I am fully retired...

The date of my retirement: \_\_\_\_\_ ....**Proceed to section V**

I work full or part-time for a company with:

LESS than 20 employees... **Proceed to section V**

MORE than 20 employees... **Proceed to section IV**

**SECTION IV**

Select the one statement that is true for you: *(This does not apply to supplemental plans or employer plans offered during retirement.)*

I have health care coverage through my employer.  NO  YES

I have health care coverage through someone else.  NO  YES

IF YES, list name of guardian and relationship: \_\_\_\_\_

**Proceed to Section V**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

### SECTION V

Is this visit related to an injury due to a fall?

YES - Did the accident occur in...  your home  public location  other

Date of Accident: \_\_\_\_\_

**OR**

Is this visit related to an illness/injury due to an automobile accident?

YES - Date of Accident: \_\_\_\_\_

**RETURN TO FRONT DESK AND PRESENT YOUR AUTOMOBILE INSURANCE CARD.**

NO **Proceed to Section VI**

### SECTION VI

Indicate which statements apply to you.

I am entitled to Worker's Compensation for this service.

I am entitled to Black Lung benefits.

I am entitled VA benefits.

I am entitled ESRD benefits.

I am entitled COBRA benefits.

I am entitled to other Federal benefits. (UMWA, Gov't research programs, Hospice) Please

Explain: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_



PATIENT: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

**PATIENT CONSENT AND AUTHORIZATIONS**

**CONSENT FOR TREATMENT:** I, the undersigned patient, parent or legal guardian, knowing that I am (the patient is) suffering from a condition requiring medical care, do hereby present myself for treatment at Florida Hospital Memorial Medical Center, **Christopher S. Kent, MD** and voluntarily consent to the rendering of such care, including treatments, photographs for treatment evaluations, administration of anesthetics and performance of diagnostic and/or surgical procedures. In the event a medical device is implanted or explanted, I agree to the release of my Social Security number to the manufacturer/FDA for tracing of the device. I understand that I am under the care and supervision of my attending physician (or in the emergency department, the emergency department physician) and it is the responsibility of the hospital and its staff to carry out the instructions of such physician(s). I understand that the physicians furnishing services to me may be employees of the hospital or may be independent contractors and not employees or agents of the hospital, and that all physicians expect payment in full upon receipt of a bill and I will assist in billing appropriate insurance companies if insurance or other benefits are involved. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments of examination in the office or hospital.

**ASSIGNMENT OF BENEFITS:** I hereby assign payment directly to Florida Hospital Memorial Medical Center, **Christopher S. Kent, MD** and the physicians accepting this assignment of all medical benefits applicable and otherwise payable to me. I understand that I am financially responsible to Florida Hospital Memorial Medical Center and their physicians for charges not covered by this assignment or for any and all charges which the insurance carrier declines to pay.

**RELEASE OF MEDICAL INFORMATION:** I, the undersigned patient, parent, or legal guardian, do hereby authorize Florida Hospital Memorial Medical Center, its officers and employees, to release to any third party payor (such as an insurance company or government agency; Example: Blue Cross/Blue Shield of Florida or Medicare) any medical, psychiatric, alcohol, drug abuse, and/or HIV (AIDS or AIDS related complex) treatment information and records, in accordance with the policy of Florida Hospital Memorial Medical Center, **Christopher S. Kent, MD** and any applicable State or Federal Statutes, concerning diagnosis and treatment for the above admission when requested by such third party payor for its use in connection with determining a claim for payment for such treatment and/or diagnosis. I authorize the release of any and all medical information to all physicians involved in my care and treatment. I do hereby release Florida Hospital Memorial Medical Center, **Christopher S. Kent, MD** from all liability that may arise from the release of the information requested.

**FLORIDA LAW:** Section 817.234 Florida Statutes, stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**FOR MEDICARE AND MEDICAID PATIENTS ONLY – CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVIII or /or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary-carriers, any information needed for this or a related Medicare or Medicaid claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for Florida Hospital Memorial Medical Center physician(s). I understand that I am responsible for any health insurance deductibles and coinsurance.

**MEDICARE BENEFICIARY NOTICE OF NON-COVERED SERVICES:** Medicare does not (initials) \_\_\_\_\_ cover some inpatient, outpatient, and emergency services. Items not covered include, but are not limited to **INPATIENT:** (lotion, toothpaste, deodorant, etc.) **OUTPATIENT AND EMERGENCY:** medications typically self-administered, annual testing and physicals.

**ACKNOWLEDGEMENT OF RECEIPT OF AN IMPORTANT MESSAGE FROM MEDICARE (FOR MEDICARE PATIENTS ONLY):** My signature only acknowledges my receipt of this message from Florida Hospital Memorial Medical Center, **Christopher S. Kent, MD** as dated below and does not waive any of my right to request a review of make me liable for any payment.

**I PERMIT A COPY OF OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL WHICH IS ON FILE IN FLORIDA HOSPITAL MEMORIAL MEDICAL CENTER – ROBERT J. MARTIN, MD.**

**FINANCIAL AGREEMENT:** The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually hereby obligates himself/herself to pay the account of Florida Hospital Memorial Medical Center physician(s) in accordance with the regular rates and terms of the physicians(s). Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Patient's representative/policy holder or spouse

Indicate relationship \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient unable to sign due to:



**Acknowledgement of Receipt  
HIPAA Notice of Patient Privacy Practices**

By signing this Written Acknowledgement of Receipt for HIPAA Notice of Patient Privacy Practices (“Acknowledgement”), I hereby expressly acknowledge my receipt of HIPAA Notice of Patient Privacy Practices.

\_\_\_\_\_  
Patient, or Legal Representative, Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Patient, or Legal Representative, Name (or label)

Acknowledgment NOT obtained because:

\_\_\_\_\_ Patient, or Legal representative, declined Notice of Patient Privacy Practices;

\_\_\_\_\_ Other \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Printed Name

**Patient Self Determination Act Questionnaire**

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following:

I have a Declaration to Decline Life-Prolonging Procedure (**Living Will**): Yes or No

I have a **Health Care Surrogate**: Yes or No

I have a **Durable Power of Attorney**: Yes or No

If you have the above document, please provide a copy for your chart.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Date

# Neurological Surgery/HCP

**Christopher S. Kent, MD. Robert J. Martin, MD & D. Mark Murphy, MD**

**I give complete authorization for the release of all medical information concerning my condition and medical treatment to all contacts listed below.**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Patient or Authorized Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

**I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and/or sexually transmitted disease.**

**Representative/Spouse:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **or Mail to:** \_\_\_\_\_

**Representative:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **or Mail to:** \_\_\_\_\_

**Representative:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **or Mail to:** \_\_\_\_\_

**Representative:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_ **or Mail to:** \_\_\_\_\_

