



Interventional Pain Management Associates

Maher Ibrahim, M.D

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Welcome!

We are pleased you have chosen Interventional Pain Management Associates for your care. We understand how traumatic and isolating chronic pain can be. Finding the right treatment plan is a step that brings you closer to relief. Our multidisciplinary team will help you feel better, improve your functionality and help you live a more satisfying life. We certainly want your appointments to be informative and productive.

In order to accommodate you, we ask that you complete the following required forms in their entirety.

- New Patient Intake Form
- Medical History Checklist

Please pay close attention to these required forms, as your appointment may need to be rescheduled if either of them is missing. Horizon NJ Health in particular has specific guidelines for their patients.

What to expect your first visit:

Your first visit will consist of a thorough history and physical examination. You will be seen by a medical assistant first, then a physician. The initial evaluation may take up to an hour from start to finish, but this time is important for an assessment and treatment plan to be formulated. Due to the length of this examination, and various other factors such as insurance authorizations, **please do not expect medications or injections during your first visit.** Out of fairness to all of our patients, we ask that you arrive 15 minutes early for your scheduled appointment, and please call at least 24 hours in advance if you must cancel. If you are more than 15 minutes late for your appointment, it may need to be rescheduled. In addition, appointments cancelled less than 24 hours in advance will be considered a no show, and after 3 no shows you will not be rescheduled.

Please bring the following to your first appointment:

- Completed intake form including medical history checklist
- Insurance cards and a form of photo ID
- **All relevant past medical records including MRI, CT scans, bone scans, and EMG Reports.**
- **Discharge letter from a previous pain management specialist (if applicable)**
- Worker's Compensation/Auto Insurance phone number, adjustor's name and mailing address.
- **Your insurance is your responsibility. Please bring your insurance card, your referral (if applicable) and a photo ID to your office visit.** Please contact your primary care physician for a referral (if applicable). **If you do not bring a referral, your office visit will be rescheduled.**
- Physical/Occupational/Aquatic therapy discharge summaries***

***** Special note to Horizon NJ Health patients: your insurance requires you to have had an MRI and completed physical therapy within the last year before they will authorize fluoroscopic injection therapy. You may want to discuss these requirements with your referring physician and have them completed before your visit in order to expedite your care.**

Interventional Pain Management Associates is committed to success and safety. Thank you for taking the time to provide this information that is important for the level of care we can provide. Your answers will help us individualize your treatment and optimize your success and safety.

Sincerely,
Maher Ibrahim, MD



Maher Ibrahim, M.D.

Appointment Date: _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ SSN: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Email Address: _____

Marital Status: _____ Religious Preference: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

Referring Physician: _____ Phone: _____

Referring Physician Address: _____

Primary Care Physician: _____ Phone: _____

Primary Care Address: _____

Pharmacy Name and Address: _____

Pharmacy Phone Number: _____

Insurance Carrier:

1. _____ ID#: _____

2. _____ ID#: _____

Claim Adjustor (if applicable): _____ Phone: _____

If you are not the insured, what relation are you to the insured? (Spouse/Child/Parent) _____

If you are not the insured, what is the insured's name and date of birth? _____

Are you Employed: (Yes or No) _____ Occupation: _____

If employed, how long? _____ If unemployed, how long? _____

Is this due to pain? (Yes or No) _____ Do you plan to go on disability? (Yes or No) _____

Patient Name: _____ DOB: _____

Please list your medical problems, other than pain (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illness, etc.):

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all your current medications with dosages:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all your medications with dosages for pain management in the past:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any allergies to medications: _____

Please list any intolerance to medications: _____

Please list any prior surgeries not related to pain, and dates performed:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any prior surgeries related to pain (such as laminectomy) and dates performed:

1. _____
2. _____
3. _____

Family Medical History:

1. _____
2. _____
3. _____
4. _____
5. _____

With whom do you live? _____

Are there any substance abuse issues in your household? ☐ Yes ☐ No

If yes, please explain: _____

Are you able to care for yourself? ☐ Yes ☐ No If no, caregiver's name and phone number: _____

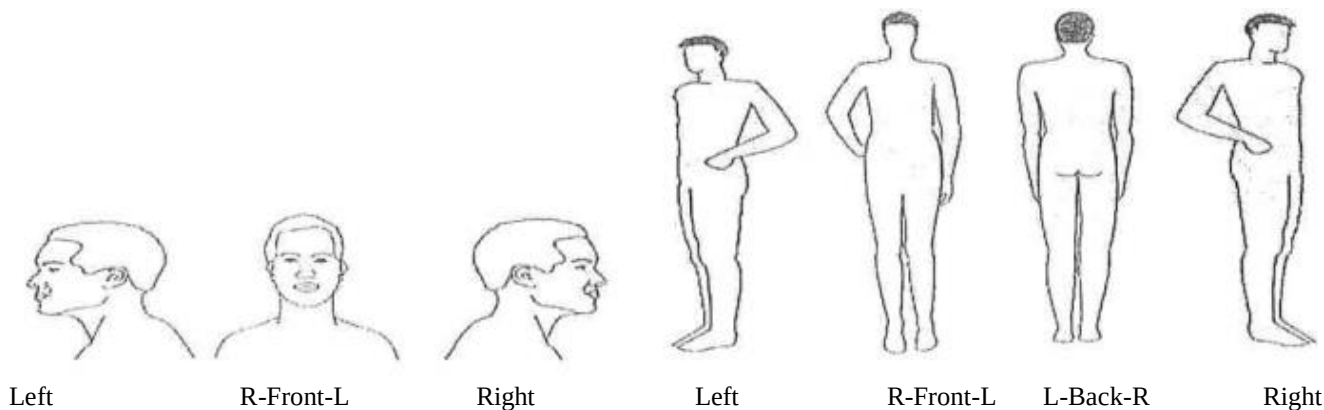
Are you currently involved in a lawsuit? ☐ Yes ☐ No

If yes, please explain: _____

Where is your pain? Please be specific and **list in order of most severe to least severe**:

1. _____ Most severe
2. _____
3. _____
4. _____
5. _____ Least severe

Please mark where your pain is located:



When did your pain start? _____

Was there a particular event that caused your pain? ☐ Yes ☐ No Please explain: _____

How often does your pain occur and for how long? _____

What makes your pain worse? _____

What makes your pain better? _____

	Date	Facility	Results
_____ X-rays	_____	_____	_____
_____ CAT scan	_____	_____	_____
_____ MRI	_____	_____	_____
_____ EMT	_____	_____	_____
_____ Myelogram	_____	_____	_____
_____ Other	_____	_____	_____

Please list any other doctors you have consulted regarding this problem:

Name	Specialty	Date	Phone
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Please check off any treatments you have undergone for this problem, and if they have helped or not helped your problem:

Treatment	Yes	No	Treatment	Yes	No
Surgery	☐	☐	Chiropractor	☐	☐
Medications	☐	☐	Acupuncture	☐	☐
Injections	☐	☐	Biofeedback	☐	☐
Bed Rest	☐	☐	Hypnosis	☐	☐
TENS	☐	☐	Exercise	☐	☐
Heat	☐	☐	PT	☐	☐
Ice	☐	☐	Traction	☐	☐
OTHER	☐	☐	OTHER	☐	☐

Pain can be very difficult to describe. It is helpful to compare the intensity of your pain at different intervals. Please rate the intensity of your pain on a scale of 0-10.

0 = no pain 10 = the worst pain you can imagine

What is your pain now? 0 1 2 3 4 5 6 7 8 9 10

What is your level of pain when it is most severe? 0 1 2 3 4 5 6 7 8 9 10

What is your level of pain when it is least painful? 0 1 2 3 4 5 6 7 8 9 10

On subsequent visits, we will refer to the 0 to 10 pain scale and ask you to rate your pain.

Please mark an "X" on the line to represent your intensity of pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain						Worst Pain				

MEDICAL HISTORY (Check answer(s) that apply)

1. Constitutional Symptoms ☐ No problems

- ☐ Weight loss _____ lbs, period of time _____
- ☐ Weight gain _____ lbs, period of time _____
- ☐ Recurrent fever
- ☐ General weakness
- ☐ Fatigue

2. Skin ☐ No problems

- ☐ Dry skin
- ☐ Recurrent rashes
- ☐ Eczema
- ☐ Itching
- ☐ Changes in skin color
- ☐ Changes in hair or nails

3. Hematologic/Lymphatic ☐ No problems

- ☐ Swollen glands
- ☐ Low blood count (anemia)
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Slow to heal after cuts
- ☐ History of blood transfusion
- ☐ Enlarged glands
- ☐ Phlebitis
- ☐ HIV positive
- ☐ On blood thinners

4. Head/Face ☐ No problems

- ☐ Headaches/migraines
- ☐ History of head injury – no residual problems
- ☐ History of head injury with residual problems
Of _____

- ☐ Facial pain
- ☐ TMF L R
- ☐ Tic douloureux L R

5. Eyes ☐ No problems

- ☐ Nearsighted
- ☐ Far sighted
- ☐ Wear glasses/contacts
- ☐ Cataracts at present time L R
- ☐ Conjunctivitis
- ☐ Glaucoma
- ☐ Double vision
- ☐ Blurred vision

6. Ear / Nose / Mouth

Ears ☐ No problems

- ☐ Hard of hearing L R
- ☐ Hearing aids L R
- ☐ Frequent earaches L R
- ☐ Chronic ear discharge L R
- ☐ Vertigo
- ☐ Ringing in the ears L R

Nose/Sinuses ☐ No problems

- ☐ Sinus discharge
- ☐ Nasal discharge
- ☐ Repeated nosebleeds
- ☐ Deviated nasal septum
- ☐ Chronic sinus problems
- ☐ Chronic stuffy nose
- ☐ Hay fever
- ☐ Nasal Polyps

Mouth/Throat ☐ No problems

- ☐ Teeth _____ loose _____ none
- ☐ Dentures _____ full _____ partial
- ☐ Bleeding gums

- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Trouble swallowing

7. Chest/Breasts

☐ No problems

- ☐ Breast masses
- ☐ Breast surgery
- ☐ Chest surgery
- ☐ Other Explain: _____

8. Respiratory

☐ No problems

- ☐ Smoker _____ pack(s) per day since _____
- ☐ Recurrent cough
- ☐ Chronic bronchitis
- ☐ Sarcoidosis
- ☐ Emphysema
- ☐ Chronic obstructive pulmonary disease
- ☐ Bronchial asthma
- ☐ Tuberculosis
- ☐ Wheezing

9. Cardiac/Peripheral - Vascular

Cardiac

☐ No problems

- ☐ Heart trouble
- ☐ Swelling of the feet
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Heart attack
- ☐ Bypass surgery
- ☐ Angioplasty
- ☐ Mitral valve prolapse
- ☐ Heart murmur
- ☐ Valvular surgery
- ☐ Heart failure
- ☐ Shortness of breath with walking

Peripheral - Vascular

☐ No problems

- ☐ Poor circulation in arm L R
- ☐ Blood clots in arm L R
- ☐ Varicose veins L R
- ☐ Poor circulation in legs L R
- ☐ Vascular surgery _____

10. Hepatic – Biliary/Gastrointestinal/Abdominal

- ☐ Any liver disease
- ☐ History hepatitis ____ Active ____ Inactive
- ☐ History jaundice due to gallbladder disease
- ☐ Gallbladder problems

Gastrointestinal

☐ No problems

- ☐ Loss of appetite
- ☐ Abdominal pain
- ☐ Problems with gas
- ☐ Heartburn
- ☐ Recurrent nausea
- ☐ Recurrent diarrhea
- ☐ Recurrent constipation
- ☐ Ulcer
- ☐ Hiatal hernia
- ☐ Regurgitation
- ☐ Reflux
- ☐ Indigestion
- ☐ History of vomiting blood
- ☐ Blood in stool

MEDICAL HISTORY (Check answer(s) that apply)

- ☐ Loss of control of bowels
- ☐ Bleeding ulcers
- ☐ Diverticular disease
- ☐ Chron's disease

11. Urinary ☐ No problems

- ☐ Frequent urination
- ☐ Difficulty with urination
- ☐ Burning while urinating
- ☐ Inability to control urine
- ☐ Blood in urine

12. Genitalia

Male ☐ No problems

- ☐ Discharge
- ☐ Painful testicles
- ☐ Lumps in testicles
- ☐ Hydrocele
- ☐ Sexually transmitted disease(s)
- ☐ Sexual dysfunction

Female ☐ No problems

- ☐ Menstruation ____ Regular ____ Irregular
- ☐ First day of last menstrual period ____/____/____
- ☐ Premenstrual syndrome, since _____
- ☐ Recurrent vaginal discharge
- ☐ Number of pregnancies _____
- ☐ _____ Miscarriages _____ Abortions
- ☐ Cesarean section(s) _____
- ☐ On hormones
- ☐ History cancer of uterus – ovaries
- ☐ Sexual Dysfunction
- ☐ Sexually transmitted disease(s)

13. Endocrine ☐ No problems

- ☐ Excessive thirst or urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Change in hat or glove size
- ☐ Thyroid trouble ____ Underactive ____ Overactive
- ☐ Sugar diabetes , since _____
- ☐ Insulin dependent ____ Yes ____ No
- ☐ Disease of pituitary gland
- ☐ Disease of adrenal gland
- ☐ Cushing's disease

14. Musculoskeletal ☐ No problems

- ☐ Muscle cramps
- ☐ Stiff joints
- ☐ Swelling of joints
- ☐ Generalized arthritis
- ☐ Rheumatoid arthritis
- ☐ Fibromyalgia syndrome
- ☐ Osteoporosis
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Heel spurs
- ☐ Gout
- ☐ Difficulty with walking
- ☐ Cold upper extremities L R
- ☐ Cold lower extremities L R
- ☐ Pain in feet

15. Neurological/Psychiatric

Neurological ☐ No problems

- ☐ Frequent or recurrent headaches
- ☐ Fainting
- ☐ Migraines
- ☐ Blackouts
- ☐ Stroke
- ☐ Dizzy spells
- ☐ Gait difficulties
- ☐ Seizures
- ☐ Epilepsy
- ☐ Tremors
- ☐ Neuropathy
- ☐ Weakness
- ☐ Paralysis

Psychiatric ☐ No problems

- ☐ Problems with concentration
- ☐ Confusion
- ☐ Problems with thinking or thought process
- ☐ Problems with memory
- ☐ Depression
- ☐ Anxious
- ☐ Shaky
- ☐ Agitated

16. Allergies/Immunologic

Allergies ☐ No problems

- ☐ Drug allergies _____
- ☐ Food allergies _____
- ☐ Environmental allergies _____

Immunologic ☐ No problems

- ☐ Immunologic disorders
- ☐ AIDS
- ☐ Lupus



Name: _____ Date: _____

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary / secondary insurance carrier will be billed to you.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of subscriber: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Primary Insurance Policy: _____

Secondary Insurance Policy: _____

I request that payment of authorized Medicare/other insurance company benefits be made either to me on my behalf or to IPMA, Interventional Pain Management Associates for any services furnished to me by that third party who accepts assignment/physician.

Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or related Medicare claim/other Insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information)

Signature of Patient or Responsible Party

Date

_____ **(Please Initial)** I have been offered a copy and an explanation of the Notice of Privacy Practices (HIPAA)



*Interventional Pain
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NO SHOW POLICY

It is our office policy to monitor and manage appointment no-shows and cancellations.

This notice is to inform you that our office No-Show Policy is as follows:

- Any scheduled office visit that is missed without a call notifying the office will be considered a “No-Show” and will result in a **\$40.00** fee.
- Any scheduled office visit that is cancelled or rescheduled less than **24 hours prior** to the scheduled appointment is considered a “Same Day Cancellation” and will result in a **\$40.00** fee.
- Any scheduled procedure that is cancelled **later than the Friday before their procedure** will result in a **\$100.00** fee.

The purpose of this policy is to ensure we can provide timely access for all patients. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

By signing below, I acknowledge that I have read and understood this policy.

Patient Name (Printed)

Patient Signature

Date



NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 14, 2003

As Required by the Privacy Regulations created as a result of the Health Insurance portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information.

- How we may use and disclose IIHI.
- Your privacy rights in your IIHI.
- Our obligations concerning the use and disclosure of your IIHI.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 , or by telephone at 609-838-2900.

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS.

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have diagnostic tests (such as laboratory or radiology testing) We may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. The people who work for our practice may use or disclose your IIHI in order to treat you or to assist others in your treatment.

Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways to which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. Treatment Options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you.

8. Disclosure Requires By Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

9. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- maintaining vital records, such as births and deaths.
- reporting child abuse or neglect.
- preventing or controlling disease, injury or disability.
- notifying a person regarding potential exposure to a communicable disease.
- notifying a person regarding a potential risk for spreading or contracting a disease or condition.
- reporting reactions to drugs or problems with products or devices.
- notifying individuals if a product or device they may be using has been recalled.
- notifying appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedure or actions or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your IIHI in response to a court or administrative order if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the

dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the patient's agreement.
- Concerning a death we believe has resulted from criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim of the crime, or the description identity or location of the perpetrator).

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death, if necessary; we also may release information in order for funeral directors to perform their jobs.

6. Research. Our practice may use and disclose your IIHI to research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only relates to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

7. Serious Threats to Health or Safety. Our practice may use or disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your IIHI to federal officials, correctional institutions or law enforcement official. If you are an inmate or under the custody of a law enforcement official, disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety of other individuals.

11. Workers' Compensation. Our practice may release your IIHI for Workers' Compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact at your home, rather than work. In order to request a type of confidential communication, you must make a written request to Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable request. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701. Telephone 609-838-2900. Your request must describe in a clear and concise fashion:

- (a) the information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure or both; and
- (c) to whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the cost of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request amendments for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900. You must provide us with a reason that supports your request for amendment.

Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the staff; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900. All requests for an "accounting of disclosure" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Interventional Pain Management Associates, 1374 Whitehorse- Hamilton Square Rd, Suite 302, Hamilton NJ 08690 - 3701 Telephone 609-838-2900.