



**BUFFALO  
NEUROSURGERY  
GROUP**

Dear Patient:

Thank you for calling our office for an appointment. We are looking forward to having you as one of our patients. Enclosed is a "Patient Data" form for you to complete. It is important that we have ***all of the clinical and billing information that this form requests***. We ask that you fill it out before you come to the office. This will assure that we have your complete record and will reduce unnecessary waiting at the time of your visit.

**Dr. Egnatchik** is a participating member of Independent Health, Community Blue, GHI, Medicare, Empire Plan, Univera, Blue Cross & Blue Shield and others. ***If you are required to have a referral, you must obtain a referral slip from your primary care physician and bring it with you for your appointment with us.***

Payment or co-payment is expected on the day the doctor sees you unless other arrangements are made in advance with us. If for any reason we have not received your payment within 30 days of the date of service, each monthly bill will include a 1.5% monthly (18% per year) billing charge which you will be responsible for. Any cancellations of appointments must be made 24 hours before your scheduled visit.

If you had any CT, MRI scans or any x-rays taken recently, we ask that you obtain the actual films/CDs and reports and bring them with you for your office visit.

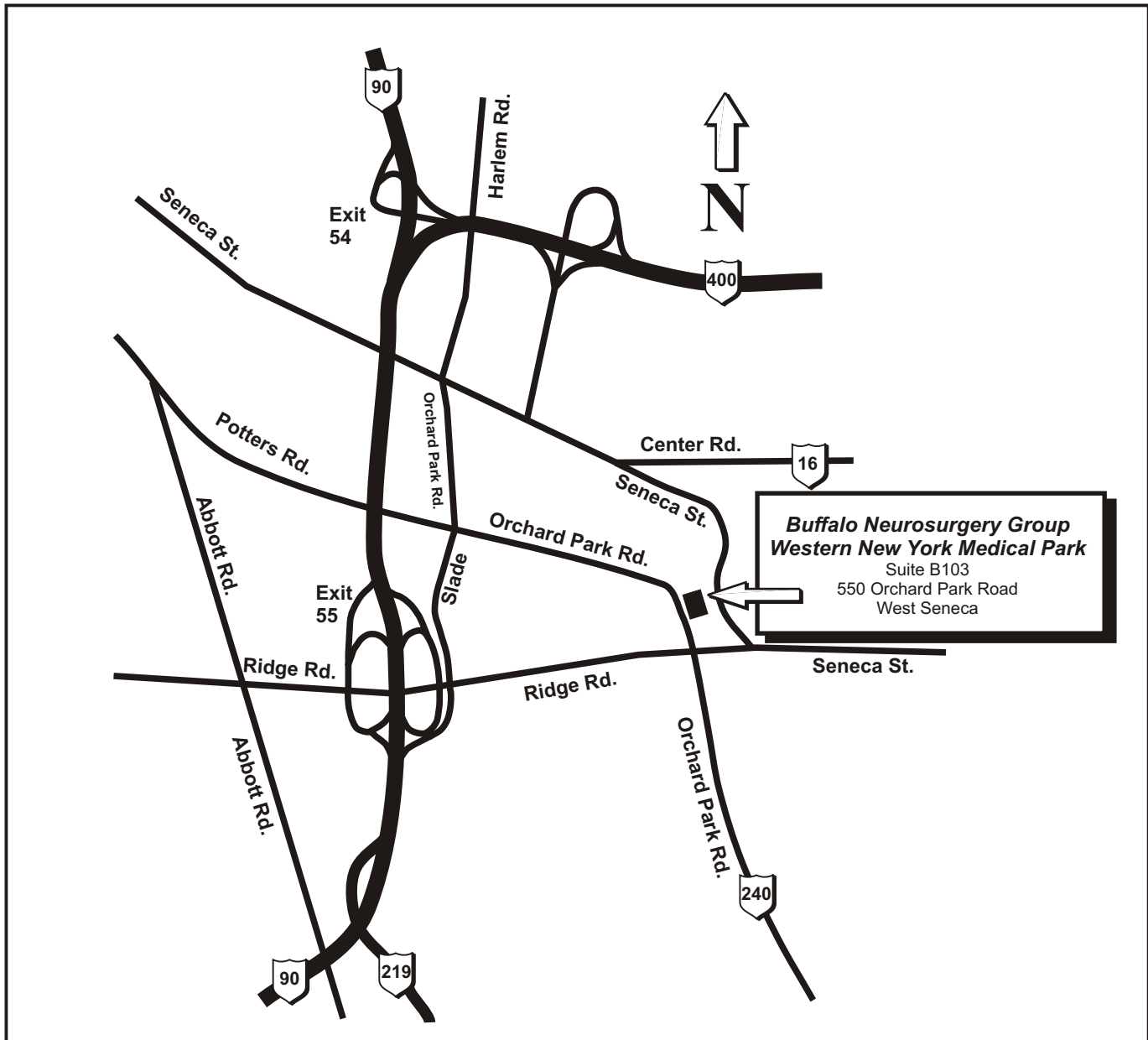
Please note that the use of cell phones or any audio or video recorders in our offices or hospitals during your encounter with our physicians and staff is strictly prohibited.

Thank you for your cooperation. If you should have any questions please call (716) 677-5005. We look forward to seeing you.  
(See map on reverse side of page.)

Buffalo Neurosurgery Group

<b>P. Jeffrey Lewis, MD, FACS</b>	<b>Douglas B. Moreland, MD, FACS Gregory J. Castiglia, MD, FACS John Pollina, Jr., MD, FACS</b>	<b>James G. Egnatchik, MD, FACS</b>	<b>Lee R. Guterman, Ph.D, MD</b>
550 Orchard Park Road Suite A-105 West Seneca, New York 14224 716.677.6000 Voice 716.677.6006 Fax	180 Park Club Lane Suite 100 Williamsville, NY 14221 716.839.9402 Voice 716.839.3570 Fax	550 Orchard Park Road Suite B-103 West Seneca, New York 14224 716.677.5005 Voice 716.712.0160 Fax	4050 Harlem Road Amherst, New York 14226 716.803.1504 Voice 716.803.1508 Fax

# James G. Egnatchik, M.D. Buffalo Neurosurgery Group at Western New York Medical Park *Suite B103*



**From the North** - Take 90 West to Exit 55 (Rt. 219).  
Get off at the Ridge Road - West Seneca exit.  
Follow Ridge Road to Orchard Park Road.  
Go Left on Orchard Park Road.  
We are on the Right side of Orchard Park Road about 1/4  
mile from Ridge Road.

**From the South** - Take 90 East to Exit 55 . (if using  
Route 400, go West on 90 at the end of the 400)  
Get off at the Ridge Road - West Seneca exit. Follow Ridge  
Road to Orchard Park Road. Go Left on Orchard Park Road.  
We are on the Right side of Orchard Park Road about 1/4  
mile from Ridge Road.



# Buffalo Neurosurgery Group

Gregory J. Castiglia, M.D.  
P. Jeffrey Lewis, M.D.

James G. Egnatchik, M.D.  
Douglas B. Moreland, M.D.

Lee R. Guterman, Ph.D., M.D.  
John Pollina, Jr., M.D.

Gregory A. Czajka, RPA-C  
Jennifer Overkamp, RPA-C  
James Bell, RPA-C

Joanne E. Pantano, MSN, ANP  
Melanie Noon, RPA-C

Edward R. Vargo, RPA-C  
Rachel Dulski, RPA-C

Anthony Gagliardo, RPA-C  
Cheryl Tanski, RPA-C

Date / /

Please list allergies - If none, print "none"

Have you been examined by any of the surgeons or practitioners listed above during the last 3 years?

Yes  No

Last Name		First Name		Middle Initial	
Address		City		State	
Your Employer		Occupation		Name of Spouse	
Employer Address		City		State	
Home Phone		Work Phone		Cell Phone	
Date of Birth		Age		Height	
				Social Security Number	
				Marital Status	
				Weight	
				Zip Code	

Referring Doctor		Referring Doctor Phone #	
Referring Doctor Address		City	
		State	
		Zip Code	
Family Doctor		Family Doctor Phone #	
Family Doctor Address		City	
		State	
		Zip Code	
Person to Contact in the Event of an Emergency (In addition to your spouse) :		Phone Number of this Person:	
Pharmacy		Pharmacy Phone Number	
Pharmacy Address		City	
		State	
		Zip Code	

Describe briefly your present symptoms:

Recent conservative care:

	<b>Physical therapy:</b> Yes No
	How long _____ last visit date _____
	Therapy Group: _____
	<b>Chiropractic:</b> Yes No
	How long _____ last visit date _____
	Chiropractor: _____
	<b>Injections:</b> Yes No

PATIENT NAME \_\_\_\_\_

DOB \_\_\_\_\_

**Past Medical History - Please circle or list any that you are being treated for:**

Diabetes	Bladder disease	Mitral Valve Prolapse (MVP)
Heart disease	Tuberculosis (TB)	Kidney disease
Heart Attack	Ulcer	Hepatitis
Seizures	Hypertension	Thyroid
Lung disease	Stroke	Other - please list:
Liver disease	Cancer	
Bowel disease	Sexual dysfunction	

**Past surgical history**

Procedure	Date	Hospital

**List any other serious injuries or diseases you have had:**


**Social History**

Do you regularly smoke?	Yes No	How many packs per day?	How many years?
Do you regularly drink?	Yes No	How many drinks per week?	How many years?
Have you been treated for alcohol abuse?	Yes No		
Have you been treated for drug abuse?	Yes No		
Have you been treated for depression?	Yes No		
Have you been treated for a psychiatric disorder?	Yes No		

**Please list any medications you are presently taking:**


**Do you know of any close relatives (parents, brothers, sisters, and children) who have had: (Circle and give relationship)**

Stroke	Asthma	Heart Attack/Heart Disease	Cerebral Aneurysm
Alcoholism	Bleeding Tendency	Thyroid problem	Diabetes
High Blood Pressure	Epilepsy/Seizure Disorder	Back Surgery	
Cancer			
Other - Please describe:			

**Demographics (Circle one that applies)**

**Race:** White      Black / African American      American Indian / Alaska Native      Asian  
 Native Hawaiian / Other Pacific Islander      Other      Patient Declined / Unknown

**Ethnicity:** Spanish / Hispanic Origin      Not of Spanish / Hispanic Origin      Patient Declined / Unknown

**Review of Systems**

Please circle the symptoms you have been experiencing recently:						
General:	Weight loss	Fatigue	Weakness	Fever	Chills	Night sweats
HEENT:	Vision Changes	Hearing Loss	Ringing in ears	Nose bleeds		
Neck:	Pain/difficulty swallowing	Sore throat	Lumps/Masses in neck	Hoarseness		
Respiratory:	Shortness of Breath	Wheezing	Dry Cough	Productive Cough		
Cardiac:	Palpitations	Chest pain	Short of breath when lying down	Swelling in legs	Short of breath when exercising	
GI:	Nausea / Vomiting	Difficulty swallowing	Indigestion	Change in bowel habits	Blood in Stools	Weight loss
GU:	Difficulty Urinating	Pain on Urinating	Prostate Problems	Urinating multiple times at night	Blood in Urine	
Vascular:	Pain in calves when walking	Clots in legs				
Musculoskeletal:	Pain/stiffness in bones or joints	Arthritis	Gout	Muscle Weakness		
Neurologic:	Numbness / weakness	Tingling	Tremors	Seizures	Blackouts	Headaches
Hematologic:	Easy Bruising / Bleeding					
Endocrine:	Heat / Cold intolerance	Excessive Thirst				
Skin:	Skin, hair or nail Changes	Rashes	Sores			
Psychiatric:	Depression	Anxiety	Thoughts of Suicide			

PATIENT NAME \_\_\_\_\_

DOB \_\_\_\_\_

**Your Insurance**

Type of Insurance	Subscriber Name	Subscriber Date of Birth
Policy or ID number	Phone Number	Relationship

**Other Insurance That Covers You (Secondary Insurance)**

Type of Insurance	Subscriber Name	Subscriber Date of Birth
Policy or ID number	Phone Number	Relationship

**If your injury was caused at work please provide the following:** Employer at time of injury - name and address (if different than current employer)

Compensation Carrier				
Compensation Carrier Address	City	State	Zip Code	Date of Injury
WCB #	Carrier Case Number		Carrier Phone Number	
Please describe how the injury/accident occurred:				Job Duty at Time of Injury

**If your injury was caused by an automobile accident please provide the following:** Insurance Carrier

Date of Injury			
No Fault Carrier Address	City	State	Zip Code
Owner of policy	Policy Number or File Number		Ins. Carrier Phone Number

**All patients - Please sign this section**

I authorize payment of medical and surgical benefits by third party carriers directly to Buffalo Neurosurgery Group. I also authorize the release of medical information about me to third party carriers responsible for paying all or part of my medical and surgical fees as well as to suppliers of medical services requesting them.

Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

I have been provided the Notice of Privacy Practices statement of Buffalo Neurosurgery Group.

Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**Patients with Medicare sign this section also**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Buffalo Neurosurgery Group for any services furnished me by Buffalo Neurosurgery Group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to Pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Medicare Beneficiary)



**BUFFALO  
NEUROSURGERY  
GROUP**

**Patient/Physician Agreement  
Regarding the Use of Pain Medication**

Narcotic medications can be harmful if used in excess. This is an important public health issue. In order for us to meet your needs in a *safe, effective and compassionate* manner, we must abide by the following rules:

- A. We cannot give out refill prescriptions when the office is closed, as we have no access to your prescription history or medical records. Our office is open 8:30 a.m. - 4:30 p.m. Monday through Friday.
- B. Please advise our office seven days prior to needing a new refill.
- C. Prescriptions should be picked up at the office, or can be mailed to the pharmacy at your request.
- D. You must be responsible for the use of your medications. All medications should be stored in a safe place and out of reach of children. We cannot refill lost or misplaced medications. Your prescriptions must not be taken by others.
- E. All narcotics may impair mental and physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. You should not perform such tasks while taking these drugs.
- F. Taking alcohol with this product must be avoided. Combining alcohol and pain medication can be harmful or fatal.
- G. If you have any questions about your medications, especially which medication may be a narcotic, please consult with one of our staff members or a pharmacist.

- 1. All prescriptions for pain medications will come from the Buffalo Neurosurgery Group or your primary care doctor, but not from both.
- 2. All prescriptions must be filled at one designated pharmacy. That pharmacy will be:

Pharmacy: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

- 3. You must not take more than the prescribed amount of medication. You will be instructed in the use of the medication so that no misunderstanding will occur.
- 4. Medication refills will be issued only for the date they are due.
- 5. In most every case, we will wean you off the narcotics. This process may take weeks to months.
- 6. Missed visits will constitute a breach of this contract, and when indicated, we may not issue medication until you have seen the doctor.
- 7. At your doctor's discretion, you agree to cooperate with random drug testing, which may be requested at any time. If you refuse, you understand any prescribed medications will be stopped. Any illegal substance found in your specimen will constitute grounds for your immediate dismissal from the doctor's practice (This includes, but is not limited to, marijuana, cocaine, heroin and any undisclosed prescribed medications).
- 8. Should you not comply with our agreement, we will be unable to continue prescribing these medications for you.
- 9. Pain medications should not be taken during pregnancy. If you become pregnant, please notify this office immediately.

**I AGREE WITH THE ABOVE INFORMATION**

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Buffalo Neurosurgery Group

## NOTICE OF PRIVACY PRACTICES

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 your 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 of 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:

**David E. Clabeaux, FACMPE, Compliance officer for Buffalo Neurosurgery Group**

### 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 laboratory tests (such as blood or urine tests), and 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. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – 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. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.
- 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. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.
- 3. Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in 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. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.
- 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. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
- 8. Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

### D. 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 agency(ies) and authority(ies) 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 procedures 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 person'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(s) 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. Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
- 7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.
- 8. Serious Threats to Health or Safety.** Our practice may use and 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.
- 9. 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.
- 10. 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.
- 11. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials 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 or the health and safety of other individuals.
- 12. Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.
- 13. HIV/AIDS.** Persons who have contracted HIV/AIDS have special confidentiality protection under federal and state law. Our practice cannot: 1) use patient HIV-related information absent a consent form for treatment, payment and health care operations; or 2) disclose HIV-related information to third parties unless the patient completes a NYS HIPAA Compliant Authorization (DOH 2557) form or the release is permitted or required by law. When written authorization for release of HIV-related information is required, only the NYSDOH-approved form *HIPAA Compliant Authorization for Release of Medical Information and Confidential HIV Related Information* (DOH 2557) will be accepted. Form DOH 2557 must be signed by the patient authorizing release of their: 1. HIV-related information; 2. Both (non-HIV medical and HIV related information); 3. only non-HIV-related information.

## 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 you at home, rather than work. In order to request a type of confidential communication, you must make a written request to David E. Clabeaux, FACMPE, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224, specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. 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 Sheila Sokach, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224. Your request must describe in a clear and concise fashion:
- the information you wish restricted;
  - whether you are requesting to limit our practice's use, disclosure or both; and
  - 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 Sheila Sokach, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs 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 an amendment 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 David E. Clabeaux, FACMPE, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224. 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 sharing information with the nurse; 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 David E. Clabeaux, FACMPE, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224. All requests for an "accounting of disclosures" 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 David E. Clabeaux, FACMPE, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224.
- 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 David E. Clabeaux, FACMPE, Administrator, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224. 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 David E. Clabeaux, FACMPE, Buffalo Neurosurgery Group, 550 Orchard Park Road - Suite A105, West Seneca, NY 14224.



2/8/10

Dear Patient,

The Federal Trade Commission (FTC) has released a new rule to protect consumers from IDENTITY THEFT. They require that we confirm your identification with your driver's license or other State or Federal picture ID.

**Please bring a picture ID with you to your appointment.**

We will take a photograph of you one time in order to eliminate the need to ask for your ID on future visits.

We regret any inconvenience this may cause. We do ask that you remember that just like many other institutions, Buffalo Neurosurgery Group must abide by federal law to keep your information protected. If you should have any questions, please do not hesitate to contact me at 677-6000.

Thank you for your patience and understanding.

David E. Clabeaux, FACMPE  
Chief Executive Officer  
Buffalo Neurosurgery Group