VIRGINIA BRAIN & SPINE CENTER

NEUROLOGICAL SURGERY
Phone (540) 450-0072
Fax (540) 450-0074
James B. Chadduck, MD
Allan H. Fergus, MD
Patrick D. Ireland, MD
Steven R. Schopick, MD
Lee A. Selznick, MD
Tamela S. Catlett, NP-C
Amanda L. Hahn Simmons, NP-C
Julie B. Henderson, NP-C
Alison K. McNeill, NP-C
Racheal A. Valcour, NP-C

PAIN MANAGEMENT
Phone (540) 450-2339
Fax (540) 450-2333
N. Scott Ashcraft, DO
Michael J. Poss, MD
Christy A. Andrews, NP-C
Brian A. Lapp, PA-C

1818 AMHERST STREET · WINCHESTER, VA 22601 · WWW.VABRAINANDSPINE.COM

Dear Patient,

We have received your information from your physician referring you to Pain Management. Enclosed is the Virginia Brain and Spine Center new patient packet for the Pain Management Department. Please complete **ALL** of the information that is requested and **bring it with you to your appointment.**

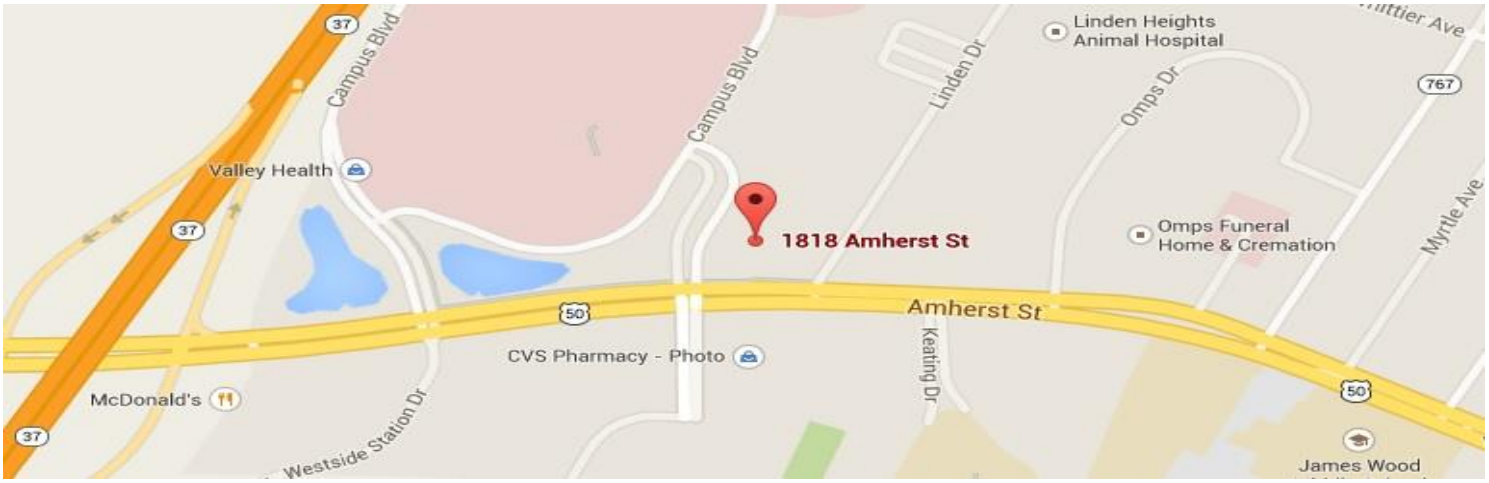
Please bring the following information with you to your appointment:

- **Insurance card(s), Photo I.D., Co-payment if applicable**
- **A list of the medications that you are currently taking and the bottles**

We realize that the content of information being received at your appointment can be very detailed and dealing with pain can be very distracting, however we encourage you to bring someone to the appointment to assist you.

If you are unable to keep your appointment, please telephone us at 540-450-2339 at least 24 hours in advance. **Please arrive 15 minutes early to *ALL* appointments so we can get you checked in.** Arrival more than 15 minutes past your appointment time will result in your appointment being rescheduled.

If you should have any questions, please feel free to contact our office at (540) 450-2339. Thank you very much for choosing our practice for your pain management needs.



Directions from North Traveling South:
•Take I-81 South
•Take Exit 317
•Turn Right onto Route 37 South
•Take Route 50 (Winchester Romney) Exit
•Turn Left onto Amherst Street
•After Third light make a U-Turn, then turn Right into VBSC

Directions from South Traveling North:
•Take I-81 North
•Take Exit 310
•Turn Left onto Route 37 North
•Take Route 50 (Winchester Romney) Exit
•Turn Right onto Amherst Street
•After the Second light make a U-Turn, then turn Right into VBSC

APPOINTMENT INFORMATION

Appointment Date: _____ Your Provider: _____

Appointment Time: _____ Please Arrive By: _____

PATIENT INSTRUCTIONS

Thank you for choosing our physicians at Virginia Brain and Spine Center, Inc. for your health care needs. We are committed to providing the very best medical care and treatment. The following is a description of some of our practice policies and guidelines for patients. Please read this before your first appointment.

MEDICATION MANAGEMENT: Virginia Brain and Spine Center does not provide narcotic medication management services to our patients. If you require narcotic medication management please consult your primary care to obtain a referral that will better suit your needs.

PRESCRIPTIONS: All medication refills are done during working hours on Monday through Thursday only. You may have your pharmacy call directly to request a medication refill. Please allow two working days for the prescription to be processed. If you need a new written prescription, please allow 5-7 business days for the prescription to be processed. We are unable to refill prescriptions after hours so allow enough time before your prescription runs out. There is a $10 recovery fee for all prescriptions that are sent via certified mail.

MISSED APPOINTMENTS: Please notify us as soon as possible if you are unable to keep a scheduled appointment. We appreciate a minimum of 24 hours notice so that we can use this time for someone else who is waiting for an appointment. Abusive missed appointments may result in your dismissal as a patient.

RESCHEDULING: As a surgical practice, emergency situations arise that may result in the physician being called away to the operating room. As a result, your appointment may need to be delayed or rescheduled. We will do our best to notify you in order to give you the opportunity to reschedule before arriving for the appointment. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is also a small fee of $10.00 plus $0.50 per page. These fees, set forth by Virginia State law, must be paid in full before your request will processed. Please allow 5-10 business days for processing. Fees are subject to change without notice.

FORMS: Forms, including, but not limited to, disability or worker's compensation, will be filled out at the physician's discretion. The fee for completion of these items is $5 per form. All fees must be paid in full before the forms will be produced. Please allow 5-7 business days for processing.

EMERGENCIES: If you have a health care emergency then call 911. If you need to speak with a physician after hours then call the Winchester Medical Center operator at 540-536-8000 and ask to have the physician on call paged. For routine questions and concerns or for prescription refills, please call our office at 540-450-0072 for Neurosurgery Department and 540-450-2339 for Pain Management Department. If your call is not immediately answered by our staff then please leave a message and your call will be returned in order of priority within 24 hours.

NEEDLE STICK POLICY: I authorize any physician, hospital, or medical care facility to provide all my medical history and treatment to Virginia Brain and Spine Center. I authorize Virginia Brain and Spine Center, Inc., to test my blood for hepatitis and for the AIDS virus, if in their opinion, an employee of Virginia Brain and Spine Center, Inc. has suffered an exposure incident as a result of my treatment defined by the Occupational Safety and Health Administration. A law was enacted in 1989 and amended in 1993 which authorizes health care providers to test their patients for HIV, Hepatitis B and C antibodies when the health care provider is exposed to the body fluid of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such exposure, you will be deemed to have consented to such testing and to the release of the test results to the health care provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained and you will be given the opportunity to ask any questions.

MEDICAL STAFF PHONE DIRECTORY: A directory of phone numbers is included below if you need to reach members of our medical staff quickly. We try to return phone calls within 48 hours (please note we are closed on all major holidays and weekends). If you are unsure which number you should dial but still need to reach our office, you can call 540-450-0072.

Neurosurgery Triage/Nurse: 540-771-2297
Secretary for Dr. Chadduck: 540-771-2292
Secretary for Dr. Fergus: 540-771-2293
Secretary for Dr. Selznick: 540-771-2294
Secretary for Dr. Schopick: 540-771-2295
Secretary for Dr. Ireland: 540-771-2296
Referral Clerk: 540-771-2298
Medical Records: 540-450-0072 x2353

Medical Assistant for Christy Andrews, NP: 540-771-2306
Medical Assistant for Brian Lapp, PA: 540-771-2307
Medical Assistants for Dr. Poss & Dr. Ashcraft: 540-771-2304
Patient Financial Counselor for Dr. Poss, Lapp PA-C, Dr. Fergus, Valcour NP-C: 540-771-2286
Patient Financial Counselor for Dr. Ashcraft, Andrews NP-C, Dr. Schopick, McNeill NP-C: 540-771-2300
Patient Financial Counselor for Dr. Chadduck, Catlett NP-C, Dr. Selznick, Hahn-Simmons NP-C, Dr. Ireland, Henderson NP-C: 540-771-2305

FINANCIAL POLICY

The following is a statement of our Financial Policy, which you must read, agree to and sign, prior-to treatment. Our Financial Policy applies to all service rendered by our physicians and staff whether inpatient or outpatient.

Practice Payment Policy Guidelines:

- **Patients/(guardians) are financially responsible for all charges, regardless of third-party involvement.**
- **Full payment is due at time of services, unless prior insurance billing arrangements have been made.**
- **Patients with insurance will be required to pay all 'out-of-pocket' financial obligations at time of service.**
- **We accept: Cash, Check, Bank Debit Card, the following credit cards: Visa / Master Card / Discover.**
- **Practice will bill non-par insurance as a courtesy to the patient. The carrier should pay the practice and in the event that the carrier pays the patient, the patient must turn funds over to the practice in 5 business days.**

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written Referrals, Pre-authorizations or Pre-certifications from your primary care physician or health plan prior-to services rendered. If we have not received the necessary authorizations prior-to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patient with Private Insurance / Medicare / Medicaid Coverage: Our physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the 'assignment of benefits' below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement:

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount due will be considered delinquent and subject to outside collection action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to 'collections', I agree to pay all collection costs, including, but not limited to, court costs, attorneys and any other costs incurred for the collection of this debt fees equal to 40% of the amount owed, and accrued interest charges to date. I agree to pay a $25.00 returned check fee. Copies of my medical records can be obtained with advanced notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a minimum charge of $25.00 for each form. Fees subject to change without notice.

Participating Insurance Plans:

- Aetna (excludes Aetna Medicare)
- Anthem BC/BS Virginia
- BC/BS PPO
- Cigna (excludes Cigna Connect)
- Healthsmart (Grant, PEIA)
- Medicaid-Virginia (Neurosurgery only)
- Medicare (includes Humana and Railroad)
- Optima/Community Health
- Physician Services-4 Most
- POMCO
- United Healthcare PPO (Options PPO and OneNet PPO networks)
- Virginia Health Network
- Virginia Premier (Neurosurgery only)
- Workers Comp-Virginia and West Virginia only

If we do not participate with your commercial plan, you will be financially responsible for our services provided to you. It is your responsibility to contact your insurance company before your appointment to verify if a preauthorization, precertification, or a referral is required. We will file your claim(s) to your insurance company based on the information that you provide our office at the time of service. If you do not have this information, you will be financially responsible for your visit. If you have any questions regarding payment, deductible, or other benefits, please contact your insurance company directly.

Patient's Full Name (First – Middle – Last)	Sex: M ☐ F ☐	Patient's Birth Date	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Mailing Address City State Zip		Cell Phone: Home Phone:	Patient's Social Security #
Physical Address (If different from above)		City, State	Zip
Responsible Party Name *Relationship?* →	☐ Self ☐ Spouse ☐ Parent	Resp Party's Birth Date	Responsible Party's SSN
Responsible Party Address ☐ *Same as Patient* City State Zip Drivers License State: Number:			Preferred Method of Contact ○ Text ○ E-Mail
Emergency Contact Name:		Emergency Contact Phone Number:	
Name of Employer Business Phone:		E-Mail Address:	

Medicare Beneficiary Lifetime "Signature on File": I request that payment of authorized Medicare benefits be made on my behalf to Virginia Brain and Spine Center, Inc. for any services furnished me by physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents information to determine benefits payable for services rendered.

_____ _____

Patient / Beneficiary Signature Date

Private Insurance and Workers Compensation Authorization for Assignment of Benefits and Information Release: I, the undersigned, authorize payment of medical benefits to Virginia Brain and Spine Center, Inc. for any services furnished me by the physician. I authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that I am financially responsible for any amount not covered by my contract.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Authorization & Assignment of Insurance Benefits: I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical service rendered, I acknowledge receiving notice of the Patient Instructions and Financial Policy and agree to pay for said medical services according to the terms and to follow patient instructions. My signature below indicates that I have read and agree to the policies.

_____ _____

Patient / Responsible Party / Guardian Signature Date

Consent for Release and Use of Confidential Information and Acknowledgement of Notice of Privacy Practices

I hereby give my consent to Virginia Brain and Spine Center, Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my private health record.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Due to HIPPA Privacy Act, we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware those listed below will be given full access to your Private Health Information.

_____ _____ _____

(1) Name, Relationship to Patient (2) Name, Relationship to Patient (3) Name, Relationship to Patient

□ Office staff may leave messages regarding treatment on phone number:_____

□ I do not want my information used for marketing or fundraising purposes.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Pain Evaluation Information Packet

Chart #: _____

Patient Name: _____ Date: _____

Please list all allergies (medications, environmental, etc.): _____

Please list all current medications, the dosages, and the prescribing doctor (or attach list): _____

_____

_____

_____

Please list all doctors/providers and the specialty (primary care, eye dr, cardiology, etc.) that are currently treating you and list your pharmacy: _____

_____

_____

Family History: Please list any diseases your relatives have/had. If they are deceased, list the age and cause of death.

Mother: _____ Father: _____ Siblings: _____

Past Medical History: Please circle any problem that you have experienced and write any problem not listed.

Rheumatic Fever	Diabetes	Knocked Unconscious	Psychotic Episode	Heart Valve
Ulcer Disease	HIV Positive	Thyroid	Meningitis	Heart Disease
Blood Disorder	Memory loss	Convulsions	Blood Pressure	Anxiety
Eye problem	Paralysis	Depression	Cancer	Hepatitis
Lupus	Multiple Sclerosis	Fibromyalgia	Active Chemotherapy	Other: _____

List all Hospitalizations, Surgeries, and Procedures:

Date:	Surgery/Diagnosis:	Hospital:	Surgeon's/Physician's Name:

_____

_____

_____

Social History (circle one): Married Widowed Divorced Separated Single Live-in

Race:_____ Ethnicity:_____ Preferred: Language_____

How many children do you have? Sons: _____ Daughters: _____

Occupation: _____ Retired? Yes No

Habits: Please truthfully answer the following questions so that we can provide safe and effective care.

Are you currently smoking? Yes No Smoking since? _____ How many cigarettes/cigars per day? _____

Have you ever smoked? Yes No Started when? _____ Stopped when? _____

Do you drink alcohol? Yes No How many drinks per week? ____ Have you ever been arrested for a DUI? Yes No

Have you ever used illicit drugs within the past year? Yes No If Yes, what? Marijuana Cocaine Heroin Amphetamine Other:_____

Have you had any drug charges in the past? Yes No Have you ever been treated for substance abuse? Yes No

Have you been treated at another pain management facility in the past? Yes No

Have you previously had injections on this area? Yes No

Where is the location of your most severe pain? _____

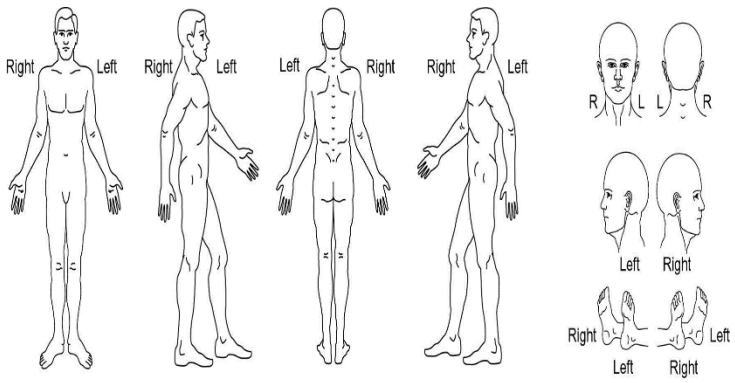
How long has this been present? _____ What caused your pain? Was it gradual in onset or triggered by an event? Is it Work related? Please describe. _____

What is your current pain level (0-10)? _____

(0-10 Mankoski Pain Scale)

0 Pain Free
1 Very minor annoyance – occasional minor twinges.
2 Minor annoyance – occasional strong twinges.
3 Annoying enough to be distracting.
4 Can be ignored if you are really involved in your work, but still distracting.
5 Can't be ignored for more than 30 minutes.
6 Can't be ignored for any length of time, but you can still go to work and participate in social activities.
7 Makes it difficult to concentrate, interferes with sleep. You can still function with effort.
8 Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9 Unable to speak. Crying out or moaning uncontrollably – near delirium.
10 Unconscious. Pain makes you pass out.

Please shade areas of pain



How often is the pain present? constant frequently (several times each hour) sporadic (several times each day) occasional (several times each week) rare (several times each month)

What words best describe your symptoms? sharp burning shooting dull throbbing aching stabbing

Do you have any of the following symptoms? numbness tingling weakness headaches

What makes your pain better? rest heat ice stretching medication_____ other_____

What makes your pain worse? lying sitting standing walking bending/twisting emotional stress moving from sitting position to standing cold weather hot weather other_____

What is the most physical activity that you are able to do?_____

What simple goal would you like to be able to do? _____

What medication (including over the counter medication) do you take for your pain? _____

Approximately what **percent** improvement does the medication provide? _____

What medications have **failed** to help? (Including over the counter medications):_____

Have you ever tried any of the following Neuropathic medications? Please circle what applies

Gabapentin/Neurontin Lyrica Cymbalta Topamax/Topiramate None

Have you ever attended Physical Therapy? Yes No If Yes, when? And was it helpful? _____

Have you ever used a TENS unit in the past? Yes No

Past Medical Testing: Please indicate when and where if you have undergone any of the following tests.

CT Scan (Spine) _____

MRI Scan (Spine) _____

EMG/Nerve Conductions _____

X-rays _____

Patient Portal Access

Patient Portal Access is the all-in-one personal health record and patient portal that lets you access your health information. You will have 24/7 online access from any computer, smartphone, or tablet. You will be able to view test and lab results, send and receive secure online messages, request Rx refills, cancel appointments, and receive email care reminders. You can also download the free portal app at your Apple or Android store (enter FollowMyHealth in the search field).

Complete this form in its entirety and you will then receive an email from Follow My Health with instructions on setting up your personal Patient Portal Access account. You must register your new account from a computer only, you cannot create an account on a tablet or smartphone. After your account is created, you will be able to access your account from any device (computer, smartphone, or tablet). **Please complete this form if you have a valid email address, as we cannot submit your request without it.**

First Name:_____

Last Name:_____

Birth Date:_____

Last Four of SSN:_____

Valid Email Address (Please Print Clearly): _____

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

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about

criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Virginia Brain and Spine Center, 1818 Amherst St. Winchester, VA 22601. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have 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 our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

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 web site, www.vabrainandspine.com

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Amy Maynard, Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

You may contact our office at:

Virginia Brain and Spine Center, 1818 Amherst St. Winchester, VA 22601 or by calling 540-450-0074.