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WILLOW LAWN

SOUTHERN PHYSICAL MEDICINE ASSOCIATES - DR.CHARLES H. BONNER

PATIENT REGISTRATION FORM

PATIENT NAME: _____ Email: _____
First Middle Last

ADDRESS: _____
Street City State & Zip

TELEPHONE: _____ MARITIAL STATUS: S M D SEP W
Home Cell

BIRTHDATE: _____ Age: _____ SS#: _____ SEX: M / F

EMPLOYER: _____ Work #: _____ Occupation

WORK ADDRESS: _____ City _____ State & Zip

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: _____ SEX: M / F
First Middle Last

ADDRESS: _____ State & Zip
Street City State & Zip

HOME TELEPHONE: _____ SS#: _____ DOB

EMPLOYER: _____ Work #: _____ Occupation

WORK ADDRESS: _____ City _____ State & Zip

INSURANCE INFORMATION

1st INSUR. CO. NAME: _____ INSURED NAME: _____ Relationship to patient

INS. ADDRESS: _____ INS. TEL.#: _____

INSURED ID# _____ Group# _____ Birthdate _____ SS# _____

2nd INSUR. CO. NAME: _____ INSURED NAME: _____ Relationship to patient

INS. ADDRESS: _____ INS. TEL.#: _____

INSURED ID# _____ Group# _____ Birthdate _____ SS# _____

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME: _____ TEL#: _____ Relationship: _____
First Last

ADDRESS: _____ City _____ State & Zip

Is this visit a result of a work injury? Yes No Date of Injury:

Is this visit a result of a car accident? Yes No Date of Accident: WC or Car Ins Pol.#

Attorney Name: Attorney Tel.#

Do you have any drug allergies?

Primary Care Doctor Tel#:

Name of referring Doctor?

I authorize any holder of medical or other information about me to release to my insurance company or Medigap or any other carrier any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be paid directly to SOUTHERN PHYSICAL MEDICINE ASSOCIATES - DR.CHARLES H. BONNER.

I understand that I am responsible for any balance not covered by my insurance carrier. In the event this account is referred to collections, then in addition to all other amounts due, patient will incur collection fees of 33% of the outstanding balance, a $10 late fee and 9% interest per month for the outstanding balances.

PATIENT'S SIGNATURE
OR RESPONSIBLE PARTY _____ DATE _____

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices and I have been provided an oportunity to review it.

NAME: _____ BIRTHDATE _____

SIGNATURE _____ DATE _____

Southern Physical Medicine Associates, Inc.
Physical Medicine Center
Charles H. Bonner, MD, MS, CRP

5922 West Broad Street
Richmond, VA 23230
Phone: (804) 282-6953
Fax: (804) 282-5777

Patient Name _____ Date of Injury _____

Attorney Name _____ Phone _____

Law Firm's Name: _____

Law Firm's Address: _____

I hereby authorize Southern Physical Medicine Associates, Inc. to furnish you my attorney, with a full report of the examination. diagnosis. treatment, progress, etc. of myself with regard to the accident which I was involved. I also authorize the release of any billing information including outstanding debts due with regard to the services rendered to me by Southern Physical Medicine Associates. Inc.

I understand that except in an emergency, I am required to call at least 24 hours in advance to cancel or reschedule my appointment. If I am unable to keep my appointment and have not been provided such notice, I realize that I will be liable for a fee to be billed to me by Southern Physical Medicine Center Associates, Inc.

I hereby authorize and direct to you, my attorney, to pay directly to Southern Physical Medicine Associates, Inc. such sums as may be due and owing them for professional services rendered to me by reason of this accident. I authorize you to withhold such sums from any settlement, judgment, or verdicts as may be necessary to protect Southern Physical Medicine Associates, Inc. I hereby further give a lien on my case to Southern Physical Medicine Associates, Inc. against any and all proceeds of any settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the results of injuries for which I have been treated for injuries in connection therewith. This lien shall be in addition to the statutory lien provided under the laws of the Commonwealth of Virginia and shall be to the extent necessary to cover all of my charges with Southern Physical Medicine Associates, Inc.

I request the payment under my insurance and/or Med Pay benefits be made directly to Southern Physical Medicine Associates, Inc.

_____ _____
Signature of Patient Date

_____
Legal Guardian- PRINT

_____
Signature of Legal Guardian

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect Southern Physical Medicine Associates. Inc.

_____ _____
Attorney Signature Date

Please sign, date and return the original copy to Southern Physical Medicine Associates, Inc. within 10 days of the date of this letter. Thank You!

Physical Medicine Center

Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

Release of Information

I _____ **authorize Southern Physical Medicine Associates to use and/ or disclose certain protected health information (PHI) about me to the following individuals:**
(Please list – i.e. family member(s), attorney, or other representative)

_____
_____

This authorization permits Southern Physical Medicine Associates to use and/ or disclose the following individually identifiable health information about me.
(Specify the information to be disclosed, such as date of service, type of service, etc.)

_____
_____

The information will be used or disclosed for the following purpose.
(Please list the purpose allowed for the information to be released)

_____
_____
(If disclosure is requested by the patient, purpose may be listed as "at the request of the individual")

This authorization will expire on _____

By signing I acknowledge that I have received a copy of the Notice of Privacy Practices

Signed by: _____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patients Name

_____ _____
Print Name of Legal Guardian (if applicable) Date

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PHYSICAL • MEDICINE • CENTER

CHARLES H. BONNER, MD, MS, CRP
PAIN MANAGEMENT & ELECTROMYOGRAPHY

Chronic Opioid Medication Agreement and Informed Consent

Patient Name:_____

Your physician has concluded that your chronic pain problems require narcotic pain medication. By signing this agreement, you understand the risks and benefits of narcotic use and agree to adhere to our policies regarding narcotic medications.

1. Narcotic pain medication will be prescribed only by Dr. Bonner. If you request or receive narcotic medication from other physicians, (except under emergency situations), while under this agreement, we will discontinue prescribing narcotics for you.
2. Patients must take medications as prescribed. Prescriptions will not be refilled early and will thereafter be given on a monthly basis when dose requirement are established.
3. To avoid losing medications, we recommend that you do not keep your full prescription with you at all times. Keep your daily amount in a pillbox. Lost medications will not be replaced and may result in being weaned from that medication.
4. Prescriptions and bottles of these medications may be sought by other individuals with chemical dependency and should be closely safeguarded. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them. *You may not share, sell, or otherwise permit others to have access to these medications.*
5. Medications will not be replaced if they are lost, get wet are destroyed, left on an airplane, etc. If your medications are stolen, a police report is required before any subsequent refill, and this will be done at the discretion of your attending physician. This includes written prescriptions not yet filled.
6. Since the drugs may be hazardous or lethal to a person who is not tolerant to their effect, especially a child, you must keep them out of reach of such people.
7. You must comply with other recommendations, which may include psychological counseling, physical therapy and nutrition changes as deemed necessary by your physician.
8. You are expected to inform our office of any new medications of medical conditions, and of any adverse effects you experience from any of the medication that you take.
9. At Dr. Bonner's discretion, unannounced random urine testing and/or serum toxicity screens may be requested, and your cooperation is required. Presence of unauthorized substances may prompt referral for assessment for addictive disorder, as well as give prescribing physician reason to discontinue prescribing particular medications. *The use of illegal substances is prohibited. If there is evidence of use by history or urine/blood screen, the narcotic medication can be discontinued at the discretion of your doctor.*
10. It is your responsibility to make sure you have enough medicine until your next office visit. All new prescriptions and refills must be given during a regular office visit. Renewals are contingent on keeping scheduled appointments. No refills will be made over the telephone. Please do not phone for prescriptions after hours or weekends. Such calls will not be accepted.
11. Prescriptions may be issued early if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist that they not be filled prior to the appropriate date.

CERTIFIED REHABILITATION PROVIDER

5922 W. BROAD ST., RICHMOND, VA 23230

804-282-6953 FAX 804-282-8215

9323 MIDLOTHIAN TPKE., SUITE R, RICHMOND, VA 23235

TELEPHONE 804-330-3369, FACSIMILE 804-323-0614

Continued

12. If in an emergency you have narcotic medications prescribed by another source, our office must be notified within 7 days.
13. Possible side effects include (a) drowsiness and sedation, (b) constipation (c)tolerance (d) physical dependence (e) addiction (f)itching (g) sweating (h) nightmares (i) sexual dysfunction (j) respiratory depression (k) nausea and vomiting (l) urinary retention (m) euphoria or dysphoria. You acknowledge the risks and potential benefits have been explained to you.
14. Operating heavy machinery or a motor vehicle should be avoided during any period of time that your narcotic medication is being adjusted. If the narcotic medication causes any degree of sedation or drowsiness, operating a motor vehicle or heavy machinery is prohibited.
15. Avoid alcoholic beverages while you are on pain medications. Alcohol can increase many of the side effects listed above, and in extreme cases can be lethal. Inform your other physicians and consult your pharmacist about your prescriptions from our office to avoid interactions with other drugs.
16. Original containers of all narcotics medications should be brought in each office visit.
17. You must keep your scheduled appointments in our office if narcotic medications are being maintained. Repeat cancellations or no-shows may result in a slow tapering and discontinuation of your narcotic medications.
18. These drugs should not be stopped abruptly, as an abstinence syndrome will likely develop.
19. Your doctor may discontinue the narcotic medication after an adequate trail, if other therapies are deemed more appropriate.
20. A copy of this contract will be given to you, and may be sent to your designated pharmacy, and to your other treating physician. The prescribing physician had permission to discuss all diagnostic and treatment details with dispensing pharmacists and other professionals who provide your health care for purposes of maintaining accountability.
21. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be notified. The pharmacy that you have selected is: Pharmacy:_____Phone:_____
22. Forging or altering a prescription is a Federal offense and will be reported to the police.
23. If the responsible legal authorities have questions concerning your treatment, as might occur, for example, if you were obtaining medications at several pharmacies, all confidentiality may be waived and these authorities may be given full access to our records of controlled substances.

This agreement has been explained to me. I have been given the opportunity to ask questions. I understand that violation of this contract can result in either cessation of opioids, or a referral to a substance abuse program for detoxification, or discharge from our office.

_____ _____

Patient Signature Witness Signature

_____ _____

Date Date

PHYSICAL ▪ MEDICINE ▪ CENTER

CHARLES H. BONNER, MD, MS, CRP
PAIN MANAGEMENT & ELECTROMYOGRAPHY

Date_____

To: _____Insurance Company

From: Patient_____/Claim No._____

Re: Medical Doctor's Lien for payment of services

I hereby authorize_____ Insurance Company to release Southern Physical Medicine Associates, Inc. full payment for diagnosis, treatment, and prognosis for me regarding injuries sustained in the accident in which I was involved on _____.

I direct you as the/insurance company to pay directly Dr. Bonner all monies owed to him in consequence of this accident, as well as any other sums outstanding to him. I authorize that these funds be withheld from any settlement made in this case.

I further give a lien on my case to Dr. Bonner against any and all proceeds of the settlement, judgment, or verdict, which may be paid to me, as a result of the injuries, sustained in the accident and treated by Dr. Bonner.

This lien does not supplant my own responsibility for outstanding medical bills, but is given as protection for the doctor and in consideration for his willingness to await delayed payment. I understand that payment of all outstanding fees to Dr. Bonner are payable upon demand and are not contingent on the receipt of an award through settlement, judgment, or verdict. Anything not covered would be my responsibility of payment.

_____ _____

Patient's Signature Date

Physical Medicine Center

Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

Auto Accident Injury Questionnaire

Patient Name:_____ Date:_____

Date of Automobile Accident:_____

What type of Vehicle were you in at the time of the accident?_____

What type of vehicle collided with your car?_____

Describe how the accident occurred:_____

_____

_____

_____

Please indicate *all* that apply to you:

☐ I was the driver ☐ I was the front seat passenger ☐ I was the back seat passenger

☐ My seat belt was fastened ☐ The air bag discharged

How was the car you were in hit?

☐ Struck from behind ☐ Hit on drivers side ☐ Hit head on

What happened to you on impact? _____

_____

_____

Did you lose consciousness? _____, If yes please explain_____

_____

_____

Were you taken to the Emergency Room?_____, If yes where?_____

_____

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Physical Medicine Center

Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

Patient Name:_____ Date of Initial Evaluation:_____

Current Complaint

What problem caused you to come to the Physical Medicine Center? _____

_____

_____

Explain how your current complaint began:

_____

Were you seen in the Emergency Room? _____

When: _____

Where:_____

Please list all providers you have seen for this condition:

Name: _____ Date: _____

Name: _____ Date: _____

Name: _____ Date: _____

Diagnostic Testing:

☐ MRI Date:_____ ☐ X-Ray Date:_____ ☐ CT Scan Date:_____

☐ Electromyogram Date:_____ ☐ Other: _____

Pharmacy Name:_____ Pharmacy Phone:_____

Please list all current medications and dosages including prescription, over the counter, and herbal medications:

_____

_____

_____

Medication Renewal Policy:

Prescriptions are given at regularly scheduled office visits. *No telephone requests will be considered on Fridays.*

Please List any Allergies:

_____

_____

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Physical Medicine Center

Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

Your Health History

Have **you** had any of the following:

☐ High Blood Pressure ☐ Stomach Problems ☐ Diabetes ☐ Sleep Problems

☐ Epilepsy ☐ Gout ☐ Fibromyalgia ☐ Weight Problems

☐ Arthritis ☐ Cancer Type:_____ ☐ Other: _____

List all previous injuries and accidents. Please include dates:

_____

_____

List all operations. Please include dates:

_____

_____

Family Health History

Has anyone in your **family** had the following:

☐ High Blood Pressure ☐ Stomach Problems ☐ Diabetes ☐ Sleep Problems

☐ Epilepsy ☐ Gout ☐ Fibromyalgia ☐ Weight Problems

☐ Arthritis ☐ Cancer Type:_____ ☐ Other: _____

Vocational History

Are you currently working? _____ If yes, please describe your job:

_____

How long have you been at this position? _____

Are you working under any restrictions? _____

If you are not currently working, when was your last day of work? _____

What is the highest level of education you have completed? (select all that apply)

☐ High School ☐ GED ☐ College ☐ Certificate Program ☐ Military Service

☐ Other_____

Social History

Please select all that apply:

☐ Married ☐ Single ☐ Divorced ☐ Widowed

☐ Children How many? _____

Physical Medicine Center

Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

PAIN

When did your pain begin?

_____

Where do you feel your pain?

_____

What time of day does your pain get worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Same throughout the day

Please check all that describes your pain:

☐ Intermittent ☐ Came on suddenly ☐ Came on Gradually ☐ Exacerbation of past injury

☐ Radiating ☐ Dull ☐ Sharp ☐ Numbness

☐ Tingling ☐ Weakness ☐ Other: _____

Please indicate activities that make your pain worse:

☐ Exercise ☐ Walking ☐ Standing ☐ Sitting ☐ Bending forward

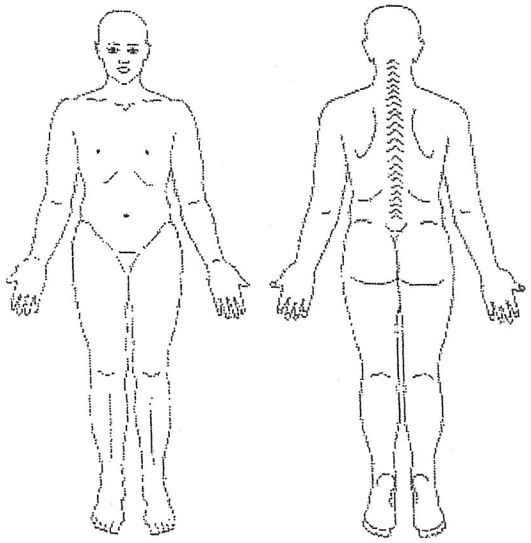
☐ Lifting ☐ Prolonged Positions ☐ Other: _____

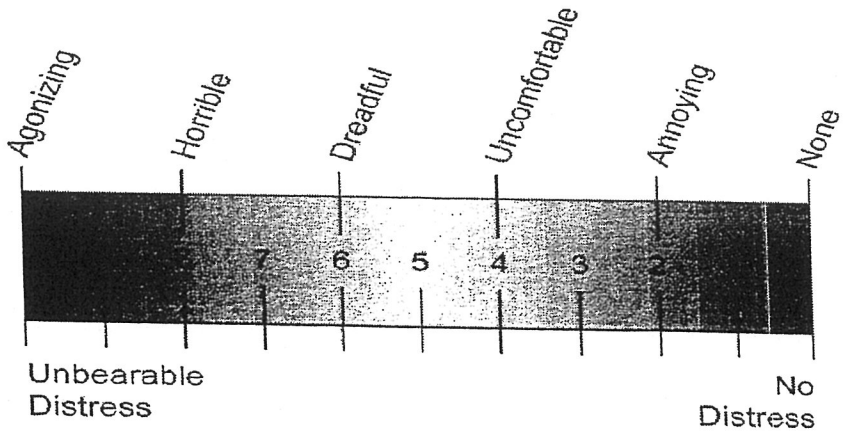
Please indicate activities that make your pain better:

☐ Lying down ☐ Standing ☐ Sitting ☐ Exercise ☐ Manipulations ☐ Rest

☐ Walking ☐ Heat / Ice ☐ Other: _____

In the diagram of the person, please color in where you feel your pain. In the pain scale please circle the number that best describes the intensity of your pain.





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Physical Medicine Center

Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

SLEEP

In general would you describe your sleep as: ☐ Refreshing ☐ Not Refreshing

On average, how many hours of sleep do you usually get in a night? _____

Do you wake up during your sleep? If yes how often? _____

If awakened, do you have trouble returning to sleep? _____

Do you take naps during the day? If yes how often? _____

Indicate which, if any, of the items listed below wake you up or keep you from sleeping:

☐ Restless legs or leg jerks ☐ Pain ☐ Trouble breathing ☐ Indigestion/ Reflux

☐ Needing to use the bathroom ☐ Anxiety ☐ Noises ☐ Can't get comfortable

☐ Racing thoughts/ Can't turn off your mind ☐ Other: _____

Activity Level

What do you do for exercise and how often?

_____

How would you describe your lifestyle? Sedentary or Active?

_____

Do you have any Hobbies?

_____

Nutrition and Lifestyle

Do you follow a specific diet? If yes please describe:

_____

Do you smoke? If yes how much, how often, and what type (i.e. cigarettes, cigars, chewing tobacco):

_____

Do you drink alcohol? If yes how much, how often and what type(i.e. beer, wine, spirits):

_____

Any other medical conditions or concerns that need to be considered:

_____

_____

_____

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Charles H. Bonner, M.D.,M.S., CRP
Ayni Sharif, MS, PA-C

Review of Symptoms

Please note whether you have had any of the following symptoms *in the past month*

N = Never, M = Moderate, S = Severe

General:	N	M	S
Fever			
Chills			
Excessive Sweating			
Weight Change			
Fatigue			
Marked weight gain or loss			
Restlessness, being hyper			
Night Sweats			
Ear, Nose, Throat & Neck:			
Loss of hearing			
Ringing in ears			
Discharge from an ear			
Nasal obstruction			
Sore gums or tongue			
Dental problems			
Jaw pain			
Hoarseness			
Neck stiffness or swelling			
Sore throat/ voice change			
Vertigo (spinning room)			
Sinus congestion			
Endocrine:			
Heat or cold intolerance			
Excessive thirst			
Diabetes			
Thyroid problems			
Cold hands & feet			
Breast/ Chest:			
Lump, pain, or discharge			
Gastrointestinal:			
Nausea			
Heartburn			
Vomiting			
Diarrhea			
Constipation			
Abdominal pain			
Genitourinary:			
Difficulty urinating			
Frequent urination			
Painful urination			
Night-time urination			

Musculoskeletal:	N	M	S
Joint pain			
Joint locking			
Joint swelling			
Joint immobility			
Muscle pain			
Muscle stiffness			
Muscle spasms			
Muscle cramps or weakness			
Neurologic/ Psychiatric:			
Headache			
Dizziness or loss of balance			
Fainting			
Memory loss, poor concentration			
Change in sensation			
Weakness or numbness			
Poor coordination			
Mood swings			
Nervousness, anxiety, fear			
Depression, grief or sadness			
Family problems			
Occupational Concerns			
Poor concentration			
Loss of energy			
Change in appetite			
Anxiety			
Skin:			
Rash or dry skin			
Hives or itching			
Non-healing sore			
Change in hair or nails			
Cardiovascular:			
Chest pain			
Swelling ankles			
High blood pressure			
Palpitations or irregularity			
Bluish fingers or breath			
Shortness of breath			
Respiratory:			
Cough			
Difficulty breathing			
Wheezing			

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PHYSICAL • MEDICINE • CENTER

CHARLES H. BONNER, MD, MS, CRP
PAIN MANAGEMENT & ELECTROMYOGRAPHY

Please choose a description that best describes the pain that you are feeling right now

10~ Worst imaginable pain; Cause you to be completely incapacitated and barely able to talk. Requires **IMMEDIATE EMERGENCY HOSPITALIZATION.**

8-9~ Pain that causes disability between levels 7 and 10. Nearing need for hospitalization.

7~ Severely disabling pain; You cannot use or move the painful area. You have difficulty talking and concentrating on anything but the pain. **Needing to lie down and /or pain related tearfulness** are also common at this level of pain.

6~ Pain that causes disability between levels 5 and 7.

5~ Very Disabling pain; Causes great difficulty moving or applying any strength through the painful area. You are unable to complete the current activity.

4~ Pain that causes disability between levels 3 and 5.

3~ Visibly disabling pain; Pain that is starting to **effect your function**. The pain is affecting your ability to perform the current activity. The pain causes decreased movement, decreased speed, and/ or the need to take brief periods of rest and/ or stretch.

0.25-2.75~ Non-disabling pain; The pain is present, but not yet at a level which limits you in performing the current activity.

0~ No pain or discomfort

Note: Please limit your lowest delineations to values of 0.25

****OBTAIN CURRENT PAIN LEVEL PRIOR TO EACH PM&R SESSION****

Southern Physical Medicine Associates, Inc.
Physical Medicine Center
Charles H. Bonner, MD, MS, CRP

Notification of Insurance Policies

Referrals
It is your responsibility to know if your insurance carrier may require a referral from your Primary Care Physician in order for any care you receive from Southern Physical Medicine Associates to be considered for coverage. I you elect to receive services from us without a required referral from your Primary Care Physician, you will be responsible for payment of any and all services rendered.

Non-Covered Services
If my insurance carrier denies payment, I agree to be personally and fully responsible for any payments due for services rendered.

Authorization to release information and assignment of insurance benefits

I authorize Southern Physical Medicine Associates, Inc. and it's staff to render medical treatment for my child or me.

1. I hereby authorized Southern Physical Medicine Associates, Inc. to release to my insurance company and its agents any medical information requested by these parties.
2. I authorize payment directly to Southern Physical Medicine Associates, Inc. of any insurance, Med Pay or other benefits otherwise payable to me.
3. I understand that I am financially responsible for charges not covered by my insurance including co pays, deductibles and other cost shares.
4. I understand that except in an emergency, I am required to call at least 24 hours in advance if I need to cancel or reschedule an appointment. If I am unable to keep my appointment and have not provided such notice, I realize that I will be liable for a fee to be billed to me by Southern Physical Medicine Associates, Inc.
5. If my account is turned over to an attorney for collection, I will be responsible for attorney fees in the amount of 35% of the total debt plus court costs and interest at the rate of one and one half percent 1.5% per month on the unpaid balance from the date that payment was first due.

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I understand that as part of my healthcare, Southern Physical Medicine Associates originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Information Practices (on back of this page that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that the Practice has already taken action in reliance thereon.

Please send any changes in your release to
Compliance Officer
Southern Physical Medicine Associates, Inc.
5922 West Broad Street
Richmond, VA 23230

jb/200

Southern Physical Medicine Associates, Inc.
Physical Medicine Center
Charles H. Bonner, MD, MS, CRP

Notice of Information Practices

Southern Physical Medicine Associates may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers: collection agencies. Healthcare operations include, but is not limited to, internal quality control and assurance including coordination of benefits with other insurers: collections agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records.

Southern Physical Medicine Associates is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

Southern Physical Medicine Associates will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.

Southern Physical Medicine Associates may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that my be of interest to the individual patient.

Southern Physical Medicine Associates will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

Southern Physical Medicine Associates reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

Southern Physical Medicine Associates will provide each patient with a copy of any revisions of the Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of patient. Copies may also be obtained at any time at our office.

Any person/patient may file a complaint to the Practice if they believe their privacy rights Compliance/Privacy Officer, at #(804) 282-6953. All complaints will be addressed and the results will be reported to the Compliance Officer/Managing Physician. In addition, any person/patient may file a complaint to the Secretary of Health & Human Services if they believe their privacy rights have been violated.

It is the policy of Southern Physical Medicine Associates that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

For further information regarding our Privacy Policies please contact the Compliance/Privacy Officer, Doctor Charles H. Bonner at 804-282-6953

The effective date of this document is April 14, 2003.

jb/200(