PATIENT INFORMATION

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY: _____

HOME PHONE: _____ ☐ WORK ☐ RETIRED ☐ DISABLED ☐ NONE
(CHECK ONE)

MOBILE PHONE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ ZIP: _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

SPOUSE/GUARDIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

INSURANCE INFORMATION

PRIMARY INSURANCE NAME: _____ POLICY HOLDER: _____

POLICY HOLDER BIRTHDATE: _____ SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE NAME: _____ POLICY HOLDER: _____

POLICY HOLDER BIRTHDATE: _____ SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____ EMPLOYER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

***IF MEDICARE IS SECONDARY:**

ARE YOU OR YOUR SPOUSE WORKING? ☐ YES ☐ NO

ARE YOU DISABLED? ☐ YES ☐ NO

PATIENT FINANCIAL RESPONSIBILITY POLICY

IT IS THE POLICY OF AVALA SPINE TO COLLECT CO-PAYS AND ANY OUTSTANDING PATIENT BALANCES BEFORE EACH VISIT. IF YOU CANNOT PAY YOUR CO-PAY AND HAVE ANY OUTSTANDING BALANCE YOUR APPOINTMENT WILL BE RESCHEDULED.

OUR BUSINESS OFFICE WILL BILL YOUR MEDICAL INSURANCE FOR THE SERVICES RENDERED IN OUR OFFICE. PAYMENT IS NOT GUARANTEED BY YOUR INSURANCE. YOU ARE ULTIMATELY RESPONSIBLE FOR ALL CHARGES. THE INSURANCE PROCESS NORMALLY TAKES APPROXIMATELY 60- 90 DAYS. YOU WILL RECEIVE MONTHLY FINANCIAL STATEMENTS TO INCLUDE ANY OUTSTANDING CHARGES ON YOUR ACCOUNT. ONCE INSURANCE HAS PROCESSED PAYMENT, YOUR FINANCIAL STATEMENT WILL REFLECT ANY DEDUCTIBLES AND/OR CO-INSURANCE DUE FROM YOU AS PER YOUR INSURANCE.

IT IS YOUR RESPONSIBILITY TO KNOW AND UNDERSTAND YOUR INSURANCE POLICY AND BENEFITS. WE WILL BILL SECONDARY INSURANCE AS A COURTESY.

OUR PROVIDERS ARE NOT CONTRACTED WITH ANY AHCCCS / MEDICAID INSURANCE PROGRAMS. YOU WILL BE RESPONSIBLE FOR OUTSTANDING BALANCES.

IF YOUR INSURANCE HAS LAPSED, IS INACTIVE, OR FOR ANY REASON DOES NOT COVER THE EXPENSES THAT YOU HAVE INCURRED AT AVALA SPINE, YOU WILL BE RESPONSIBLE FOR THE FULL CHARGES THAT HAVE BEEN BILLED TO YOUR INSURANCE COMPANY. PAYMENT FOR THESE CHARGES MUST BE RECEIVED WITHIN 30 DAYS FROM RECEIPT OF YOUR BILL.

IF YOU CHOOSE TO PAY BY CHECK AND YOUR CHECK DOES NOT CLEAR, YOU WILL BE RESPONSIBLE FOR PAYING THE BANK ADMINISTRATIVE CHARGE OF $25.00 PLUS THE AMOUNT OF YOUR ORIGINAL CHECK.

IF WE HAVE HAD NO RESPONSE OR CONTACT FROM YOU WITHIN 60 DAYS TO PAY OFF YOUR BALANCE, THE BUSINESS OFFICE WILL TURN YOUR ACCOUNT OVER TO OUR COLLECTION AGENCY. THE COLLECTION AGENCY WILL ASSESS A 20% COLLECTION FEE DUE IN ADDITION TO YOUR ORIGINAL BALANCE.

OUT OF NETWORK POLICY: IF WE ARE OUT OF NETWORK WITH YOUR INSURANCE COMPANY AND YOUR INSURANCE PAYS YOU DIRECTLY, YOU ARE RESPONSIBLE FOR PAYMENT AND AGREE TO FORWARD THE PAYMENT TO US.

_____ **INITIAL**

SELF-PAY PATIENT POLICY: WE DO SEE PATIENTS ON A SELF-PAY BASIS. THE CHARGE FOR SERVICES WILL BE COLLECTED PRIOR TO THE SERVICE BEING RENDERED. CASH, CHECK, DEBIT CARD WITH VISA/MASTERCARD GUARANTEE, OR CREDIT CARD PAYMENT IS THE ONLY ACCEPTED FORM OF PAYMENT FOR SELF-PAY PATIENTS.

SURGICAL PROCEDURE POLICY: IF YOU BECOME A CANDIDATE FOR INJECTIONS OR SURGERY, IT IS OUR POLICY TO COLLECT ANY DEDUCTIBLE OR CO-INSURANCE THAT MAY BE DUE IN ADVANCE. CASH, DEBIT CARD WITH VISA/MASTERCARD GUARANTEE, OR CREDIT CARD PAYMENT ARE THE ONLY ACCEPTED FORMS OF PRE-PAYMENT FOR THESE SERVICES. SORRY, NO PERSONAL CHECKS ARE ACCEPTED. PAYMENT MUST BE RECEIVED NO LATER THAN ONE (1) WEEK PRIOR TO SURGERY OR YOUR PROCEDURE WILL BE CANCELLED. TO DETERMINE ANY FINANCIAL RESPONSIBILITY TO THE FACILITY, PLEASE CONTACT THE FACILITY PRIOR TO YOUR PROCEDURE.

DISABILITY/ MEDICAL LEAVE FORM POLICY: IF YOU NEED A DISABILITY / MEDICAL LEAVE FORM FILLED OUT THERE WILL BE A $20.00 CHARGE FOR EACH FORM. BY SIGNING THIS AGREEMENT, YOU UNDERSTAND THAT YOU WILL NEED TO PREPAY THE $20.00 CHARGE FOR THIS FORM TO BE COMPLETED AND SUBSEQUENTLY RELEASED.

CANCELLATION/ NO SHOW POLICY FOR DOCTOR APPOINTMENT: WE UNDERSTAND THAT THERE ARE TIMES WHEN YOU MUST MISS AN APPOINTMENT DUE TO EMERGENCIES OR OBLIGATIONS FOR WORK OR FAMILY. HOWEVER, WHEN YOU DO NOT CALL TO CANCEL AN APPOINTMENT, YOU MAY BE PREVENTING ANOTHER PATIENT FROM GETTING MUCH NEEDED TREATMENT. IF AN APPOINTMENT IS NOT CANCELLED AT LEAST 24 HOURS IN ADVANCE YOU WILL BE CHARGED A FIFTY-DOLLAR ($50) FEE; THIS WILL NOT BE COVERED BY YOUR INSURANCE COMPANY.

THANK YOU FOR YOUR UNDERSTANDING OF OUR FINANCIAL POLICIES AT AVALA SPINE. IF YOU HAVE ANY QUESTIONS, PLEASE DO NOT HESITATE TO GIVE OUR BUSINESS OFFICE A CALL AT 985-400-5778.

PATIENT SIGNATURE _____ DATE _____

AVALA SPINE ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I HEREBY ASSIGN AND CONVEY DIRECTLY TO DISC OF LOUISIANA, INC., D/B/A "AVALA SPINE" AS MY DESIGNATED AUTHORIZED REPRESENTATIVE, ALL MEDICAL BENEFITS AND/OR INSURANCE REIMBURSEMENT, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES, TREATMENTS, THERAPIES, AND/OR MEDICATIONS RENDERED OR PROVIDED BY AVALA SPINE REGARDLESS OF ITS MANAGED CARE NETWORK PARTICIPATION STATUS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES REGARDLESS OF ANY APPLICABLE INSURANCE OR BENEFIT PAYMENTS. I HEREBY AUTHORIZE AVALA SPINE TO RELEASE ALL MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIMS. FURTHER, I HEREBY AUTHORIZE MY PLAN ADMINISTRATOR FIDUCIARY, INSURER, AND/OR ATTORNEY TO RELEASE TO AVALA SPINE ANY AND ALL PLAN DOCUMENTS, SUMMARY BENEFIT DESCRIPTION, INSURANCE POLICY, AND/OR SETTLEMENT INFORMATION UPON WRITTEN REQUEST FROM AVALA SPINE OR ITS ATTORNEYS IN ORDER TO CLAIM SUCH MEDICAL BENEFITS.

IN ADDITION TO THE ASSIGNMENT OF THE MEDICAL BENEFITS AND/OR INSURANCE REIMBURSEMENT ABOVE, I ALSO ASSIGN AND/OR CONVEY TO THE ABOVE NAMED HEALTH CARE PROVIDER ANY LEGAL OR ADMINISTRATIVE CLAIM OR CHOSE AN ACTION ARISING UNDER ANY GROUP HEALTH PLAN, EMPLOYEE BENEFITS PLAN, HEALTH INSURANCE OR TORT FEAS OR INSURANCE CONCERNING MEDICAL EXPENSES INCURRED AS A RESULT OF THE MEDICAL SERVICES, TREATMENTS, THERAPIES, AND/OR MEDICATIONS I RECEIVE FROM AVALA SPINE. (INCLUDING ANY RIGHT TO PURSUE THOSE LEGAL OR ADMINISTRATIVE CLAIMS OR CHOSE AN ACTION). THIS CONSTITUTES AN EXPRESS AND KNOWING ASSIGNMENT OF ERISA BREACH OF FIDUCIARY DUTY CLAIMS AND OTHER LEGAL AND/OR ADMINISTRATIVE CLAIMS.

I INTEND BY THIS ASSIGNMENT AND DESIGNATION OF AUTHORIZED REPRESENTATIVE TO CONVEY TO THE ABOVE-NAMED PROVIDER ALL MY RIGHTS TO CLAIM (OR PLACE A LIEN ON) THE MEDICAL BENEFITS RELATED TO THE SERVICES, TREATMENTS, THERAPIES, AND/OR MEDIATIONS PROVIDED BY AVALA SPINE INCLUDING RIGHTS TO ANY SETTLEMENT, INSURANCE OR APPLICABLE LEGAL OR ADMINISTRATIVE REMEDIES (INCLUDING DAMAGES ARISING FROM ERISA BREACH OF FIDUCIARY DUTY CLAIMS). THE ASSIGNEE AND/OR DESIGNATED REPRESENTATIVE (ABOVE-NAMED PROVIDER) IS GIVEN THE RIGHT BY ME TO (1) OBTAIN INFORMATION REGARDING THE CLAIM TO THE SAME EXTENT AS ME; (2) SUBMIT EVIDENCE; (3) MAKE STATEMENTS ABOUT FACTS OR LAW; (4) MAKE ANY REQUEST INCLUDING PROVIDING OR RECEIVING NOTICE OF APPEAL PROCEEDINGS; (5) PARTICIPATE IN ANY ADMINISTRATIVE AND JUDICIAL ACTIONS AND PURSUE CLAIMS OR CHOSE IN ACTION OR RIGHT AGAINST ANY LIABLE PARTY, INSURANCE COMPANY, EMPLOYEE BENEFIT PLAN, HEALTH CARE BENEFIT PLAN, OR PLAN ADMINISTRATOR. THE ABOVE-NAMED PROVIDER AS MY ASSIGNEE AND MY DESIGNATED AUTHORIZED REPRESENTATIVE MAY BRING SUIT AGAINST ANY SUCH HEALTH CARE BENEFIT PLAN, EMPLOYEE BENEFIT PLAN, PLAN ADMINISTRATOR OR INSURANCE COMPANY IN MY NAME WITH DERIVATIVE STANDING AT PROVIDER'S EXPENSE.

UNLESS REVOKED, THIS ASSIGNMENT IS VALID FOR ALL ADMINISTRATIVE AND JUDICIAL REVIEWS UNDER PPACA (HEALTH CARE REFORM LEGISLATION), ERISA, MEDICARE AND APPLICABLE FEDERAL AND STATE LAWS. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED VALID, THE SAME AS IF IT WAS THE ORIGINAL.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

PATIENT SIGNATURE _____ DATE _____

MEDICAL HISTORY

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

PRIMARY CARE PHYSICIAN: _____

HISTORY OF THE PROBLEM FOR WHICH YOU ARE SEEING US

WHEN DID THE SYMPTOMS START? _____

HOW DID IT START? ☐ HOME/LEISURE ☐ WORK ☐ CAR ☐ FALL ☐ OTHER

WHAT DO THE CURRENT SYMPTOMS FEEL LIKE?

☐ ACHING ☐ BURNING ☐ THROBBING
☐ SHOOTING ☐ STABBING ☐ TIGHTNESS
☐ TINGLING ☐ PRESSURE ☐ PINS AND NEEDLES

HOW OFTEN DO YOU FEEL THESE SYMPTOMS?

☐ CONSTANT ☐ INTERMITTENT ☐ RARE

DOES ANYTHING MAKE THE PAIN FEEL BETTER? ☐ YES ☐ NO

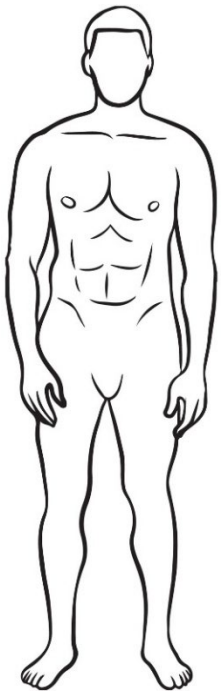
DO ANY OF THE FOLLOWING MAKE THE PAIN/SYMPTOMS WORSE? (CHECK ALL THAT APPLY)

☐ WALKING ☐ STANDING ☐ SITTING ☐ PUSHING
☐ LIFTING ☐ TWISTING ☐ WORKING OVERHEAD ☐ OTHER: _____
☐ PULLING ☐ SIT TO STAND ☐ BENDING

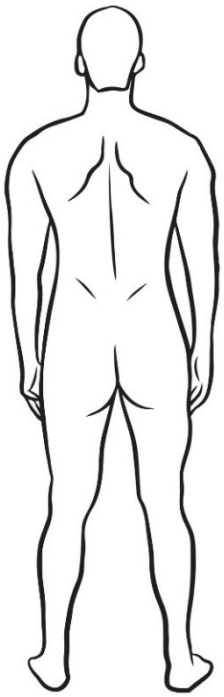
ANY WEAKNESS OR NUMBNESS? ☐ YES ☐ NO IF SO, WHERE? _____

PLEASE MARK AN "X" ON THE BODY PART(S) WHERE YOU HAVE PAIN, AND AN "0" ON THE BODY PART(S) WHERE YOU HAVE NUMBNESS.

RIGHT LEFT



LEFT RIGHT



SELECT A NUMBER TO INDICATE TYPICAL LEVEL OF PAIN

NECK/ARMS

1 2 3 4 5 6 7 8 9 10

BACK/LEGS

1 2 3 4 5 6 7 8 9 10

HISTORY OF TREATMENT

TEST	RECEIVED		PHYSICIAN	FACILITY	DATE
X-RAY (BRAIN OR SPINE)	☐ YES	☐ NO			
MRI SCAN (BRAIN OR SPINE)	☐ YES	☐ NO			
CT SCAN (BRAIN OR SPINE)	☐ YES	☐ NO			
OTHER IMAGING:	☐ YES	☐ NO			
PAIN MANAGEMENT	☐ YES	☐ NO			
PHYSICAL THERAPY	☐ YES	☐ NO			
CHIROPRACTOR	☐ YES	☐ NO			

PAST MEDICAL HISTORY

☐ AIDS
☐ ANEMIA
☐ ANXIETY PROBLEM
☐ ARTHRITIS
☐ ASTHMA
☐ BIPOLAR DISEASE
☐ CANCER
☐ COLON POLYP
☐ CONGESTIVE HEART DISEASE
☐ COPD/EMPHYSEMA
☐ DEPRESSION
☐ CARDIAC LOOP RECORDER
☐ DIABETES
☐ DIVERTICULOSIS
☐ ENDOMETRIOSIS
☐ ENLARGED PROSTATE
☐ FIBROMYALGIA
☐ GASTRITIS
☐ GLAUCOMA
☐ GOUT
☐ HEART ATTACK
☐ HEART DISEASE
☐ HIGH BLOOD PRESSURE
☐ PULMONARY EMBOLISM
☐ HEPATITIS C
☐ HIGH CHOLESTEROL
☐ HIV
☐ IRREGULAR HEARTBEAT
☐ IRRITABLE BOWEL SYNDROME
☐ KIDNEY DISEASE
☐ KIDNEY STONES
☐ LIVER DISEASE
☐ LUPUS
☐ OSTEOPOROSIS
☐ PERIPHERAL VASCULAR DISEASE
☐ PACEMAKER
☐ SCOLIOSIS
☐ SEIZURES
☐ STROKE
☐ THYROID DISEASE
☐ TUBERCULOSIS
☐ ULCERS
☐ DVT/BLOOD CLOT
☐ OTHER: _____

PAST SURGICAL HISTORY

PROCEDURE	HOSPITAL	YEAR

☐ I HAVE NOT HAD SURGERY OR BEEN HOSPITALIZED

FAMILY HISTORY CHECK BOX IF A BLOOD RELATIVE HAS BEEN DIAGNOSED WITH THE FOLLOWING

	MOTHER	FATHER	SIBLING	GRANDPARENT
CANCER	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐
STROKE/SEIZURES	☐	☐	☐	☐
OTHER	☐	☐	☐	☐

SOCIAL HISTORY

DO YOU SMOKE/VAPE? ☐ YES ☐ NO HAVE YOU SMOKED/VAPED IN THE PAST? ☐ YES ☐ NO

HOW LONG? _____ # PACKS A DAY: _____ BRAND: _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO HOW MANY DRINKS A MONTH? _____

DO YOU HAVE A HISTORY OF DRUG/ALCOHOL ABUSE? ☐ YES ☐ NO

REVIEW OF SYSTEMS CHECK ANY/ALL YOU HAVE EXPERIENCED IN THE PAST MONTH

CONSTITUTIONAL	GASTROINTESTINAL	CARDIOVASCULAR	EYES
☐ FEVER/CHILLS	☐ ABDOMINAL PAIN	☐ CHEST PAIN	☐ BLURRY VISION
☐ NIGHT SWEATS	☐ BLOATING	☐ P.N.D.	☐ DISCHARGE
☐ WEIGHT CHANGE	☐ CONSTIPATION	☐ CLAUDICATION	☐ BURNING
☐ BLOOD CLOTS	☐ CRAMPING	☐ MURMUR	☐ PAIN
GENITOURINARY	☐ DIARRHEA	☐ ORTHOPNEA	☐ REDNESS
☐ DRIBBLING	☐ PAINFUL SWALLOWING	☐ PALPITATIONS	☐ DRY
☐ BLOODY URINE	☐ HEARTBURN/ACID RELIEF	☐ VALVULAR DISEASE	**OTHER**
☐ STD (HX)	☐ JAUNDICE	☐ EDEMA	
☐ URINARY INCONTINENCE	☐ BLOODY STOOL	☐ SYNCOPE	
☐ FREQUENT URINATION	☐ NAUSEA/VOMITING	**ENT/MOUTH**	
☐ URINARY URGENCY	☐ STOMACH ULCERS	☐ EAR DRAINAGE	
ENDOCRINE	☐ COLITIS	☐ HEARING LOSS	
☐ EXCESS THIRST	☐ RECTAL BLEEDING	☐ EAR RINGING	
☐ COLD INTOLERANCE	☐ RECTAL PAIN	☐ BLEEDING GUMS	
☐ HEAT INTOLERANCE	☐ DIVERTICULITIS	☐ ORAL LESIONS	

MEDICATION HISTORY LIST ALL MEDICATIONS YOU TAKE **WITH OR WITHOUT** A PRESCRIPTION

PHARMACY NAME: _____ **PHONE NUMBER:** _____

NAME OF MEDICATION	DOSAGE	REASON FOR TAKING

DO YOU HAVE DRUG ALLERGIES? ☐ YES ☐ NO

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

SECTION A: REQUIRED FOR ALL AUTHORIZATION FOR RELEASE OF PHI OR RIGHT OF ACCESS

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT ADDRESS: _____ SS NUMBER:(OPTIONAL) _____

PHI RECIPIENT NAME: AVALA SPINE FAX NUMBER: 985-888-1042

PHI SENDER NAME: _____ FAX NUMBER: _____

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING: (FILL IN THE DATE OR EVENT, BUT NOT BOTH)

DATES: _____ EVENT: _____

PLEASE CHECK WHICH OF THE FOLLOWING YOU WOULD LIKE TO BE REQUESTED:

☐ ALL PHI IN RECORD	☐ PHYSICIAN ORDERS	☐ DEMOGRAPHICS
☐ HISTORY AND PHYSICAL	☐ LABORATORY	☐ REHABILITATION SERVICES
☐ CONSULT REPORT	☐ IMAGING/RADIOLOGY	☐ SPECIAL TEST/THERAPY
☐ OPERATIVE REPORT	☐ NURSING NOTES	☐ ITEMIZED BILL/CLAIMS
☐ PROGRESS NOTE	☐ MEDICATION RECORD	☐ OTHER

I ACKNOWLEDGE AND HEREBY CONSENT TO SUCH THAT THE RELEASE INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, OR PSYCHIATRIC. HIV TESTING, HIV RESULTS, OR AIDS INFORMATION.

_____ **INITIAL** ☐ IF NOT APPLICABLE, CHECK HERE

I UNDERSTAND THAT:

- I MAY REFUSE TO SIGN THIS AUTHORIZATION, AND MY TREATMENT WILL NOT BE CONDITIONED UPON THE SIGNATURE OF THIS AUTHORIZATION (EXCEPT FOR NON-HEALTH-RELATED SERVICES SUCH AS PRE-EMPLOYMENT TESTING, LIFE INSURANCE EXAMS, OR DRUG SCREENINGS).
- I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON ANY ACTIONS TAKEN BEFORE RECEIVING THE REVOCATION. FURTHER DETAILS MAY BE FOUND IN THE NOTICE OF PRIVACY PRACTICES.
- IF THE REQUESTOR OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL REGULATIONS AND MAY BE RE-DISCLOSED.
- I UNDERSTAND THAT I MAY SEE AND OBTAIN A COPY OF THE INFORMATION DESCRIBED ON THIS FORM FOR A REASONABLE COPY FEE IF I ASK FOR IT.
- I WILL RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

SECTION C: SIGNATURES

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

_____ _____

PATIENT/GUARDIAN/PATIENT REPRESENTATIVE SIGNATURE DATE

_____ _____

PRINT NAME OF PATIENT'S REPRESENTATIVE: RELATIONSHIP TO THE PATIENT

PLEASE MAIL MEDICAL RECORDS TO AVALA SPINE AT
76 STARBRUSH CIRCLE, COVINGTON, LA, 70433, OR FAX RECORDS TO 985-888-1042.

DESIGNATION OF INDIVIDUAL INVOLVED IN MY CARE

UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA"), YOU HAVE THE RIGHT TO AUTHORIZE THE RELEASE OF YOUR PROTECTED HEALTH INFORMATION, INCLUDING MEDICAL AND BILLING RECORDS, TO AN INDIVIDUAL(S) YOU DESIGNATE. PLEASE COMPLETE THIS FORM IN ITS ENTIRETY, DESIGNATING THE INDIVIDUAL(S) WITH WHOM YOU WOULD LIKE AVALA TO SHARE YOUR INFORMATION.

PATIENT NAME: _____ DATE OF BIRTH: _____

DESIGNATION OF INDIVIDUAL(S) INVOLVED IN MY CARE:

AT MY REQUEST, I HEREBY IDENTIFY THE FOLLOWING INDIVIDUAL(S):

_____

_____

_____

(COLLECTIVELY, THE "DESIGNATED INDIVIDUAL") AS AN INDIVIDUAL(S) INVOLVED IN MY CARE, I HEREBY AUTHORIZE AVALA TO RELEASE ANY AND ALL PROTECTED HEALTH INFORMATION ABOUT ME, INCLUDING BILLING AND MEDICAL RECORDS, TO THE DESIGNATED INDIVIDUAL. THIS AUTHORIZATION PERMITS THE DISCLOSURE OF PAPER RECORDS, ELECTRONIC RECORDS, AND VERBAL COMMUNICATIONS. ADDITIONALLY, TO THE EXTENT MY MEDICAL OR BILLING RECORDS CONTAIN INFORMATION RELATED TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC CARE, SEXUALLY TRANSMITTED DISEASE, HEPATITIS B OR C TESTING, HIV/AIDS, AND/OR OTHER SENSITIVE INFORMATION, I HEREBY AGREE TO ITS RELEASE

TERMINATION/REVOCATION OF DESIGNATION: UNLESS TERMINATED SOONER IN WRITING BY ME, THIS AUTHORIZATION WILL TERMINATE THREE (3) YEARS AFTER MY LAST DATE OF TREATMENT BY AVALA. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AND CANCEL THIS DESIGNATION BY SENDING A WRITTEN REVOCATION OF DESIGNATION FORM TO AVALA. I UNDERSTAND AND ACKNOWLEDGE THAT THE REVOCATION OR CANCELLATION OF THIS DESIGNATION SHALL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED BEFORE THE REVOCATION/CANCELLATION DATE.

RE-DISCLOSURE: I UNDERSTAND THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO RE-DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY HIPAA.

NO OBLIGATION TO SIGN: I UNDERSTAND I DO NOT HAVE TO SIGN THIS AUTHORIZATION, AND TREATMENT WILL NOT BE DENIED IF I DO NOT SIGN THIS FORM. I HEREBY RELEASE AND DISCHARGE AVALA, ITS EMPLOYEES, AGENTS, AND OWNERS OF ANY LIABILITY AND WILL HOLD THEM HARMLESS OR COMPLYING WITH THIS AUTHORIZATION.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES OF **AVALA SPINE.**

ACKNOWLEDGEMENT

_____ _____

PATIENT SIGNATURE DATE