1120 West Avenue M-4, Palmdale, CA. 93551 Phone 661.480.2377 Fax 661.480.2378
16311 Ventura Blvd. Suite 1080P Encino, CA. 91436 Phone 661.480.2377 Fax 661.480.2378
8920 Wilshire Blvd. Suite 301 Beverly Hills, CA. 90211 Phone 661.480.2377 Fax 661.480.2378

Patient: Last_____First:_____MI: _____

Birth Date: /___/_____Sex: M / F Soc. Security Number: _____

Address:_____City:_____Zip Code: _____

Cell Phone Number:_____Home Phone Number: _____

Email Address:_____CDL No: _____

Primary Care Provider:
Name:_____Office: _____

Address:_____City:_____Zip Code: _____

Telephone Number:_____Fax Number: _____

Emergency Contact's Name:_____
Address:_____City:_____Zip Code: _____

Telephone number to best reach them:_____Relationship: _____

Insurance Information: Name ofInsurance: _____

Primary Holder ofInsurance: _____

Insurance ID #:_____Group #: _____

Address:_____City:_____Zip Code: _____

Telephone Number:_____Fax Number: _____

The Above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize NeuroSpine Institute or insurance company to release any information required to process my claims. I acknowledge I have received NeuroSpine notice of privacy practices.

Patient/Guarantor Signature: _____

NEUROSPINE INSTITUTE

DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE

AGREEMENT AS TO RESOLUTION OF CONCERNS OF DISSATISFACTION
READ CAREFULLY

We take pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We therefore recognize and respect a patient right to pursue legal action if he/ she feels we have been negligent in some way. While some health care legal claims are justified, there are also frivolous legal claims filed in our country, which drive up insurance rates and adversely impact court decisions for patients who deserve compensation. As such, we believe that an agreement early in the treatment process regarding the use of board-certified experts may help expedite resolution of concerns.

OUR COMMITMENT TO YOU: We commit to using only American Osteopathic Board of Surgeons, American Board of Medical Specialties, board certified expert witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics. We demonstrate this commitment to you with our signature on this form (which you may receive a copy of at any time after such signature is affixed) **WHAT WE ARE ASKING YOU TO DO**: We are asking you or any representative to commit to a process also, by using only American Osteopathic Board of Surgeons, American Board of Medical Specialties, board- certified physician expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action. I understand that I am entering into a contractual relationship with the DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE for professional services. I further understand that claims that are without merit or are frivolous have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided me by DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE claims of medical malpractice against the providers within the DR. KAMRAN PARSA. DBA NEUROSPINE INSTITUTE should I initiate or pursue a medical malpractice claim against a provider within the DR. KAMRAN PARSA. DBA NEUROSPINE INSTITUTE, I agree to use as expert witness only physicians who are board certified by the American Osteopathic Board of Surgeons, , American Board of Medical Specialties in the same or similar specialty as the provider against whom the claim is being made. Further I agree that these physicians retained by me or on my behalf to be an expert witness will be a member in good standing of the medical specialty society to which the provider belongs. I agree an expert will be obligated to adhere to the guidelines or code of conduct defined by that physicians or providers specialty society. I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, DR. KAMRAN PARSA INC. DBA NEUROSPINE INSTITUTE also agree to exactly the same above referenced stipulations.

Each party agrees that his/her counsel shall have the right and be free to depose the other partys expert witness(es) at least 120 days before any scheduled trial date.

Each party agrees that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other defendants.

Each party agrees that these provisions apply to any claim for medical malpractice whether based on a theory of contract, negligence, battery or any other theory of recovery.

PRINT PATIENT NAME_____

PATIENT SIGNATURE_____ Date_____

PHYSICIAN SIGNATURE_____ Date_____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient Information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient Files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restriction in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature:_____

NEUROSPINE INSTITUTE

Patient Record of Disclosures of Protected Health Information (PHI)

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

☐ Appointment Dates/Times ☐ Diagnosis ☐ Imaging Results

☐ Medications ☐ Lab Tests/Results ☐ Medical Records

☐ Care Plan ☐ Other (specify)

Indicate Confidential Information:_____

_____

Patient Name: _____

Date of Birth: _____ Email Address:_____

Informed to be released to: _____

Name: _____

Relationship: _____

Address: _____

Phone: _____

This authorization shall remain in effect from the date signed below until (please check one):

☐ _____ (Specify expiration date or event)

☐ NO EXPIRATION

Signature: _____ Date: _____

Relationship to Patient (If signed by personal representative of Patient): _____