GULF COAST
BRAIN & SPINE CENTER

Patient Information Form

PATIENT INFORMATION

FULL NAME ____ SEX ____________

ADDRESS ____

HOME PH (____) ____________ CELL PH (____) ____________ DATE OF BIRTH _____/_____/_____

SOCIAL SECURITY ______-______-______ RACE ______________

EMAIL ____

EMPLOYER____ PHONE (____) _____________

GENERAL

Who referred you to our office? ________________________________ PHONE (____) _____________

Primary Care Physician ____________________________________ PHONE (____) _____________

In case of emergency notify:____________________________________

RELATIONSHIP ____ PHONE (____) _____________

Do you have Advance Directives? Y/N ________________________

INSURANCE INFORMATION

PRIMARY INSURANCE _______________________ POLICY HOLDERS NAME _________________

ID#_____________________ GROUP# ____________________ PHONE (____) _____________

SECONDARY INSURANCE ____________________ POLICY HOLDERS NAME _________________

ID#_____________________ GROUP# ____________________ PHONE (____) _____________

PHARMACY

PREFERRED PHARMACY __________________________________ PHONE (____) _____________

PHARMACY ADDRESS____

_ _

*Only complete this section if you were seen as a Trauma Patient at Gulf Coast Medical Center AND applies to current situation.

AUTO INJURY	**Date of Injury:**	
Adjustors Name:	**Adjustors Number:**	**Adjustors Fax:**
WORKERS COMPENSATION INJURY	**Date of Injury:**	
Adjustors Name:	**Adjustors Number:**	**Adjustors Fax:**

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BRAIN & SPINE CENTER

Medical History

FULL NAME _____ DATE OF BIRTH _____/_____/_____

CHIEF COMPLAINT:

What is the reason for your visit today? _____

_____

Are you experiencing any pain (circle one) **YES** or **NO**, if yes, where is the pain located _____?

IF YOU MARKED YES, please rate pain on a scale of 0-10 with 10 being the highest. **1 2 3 4 5 6 7 8 9 10**

Date symptoms began. _____ weeks/ months/ years

Severity (X on choice) Mild____ Moderate ____ Severe ____ Incapacitating ____

Aggravated by: _____ Relieved by: _____

PAST TREATMENTS FOR SYMPTOMS:

- o Over the counter medications: _____
- o Prescription Medications: _____
- o Physical Therapy: _____ (Include dates and Locations of facility)
- o Pain Management: _____ (Physician and most recent appointment)
- o Spinal Injections: _____ (Physician and Dates)
  - o Epidural
  - o Facet Blocks
  - o Facet Rhizotomies
  - o Trigger Point Injections
  - o SI Joint
  - o Other Injections (s): _____

Have you seen any other specialist or had additional testing for today's chief complaint? (CT Scan, MRI, EMG/ Nerve study) If yes, please describe? _____

_____

PAST MEDICAL HISTORY: *Check (X) conditions you have been diagnosed with.*

o **No Medical History** o Anemia o Anxiety o Arrhythmia o Asthma o Bleeding Disorders o Blood Clots o Brain Aneurysm / AVM o Brain Mass/ Tumor o Cardiovascular accident/ MI o Cirrhosis/ liver disease o Constipation	o Cancer Type: _____ o Congestive Heart Failure o COPD o Coronary Artery Disease o Depression o Diabetes o Fibromyalgia o Hepatitis C o HIV/ AIDS o Hypertension o Hyperthyroidism o Hypothyroidism	o IBS o Irregular heartbeat o Kidney Failure o Liver Disease o Lung Cancer o Migraine Headaches o Murmurs o Multiple Sclerosis o Osteopenia o Osteoporosis o Parkinson's Disease o Peripheral Nerve Disorder	o Renal Disease o Rheumatoid Arthritis o Seizures o Spinal Cord Tumor o Stroke o Tuberculosis o Tremor o Ulcers o Other: _____ _____ o Other: _____ _____

Please list any other health issues not referenced above: _____

SURGICAL HISTORY: *List all Major Surgeries and Dates*

_____

_____

GULF COAST
BRAIN & SPINE CENTER

_____

_____

_____

MEDICATON LIST: *Please list ALL medications/ supplements below OR provide a printed list.*

CURRENT MEDICATION	DOSE	FREQUENCY

o ___I do NOT take any medications

ALLERGIES: List all drug and food allergies: _____

_____

o ___I do NOT have any known allergies

SOCIAL HISTORY:

Occupation:_____

Marital Status: _____

Are you a smoker? **N** or **Y:** ____ Packs per day for ____ years Former smoker: Quit _____(date)

Do you drink Alcohol? **N** or **Y:** On occasion _____ *or* moderately _____

FAMILY HISTORY: *List all pertinent family history of immediate family*

_____

_____

_____

To the best of my knowledge the above information is complete and correct. I understand that reporting incomplete information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I ever have a change in health.

_____ _____ _____

Patient signature or Authorized Representative | Printed Name | Date

_____

GULF COAST
BRAIN & SPINE CENTER

Authorized Representatives Relationship
to patient

Office Policies

Medical Consent: I consent to all care, treatment, diagnostic imaging, laboratory testing and other medical procedures performed or prescribed by a physician of Gulf Coast Brain and Spine Center and his/her designees

Right of Refusal of Treatment: I understand that I have the right to make informed decisions regarding all aspects of my care. I should ask my health care provider to furth clarify and explain anything I do not understand. I have the right to refuse treatment.

Acknowledgement of Receipt of Patient Rights and Notice of Privacy Practices: I have acknowledged that I have received both notices, Notice of Patient Rights/Responsibilities and HIPAA Notice of Privacy Practices.

Release of Medical Information: I authorize Gulf Coast Brain and Spine Center to release any information necessary to facilitate healthcare processing of claims, or audit of payments in relation to my care and treatment. I also consent to the release of any information needed to other facilities, agencies or healthcare providers as per Gulf Coast Brain and Spine Center's discretion. This order will remain in effect until revoked by me in writing.

Financial Policy: I certify that the insurance information that I have provided to Gulf Coast Brain and Spine Center is accurate, complete, and current. I certify that no other coverage of insurance exists. It is my responsibility to understand the terms and benefits of my insurance plan. I understand I am financially responsible for charges not paid by my insurance. I may be required to pay co-payments, co-insurance, or deductibles at the time of service unless other arrangements have been made in advance. Gulf Coast Brain and Spine Center will make every attempt to notify me in advance if a service is not covered. If my insurance has not paid my bill in full within 60 days, I will be expected to pay the remaining balance within 30 days. In the even of a large balance due from an operation, Gulf Coast Brain and Spine Center may be able to arrange a payment plan suitable for all parties concerned.

Forms and Medical Records: If you require our office to complete any disability, FMLA, school/work or personal forms; the first form is free; however, each additional form is a charge of $15 per form. Forms will be completed within 10-14 business days. If you Require a copy of your medical records, you must sign a Medical Records Release Form. Your request will be completed within 10-14 business days.

Appointment No Show/ Cancellations: If it is necessary to cancel/reschedule your appointment, please do so 24 hours PRIOR to the time of your scheduled appointment. If you do not cancel and appointment or no show, you will be responsible for a $25.00 charge. This fee is the responsibility of the patient and is not billable to any insurance.

Surgery Cancellations: If you must cancel a scheduled surgery, please notify our office by **12:00PM THREE (3) BUSINESS DAYS (Monday- Friday)** prior to surgery to avoid a cancellation fee of $150.

Dispensing of Opioid (Narcotic) Pain Medications: In response to the "Opioid Crisis," The State Legislature of Florida passed the Controlled Substance Bill (CS/CS/HB 21) which regulates the prescribing of Schedule II and Schedule III pharmaceuticals. These regulations affect the prescriptions your providers are allowed to prescribe you after surgery. Schedule II narcotics are limited to a three (3) day supply for "acute pain." A seven (7) day supply can be provided under special circumstances. Our office will limit dispensing Schedule II and III prescriptions to 14 days post-op. It is important to understand that Gulf Coast Brain and Spine Center does not manage chronic pain. If you need chronic pain management, we are happy to provide a referral to a pain management specialist.

Return of Imaging CDs/Films: It is important for our providers to review your images for proper diagnosis and treatment: however, our office does not have the capacity to store these films. A copy of your images will be downloaded to our system at your appointment. Your images will be returned to you at the end of your appointment. If you leave your images for any reason past your appointment date, we will store them for 90 days as a courtesy. During 90 days, you have the option to pick them up at the office at no charge, or we can ship them to you for $10 service and handling fee. After 90 days, any remaining CDs/ Films will be disposed per HIPAA guidelines.

GULF COAST
BRAIN & SPINE CENTER

Patient signature	Printed Name	Date

General Consent for Treatment

Medical Consent: I consent to all medical care, treatment, laboratory, imaging and other medical procedures performed or prescribed by a physician of Gulf Coast Brain and Spine Center and his/her designees as directed in his/her judgement

Right to Refuse Treatment: I understand that I have the right to make informed decisions regarding all my care and treatments, and that I should ask my healthcare professional to clarify or explain anything I do not understand. This right includes the right to refuse any treatment I do not want.

Acknowledgement of Receipt of Patients' Rights and Notice of Privacy Practices: I acknowledge that I have received both notices, Notice of Patient Right and Notice of Privacy Practices.

Advance Directives: I understand that I have an opportunity to make known my wishes, in writing regarding my health care and/ or end of life decisions. This directive is in the form of a living will and/ or durable power of attorney for health care.

Release of Medical Information: I authorize Gulf Coast Brain and Spine Center to release any information necessary to facilitate healthcare processing of claims, or audit of payments in relation to my care and treatment. I also consent to the release of any information needed to other facilities, agencies, or healthcare providers as per Gulf Coast Brain and Spine Center's discretion. This order will remain in effect until revoked by me in writing.

Financial Policy: I certify that the insurance information that I have provided to Gulf Coast Brain and Spine Center is accurate, complete, and current. I certify that no other coverage of insurance exists. It is my responsibility to understand the terms and benefits of my insurance plan. I understand I am financially responsible for charges not paid by my insurance. I may be required to pay co-payments, co-insurance, or deductibles at the time of service unless other arrangements have been made in advance. Gulf Coast Brain and Spine Center will make every attempt to notify me in advance if a service is not covered. If my insurance has not paid my bill in full within 60 days, I will be expected to pay the remaining balance within 30 days. In the event of a large balance due from an operation, Gulf Coast Brain and Spine Center may be able to arrange a payment plan suitable for all parties concerned.

Assignment of Insurance Benefits: I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medigap, Medicare Replacement, private insurance, and any other health/ medical plan, to issue payment check(s) directly to **Gulf Coast Brain and Spine Center** for medical services rendered to myself. I understand that I am responsible for any amount not covered by insurance.

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII 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 intermediaries or carriers, any information needed for this or related to Medicare claim. I request that payment of authorized benefits be made on my behalf (consent applies only when applicable).

ePrescribe Medication: I authorize Gulf Coast Brain and Spine Center to submit all prescriptions electronically to preferred pharmacy.

Patient signature	Printed Name	Date

GULF COAST
BRAIN & SPINE CENTER

Opioid (Narcotic) Policy Agreement

Gulf Coast Brain and Spine Center has a primary goal of providing excellence in care to our patients.

The best practice in Neurosurgery recognizes that patients undergoing operative procedures may require narcotic pain medications. Your physician may prescribe pain medication during your post-operative period with a limited supply and in accordance with The Florida Medical Board regulations.

It is important to understand the providers of Gulf Coast Brain and Spine Center DO NOT prescribe pain medication pre-operatively (before you have surgery).

The physicians at Gulf Coast Brain and Spine Center do not manage chronic pain, if you need chronic pain management, we can provide you with a referral to a pain management specialist.

To ensure that, as the provider, and you as the patient, understand how our practice will ensure high quality and safety in prescribing narcotics you will need to adhere and agree to the policy agreement outlined below.

I,_____ understand that I may receive narcotic medication from Gulf Coast Brain and Spine Center to treat my post-operative pain.

- I understand that if I am receiving long term pain medicine from a pain management physician, I will make arrangements for post operative pain medication with that physician. I will not receive pain medications post operatively from a Gulf Coast Brain and Spine Center physician
- I will not take prescribed narcotics in large amounts or more frequently than prescribed.
- I will not buy or use additional narcotics or borrow/use narcotics prescribed to another individual.
- I will not use any illegal or street drugs (ex. Cocaine or Methamphetamines) while under the care of a Gulf Coast Brain and Spine Center physician.
- I will not purchase or use narcotics which may be available in another country or through mail order.
- I understand that Gulf Coast Brain and Spine Center will not provide refills on narcotics. A new prescription may be provided at the first post operative visit. Any ongoing need for narcotic pain medication beyond that point will be referred to pain management specialist.
- I will not drink alcohol while on narcotics.
- If I have left over narcotic pain medication, I will dispose of it. I will not donate or sell extra narcotics to another individual.
- I understand that if my pain acute post operative pain medication requirements are beyond a neurosurgeon's scope of practice to manage, I will be referred to a pain management physician. I understand it is my responsibly to follow up and schedule an appointment.

_____ _____ _____

Patient signature Printed Name Date

GULF COAST
BRAIN & SPINE CENTER

Financial Policy

Health Insurance: Gulf Coast Brain and Spine Center will bill your health insurance provider(s) for each visit unless you are within the 90-day post-operative period. You are responsible for paying co-payments and outstanding balances due at the time of your visit. We accept cash and credit card. We recommend that you familiarize yourself with your insurance plan so there are no surprises when it come to your bill.

Non-Participating Insurance Accounts: A patient who is insured by an insurance carrier with which Gulf Coast Brain and Spine Center do not participate, is considered a self-pay patient. It is the patient responsibility to inform the practice of any insurance coverage changes, to confirm the practice's participation and to verify their eligibility before each visit. If you are covered by an insurance carrier that Gulf Coast Brain and Spine Center does not participate with you are responsible for full charges at the time of service.

Self-Pay Patients: Self-pay patients are those who are covered by an insurance carrier with which the practice does not participate or patients without insurance at the time of service. As a self-pay patient, you are individually responsible to pay the full charges at the time of service.

HMO Referrals and Authorizations: If your insurance is an HMO (has a designated primary care physician), you are required to inform the office of this at the time of scheduling your appointment so and authorization may be obtained. If this information is not provided at the time of scheduling, you will be asked to reschedule your appointment.

Non-Covered Services: It's important to understand that some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services. It is the patient's responsibility to understand what your plan covers and does not cover. You will be responsible for all non-covered charges/services.

Appointment No Show/ Cancellations: If it is necessary to cancel/reschedule your appointment, please do so 24 hours PRIOR to the time of your scheduled appointment. If you do not cancel and appointment or no show, you will be responsible for a $25.00 charge. This fee is the responsibility of the patient and is not billable to any insurance.

Surgery Cancellations: If you must cancel a scheduled surgery, please notify our office by **12:00PM THREE (3) BUSINESS DAYS (Monday- Friday)** prior to surgery to avoid a cancellation fee of $150.

_____	_____	_____
Patient signature	Printed Name	Date

GULF COAST
BRAIN & SPINE CENTER

HIPAA Notice of Privacy Practices: Consent to Use or Disclose Information for Treatment, Payment or Health Care Operations

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patients medical record information by Gulf Coast Brain and Spine Center (the "Practice") in order to carry out treatment, payment or health care operations. The patient should review the Practice's Notice of Privacy Practices for more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Practices, Patient may obtain a copy of the revised notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the practice does agree to Patient's requested restriction(s), such restrictions are then binding on the practice as it pertains to the patient only.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patients Family members, legal representative, guardians, health care surrogates, or have power of attorney on behalf of the Patient (list names below):

_____

_____

_____

The patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records below, unless otherwise indicated (Please initial on IF YOU DO NOT WISH to disclose):

_____ HIV/ AIDS Information
_____ Mental Health Information
_____ Substance Abuse Information
_____ Sexually Transmitted Disease Information
_____ Pregnancy Information (if patient is under 18 years of age)

At all times, Patient retains the right to revoke this consent. Such revocation must be submitted to the practice in writing. The revocation shall be effective except to the extent that the practice has already take action in reliance on the consent.

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND I AM THE PATIENT OR I AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ _____ _____

Patient signature or Authorized Representative | Printed Name | Date

_____

GULF COAST
BRAIN & SPINE CENTER

Authorized Representatives Relationship
to patient

HIPAA NOTICE OF PRIVACY PRACTICES

Gulf Coast Brain and Spine Center is required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect.

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

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

- **TREATMENT** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. We will abide by the patient's request not to disclose PHI to a health plan for services which the patient has paid out of pocket and requests the restriction

- **PAYMENT** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

- **HEALTHCARE OPERATIONS** We may use or disclose, as needed your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, and training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues as required by law, communicable diseases, health oversight, immunizations to schools, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

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BRAIN & SPINE CENTER

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. The same authorization/restrictions that were used while you are alive will remain in place for up to 50 years after your death. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. **You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information:

You have the right to inspect and have a copy of your protected health information (fees may apply). Pursuant to your written request you have the right to inspect or have a copy your protected health information whether in paper or electronic format. The records will be provided within 30 days of request. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

Patient Requesting Medical Record Copies. There may be fees associated with requesting copies of medical records, such as copy fees, and/or shipping and handling fees. You have the right to request a restriction of your protected health information. You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request to receive confidential communications. You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

You have the right to request an amendment to your protected health information. You may ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, but we will tell you why in writing within 60 days.

You have the right to receive an accounting of certain disclosures. You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law for up to six years prior to the date of the request.

You have the right to receive notice of a breach. We will notify you if your unsecured protected health information has been breached.
You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

If you believe that your privacy rights as described in this notice have been violated, you may file a complaint with the practice at the following address or telephone number:

Gulf Coast Brain and Spine Center, LLC
Attn: HIPAA Officer
10201 Arcos Ave. STE 202
Estero, FL 33928
(239) 908-3938

GULF COAST
BRAIN & SPINE CENTER

To file a complaint, you may either call or send a written letter. The practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services

Your Rights

Here at Gulf Coast Brain and Spine Center we recognize and respect your rights as a patient with unique healthcare needs. We want you to know what your rights are as a patient. We encourage a partnership between you and your healthcare team. Your role as a member of this team is to exercise your rights and to take responsibility for things you do not understand.

As a patient you have the right to…

- To be informed of your rights and responsibility as a patient of Gulf Coast Brain and Spine Center.
- To be informed of rules, regulations and services provided by each physician and clinic including days and hours of service and what to do in an emergency, and clinic numbers.
- To receive care in a safe setting that is free from abuse, neglect and harassment by physicians and clinic employees
- To receive considerate and respectful care. We respect your right to:
    - Expect quality treatment with the scope of our mission
    - Be treated with dignity, free of discrimination. Your care will not be affected by race, religion, beliefs, cultural values, sex or age.
    - Choose your own physician.
    - Ask all personnel involved in your care to introduce themselves, state their role in your care and explain what they are doing for you.
- To be informed about your treatment and healthcare including
    - A description of your condition and diagnosis
    - Treatment plan
    - Alternative treatments
    - Prognosis and any problems related to treatment
    - Recuperation
    - Benefits and risks of each treatment option and alternatives
    - Explanations of risks faced if treatment is not pursued
- The right to make an informed consent.
- The right to make treatment choices, including the right to refuse treatment.
- To receive a reasonable estimate of charges for medical care.
- To have privacy and confidentiality respected. Your health care team will:
    - Respect your privacy related to your medical care.
    - Provie confidential treatment of your condition, medical care, medical records, and financial information.
- To have access to your personal medical records and obtain copies upon written request.

_____	_____	_____
Patient signature	Printed Name	Date

GULF COAST
BRAIN & SPINE CENTER