DR. JOSEPH K. JAMARIS, LLC

Diplomate American Board of Neurological Surgery

THE EXECUTIVE BUILDING
300 HOSPITAL DRIVE
SUITE 226
GLEN BURNIE, MD 21061

Telephone: 410-768-4644
Fax: 410-768-4648

CELL PHONE # _____

Primary Care Doctor: _____ Phone _____

PATIENT# _____

REFERRING DOCTOR

PLEASE PRINT CLEARLY

REFERRING DOCTOR ADDRESS | PHONE

PATIENT REGISTRATION

PATIENT NAME (LAST / FIRST / MI)
MR.
MRS.

HOME ADDRESS | APT. NO. | CITY | STATE | ZIP | BIRTHDAY | AGE | SEX

HOME PHONE | WORK PHONE | SOCIAL SECURITY NO. | PATIENT STATUS ☐ SINGLE ☐ MARRIED ☐ OTHER ☐ EMPLOYED ☐ FULL TIME STUDENT ☐ PART TIME STUDENT

EMPLOYER NAME | EMPLOYER ADDRESS | OCCUPATION

SPOUSE'S NAME | SPOUSE'S DATE OF BIRTH | SPOUSE'S EMPLOYER AND ADDRESS

IN CASE OF EMERGENCY PLEASE NOTIFY NAME | ADDRESS | PHONE

PRIMARY INSURANCE CO.

☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER | NAME (IF DIFFERENT THAN PATIENT) | INSURED DATE OF BIRTH | EMPLOYER NAME

ADDRESS (IF DIFFERENT THAN PATIENT) | CITY | STATE | ZIP | HOME PHONE | WORK PHONE

INSURANCE COMPANY NAME | ADDRESS | CITY | STATE | ZIP

POLICY NO. | GROUP NO. EFFECTIVE DATE | INSURED S.S.# | PHONE NO.

SECONDARY INSURANCE CO.

☐ PATIENT ☐ SPOUSE ☐ PARENT ☐ OTHER | NAME (IF DIFFERENT THAN PATIENT) | INSURED DATE OF BIRTH | EMPLOYER NAME

ADDRESS (IF DIFFERENT THAN PATIENT) | CITY | STATE | ZIP | HOME PHONE | WORK PHONE

INSURANCE COMPANY NAME | ADDRESS | CITY | STATE | ZIP

POLICY NO. | GROUP NO. EFFECTIVE DATE | INSURED S.S.# | PHONE NO.

FOR AUTO OR PERSONAL ACCIDENT

YOUR AUTO INSURANCE CO. NAME | HOW INJ. OCCURRED | DATE OF INJURY

ADDRESS | PHONE NO. | POLICY NO.

CLAIM NO. | ADJUSTER'S NAME & PHONE #

OTHER INSURANCE CO. NAME | ADDRESS

PHONE | POLICY NO. | CLAIM NO. | ADJUSTER

FOR WORK RELATED INJURIES

EMPLOYER | DATE OF INJURY

ADDRESS | PHONE | ADJUSTER'S NAME & PHONE #

COMPENSATION INSURANCE CARRIER | ADDRESS

PHONE | CLAIM NO. | ID/POLICY NO.

ATTORNEY'S NAME | ADDRESS | PHONE

OVER →

RELEASE AND ASSIGNMENT

Date _____

To: _____
(Insurance Company)

Group No. _____ Certificate No. _____

I hereby authorize Dr. _____ to release to your company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Basic Medical, Major and/or Surgical treatment or services, by reason of such treatment or services rendered to:

_____
(Patient)

_____
(Signature of Insured)

_____
(Witness) (Address)

BILLING AND PAYMENT PROCEDURES

Payment is requested at the time services are rendered. If expensive or extended treatment is anticipated, arrangements may be made for a payment plan. All professional services rendered are charged to the patient, the patient is responsible for all fees. This office is a participating member of Blue Shield/Medicare and certain HMO/PPO's. Our staff will assist you in completing any forms necessary to expedite reimbursement from insurance carriers at no additional charge. If person other than patient, patient's spouse or parent, has accepted financial responsibility for medical bills, a signed consent to that effect must be on file. Any remaining balance on accounts is payable within thirty days of the date when service is rendered. Our staff will gladly explain or assist you with any aspect of this policy.

_____
(Signature of Patient) (Date)

MEDICARE RELEASE
EXTENDED PAYMENT REQUEST FOR PHYSICIAN SERVICES

Name of Beneficiary Health Insurance Claim Number

_____ _____
(Print or Type Last-First-Init.)

I request the payment of authorized Medicare benefits to be made to me on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____
(Signature of Beneficiary or Witness)

For the purpose of identifying applicable claims, the phrase "extended signature request on file" should be indicated in the space for beneficiary's signature on the Medicare claim.

_____

PRINT FULL NAME

DATE OF ONSET / INJURY: _____

WORK INJURY: **YES** **NO** **MVA INJURY:** **YES** **NO**

Please describe symptoms: _____

_____

_____

_____

_____

_____

Please list any major medical problems: _____

_____

_____

_____

_____

Prior Surgeries: _____

_____

_____

_____

Daily Medications: _____

_____

_____

Pharmacy Name and Number: _____

_____

Allergies to any medications: _____

_____

_____

_____

_____ _____

Signature Date

Dr. Joseph K. Jamaris, LLC

BACK - NECK INDEX SURVEY

PATIENT NAME: _____ **DATE:**_____

This questionnaire will give your provider information about how your back - neck condition affects your everyday life. Please answer every section by circling the one statement that applies to you. If two or more statements in one section apply, please circle the one that most closely describes your problem.

PAIN INTENSITY
0 The pain comes and goes and is very mild.
1 The pain is mild and does not vary much.
2 The pain comes and goes and is moderate.
3 The pain is moderate and does not vary much.
4 The pain comes and goes and is very severe.
5 The pain is very severe and does not vary much.

SLEEPING
0 I get no pain in bed.
1 I get pain in bed but it does not prevent me from sleeping well.
2 Because of my pain my normal sleep is reduced by less than 25%.
3 Because of my pain my normal sleep is reduced by less than 50%.
4 Because of my pain my normal sleep is reduced by less than 75%.
5 Pain prevents me from sleeping at all.

SITTING
0 I can sit in any chair as long as I like.
1 I can only sit in my favorite chair as long as I like.
2 Pain prevents me from sitting more than 1 hour.
3 Pain prevents me from sitting more than 1/2 hour.
4 Pain prevents me from sitting more than 10 minutes.
5 I avoid sitting because it increases pain immediately.

STANDING
0 I can stand as long as I want without pain.
1 I have some pain while standing but it does not increase with time.
2 I cannot stand for longer than 1 hour without increasing pain.
3 I cannot stand for longer than 1/2 hour without increasing pain.
4 I cannot stand for longer than 10 minutes without increasing pain.
5 I avoid standing because it increases pain immediately.

WALKING
0 I have no pain while walking.
1 I have some pain while walking but it doesn't increase with distance.
2 I cannot walk more than 1 mile without increasing pain.
3 I cannot walk more than 1/2 mile without increasing pain.
4 I cannot walk more than 1/4 mile without increasing pain.
5 I cannot walk at all without increasing pain.

CHANGING DEGREE OF PAIN
0 My pain is rapidly getting better.
1 My pain fluctuates but overall is definitely getting better.
2 My pain seems to be getting better but improvement is slow.
3 My pain is neither getting better or worse.
4 My pain is rapidly worsening.

WORK
0 Missing no work.
1 Rarely missing work.
2 Missing work occasionally.
3 Missing work frequently.
4 Not worked since _____.
Is this work related?_____.

PERSONAL CARE
0 I do not have to change my way of washing or dressing in order to avoid pain.
1 I do not normally change my way of washing or dressing even though it causes some pain.
2 Washing and dressing increases the pain but I manage not to change my way of doing it.
3 Washing and dressing increases the pain and find it necessary to change my way of doing it.
4 Because of the pain I am unable to do some washing and dressing without help.
5 Because of the pain I am unable to do any washing and dressing without help.

LIFTING
0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor.
3 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
4 Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
5 I can only lift very light weights.

TRAVELING
0 I get no pain while traveling.
1 I get some pain while traveling but none of my usual forms of travel make it worse.
2 I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
3 I get extra pain while traveling which causes me to seek alternate forms of travel.
4 Pain restricts all forms of travel except that done while lying down.
5 Pain restricts all forms of travel.

SOCIAL LIFE
0 My social life is normal and gives me no extra pain.
1 My social life is normal but increases the degree of pain.
2 Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing etc).
3 Pain has restricted my social life and I do not go out very often.
4 Pain has restricted my social life to my home.
5 I have hardly any social life because of the pain.

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of our personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those that we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature:_____ Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our valued patients.

HIPAA NOTICE OF PRIVACY PRACTICES

Dr. Joseph K. Jamaris, LLC
300 Hospital Drive
Suite 226
Glen Burnie, MD 21061

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose protected health information (PHI) to carry out, treatment, payment, or health care operations (TPO) 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, related to your past, present or future physical or mental health or 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, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to to ensure that the physician has the necessary information to diagnose or treat you.

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 in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, 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.

We may use or disclose 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: Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your Consent, Authorization, or Opportunity to object unless required by law.

You may revoke this 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

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means 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 the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are 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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at main office phone number, 410-768-4644.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____