SURGICAL SPINE ASSOCIATES

Registration Form

Patient Legal Name: First: _____ MI: ____ Last: _____ _____

Date of Birth (MM/DD/YYYY): ____ /____ /_____ Patient Social Security Number: ____ - ___ - _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email Address: _____

Preferred Patient Language: _____ Interpreter Needed: YES NO

I was referred to this clinic by (circle one): Doctor Hospital Friend Family Internet Search

Insurance Information – You must also present your insurance card at your visit

Primary Insurance/Medicaid/Medicare: _____

Subscriber Information: First: _____ MI: ____ Last: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance/Medicaid/Medicare: _____

Subscriber Information: First: _____ MI: ____ Last: _____

Subscriber ID: _____ Group Number: _____

Worker's Comp / Accident Information-Please only complete if this is related to an accident

Worker's Comp / Auto Company: _____ Caseworker: _____

Address: _____ Phone: _____

Claim #: _____ Date of Injury/Accident: _____

Injury Type (please circle): Automobile Work Related Other

Emergency Contact

Name/Relationship: _____ Contact Number: _____

The above information is true to the best of my knowledge. I request that payment of authorized Medicare/ other insurance benefits be made on my behalf to Surgical Spine Associates for any services furnished to me by the physician or supplier. I authorize the release of my medical information to the Centers for Medicare and Medicaid Services and/or my insurance company and its agents, and any information needed to determine this benefit or benefits payable for related services. I am responsible for all charges, regardless of insurance status, as well as copayments and deductibles.

Patient/Guardian Signature: _____ Date: _____

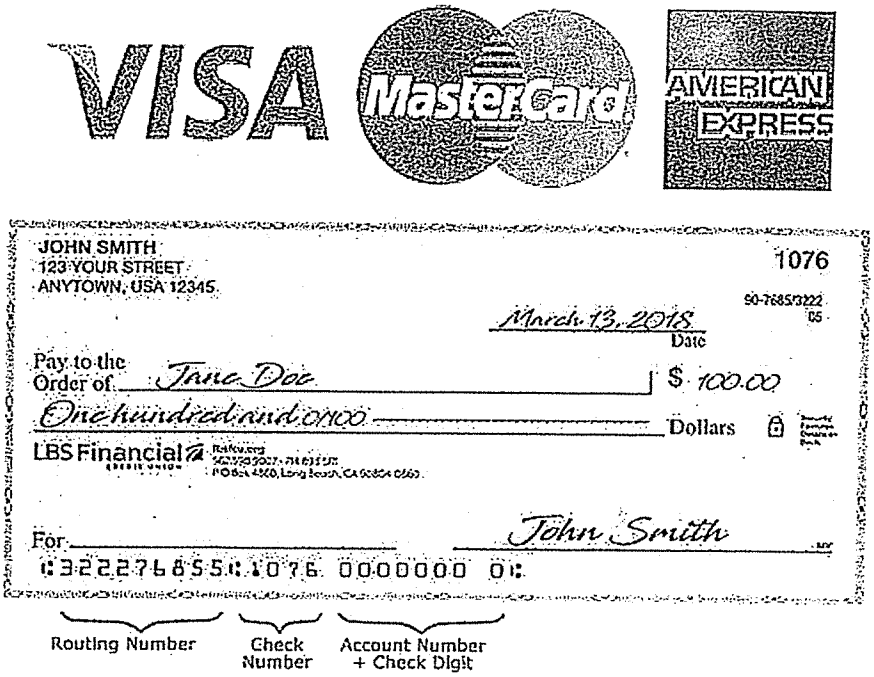
As of July 31, 2023,

Surgical Spine Associates is now

CASHLESS.

We will accept credit cards, debit cards, health savings cards and personal checks for any co-pays that are due at your appointment time.

Thank You



SURGICAL SPINE ASSOCIATES

EUGENE A. BONAROTI, MD, FACS

Phone: 412-275-0227 • **Fax:** 412-291-2111

Surgical Spine Associates offers three conveniently located offices for you neurosurgical needs.
Our locations are as below:

Monroeville

2790 Mosside Blvd
Suite 700
Monroeville, PA 15146
Located in the William Penn Plaza building directly across the street from UPMC East hospital

Warrendale

151 Fowler Rd
Warrendale, PA 15086
Located directly above Napa Prime restaurant

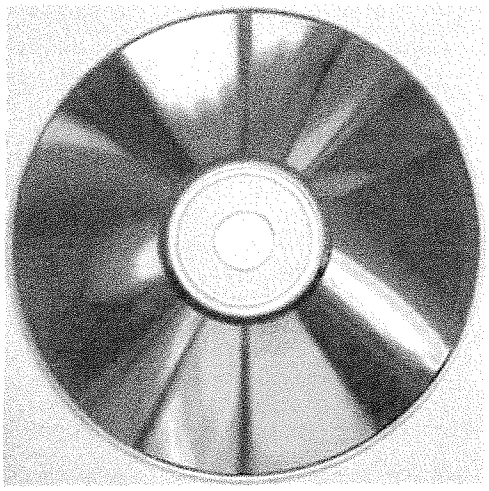
Washington

100 Trich Drive
Washington, PA 15301
Located in the Advanced Surgical hospital on the Orthopaedic side of the building

Please be advised that it is the patient's responsibility to bring all imaging to your appointment on a CD to review. Failure to do so will result in a cancelled appointment, as we cannot adequately review the testing.

The facilities will only send us the reports, not the CD's.

This includes X-rays, Ct scans, MRI scans, Bone scans and CT Myelograms



Thank you for your cooperation.

PATIENT HEALTH HISTORY

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please complete all pages. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess.

Last Name:_____ First Name:_____ Middle Initial:_____ Birthdate:_____

Gender:_____ Preferred Pronouns:_____ Pharmacy Name/Number:_____

Primary Care Physician:_____ Referring Physician:_____

REASON FOR TODAY'S VISIT:_____

Neurosurgical history:_____ First opinion _____ Second opinion

MEDICATION NAME	DOSE/MG	TIMES PER DAY

YOU MAY ALSO PROVIDE A MEDICATION LIST IF YOU PREFER*

ALLERGIES:_____YES _____NO-IF YES, PLEASE LIST BELOW

LATEX ALLERGY:_____ CONTRAST DYE ALLERGY:_____

NAME OF MEDICATION /PRODUCT	REACTION

SURGERIES AND HOSPITILAZATIONS

SURGERIES (PLEASE INCLUDE ALL):

_____

_____

_____

HOSPILAIZATIONS FOR NON SURGICAL REASONS:_____

Implanted Medical Devices:_____

HAVE YOU EVER HAD PROBELMS WITH ANESTHESIA (BEING NUMBED OR PUT TO SLEEP):_____YES _____NO

SIGNIFICANT FAMILY MEDICAL HISTORY:

_____

_____

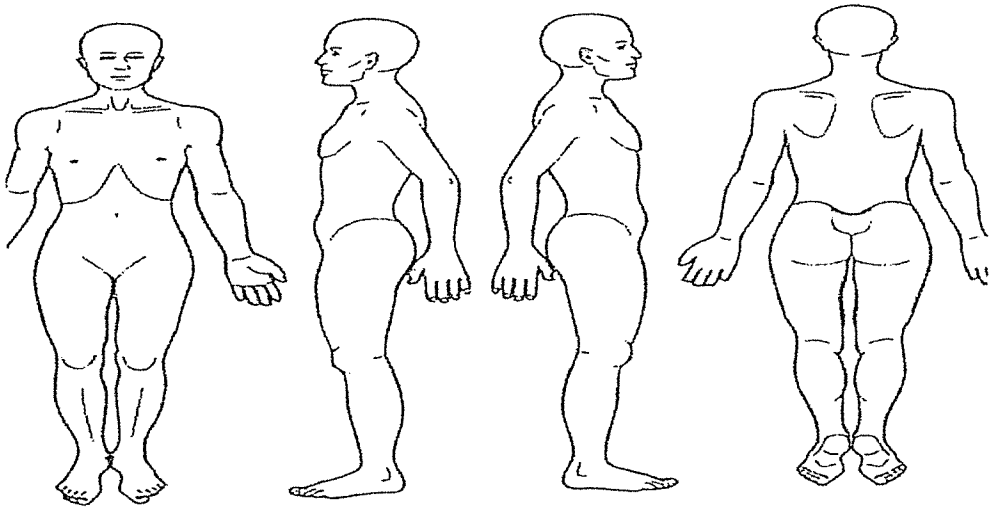
Most recent: Height:_____ Weight:_____

Indicate the current severity of your pain by circling a number below:

At its LEAST: 0 1 2 3 4 5 6 7 8 9 10 At its WORST: 0 1 2 3 4 5 6 7 8 9 10

Please use the illustration below to shade affected areas:

^^^ Aching /// Stabbing XXX Burning .... Pins/Needles --- Numbness ****Shooting



Approximate date of symptom onset:_____ How often is your pain: _____

- Duration (how long have you been experiencing the pain?) _____

- Timing (constant, intermittent, at night, with activity, etc) _____

- Does anything make the pain better? _____

- Does anything make the pain worse? (lifting, coughing, sitting, standing, walking, climbing stairs, etc)

_____

- Associated symptoms (circle): Numbness Tingling/Pins and Needles Weakness Piercing Stabbing Shooting Grinding Throbbing Cramping Aching Stinging Squeezing

- Any change in bowel, bladder, or sexual function? If yes, please explain:

_____

Do you have any other Healthcare providers involved in your care for this issue? Please list below:

_____

_____

REVIEW OF SYSTEMS

In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY, or explain any that may not be listed.** If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ☐ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Indicate what treatments you have already tried for your current problem, please include date and duration:

□ Surgery _____

□ Physical Therapy_____ □ Chiropractor/Chiropractic Treatment_____

□ Trigger Point Injections_____ □ Massage or Ultrasound_____

□ Epidurals/Nerve Blocks_____

□ Dry Needling/Acupuncture_____ □ Other treatments:_____

Medical History: check any medical problems you have been treated for.

□ Alcoholism □ Anemia □ Arrhythmia (irregular heartbeat) □ Arthritis □ Asthma □ Atrial fibrillation

□ Coronary Artery/Heart Disease □ Cancer (Type_____) □ Cardiovascular disease □ Congestive Heart Failure

□ Crohn's Disease □ Cirrhosis □ Colitis □ COPD (lung disease) □ Chronic Renal Failure □ CVA (stroke)

□ Dementia/Alzheimer's □ Diabetes, Type I or Type II □ Emphysema □ Epilepsy □ Fracture □ GERD

□ Hepatitis □ High Cholesterol □ High Blood Pressure □ Kidney Disease □ Ulcers □ Liver Disease □ Migraine

□ Multiple Sclerosis □ Osteoarthritis □ Osteoporosis □ Prior MI (Heart Attack) □ Pulmonary (Lung) Disease

□ RA (Rheumatoid Arthritis) □ Seizures □ Thyroid Disease

If YES to osteoporosis or osteopenia, date of last DEXA/Bone Density Scan: _____

SOCIAL HISTORY

Tobacco: Never smoker____Current every day smoker_____ Current some day smoker_____ Former smoker – Year quit_____, Years smoked_____

E-Cigarette/Vaping: Everyday user___ Someday user____ Former user____ Never User

Alcohol: Never_____ Rarely_____ Occasionally_____ Daily_____

Illicit Drug Use: Current____ Previous _____Never_____

Marijuana Use: Current____ Previous _____Never_____

Marital Status: Single _____ Life Partner ____ Married ____ Divorced ____ Separated ____ Widowed ____

With whom do you live: Alone _____ Children _____ Spouse/partner _____ Parents _____

Education Level: Less than high school_____ High School Graduate/GED: _____ Some College: _____

Associates: _____ Bachelors: _____ Advanced Degree: _____

Occupation current / previous:_____ Employment Status: _____

Signature of individual completing this form: _____

If it was completed by someone other than the patient, please print, sign, and state your relationship:

Name: _____ Signature:_____Relationship: _____

SURGICAL SPINE ASSOCIATES

EUGENE A. BONAROTI, MD, FACS
2790 Mosside Blvd Monroeville, PA 15146
Phone: 412-275-0227 • **Fax:** 412-291-2111

COMMUNITY CHART CONSENT

I,_____, give consent to SURGICAL SPINE ASSOCIATES to access the Community Chart in order to access and share my medical records if available through other entities operating under the Carequality Interoperability Framework, including Surescripts. This includes demographic information as well as other relevant clinical documentation.

Signature: _____ Date: _____

24 HOUR CANCELLATION / NO SHOW POLICY

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Surgical Spine Associates, reserves the right to charge a $50 fee for all missed appointments without a proper 24 hour notice or compelling reason for absence. A No Show fee will be directly billed to the patient. This fee is not covered by insurance and must be paid prior to scheduling another appointment in the office. Multiple occurrences in any 12 month. May result in termination from our practice. Thank you for your understanding and cooperation as we strive to best serve the needs of our patients. By signing below, you acknowledge that you have received this notice and understand the policy.

Signature: _____ Date: _____

SURGICAL SPINE ASSOCIATES

www.surgical-spine-associates.com
Phone: 412-275-0227 Fax: 412-291-2111

Authorization for USE or DISCLOSURE of Protected Health Information

I hereby authorize: _____ to release information
(Name of facility, entity, or practitioner)

From the record of: _____
Date of Birth: _____
SSN: _____

Release/disclose information to:

SURGICAL SPINE ASSOCIATES
2790 Mosside Blvd, Suite 700
Monroeville, PA 15146

For the specific purpose of:
__ Continued Care
__ Legal
__ Personal
__ Insurance
__ Other_____)_____

Dates of treatment (approximate, if known): _____

____ Discharge Summary	____ PT, OT, SLP Evaluation	____ Radiology Reports
____ History/Physical Exam	____ Progress Notes	____ Photos, videos, images and films
____ Consults	____ Lab Tests/Exams	____ Psych Diagnostic Interview
____ Operative Report	____ Complete Health Record	Other _____

NOTE: Psychotherapy notes are excluded from this authorization, as they require a special authorization for use/ disclosure.

Behavioral Health, AIDS or HIV, and Drug and Alcohol related information may be documented within the record indicated above and will be released through this authorization unless otherwise indicated.

Name: _____ Date:_____

PLEASE BE CERTAIN TO PROVIDE ALL APPROPRIATE SIGNATURES ON PAGE TWO OF THIS FORM. IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING INFORMATION THAT RELATES TO YOUR SIGNING THIS AUTHORIZATION TO USE/DISCLOSE. PLEASE INITIAL WHERE INDICATED.

I **understand** that my authorization is necessary to **obtain or release** my health information and that I may revoke this authorization at any time, **in writing**, except to the extent that Surgical Spine Associates may have already relied upon it in making a use or disclosure. My written revocation will become effective upon Surgical Spine Associates having knowledge of it. If I have provided this authorization to obtain insurance coverage, I may not have the right to revoke the authorization to the extent that it pertains to the insurer's right under law to contest a claim under my insurance policy. I understand that to revoke this authorization, I must send my written request to Surgical Spine Associates.

This authorization is **limited** to the **purpose** and to the person listed above and will be in effect for **6 months** after the date of my signature, unless otherwise specified.

_____This authorization will expire on the following date: _____

_____Or when the following event occurs _____

I **understand** that information released by Surgical Spine Associates under this authorization may be re-disclosed by the receiving party, and therefore Surgical Spine Associates and its employees have no responsibility or liability as a result of any re-disclosure; as such, the released information is no longer protected by the Privacy Rule.

I **understand** that Advanced Pain Medicine cannot make me sign this authorization as a condition to receive treatment. I **understand** that I am entitled to a completed copy of the Authorization for Use/Disclosure form.

X_____ X_____

Date of Patient Signature Patient Signature

(My signature confirms my understanding of the intended use of this authorization)

_____ _____

Date of Witness Signature Witness Signature

SURGICAL SPINE ASSOCIATES

Surgical Spine Associates Privacy Practices Notice Acknowledgement

I acknowledge that I have received the attached copy of the Surgical Spine Associates Notice of Privacy Practices. I also acknowledge that a copy of the Privacy Practices is available on the internet at www.surgical-spine-associates.com.

Patient or Personal Representative Signature: _____ Date: _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

Consent To Communicate

METHOD	OK TO LEAVE VOICEMAIL	OK TO LEAVE MESSAGE WITH ANOTHER PERSON	PREFERRED CONTACT METHOD
HOME NUMBER	___YES ___NO	___YES ___NO	
CELL NUMBER	___YES ___NO	___YES ___NO	
WORK NUMBER	___YES ___NO	___YES ___NO	

If you gave permission to leave a message with another person, please list them below:

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Name: _____ Relationship: _____ Contact #: _____

Patient/Guardian Signature: _____ Date: _____

SURGICAL SPINE
ASSOCIATES

www.surgical-spine-associates.com
Phone: 412-275-0227 Fax: 412-291-2111

PATIENT FINANCIAL POLICY

Surgical Spine Associates (SSA) is committed to providing you with the best possible care and will be happy to discuss questions regarding our policies, fees or your responsibilities at any time. A clear understanding of the "Patient Financial Policy" is important for the entire scope of your care.

All patients must complete our "Patient Information Form" **before** seeing a provider. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance, phone changes etc....)

INSURANCE: As a courtesy we will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductibles, co-payments, non-covered charges. We will supply factual information as necessary. We do provide expert opinions in workers compensation cases as a separate service.

REGARDING HMO'S, PPO'S AND MANAGED CARE PROGRAMS: It is your responsibility to obtain referral forms required by your particular insurance company. We will do our best to remind you when a referral is due, but ultimately you are required to keep track of the referrals on hand. If you present to the office without a current referral you may be rescheduled. If you are seen without the referral you will be responsible for the bill.

COPAYS: You are expected to pay your co pay prior to seeing your provider. If you are unable to pay, you may be required to reschedule your appointment.

REGARDING PATIENTS WITH NO INSURANCE: We will set up payment arrangements for office visits and and for surgical procedures. Therefore if you do not have coverage you will be required to pay for your service in full on the date of the appointment unless prior arrangements have been made. We accept credit cards, money orders and cash payments for your initial evaluation. We will not accept PERSONAL CHECKS for the initial evaluation.

REGARDING MEDICARE: Our providers participate with Medicare. We will file all claims with your Medicare and your supplemental insurance, if applicable. If you do not have a supplemental insurance you will be responsible for the co-insurance and/or deductible amount following the processing of your claim.

MEDICAL RECORDS/FORM COMPLETION: A charge of $20.00 is due before the forms will be completed. (Disability, FMLA, Physician statements, etc.).

SURGICAL SPINE ASSOCIATES

WORKERS COMPENSATION: Our office requires verification of your claim prior to the initial visit. You are also to provide us with any other health insurance coverage in case your workers compensation denies the services. If you do not have health insurance coverage you will be asked to self pay for claims denied by your workers compensation claim.

AUTO LIABILITY: Our office requires verification of the claim prior to the initial visit. You are also required to provide your health insurance coverage. If you do not have health insurance coverage, we will not be able to schedule an appt. In the case that your do have health insurance coverage and it terms you will be responsible to self pay for claims not covered by your auto claim.

COPAYS/DEDUCTIBLES/GUARANTOR RESPONSIBILITY: Our office requires payment in full for any balance not paid by insurance within three months from the date of service. If you are unable to pay our balance in full it is the patient's responsibility to make arrangements with our billing office.

RETURNED CHECKS: There is a $30.00 returned check fee payable in cash or money order.

NO SHOW APPOINTMENTS: You are expected to show for the appointments made for you to adequately provide care. Failure to provide notice (of 24hrs for office visits) that you will not be keeping your appointment may result in a delay

By signing this from I acknowledge that I have read this policy and understand the terms outlined above.

Patient Name (Please print) Patient Signature Date

SURGICAL SPINE
ASSOCIATES

Understanding Your Bill

Initial Consultations
If you are evaluated by a physician or physician assistant in one of our offices for an initial consultation, charges incurred cover the time required to obtain a history, your physical examination, review of X-rays, MRIs, and CT scans, review of laboratory studies, review of previous medical records, discussion of your diagnosis and treatment plan, and preparation of a detailed written report which will be sent to your referring physician.

You must be referred by another physician for an initial consultation.

Insurance co-payments are due at the time of your visit.

Office Visit
An "office visit" is exactly the same as a "consultation", except that there is no physician referral. Our practice is a specialty practice that works almost exclusively on a referral basis, so this type of charge is not commonly used.

Follow-up Visits
Subsequent or follow-up visits are typically briefer and have a lower fee than initial consultations.

Insurance co-payments are due at the time of your visit.

Hospital Care
If you receive non-surgical care in a hospital setting, charges apply for initial consultation and for hospital visits on subsequent days, similar to those described above for the outpatient setting.

Insurance co-payments are NOT required for inpatient services.

Surgical Care
If you undergo a surgical procedure with one of our surgeons, charges are typically billed as a **"global fee"**, which covers the surgeon's fee for the surgical procedure, as well as all subsequent inpatient and outpatient care for a "global period" of 90 days after the procedure. (less for some minor procedures).

The fees paid to Surgical Spine Associates specifically DO NOT include fees for the hospital, anesthesia services, operating room time, Xray CT and MRI interpretation by a radiologist, and other hospital charges which are billed separately.

SURGICAL SPINE ASSOCIATES

Understanding Your Bill

Information for Patients with Insurance

Surgical Spine Associates participates with most major insurance plans including Medicare, Medicaid, Highmark, UPMC, Aetna, United Healthcare and others. A complete up-to-date list is maintained on our website www.surgical-spine-associates.com.

(Note: This list is updated periodically. Insurance contracts require renewal on a yearly basis, so check with your insurance carrier if there is any doubt about our participation.)

If Surgical Spine Associates "participates" with your insurance plan, then we have negotiated an agreement with your insurance carrier, and have agreed to accept a predetermined amount for services rendered.

Under the terms of all insurance plan, the patient is responsible for obtaining their own referral.

EVERY INSURANCE PLAN IS DIFFERENT. YOU MUST READ YOUR PLAN CONTRACT TO DETERMINE YOUR SPECIFIC COVERAGE.

Even if you have insurance coverage, you may still be responsible for some or all of the fees for your care:

1. Most insurance plans require small co-payments for initial consults and office visits. Co-payments are due and payable at the time that services are rendered.
2. Pre-approval of services is required by many carriers. Without pre-approval, you may be responsible for fees.
3. Your insurer may only pay a certain percentage of your charges, in which case you will be responsible for the balance.
4. Your insurer may choose not to approve payment for certain services base upon the determination of "medical necessity". In this case, you can appeal the insurers decision. We can support you in your appeal, but your insurer makes the final determination, regardless if your surgeon documents his opinion on the medical necessity of the procedure.
5. Your insurer may place lifetime or annual limits on some care, such as physical therapy services. Your surgeon CANNOT appeal coverage decisions based upon these limits.
6. Your insurer may consider certain procedures "experimental", in which case they may choose not to cover services.
7. Your insurer may choose not to cover services of a physician assistant.

AGAIN: EVERY INSURANCE PLAN IS DIFFERENT. YOU MUST READ YOUR PLAN CONTRACT TO DETERMINE YOUR SPECIFIC COVERAGE.

SURGICAL SPINE ASSOCIATES

Understanding Your Bill

Information for Patients with Nonparticipating Insurance

- If your insurer does not have a contract with Surgical Spine Associates, then services rendered by our physicians are considered "out-of-network".
- Check your plan contract to see if "out-of-network" services are authorized.
- Typically, "out-of-network" services, if covered, are covered at 50-80% of our usual and customary fees. You **will be** responsible for any balance not covered by your insurer.
- If your insurance plan does not allow "out-of-network" services, see information below for patients with no insurance.

Information for Patients covered by Workers Compensation or Auto Insurance

- Surgical Spine Associates DOES participate with many workers compensation and auto insurance plans.
- We require a determination letter from the compensation or auto carrier that you have a valid claim, and that payment is guaranteed.
- Many compensation and auto claims are contested or disputed – therefore, without a letter of coverage, we require coverage from a standard health insurer (such as Blue Cross/Blue Shield) as a "backup" plan.
- If you do not have a letter of determination yet, and have no standard insurance as a "backup", then see the information below for patients with NO insurance.

Information for Patients with NO Insurance

- We will not turn away patients because of a lack of insurance.
- Just like our insured patients, you will need to sign a financial responsibility form.
- Call our billing office to make arrangements for payment – our staff can arrange a payment plan.
- In cases of demonstrated financial need, fees can be reduced or waived.
- In the case of inpatient care or surgery, keep in mind that separate arrangement will need to be made with the hospital which bills separately for its services.

Payment Options

Surgical Spine Associates accepts the following forms of payments:

- Cash, Check, or Money Order
- Visa, Mastercard, Discover, American Express
- Debit Cards

SURGICAL SPINE ASSOCIATES

EUGENE A. BONAROTI, MD, FACS
2790 Mosside Blvd, Monroeville, PA 15146
Phone: 412-275-0227 • Fax: 412-291-2111

ARTIFICAL INTELLIGENCE (AI) SCRIBE DICTATION

I, _____, hereby consent to the use of Artificial Intelligence (AI) scribe dictation technology in the documentation of my medical records at Surgical Spine Associates. This form provides information about the use of AI technology, its purposes, and the security measures in place to protect my privacy.

PURPOSE OF AI DICTATION:
AI scribe dictation technology is utilized to convert spoken words into text format for the purpose of documenting medical information in an efficient and accurate manner. The AI system may be employed in the transcription of medical notes, reports, and other relevant documents.

HOW AI DICTATION WORKS:
During my medical appointments, any verbal information provided by me or my healthcare provider may be recorded using AI scribe dictation. The AI system processes and transcribes spoken words into text, contributing to the creation of my medical records. The AI scribe will not be used to make any decisions about your care. Your doctor will review all of the information in your medical record, including the AI-scribed notes, before making any decisions about your care.

SECURITY MEASURES:
The medical practice employs robust security measures to safeguard the confidentiality and integrity of the information processed through AI dictation. These measures include encryption, access controls, and regular security audits to prevent unauthorized access and protect against data breaches.

PATIENT RIGHTS:
1. Access to Information: I have the right to request access to my medical records and transcripts generated through AI dictation.
2. Amendment of Information: I have the right to request corrections or amendments to any inaccuracies in my medical records.
3. Withdrawal of Consent: I have the right to withdraw my consent for the use of AI dictation at any time. However, withdrawal may affect the efficiency of medical record documentation.

PATIENT CONSENT:
I have read and understand the information provided in this consent form. I have had the opportunity to ask questions, and any concerns have been addressed to my satisfaction. By signing below, I voluntarily consent to the use of AI dictation technology in the creation of my medical records at Surgical Spine Associates.

Patient Signature: _____

Date: _____