North American Partners in Pain Management, LLP

NOTICE OF PRIVACY PRACTICES

Notice of Privacy Practices
Effective: September 23, 2013

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

If you have any questions about this Notice of Privacy Practices, please contact our Privacy Officer, Leslie Russo, Vice President, Human Resources & Compliance at (516) 945-3057.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of this Notice at any time. Any revised Notice of Privacy Practices would be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail. A copy of the current Notice of Privacy Practices will be prominently displayed in our office at all times and posted on our website at www.napaanesthesia.com.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Uses and Disclosures of Protected Health Information

Prior to disclosing your protected health information to outside health care providers or to obtain payment, **North American Partners in Pain Management ("NAPPM")** will obtain your general consent, usually at your first visit to our facility. However NAPPM is legally permitted to use or disclose your protected health information without your consent in order to carry out treatment, payment and health care operations, some example of which are described here:

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related treatment. This includes the coordination or management of your health care with a third party that already has obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to your primary care physician. We also may disclose protected health information to other specialist physicians who may be treating you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we provide for you, determining your eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to an insurer or accreditation agency that performs chart audits. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may use or disclose your protected health information, as necessary, to contact you to remind you of a scheduled appointment or procedure. You may request, however, that we contact you only at a certain phone number or that we refrain from leaving messages on an answering machine or with someone else. We will accommodate all reasonable requests.

We will share your protected health information with third party "business associates" that perform various activities for our practice (e.g., billing and collection companies, computer consulting company, law firm or other consultants). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your signed, written

authorization, unless otherwise permitted or required by law or as described below. For example, NAPPM will not sell your protected health information or use or disclose it for marketing purposes without getting a signed authorization from you to do so. NAPPM will also not use or disclose psychotherapy notes relating to you without your written authorization.

You Have a Right to Revoke Your Authorizations.

You may revoke your authorizations at any time, in writing, except to the extent that NAPPM has already taken an action in reliance on the use or disclosure indicated in the authorization.

Uses and Disclosures To Which You Have an Opportunity to Object

Others Involved in Your Health Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify as being involved in your medical care or payment for such care any of your protected health information that directly relates to that person's involvement in your health care. If you bring someone with you into a treatment room, you are hereby notified that you will have identified that person to us as being so involved in your care, and may discuss your protected health information in their presence in front of you. In an emergency or when you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based upon our professional judgment. We will give you the opportunity to object to future disclosures to family and friends.

Other Permitted and Required Uses and Disclosures that May be Made without your Consent or Authorization

We may use and disclose your health information legally in a number of ways without your authorization. Such uses and disclosures include the following categories:

Required by Law: We may use or disclose your protected health information to the extent that we are required by law to do so. The use or disclosure will be made in compliance with the law.

Public Health: We may disclose your protected health information for public health activities to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We also may disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your protected health information to a governmental agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information.

Product Monitoring and Recalls: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, and biologic product deviations; to track products; to enable product recalls; to make repairs or replacements, or in connection with post-marketing surveillance, as required by law.

Research: We may use and disclose your health information for research purposes, provided the information does not identify you, or a waiver has been issued by an institutional review board or a privacy board after the board has reviewed the research proposal and protocols to guarantee the privacy of your health information, or such information is only released to researchers in connection with their preparing to conduct a research project and during such preparations no health information relating to you leaves NAPPM.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in response to a subpoena, discovery request or other lawful process if certain efforts to notify you or to obtain protective orders relating to such information are made.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) as required by law (including such legal processes as court orders or in connection with warrants or subpoenas) and pursuant to administrative requests, (2) requests to identify or locate a suspect, fugitive, witness or missing person, (3) pertaining to law enforcement requests about a victim or suspected victim of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of NAPPM, and (6) medical emergency not occurring on NAPPM's

premises when needed to inform law enforcement about the details of a crime that has occurred.

Decedents: Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation: Your health information may be used or disclosed for cadaver organ, eye or tissue donation purposes.

Criminal Activity: We may disclose your protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety or a person or the public. We also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for authorized military purposes, as required by law, or to authorized federal officials for intelligence or counterintelligence activities, or as authorized by federal officials to protect the President or other persons or foreign leaders, or to conduct special investigations.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Inmates: If you are an inmate, we may use or disclose your protected health information to a correctional facility or a law enforcement official if you are an inmate of that facility or in that official's custody. This information would be necessary for the facility to provide you with health care, protect the health and safety of others or the facility itself.

Required by HHS: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the federal privacy regulations.

2. YOUR RIGHTS

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a paper copy of protected health information about you that is contained in a medical record maintained by NAPPM for as long as we maintain the protected health information. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying, by law. We may require that you submit your request in writing to our privacy officer at the address or facsimile number at the end of this notice, and may charge you our standard fee for the costs of copying, mailing or other supplies we use to fulfill your request. We will have 30 days to respond to your request. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you of this delay.

If we maintain your protected health information in an electronic medical record, you have the right to obtain electronic copies of your protected health information or to direct us to get it to a third party; we may charge a reasonable cost based fee limited to the labor costs connected with transmitting the information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You also may request that all or any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

In most circumstances, your physician is not required to agree to any restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, this information will not be restricted.

You have a right to restrict your protected health information sent to a health plan in certain circumstances. If you request us to restrict disclosures to health plans that we would normally make as part of payment or health care operations, we ***must*** agree to that restriction if the protected health information relates to health care which you have already paid for (or had someone pay for) in full out of pocket (meaning your insurance did not pay for it).

If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction using the form for requests for restrictions on protected health information from the Privacy Officer, or you may provide us your request, in writing. Your written request must include (a) the information you wish restricted; (b) whether you are requesting to limit the Practice's use, disclosure, or both; and (c) to whom you want the limits to apply.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. For example, you may ask us to contact you by mail, rather than by phone at home. You do

not have to provide us a reason for this request. We will accommodate reasonable requests. We also may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you that we maintain that you feel is incomplete or inaccurate. Your request must be in writing and provide a reason that supports your request. We may deny your request for an amendment in certain cases, for example, because you fail to provide a reason to support your request, or the information was not created by NAPPM (unless the entity or person that did create the information no longer exists) or not kept by NAPPM, or because upon review the information is found to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have a right to be notified following a breach of your unsecured protected health information. Where there has been an improper disclosure or use of your protected health information, we will notify you of the facts surrounding such breach, what we have done or are doing about it and how to best protect yourself in our opinion.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies generally to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. However, you do have the right to an accounting of disclosures for treatment, payment or health care operations if the disclosures were made from an electronic health record. Your right to an accounting of disclosures excludes disclosures we may have made to you, or to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding other disclosures that occurred up to six years from the date of your request (three years in the case of disclosures from an electronic health record made for treatment, payment or health care operations). You may request a shorter timeframe. The first list you request within a 12-month period is free of charge, but there is a charge involved with any additional lists within the same 12-month period. We will inform you of any costs involved with additional requests, and you may withdraw your request before you incur any costs.

You have the right to obtain a paper copy of this Notice from us.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us, at U.S. Department of Health & Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201; phone 202-619-0257, toll free 877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints. You may file a complaint with us by notifying our Privacy Officer of your complaint within 180 days of the suspected violation. Please provide as much detail as you can and send it our Privacy Officer at the address below. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, Leslie Russo, at (516) 945-3057, fax (516) 945-333, 68 South Service Road, Suite 350, Melville, NY 11747, for further information about the complaint process.

TOTAL PAIN CARE
(A SUBDIVISION OF NAPPM-NJ)

REGISTRATION FORM

Name: ______________________________ Date: ______________

Street Address: ____

City: ____________________ State: ________ Zip Code: ______________

Home Phone #: (____)__________ Cell #: (____)__________ Work #:(_____)__________

Sex: M _____ F _____ Date of Birth: ______________ Social Security #: ______________

E-Mail Address: ____

Referring MD: ____________________ Primary MD: ____________________

Emergency Contact: ______________ Phone #: (__)__________ Relationship: ______________

Employer's Name: ____________________ Employer's Phone #: ______________

Pharmacy Name: ____________________ Phone #: (_____)__________ City: ______________

INSURANCE

Is your visit related to: 1) Motor Vehicle Accident? 2) Worker's Comp? (If yes, circle one)

MVA or WC Insurance Name: ______________ Claim #: ______________ Date of Accident ________

Adjuster/Case Mgr Name: ____________________ Phone #: (____)______________

Attorney Name: ______________ Address: ______________ Phone #:(_____)__________

Primary Health Insurance: ____________________ Effective Date: ______________

Member ID #: ____________________ Group ID #: ____________________

Primary Insurance Address: ____

Primary Insurance Phone #: (____)______________ Policyholder's Name: ______________

Policyholder's DOB: ____________________ Policyholder's SSN: ______________

Secondary Health Insurance: ______________ ________ Effective Date: ______________

Member ID #: ____________________ Group ID #: ____________________

Secondary Insurance Address: ____

Secondary Insurance Phone #: (____)______________ Policyholder's Name: ______________

Policyholder's DOB: ____________________ Policyholder's SSN: ______________

I AUTHORIZE THE RELEASE OF INFORMATION REQUESTED BY MY INSURANCE CARRIER, MY ATTORNEY AND MY EMPLOYER. I ACCEPT FULL RESPONSIBILITY FOR THE PAYMENT OF SERVICES RENDERED AND AGREE TO PAY FOR THEM.

Signature: ______________________________ Date: ______________

ASSIGNMENT OF BENEFITS

Patient Name:____

Patient Address:____

Date of Loss:____

Insurance Company:_______________________________________

Name of Policyholder:_____________________________________

Policy Number:____

Claim Number:____

1. I, the undersigned, hereafter referred to as "the patient" do hereby assign all of my rights and interests to North American Partners In Pain Management-New Jersey LLC, hereafter referred to as "the medical provider" to pursue and obtain payment from the above mentioned insurance carrier. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.
2. I, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement made on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider's medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.
7. To prevent the insurance carrier and/or the vendor designated by the insurance carrier from refusing to accept my Assignment or submitting a challenge to my Assignment as being invalid, I execute this Special Power of Attorney and appoint and authorized the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the insurance carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name. I understand and acknowledge that the attorney chosen by the medical provider is to represent me individually on any claim for outstanding treatment with the medical provider in any appropriate forum. This Assignment serves as a limited retainer agreement between me and the attorney chosen by the medical provider for the sole purpose of representing me on a claim for outstanding treatment. I have been advised that if an arbitration and/or lawsuit is filed in my name individually, failure to include and outstanding medical provider's bills whom I have not executed an Assignment of Benefits with could make me liable for payment to the provider. In consideration, this medical provider has agreed to accept as payment in full, the amount awarded and/or settled and will not seek additional payment from other insurance carriers.

Signed:_____________________________

Patient's Name:________________________

Date:_______________________________

ACKNOWLEDGEMENT OR RECEIPTS OF THE NOTICE OF PRIVACY PRACTICES OF TOTAL PAIN CARE

(A SUBDIVISION OF NAPPM-NJ)

Patient Name: ______________________ **Date of Birth:** ______________________

Address: ______________________ **Telephone No:** ______________________

____

____

I hereby acknowledge that I have received form Total Pain Care / A subdivision of NAPPM-NJ, a copy of its Notice of Privacy Practice. I understand that the Notice of Privacy Practices sets forth my rights relating to the use of a disclosure of my personal health information and explains how Total Pain Care / A subdivision of NAPPM-NJ can use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact Total Pain Care / A subdivision of NAPPMY-NJ if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Total Pain Care / A subdivision of NAPPM – NJ.

______________________ ______________________

Signature of Patient or Patient's Representative **Date**

RELEASE OF RECORDS

Patient Name:______________________________

Date of Birth: ______________________________

SSN: ______________________________________

You are hereby requested and authorized to disclose, make available and furnish to my physician whose name and address is:

Total Pain Care
703 Main St
Paterson, NJ 07503
Phone: 973-754-2499
Fax: 973-754-2479

Please furnish copies of any and all medical records and reports of office visit notes, x-rays, lab reports, radiology reports, neurological consultations and diagnostic reports. This authorization shall be considered as continuing and you may rely upon it in all respects. It is expressly understood by the patient and you are hereby authorized to fax or mail the above mentioned medical records.

______________________________ ________________________
Patient Signature Date

Total Pain Care
(A SUBDIVISION OF NAPPM-NJ)

Pain Assessment Form

Name:______________________________ Age:__________ Date:__________

1.Please describe as best you can, the **location** of your pain:

____

____

____

____

2. Does your pain **radiate** anywhere? If yes, where?______________________________

3. Do you have any numbness or tingling? ☐ Yes ☐ No
If yes, describe where______________________________

4. **How long** have you had this pain? ______________________________

5. Please mark the **events** which led to your present pain:

☐ Motor Vehicle Accident ☐ Worker's Comp ☐Fall ☐ Other:__________

6. **How often** does the pain occur?

☐ Constant (100% of the time) ☐ Frequent (75% /time)
☐ Intermittent (50% /time) ☐ Occasional (25% /time)

7. What **worsens** your pain?

☐ Standing ☐ Walking ☐ Sitting ☐ Activity ☐Bending ☐Twisting ☐Lying Down

8. What **relieves** your pain?

☐ Sitting ☐ Lying down ☐ Standing ☐ Physical Therapy ☐ Medication

9. Please choose up to **3** options that **best describe** your pain?

☐ Sharp ☐ Aching ☐ Burning ☐ Throbbing ☐ Shooting ☐ Electric
☐ Pricking ☐ Nagging ☐Stabbing ☐Pressing ☐ Crushing ☐ Dull
☐ Tingling ☐ Itching ☐ Squeezing ☐ Gnawing ☐ Cramping ☐ Cutting

10. Does the pain interrupt your sleep?

☐ Yes ☐ No ☐ Sometimes

11. Does the pain affect your activity in these different areas?

☐ School ☐ Work ☐ Household chores ☐ Social interactions ☐ Leisure ☐ Sexual activity

12. What treatments have you already tried for your pain?

Treatment	No Help	Some Help	Great Help	How Long	Now Using
Acupuncture	______	______	______	______	______
Chiropractic Therapy	______	______	______	______	______
Epidural Injections	______	______	______	______	______
Exercise	______	______	______	______	______
Massage	______	______	______	______	______
Nerve Blocks	______	______	______	______	______
Physical Therapy	______	______	______	______	______
Surgery	______	______	______	______	______
TENS Unit	______	______	______	______	______
Trigger Point Injections	______	______	______	______	______
Medications for pain	______	______	______	______	______

13. Do you have any of these **symptoms/ medical problems**?

☐ Heart Trouble/ Irregular heart rate ☐ Stroke ☐ High Cholesterol ☐Diabetes

☐ High Blood Pressure ☐ Asthma ☐ Seizures ☐ Chest Pain

☐ Low Blood Pressure ☐ Cancers ☐Thyroid Problem ☐ Bronchitis

☐ Renal/kidney disease ☐ Fatigue ☐ Liver problems ☐ Depression

☐ Shortness of Breath ☐ Anxiety ☐ Trouble sleeping ☐ Dizziness

14. Have you ever had any **surgeries/ operations** before?

If yes, please explain:

____

____

____

15. List all **medication**(s) and dosages of what you are currently taking:

____

____

____

____

____

____

16. Do you have any **allergies** to any medications? ☐ Yes ☐ No

Seafood ☐ Yes ☐ No

Contrast Dye ☐ Yes ☐ No

If yes, which medication(s) are you allergic to and the reaction to it?

____

17. Do you, or have you ever used **tobacco**? ☐ Yes ☐ No

If yes, how much and how often?____

18. Do you, or have you ever used **alcohol**? ☐ Yes ☐ No

If yes, how much and how often?____

19. Do you, or have you used **illicit drugs**? ☐ Yes ☐ No

If yes, briefly describe____

20. Are you: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

21. Do you have children? ☐ Yes ☐ No

If yes, how many? ____

22. Are your **parents and siblings** alive and healthy? If not, please explain:

____

23. Are you: ☐ Employed Full-Time ☐ Part-time ☐ Unemployed ☐ On disability

24. Have you had any:

☐ MRIs ☐ X-Rays ☐ CT scan ☐ EMG/ Nerve test

Stress test

25. Do you have any **implants**? ☐ Yes ☐ No

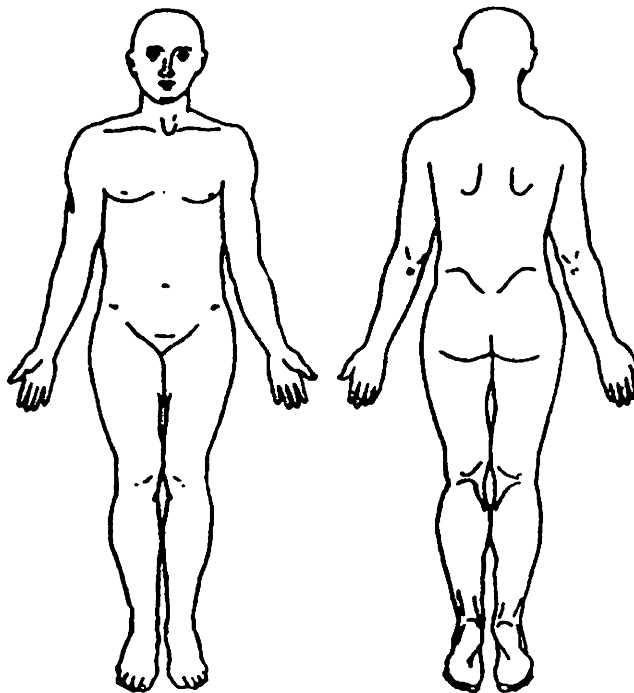
If yes, describe____

(Pacemaker, Stents, etc.)

Pain Diagram and Pain Rating

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY: Pins and Needles = **0000000** Pain = **XXXXXX**



Please rate your **current level of pain** on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your **worst level of pain** in the last 1 week on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate **your best level of pain** in the last 1 week on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Referral Source Form

Primary Physician: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Chiropractor: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Physical Therapy: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Orthopedist: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Neurologist: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Attorney: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Cardiologist: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________

Pharmacy: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Fax #: ______________________________