MONOS HEALTH
6120 S Fort Apache Rd. Suite#100 Las Vegas, NV. 89148
Phone (702) 948-8660 • Fax (702) 948-8641

Today's Date: _____

Referral Source:
☐ Self ☐ Physician/Provider ☐ Adjuster ☐ Attorney ☐ Residential Treatment

Referred For:
☐ Pain Management ☐ Neurosurgery/Consult ☐ Addiction

Referring Doctor's Name: _____
FIRST LAST

Patient's Name: _____
FIRST MIDDLE LAST

Address: _____
City: _____ State: _____ Zip Code: _____
Sex: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Date of Birth: _____ Age: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ May we send information here? ☐Yes ☐No
Employer: _____ Occupation: _____
Employer's Address: _____ Work Phone: _____
City: _____ State: _____ Zip Code: _____
Race/Ethnicity: ☐American Indian ☐Asian ☐African American ☐White/Caucasian
☐ Hispanic ☐Pacific Islander ☐Other ☐Do not wish to provide
Primary Language: ☐English ☐Spanish Other _____

GUARDIAN/PARENT INFORMATION (financially responsible, if other than the patient)

Name:_____
FIRST MIDDLE LAST

Address: _____
City: _____ State: _____ Zip Code: _____
Sex: ☐Male ☐ Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Date of Birth: _____ Age: _____ Social Security #: _____
Home Phone: _____ Cell Phone: _____
Relationship to patient?: _____
Employer: _____ Occupation: _____
Employer's Address: _____ Work Phone: _____
City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT INFO
Name: _____ Relationship to patient_____

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Home Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

We will need your current insurance card and your driver's/form of identification.

Are you being seen due to an Accident or Injury? ☐ Yes ☐ No
If Yes, date of accident/injury: _____
Type of Accident: ☐ Work Related ☐ Auto ☐ Other:_____

Primary/Health Insurance

Insurance Company: _____
Address: _____
City: _____State: _____Zip Code: _____
Employer: _____ Insured's DOB: _____
Insured's SS#:_____ Insured's Employer Name: _____
Policy/Claim #: _____ Group #: _____

Workers' Compensation Information

Insurance Company/TPA:_____
Mailing Address: _____
City: _____State: _____Zip Code: _____
Adjuster/Contact Name: _____ Phone #: _____
Employer: _____
Phone: _____ Fax: _____
Policy/Claim #: _____
Accepted Body Part(s): _____
C4 on file: ☐ Y ☐ N

Secondary Insurance or Attorney Information

Insurance Company: _____
Address: _____
City: _____State: _____Zip Code: _____
Insured's Name: _____ Insured's DOB: _____
Insured's SS#:_____ Insured's Employer Name: _____
Policy/Claim #: _____ Group #: _____
Attorney/Contact Name: _____ Phone #: _____

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Payment Policy

Our office will file insurance for all reimbursable services, to the patient's primary and secondary insurance carriers. Please remember that the patient is responsible for all deductible, copay, and non-covered service amounts. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage.

If the patient chooses to be treated by an out-of network provider he/she understands that they will be subject to higher out-of-pocket rates if their insurance company allows for out-of-network services. If the patient's insurance does not allow out-of-network services he/she understands that they will responsible for the entire balance. In the event of collection proceedings due to lack of payment on my part, the patient/guarantor agrees to pay any and all collection fees that may be added to their account in order to recover monies due to their account in order to recover lost fees.

No Show Policy

In the event of a no show patient/guarantor understands there will be a charge of $50.00 for office visits and $150.00 for procedure visits not canceled within 48-72 hours prior to visit pending emergencies, in the case of multiple no shows or cancelations Dr. Lipshutz and Dr. Wills do reserve the right to refuse service.

The undersigned guarantees payment in full. Guarantor understands all patients including those with Medicare or other insurance, are personally responsible for the balance after the insurance company has made payment. I hereby assign and direct you to pay any procedure/ surgical or medical benefits under claims submitted directly to Jeremy Lipshutz, MD and Heath Wills, MD. I also authorize the release of any medical records or information requested by the insurance companies in connection with the above assignments. I understand that my doctor has no obligation to my attorney to furnish consult, narrative reports, or depositions. I also understand that under no circumstances, will my doctor appear as a witness in court on my behalf.

Attestations

Signature of patient/responsible party: _____

Date: _____

Witness: _____ Date: _____

For internal use only:

Patient present with ID and/or insurance card(s) ☐ Yes ☐ No

If no, reason card(s) are not presented _____

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DISCLOSURE OF INFORMATION

I, _____,
(please print your full legal name)

give permission for this office to leave detailed messages on the answering service/voicemail messaging at:

☐ My home (please initial) _____ ☐ My cellular phone (please initial) _____

DISCLOSURE OF INFORMATION TO PATIENT'S COMPANION(S)

The physicians at Monos Health Institute are committed to complying with HIPAA regulations. Therefore, we require our patients to sign authorization stating that companion(s) (family members, friends, etc.) accompanying them to their appointment are approved to hear discussion regarding the patients health information.

TO BE COMPLETED BY THE PATIENT

I authorize the following individuals to be involved in the discussion of my medical health information and relieve Monos Health Institute of any responsibility for harmful neglect (release of medical health information) by my authorized companion(s):

Relationship	Name
_____	_____
_____	_____
_____	_____

Patient Name: _____
Please Print

Patient Signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the *Monos Health Institute* Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by *Monos Health Institute* and how I may obtain access to and control this information.

X_____ /Date: _____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

X_____/Date: _____
PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE

THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGEMENT NOT OBTAINED

We have made a good faith effort to obtain an individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s):

☐ The individual refuses to sign or otherwise fails to provide an acknowledgement

☐ The individual was mailed a copy of the Notice and did not mail back his or her receipt of acknowledgement.

XX_____ Date: _____
Signature – *Monos Health Institute* Representative

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CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

____Controlled substance medications (narcotics) can be very useful, but have a high potential for misuse and abuse and are therefore, closely controlled by the local and federal government. Used properly, they are very effective pain medications. If used improperly, however, they can cause adverse effects such as vomiting, constipation, lethargy, respiratory arrest or even death. To insure these medications are used properly, I agree to the following conditions:

____I AM RESPONSIBLE FOR MY CONTROLLED SUBSTANCE MEDICATION. IF THE PRESCRIPTION OR MEDICATION IS LOST, MISPLACED, STOLEN, OR IF I USE IT ALL SOONER THAT PRESCRIBED, I UNDERSTAND THAT IT WILL NOT BE REPLACED.

____I understand that should my medication not be working, I shall inform the office immediately and bring the remaining prescription into the office. I understand that I should not give away or share my medication with family, friends, etc. UNDER ANY CIRCUMSTANCES.

____I WILL NOT REQUEST NOR ACCEPT CONTROLLED SUBSTANCE MEDICATION FROM ANY OTHER PHYSICIAN OR INDIVIDUAL WHILE I AM RECEIVING SUCH MEDICATION FROM MONOS HEALTH INSTITUTE (except if I am a patient in the hospital). Besides being illegal to do so (NRS.453.392), I understand that it is dangerous to do so, and may endanger my health.

____REFILLS of controlled substance medication will be made only during regular office hours, in person, during a scheduled office visit. Refills will not be made at night, on holidays, weekends, or over the telephone.

___I will not request "Name Brand Medically Necessary" unless I am paying for my controlled substance medications.

___I understand that if I violate any of the above conditions, or decline to take a urine test for drugs at my physician's request (or if a urine drug test demonstrates the use of illicit drugs or of other prescription medications not prescribed by Monos Health Institute), my controlled substance prescription and/or treatment at Monos Health Institute may end immediately. If the violation involved obtaining controlled substances from another individual, as described above, it may also be reported to other physicians, local medical facilities, and other authorities.

____I have been informed by my physician about the effects of narcotics. These effects include:

- Normal physiologic effects of tolerance – the need for more medication to achieve the same pain relief.
- Dependence – withdrawal symptoms will occur if I stop the medications abruptly.
- Addiction – abnormal psychological dependence, which is rare in patient's with pain.

____I understand that THE MAIN TREATMENT GOAL is to improve my ability to function and/or work. In consideration of that goal, and that I am being given potential narcotic pain medication to help me reach that goal, I agree to help myself by following better health habits, specifically involving exercise weight control, and limiting the use of unhealthy substances.

_____ _____
Pharmacy Phone Number

_____
Name (Please Print)

_____ _____
Signature Date

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Patient Name:_____ DOB:_____

Height: _____ Weight: _____

Do you have any implanted metal objects in your body? ☐No ☐Yes:

Where: _____ When: _____

Do you have any vascular grafts? ☐No ☐Yes

Where: _____ When: _____

Do you have a pacemaker? ☐No ☐Yes

Are you claustrophobic? ☐No ☐Yes

Do you wish to be pre-medicated (sedated) for MRI scans? ☐No ☐Yes

How did you hear about our practice?

☐Physician: ☐Friend: ☐Magazine: ☐ Hospital: ☐Newsletter: ☐Phone Book: ☐Patient:
☐Newspaper: ☐Internet:
☐ Other: _____

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PATIENT HISTORY

Date: _____ Physician: _____

Patient Name: _____ DOB: _____

Referring Physician: _____Phone: _____

Primary Care Physician: _____ Phone: _____

When did your pain start? _____

What caused you pain? ☐Accident ☐Cancer ☐Other Disease ☐No Obvious Cause

☐ Surgery (specify):_____

☐ Other: _____

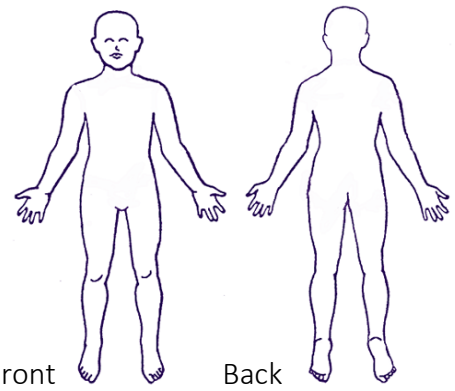
Describe in your own words the pain problem(s) that you would like help with:

_____

_____

Right Left | Left Right

Please mark the location(s) of your pain on the diagrams with an "X". If whole areas are painful, please shade the painful area.



Explain if necessary: _____
_____
_____
_____

How often does your pain occur?

☐Continuous
☐Several times a day
☐Once a day
☐Several times a week
☐ Once a week
☐ Less than once a week
☐ Never

How long does your pain last?

☐ Continuous
☐ Weeks
☐ Days
☐ None
☐Hours
☐ Minutes
☐ Seconds

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Below is a list of words that might describe your pain. Check all that apply.

☐ Throbbing	☐ Cramping	☐ Hot-Burning	☐ Splitting
☐ Shooting	☐ Gnawing	☐ Aching	☐ Tired - Exhausting
☐ Stabbing	☐ Sickening	☐ Heavy	☐ Fearful
☐ Sharp	☐ Punishing – Cruel	☐ Tender	☐ Other: _____

Circle the number below to indicate your highest pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most

Circle the number below to indicate you lowest pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most

Circle the number to indicate your unusual pain intensity over the past week:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most

Using the same scale, what level of pain us ACCEPTABLE for you:

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Most

Do you have any of the following associated with your pain? (indicate all that apply):

☐ Bowel/Bladder Incontinence ☐ Muscle Weakness ☐ Numbness/Tingling/Pins/Needles

Have you ever been seen by another pain specialist? ☐ Yes ☐ No

If so, what is the name of the physician or practice? _____

	Yes	*No*		*Yes*	*No*		*Yes*	*No*
Fever	☐	☐	Headache	☐	☐	Constipation	☐	☐
Night Sweats	☐	☐	Dizziness	☐	☐	Black Bowel Mvmt	☐	☐
Rash	☐	☐	Easy Bruising	☐	☐	Bowel Incontinence	☐	☐
Sputum Production	☐	☐	Weight Loss	☐	☐	Nausea	☐	☐
Wheezing	☐	☐	Weight Gain	☐	☐	Chest Pain	☐	☐
Swelling	☐	☐	Light Headedness	☐	☐	Vision Changes	☐	☐
Abdominal Pain	☐	☐	Cough	☐	☐	Difficulty Urinating	☐	☐
Diarrhea	☐	☐	Shortness of Breath	☐	☐	Urinary Frequency	☐	☐

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Blood in Stool ☐ ☐ Chest Pain ☐ ☐ Bladder Incontinence ☐ ☐
Weakness/Paralysis of ☐ ☐ Palpitations ☐ ☐ Arms and/or Legs ☐ ☐

What medications for pain have you tried in the past?

Medication	*Dosage*	*Frequency*

Do you have any allergies to medications? _____

Are you currently taking COUMADIN or BLOOD THINNERS? ☐ Yes ☐ No

Are you afraid of becoming addicted to your medications? ☐ Yes ☐ No

Please list all your current medications including "over the counter medications" below. If more room is needed, use the back side of this paper.

Medication	*Strength (how many milligrams?)*	*Total Daily Dose*	*Is It Effective? (Yes, No, or somewhat)*	*Ordering Physician*

Are there things that influence you pain? Please check all that apply.

Treatment	*Worsens*	*Relieves*	*No Difference*	*Comments*
Exercise	☐	☐	☐	
Walking	☐	☐	☐	
Massage	☐	☐	☐	
Sitting	☐	☐	☐	
Standing	☐	☐	☐	
Temperature (hot)	☐	☐	☐	
Temperature (cold)	☐	☐	☐	
Weather	☐	☐	☐	
Emotional Stress	☐	☐	☐	
Sexual Activity	☐	☐	☐	
Medicines	☐	☐	☐	
Stairs	☐	☐	☐	
Other (explain)				

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Regarding you current pain, have you had any of the following? (please put a check mark in the appropriate column)

	Helpful	*Not Helpful*	*Comments*
Surgery	☐	☐	
Nerve Blocks	☐	☐	
Steroid Injections	☐	☐	
Acupuncture	☐	☐	
Trigger Point Injection	☐	☐	
TENS unit	☐	☐	
Heat/ice treatment	☐	☐	
Biofeedback	☐	☐	
Hypnosis	☐	☐	
Relaxation training	☐	☐	
Counseling	☐	☐	
Physical therapy	☐	☐	
Other (explain)			

Lifestyle Changes

During the past month how much did pain interfere with the following activities? (check the number that best describes your situation)

	Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
Going to work	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Performing household chores	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Yard work or shopping	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Socializing with friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Recreation and hobbies	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Having sexual relations	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Physical exercise	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Appetite	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Do you have problems with any of the following? (check all that apply)

	Yes	*No*		*Yes*	*No*
Sleep	☐	☐	Concentration	☐	☐
Mood	☐	☐	Anxiety	☐	☐
Depression	☐	☐	Suicidal thoughts	☐	☐
Self-worth	☐	☐	Homicidal thoughts	☐	☐

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Circle the correct number below to indicate your current MOOD now.

0	1	2	3	4	5	6	7	8	9	10
Worst		Poor			Fair		Good			Best

Social History

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnership

With whom do you live? ☐ Self ☐ Spouse ☐ Children ☐ Parents ☐ Friends ☐ Other: _____

What is your current employment status? ☐ Employed full time ☐ Employed part time ☐ Self employed

☐ Retired ☐ Homemaker ☐ Unemployed due to pain ☐ Unemployed due to reason other than pain

---

Medical History

Do you drink alcohol? ☐ Yes ☐ No If so, specify _____

Do you smoke? ☐ Yes ☐ No If so, specify _____

Do you currently or have you ever abused recreational drugs? ☐ Yes ☐ No

If so, specify _____

Do you have a history of any of the following? (check all that apply)

	Yes	*No*		*Yes*	*No*
Arrhythmia	☐	☐	Liver disease	☐	☐
High blood pressure	☐	☐	Hepatitis	☐	☐
Angina/heart disease	☐	☐	Kidney disease	☐	☐
Heart attack	☐	☐	Ulcers	☐	☐
Heart failure	☐	☐	Acid reflux	☐	☐
Emphysema/Asthma	☐	☐	Other GI illness	☐	☐
COPE	☐	☐	Bleeding disorder	☐	☐
Stroke	☐	☐	Taking blood thinners	☐	☐
Seizures	☐	☐	Thyroid disease	☐	☐
Cancer	☐	☐	HIV	☐	☐
Arthritis	☐	☐	Irritable bowel syndrome	☐	☐
Diabetes	☐	☐	Skin condition	☐	☐
Migraine/headaches	☐	☐	Depression	☐	☐

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Psychiatric illness ☐ ☐ Other:_____ ☐ ☐

Please list all past surgeries/hospitalizations. If more room is needed, use the back of this paper.

Date	*Surgery or reason for hospitalization*

Surgeries/hospitalizations cont'd

Date	*Surgery or reason for hospitalization*

Have you had any of the following test to evaluate you pain? (please provide details)

☐ X-Rays _____

☐ MRI _____

☐ CT _____

☐ Myelogram _____

☐ EMG _____

☐ Blood tests _____

☐ Bone scan _____

☐ Discogram _____

Family History

Has anyone in your immediate family had any of the following?

✓	*Disease/Disorder*	*Who*	*Living/Decease/Age*
☐	Cancer		
☐	Tuberculosis		
☐	Diabetes		
☐	Heart attack		
☐	High blood pressure		
☐	Stroke		
☐	Seizure		
☐	Asthma/Emphysema		
☐	Thyroid disease		
☐	Kidney disease		

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☐	Bleeding disorders		
☐	Stomach disorders		
☐	Mental Disorders		
☐	Suicide		

Are you on disability?

☐ Yes ☐ No

Do you have an attorney or legal action pending related to this pain or any other health problems?

☐ Yes ☐ No

If so, please list attorney's contact

info:_____

Expectations from this pain clinic:

_____

_____

_____

_____

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

NOTICE OF PRIVACY POLICY

Effective November 21, 2011

The following is the privacy policy ("Privacy Policy") of Monos Health Institute as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, commonly known as HIPAA. HIPAA requires Monos Health Institute by law to maintain the privacy of your personal health information and to provide you with notice of Monos Health Institutes legal duties and privacy policies with respect to your personal health information. We are required by law to abide by the terms of this Privacy Notice.

Your Personal Health Information

We collect personal health information from you through treatment, payment and related healthcare operations, the application and enrollment process, and/or healthcare providers or health plans, or through other means, as applicable. Your personal health information that is protected by law broadly includes any information, oral, written or recorded, that is created or received by certain health care entities, including health care providers, such as physicians and hospitals, as well as, health insurance companies or plans. The law specifically protects health information that contains data, such as your name, address, social security number, and others, that could be used to identify you as the individual patient who is associated with that health information.

Uses or Disclosures of Your Personal Health Information

Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission. The following are the circumstances under which we are permitted by law to use or disclose your personal health information.

Without Your Consent

Without your consent, we may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services, and to conduct other related health care operations otherwise permitted or required by law. Also, we are permitted to disclose your personal health information within and among our workforce in order to accomplish these same purposes. However, even with your permission, we are still required to limit such uses or disclosures to the minimal amount of personal health information that is reasonably required to provide those services or complete those activities.

Examples of treatment activities include: (a) the provision, coordination, or management of health care and related services by health care providers; (b) consultation between health care providers relating to a patient; or (c) the referral of a patient for health care from one health care provider to another.

Examples of payment activities include: (a) billing and collection activities and related data processing; (b) actions by a health plan or insurer to obtain premiums or to determine or fulfill its responsibilities for coverage and provision of benefits under its health plan or insurance agreement, determinations of eligibility or coverage, adjudication or subrogation of health benefit claims; (c) medical necessity and appropriateness of care reviews, utilization review activities; and (d) disclosure to consumer reporting agencies of information relating to collection of premiums or reimbursement.

Examples of health care operations include:

(a) development of clinical guidelines; (b) contacting patients with information about treatment alternatives or communications in connection with case management or care coordination; (c) reviewing the qualifications of and training health care professionals; (d) underwriting and premium rating; (e) medical review, legal services, and auditing functions; and (f) general administrative activities such as customer service and data analysis.

As Required By Law

We may use or disclose your personal health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law. *Examples of instances in which we are required to disclose your personal health information include*: (a) public health activities including, preventing or controlling disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food or dietary supplements or product defects or problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury in order to comply with Federal or state law; (b) disclosures regarding victims of abuse, neglect, or domestic violence including, reporting to social service or protective services agencies; (c) health oversight activities including, audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs; (d) judicial and administrative proceedings in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process; (e) law enforcement purposes for the purpose of identifying or locating a suspect, fugitive, material

witness, or missing person, or reporting crimes in emergencies, or reporting a death; (f) disclosures about decedents for purposes of cadaveric donation of organs, eyes or tissue; (g) for research purposes under certain conditions; (h) to avert a serious threat to health or safety; (i) military and veterans activities; (j) national security and intelligence activities, protective services of the President and others; (k) medical suitability determinations by entities that are components of the Department of State; (l) correctional institutions and other law enforcement custodial situations; (m) covered entities that are government programs providing public benefits, and for workers' compensation.

All Other Situations, With Your Specific Authorization

Except as otherwise permitted or required, as described above, we may not use or disclose your personal health information without your written authorization. Further, we are required to use or disclose your personal health information consistent with the terms of your authorization. You may revoke your authorization to use or disclose any personal health information at any time, except to the extent that we have taken action in reliance on such authorization, or, if you provided the authorization as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

Miscellaneous Activities, Notice

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you to raise funds for Monos Health Institute. If we are a group health plan or health insurance issuer or HMO with respect to a group health plan, we may disclose your personal health information to be sponsor of the plan.

Your Rights With Respect to Your Personal Health Information

Under HIPAA, you have certain rights with respect to your personal health information. The following is a brief overview of your rights and our duties with respect to enforcing those rights.

Right To Request Restrictions On Use Or Disclosure

You have the right to request restrictions on certain uses and disclosures of your personal health information about yourself. *You may request restrictions on the following uses or disclosures*: to carry out treatment, payment, or healthcare operations; (b) disclosures to family members, relatives, or close personal friends of personal health information directly relevant to your care or payment related to your health care, or your location, general condition, or death; (c) instances in which you are not present or your permission cannot practicably be obtained due to your incapacity or an emergency circumstance; (d) permitting other persons to act on your behalf to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of personal health information; or (e) disclosure to a public or private SBI authorized by law or by its charter to assist in disaster relief efforts.

While we are not required to agree to any requested restriction, if we agree to a restriction, we are bound not to use or disclose your personal healthcare information in violation of such restriction, except in certain emergency situations. We will not accept a request to restrict uses or disclosures that are otherwise required by law.

Right To Receive Confidential Communications

You have the right to receive confidential communications of your personal health information. We may require written requests. We may condition the provision of confidential communications on you providing us with information as to how payment will be handled and specification of an alternative address or other method of contact. We may require that a request contain a statement that disclosure of all or a part of the information to which the request pertains could endanger you. We may not require you to provide an explanation of the basis for your request as a condition of providing communications to you on a confidential basis. We must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations. If we are a health care plan, we must permit you to request and must accommodate reasonable requests by you to receive communications of personal health information from us by alternative means or at alternative locations if you clearly state that the disclosure of all or part of that information could endanger you.

Right To Inspect And Copy Your Personal Health Information

Your designated record set is a group of records we maintain that includes Medical records and billing records about you, or enrollment, payment, claims adjudication, and case or medical management records systems, as applicable. You have the right of access in order to inspect and obtain a copy your personal health information contained in your designated record set, *except for* (a) psychotherapy notes, (b) information complied in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding, and (c) health information maintained by us to the extent to which the provision of access to you would be prohibited by law. We may require written requests. We must provide you with access to your personal health information in the form or format requested by you, if it is readily producible in such form or format, or, if not, in a readable hard copy form or such other form or format. We may provide you with a summary of the personal health information requested, in lieu of providing access to the personal health information or may provide an explanation of the personal health information to which access has been provided, if you agree in advance to such a summary or explanation and agree to the fees imposed for such summary or explanation. We will provide you with access as requested in a timely manner, including arranging with you a convenient time and place to inspect or obtain copies of your personal health information or mailing a copy to you at your request. We will discuss the scope, format, and other aspects of your request for access as necessary to facilitate timely access. If you request a copy of your personal health information or agree to a summary or explanation of such information, we may charge a reasonable cost-based fee for copying, postage, if you request a mailing, and the costs of preparing an explanation or summary as agreed upon in advance. We reserve the right to deny you access to and copies of certain personal health information as permitted or required by law. We will reasonably attempt to accommodate any request for personal health information by, to the extent possible, giving you access to other personal health information after excluding the information as to which we have a ground to deny access. Upon denial of a request for access or request for information, we will provide you with a written denial specifying the legal basis for denial, a statement of your rights, and a description of how you may file a complaint with us. If we do not maintain the information

that is the subject of your request for access but we know where the requested information is maintained, we will inform you of where to direct your request for access.

Right To Amend Your Personal Health Information

You have the right to request that we amend your personal health information or a record about you contained in your designated record set, for as long as the designated record set is maintained by us. We have the right to deny your request for amendment, if: (a) we determine that the information or record that is the subject of the request was not created by us, unless you provide a reasonable basis to believe that the originator of the information is no longer available to act on the requested amendment, (b) the information is not part of your designated record set maintained by us, (c) the information is prohibited from inspection by law, or (d) the information is accurate and complete. We may require that you submit written requests and provide a reason to support the requested amendment. If we deny your request, we will provide you with a written denial stating the basis of the denial, your right to submit a written statement disagreeing with the denial, and a description of how you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services ("DHHS"). This denial will also include a notice that if you do not submit a statement of disagreement, you may request that we include your request for amendment and the denial with any future disclosures of your personal health information that is the subject of the requested amendment. Copies of all requests, denials, and statements of disagreement will be included in your designated record set. If we accept your request for amendment, we will make reasonable efforts to inform and provide the amendment within a reasonable time to persons identified by you as having received personal health information of yours prior to amendment and persons that we know have the personal health information that is the subject of the amendment and that may have relied, or could foreseeably rely, on such information to your detriment. All requests for amendment shall be sent to SBI.

Right To Receive An Accounting Of Disclosures Of Your Personal Health Information

Beginning April 14, 2003, you have the right to receive a written accounting of all disclosures of your personal health information that we have made within the six (6) year period immediately preceding the date on which the accounting is requested. You may request an accounting of disclosures for a period of time less than six (6) years from the date of the request. Such disclosures will include the date of each disclosure, the name and, if known, the address of the Monos Health Institute or person who received the information, a brief description of the information disclosed, and a brief statement of the purpose and basis of the disclosure or, in lieu of such statement, a copy of your written authorization or written request for disclosure pertaining to such information. *We are not required to provide accountings of disclosures for the following purposes*: (a) treatment, payment, and healthcare operations, (b) disclosures pursuant to your authorization, (c) disclosures to you, (d) for a facility directory or to persons involved in your care, (e) for national security or intelligence purposes, (f) to correctional institutions, and (g) with respect to disclosures occurring prior to 4/14/03. We reserve our right to temporarily suspend your right to receive an accounting of disclosures to health oversight agencies or law enforcement officials, as required by law. We will provide the first accounting to you in any twelve (12) month period without charge, but will impose a reasonable cost-based fee for responding to each subsequent request for accounting within that same twelve (12) month period. All requests for an accounting shall be sent to Monos Health Institute.

Complaints

You may file a complaint with us and with the Secretary of DHHS if you believe that your privacy rights have been violated. You may submit your complaint in writing by mail or electronically to our privacy officer. A complaint must name Monos Health Institute that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable requirements of HIPAA or this Privacy Policy. A complaint must be received by us or filed with the Secretary of DHHS within 180 days of when you knew or should have known that the act or omission complained of occurred. You will not be retaliated against for filing any complaint.

Amendments to this Privacy Policy

We reserve the right to revise or amend this Privacy Policy at any time. These revisions or amendments may be made effective for all personal health information we maintain even if created or received prior to the effective date of the revision or amendment. We will provide you with notice of any revisions or amendments to this Privacy Policy, or changes in the law affecting this Privacy Notice, by mail or electronically within 60 days of the effective date of such revision, amendment, or change.

On-going Access to Privacy Policy

We will provide you with a copy of the most recent version of this Privacy Policy at any time upon your written request sent to Monos Health Institute. For any other requests or for further information regarding the privacy of your personal health information, and for information regarding the filing of a complaint with us, please contact our privacy officer at the address, telephone number, or e-mail address listed above.

MONOS HEALTH
6120 S Fort Apache Rd. Suite#100 Las Vegas, NV. 89148
Phone (702) 948-8660 • Fax (702) 948-8641

ACKNOWLEDGEMENTS

NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a copy of Monos Health Institute's Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Monos Health Institute and how I may obtain access to and control this information.

_____ _____
Patient (Patient's Representative) Signature Date

PATIENT RIGHTS & RESPONSIBILITIES

I acknowledge that I have received a copy of Monos Health Institute's Patient Rights & Responsibilities. I understand that I may address any questions I have regarding the form to the facility's representative.

_____ _____
Patient (Patient's Representative) Signature Date

ADVANCE DIRECTIVES

I acknowledge that I have received a copy of Monos Health Institute's policy on Advance Directives. I understand that I may address any questions I have regarding the form to the facility's representative.

_____ _____
Patient (Patient's Representative) Signature Date

OWNERSHIP DISCLOSURE

I am aware that my physician has ownership interest in Monos Health Institute. I understand that I may choose another facility for the purpose of having the procedure performed.
I have decided to have my procedure at Monos Health Institute.

_____ _____
Patient (Patient's Representative) Signature Date