Institute for Neuro-Immune Medicine
NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

DEAR NEW PATIENT

Welcome to the Institute for Neuro-Immune Medicine Clinics located in Davie (Fort Lauderdale) and Kendall (Miami) Florida. The INIM Davie clinic is located on the main NSU Campus in the Center for Collaborative Research (CCR) building. The Kendall clinic is in the Performing Arts Building.

INIM Davie
7595 SW 33rd Street, Suite 405
Davie, FL 33314
Phone:954 262 2850
Fax: 954 262 3850

INIM Kendall
8501 SW 124th Ave, Suite 111A
Miami, FL 33183
Phone:954 262 2850
Fax: 954 262 3850

The following forms in this New Patient Packet need to be filled out and returned to the office before the appointment. If you have any pertinent medical records/labs and/or recent lab work, please provide these before the appointment as well. Please return these forms and any records via fax, by mail, or by bringing them to the office before the day of the appointment.

On the day of the appointment, you will need to present your insurance card and identification card. Please note that INIM clinic is a self-pay clinic. The only insurance we accept is Medicare Part B (not the Medicare Advantage plans).

Prior to the appointment, a link to the Redcap survey will be sent to the email address you provide. Note, this email will be from INIMSurveys@nova.edu and it is sent on the day and time that the appointment is made. Please complete the survey prior to the visit.

We look forward to your visit with us.

Sincerely,

INIM Clinic

New Patient Packet Forms

- Initial Assessment of CFS Patients (18 pages)
    - Medical History
    - Family History
    - Social History
    - Fatigue History
    - Symptoms Questionnaire
    - Multidimensional Fatigue Inventory
    - Karnofsky Performance Scale
    - Brief Pain Inventory
    - General Health Questionnaire
    - HAD Scale
    - Sleep Assessment Questionnaire

- Consent forms, Signatures Required:
    - NSU Consent for treatment (7 Pages)
        - Addendum for Established Patients Release of Information for Treatment and Health Care Operations
    - HIPAA Agreement (8 Pages)
    - PHI form (3 pages)
        - Fill this out for yourself and for any providers you may wish us to send your records to. Make multiple copies, one for you and for each provider/office.
        - These forms expire every 90 days unless a different date or expiration event is placed on the second page. You may put “end of treatment” as the expiration event.
    - Family and Friends Communication Designation form (2 pages)
        - Fill this out for your family members who may call on your behalf. Our office cannot speak with a family member or friend if they are not on file.

INITIAL ASSESSMENT OF CFS PATIENT

Date: _____/_____/_____

CONTACT INFORMATION

Please answer a few questions about your background. Please fill in the answers to the questions below. All information will be kept strictly confidential.

1. Last Name: _____
2. First Name: _____
3. Current Address: _____

   Street Apt City State Zip
4. Telephone number: _____

   Other number: _____

   May we leave messages at this number? _____ yes _____ no
5. Date Of Birth: ___ ___ / ___ ___/ ___ ___ ___ ___ Social Sec # _____
6. E-Mail Address: _____
7. (A) Emergency Contact Name:_____

   Emergency Contact Number: _____

   (B) Emergency Contact Name:_____

   Emergency Contact Number: _____

   (C) Emergency Contact Name:_____

   Emergency Contact Number: _____
8. Primary Care Physician's name: _____

   Phone number: _____ Fax number: _____
9. If we can't find you through e-mail or phone, may we contact a member of your family to locate you? ____ **YES** ____ **NO**

   If yes which of the above named persons listed in question 7 should we contact? ____7A ____7B ____ 7C
10. What type of insurance do you have? _____

    ID# _____ Group # _____

    Do you know which lab they prefer/require? _____ Quest _____ Lab Corp

11. May we have your permission to:

____ Contact you about special events regarding Dr. Klimas or CFS or related topics?
____ Send you information about upcoming seminars and conferences?
____ Send you a newsletter from the Chronic Fatigue Center?
____ Contact you about research and/or foundation related fundraising events?
____ Store your blood sample in case we need to do additional studies?
____ Use stored blood for research purposes including genetic studies?
____ Contact you for any research studies related to CFS?

12. We are interested in learning more about CFS and its long term effects. Would you allow us to contact you annually and have you fill out forms similar to these?

____ YES ____ NO

_____ _____

Signature Date

Last name, First name: _____

MEDICAL HISTORY

Please answer the following questions about your medical history. All information will be kept strictly confidential. Mark XX by the appropriate answer.

Hospitalizations

1. Have you had any hospitalizations overnight or longer other than to have surgery?

____**YES** ____ **NO** ____ **NOT SURE** If yes, please give details.

a)_____

_____

b)_____

_____

c)_____

_____

d)_____

_____

e)_____

_____

2. Have you ever had surgery? ____**YES** ____ **NO** ____ **NOT SURE**

If yes, please list each operation and your age when the surgery was performed

A)_____

B)_____

C)_____

Allergy

3a. Are you allergic to any medicines?

Medicine:	**allergic?**		**Confirmed by doctor**	
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO

3b. Are there any medicines that you do not tolerate?

_____

_____

_____

3c. Are you allergic to any foods:	**allergic?**		**Confirmed by doctor**	
_____	____YES	____ NO	____YES	____ NO
_____	____YES	____ NO	____YES	____ NO

4. Current Weight: _____ Height: _____

a) Has your weight increased or decreased by more than 10 pounds in the last year?

____ YES ____ NO

b) If you had specific weight changes, how many times did that happen? _____

c) By how much? _____ pounds

5. In the past year, how many colds, bouts of flu or upper respiratory infections have you had? (Indicate if continuous)

_____

6. Are you presently experiencing a cold or flu? ____ YES ____ NO ____ NOT SURE

7. Are you presently on any medications?

If yes, please list below any prescription, over the counter, or herbal medications you are currently taking.

Medication	Date of Start/Duration	Dosage	Clinical Reason
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____
5) _____	_____	_____	_____
6) _____	_____	_____	_____
7) _____	_____	_____	_____
8) _____	_____	_____	_____
9) _____	_____	_____	_____
10) _____	_____	_____	_____
11) _____	_____	_____	_____

Have you ever been told by a physician that you had any of the following conditions or illness?

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Cardiovascular					□Yes □No
Angina					□Yes □No
Heart attack					□Yes □No
Heart condition that limits walking					□Yes □No
Heart failure					□Yes □No
Heart murmur					□Yes □No
Stroke					□Yes □No
Hypertension					□Yes □No
Low blood pressure					□Yes □No
Phlebitis					□Yes □No
Peripheral vascular disease					□Yes □No
Hemorrhoids					□Yes □No
Chest					
Asthma					□Yes □No
Chronic bronchitis					□Yes □No
Emphysema					□Yes □No
Pneumonia					□Yes □No
Tuberculosis					□Yes □No
Endocrine					
Adrenal insufficiency					□Yes □No
Overactive adrenal (Cushing's disease)					□Yes □No
Diabetes (1 or 2)					□Yes □No
Hypoglycemia					□Yes □No
Overactive thyroid					□Yes □No
Underactive thyroid					□Yes □No
Gastrointestinal					
Colitis					□Yes □No
Enteritis					□Yes □No
Gastritis					□Yes □No
Gallstones					□Yes □No
Crohn's disease					□Yes □No
Ulcerative colitis					□Yes □No
Irritable bowel Syndrome					□Yes □No
Malabsorption					□Yes □No
Celiac disease					□Yes □No
Pancreatitis					□Yes □No
Stomach or duodenal ulcer					□Yes □No
Liver Cirrhosis					□Yes □No
Chronic Hepatitis (A,B or C)					□Yes □No
Acute hepatitis (A,B or C)					□Yes □No
Liver damage due to alcohol					□Yes □No
Hematology					
Anemia requiring blood transfusion					□Yes □No
Malaria					□Yes □No

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Hematology cont.					
Mononucleosis					□Yes □No
Sickle cell trait					□Yes □No
Sickle cell disease					□Yes □No
Neurological					
Meningitis					□Yes □No
Migraine					□Yes □No
Multiple sclerosis					□Yes □No
Neuralgia					□Yes □No
Peripheral neuropathy					□Yes □No
Seizure disorder					□Yes □No
Psychological					
Anorexia					□Yes □No
Bulimia					□Yes □No
Delusions					□Yes □No
Dementia					□Yes □No
Depression					□Yes □No
Drug abuse					□Yes □No
Alcohol abuse/dependency					□Yes □No
Bipolar disorder					□Yes □No
Rheumatologic					
Fibromyalgia					□Yes □No
Gout					□Yes □No
Systemic Lupus Erythematosus					□Yes □No
Lyme disease					□Yes □No
Osteoarthritis					□Yes □No
Psoriasis					□Yes □No
Rheumatic fever					□Yes □No
Rheumatoid arthritis					□Yes □No
Sjogren's syndrome					□Yes □No
TemporoMandibular Joint Syndrome					□Yes □No
Other autoimmune Specifiy:					□Yes □No
Tumors					
Malignant (include.lymphoma and leukemia) Specify					□Yes □No
Benign: Specify					□Yes □No
Urogenital					
Genital herpes					□Yes □No
Interstitial cystitis					□Yes □No
Kidney failure					□Yes □No
Kidney or bladder stone					□Yes □No
Urinary tract infection					□Yes □No

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Female only					
Endometriosis					□Yes □No
Pelvic inflammatory disease					□Yes □No
Premenstrual syndrome					□Yes □No
Vaginal yeast infection					□Yes □No
Male only					
Epididymitis					□Yes □No
Prostatitis					□Yes □No
Varicocele					□Yes □No
Impotence					□Yes □No
Miscellaneous					
HIV infection					□Yes □No
Chronic fatigue syndrome					□Yes □No

CONDITION/ ILLNESS	Don't know	N0	YES	Year of diagnosis	Still present
Eczema					□Yes □No
Oral herpes (cold sores)					□Yes □No
Glaucoma					□Yes □No
Multiple chemical sensitivity					□Yes □No
Environmental hypersensitivity					□Yes □No
Sleep apnea					□Yes □No
Neurally mediated hypotension					□Yes □No
Postural orthostatic tachycardia syndrome					□Yes □No
Other:					

For women: Please mark accordingly

Have you had a hysterectomy?	□ Yes □ No □ Not sure
Have you had a tubal ligation? (had your tubes tied)	□ Yes □ No □ Not sure
Are you taking female hormones? (i.e. premarin, estrogen, estrogen patch, birth control pills)	□ Yes □ No □ Not sure
If using a birth control method, please specify which one	
Are you pregnant now	□ Yes □ No □ Not sure
Do you intend to become pregnant within the next 6 months?	□ Yes □ No □ Not sure
Have you been pregnant in the past?	□ Yes □ No □ Not sure
Are you currently breastfeeding?	□ Yes □ No
How old were you when you began menstruating?	_____years □ Not sure
Are you still menstruating?	
If yes:	
Last menstrual period began on date	___/ ___/ ____
1. Exact date 2. Approximate date	
How many days between menstrual periods	_____ days
If no,	
When did you stop menstruating?	___/ ____/ ____
Do you have any menopausal symptoms? (Please describe i.e hot flashes, night sweats, vaginal dryness)	
Are they mild, moderate or severe	

FAMILY MEDICAL HISTORY

Please answer the following questions about your family medical history. All information will be kept strictly confidential. Fill in the information or mark with X to indicate your answers.

RELATIVE	ALIVE	AGE	If deceased, cause of death
Mother	□ Yes □ No □ Don't know		
Father	□ Yes □ No □ Don't know		
Mother's mother	□ Yes □ No □ Don't know		
Mother's father	□ Yes □ No □ Don't know		
Father's mother	□ Yes □ No □ Don't know		
Father's father	□ Yes □ No □ Don't know		

SIBLINGS: (include siblings who have died, no half or stepbrothers or sisters)

Brothers: #	Ages:	If dead, age of death:
Sisters: #	Ages:	

ILLNESS	MOTHER	FATHER	SISTERS	BROTHERS	Mother's mother	Father's mother	Mother's father	Father's father
Heart attack								
Angina pectoris								
Heart disease								
Cancer (specify)								
Hypertension								
Low blood pressure								
Stroke								
Diabetes type 1								
Diabetes type 2								
Lung disease								
Chronic fatigue syndrome								
Hypothyroidism								
Major depressive disorder								
Autoimmune disease								
Fibromyalgia								
Any other serious illness. Specify								

Social History

Are you now:	□ Single □Married □Widowed □Divorced □Separated □Living with partner □Refuse to answer
If you have children	□ How many do you have: _____ □ How old are they: _____ years old
Highest grade or level of school you have completed	□ High school graduate □GED ore equivalent □ some college □ College graduate □ Graduate degree □ Professional degree □ Refuse to answer
We would like to know what you do. Check the one that best describes your current situation.	□ Working full-time □ Working part-time □ Temporarily laid off □ Sick leave □ Maternity leave □ Looking for work/ unemployed □ Retired □ Keeping house □ Disabled (permanently or temporarily) □ Student □ Other
If you stopped working, was it because of illness?	□ Yes □ No □ Other (specify) _____
Including yourself, how many people (related or not are living or staying at your home?	
Are you covered by health insurance or some other kind of health plan?	□ Yes, pleas name it _____ □ No
What kind of house do you currently live in?	□ Detached house □ Duplex or triplex □ Row house □ Mobile home or trailer □ Low rise apartment (1-3 floors) □ High rise apartment (>3 floors) □ Other
How old is the house/ building you live? (in years)	
Is there an enclosed garage attached?	□ Yes □No □Don't know
During the past 12 months, has there been water of dampness in your home from broken pipes, leaks, heavy rain or floods?	□ Yes □No □Don't know
Does your home frequently have a mildew odor or musty smell?	□ Yes □No □Don't know
Is air conditioning (refrigeration) used?	□ Yes □No □Don't know
In the last 12 months, did any dogs, cats or other small furry animals (like rabbit, guinea pig, hamster) live or spend time inside your home?	□ Yes □No □Don't know
What is the primary source of drinking water ?	□ Private well □Community supply □Bottled water □ Other
Have you EVER consumed unpasteurized dairy products (milk, cheese, goat cheese, etc)?	□ Yes □No □Don't know
Have you donated blood?	□ Yes □No □Don't know
If yes: have you donated blood or blood products in excess of 500ml within the past 56 days?	□ Yes □No □Don't know
How many times have you donated in the past 12 months?	
How many times have you donated in the past 10 years?	
How often do you have a drink containing alcohol?	□ Never □ Monthly or less □ 2-4 times a month □ 2-3 times per week □ 4 or more times a week
Which statement best describes your smoking status?	□ Never smoked □ Quit smoking □ Currently smoking
If you smoke, are you ready to stop smoking now?	□ No □ Yes, considering quitting □ Yes, attempting to quit now

Fatigue History

Did a physician or healthcare provider diagnose you with CFS?	□ Yes □ No
Do you have documentation of a CFS diagnosis from your physician or healthcare provider?	□ Yes □ No
How old were you when CFS first appeared?	
How old were you when you were first diagnosed with CFS by a healthcare provider?	
How would you describe the **ONSET** of your CFS □ Less than 24hours □ Over 48 hours □ A week □ A month □ Longer than a month □ Don't know	
Select the primary factor that you believe contributed to your **GETTING** CFS □ Infection □ Toxic exposure □ Vaccination □ Physical trauma □ Emotional trauma □ Other	
Select the primary factor that you believe contributed to your **STAYING ILL** with CFS □ Infection □ Toxic exposure □ Vaccination □ Physical trauma □ Emotional trauma □ Other	
Was your CFS linked to travel outside of the US?	□ Yes □ No
If yes, what country did you travel to?	
Since the **onset** of my condition, I consider it: □ Improved □ Worsened □ About the same	

Fatigue Characteristics

How frequently do you feel fatigued, tired or lack energy?	□ Less than once a week □ 1 to 4 times a week □ More than 4 times a week
When you feel well or greatly better, is it	□ for weeks or more at a time □ for days at a time □ Never
Is your fatigue made worse by physical exertion (effort or activity?	□ Yes □ No
Is your fatigue made worse by mental exertion (effort or activity?	□ Yes □ No
How long does it take the fatigue to begin after physical or mental exertion?	□ Immediately □ About one hour □ From one to three hours □ More than three hours □ More than 24 hours
How long does the fatigue last after physical or mental exertion?	□ One hour or less □ From one to three hours □ More than three hours, please specify # or hours ___
Does rest make your fatigue better?	□ Not at all □ A little bit □ A lot □ Don't know
Which of the following statements best describes our fatigue during the last month?	□ I am not able to work or do anything and I am bedridden □ I can walk around the house, but I cannot do light housework □ I can do light housework, but I cannot work part time □ I can only work part-time or on some family responsibilities □ I can work full time, but I have no energy left for anything else □ I can work full time and finish some family responsibilities but I have no energy left for anything else.
From 1 to 10, 10 being the worst How do you score your fatigue	
Today	
Usual fatigue level since your last visit	
Worst level of fatigue since last visit	

Symptom Questionnaire

Circle one number for <u>how often</u> and <u>how</u> <u>much</u> each symptom has bothered you <u>OVER THE PAST 6 MONTHS</u>. Go from left to right

Symptoms	How **<u>often</u>** have you had this symptom?					**How <u>much</u>** has this symptom bothered you?				
	None of the time 0	**A little of the time 1**	**About half of the time 2**	**Most of the time 3**	**All of the time 4**	**Symptom not present 0**	**Mild 1**	**Moderate 2**	**Severe 3**	**Very severe 4**
Fatigue/extreme tiredness	□	□	□	□	□	□	□	□	□	□
Dead, heavy feeling after starting to exercise	□	□	□	□	□	□	□	□	□	□
Next day soreness or fatigue after non-strenuous, everyday activities	□	□	□	□	□	□	□	□	□	□
Mentally tired after the slightest effort	□	□	□	□	□	□	□	□	□	□
Physically tired after minimum exercise	□	□	□	□	□	□	□	□	□	□
Physically drained or sick after mild activity	□	□	□	□	□	□	□	□	□	□
Feeling unrefreshed after waking up in the morning	□	□	□	□	□	□	□	□	□	□
Need to nap daily	□	□	□	□	□	□	□	□	□	□
Problems falling asleep	□	□	□	□	□	□	□	□	□	□
Problems staying asleep	□	□	□	□	□	□	□	□	□	□
Waking up early in the morning (e.g. 3am)	□	□	□	□	□	□	□	□	□	□
Sleep all day and stay awake all night	□	□	□	□	□	□	□	□	□	□
Muscle pain or aching	□	□	□	□	□	□	□	□	□	□
Pain/stiffness/tenderness in more than one joint without swelling or redness	□	□	□	□	□	□	□	□	□	□
Eye pain	□	□	□	□	□	□	□	□	□	□
Chest pain	□	□	□	□	□	□	□	□	□	□
Bloating	□	□	□	□	□	□	□	□	□	□
Abdomen/stomach pain	□	□	□	□	□	□	□	□	□	□
Headaches	□	□	□	□	□	□	□	□	□	□
Muscle twitches	□	□	□	□	□	□	□	□	□	□
Muscle weakness	□	□	□	□	□	□	□	□	□	□
Sensitivity to noise	□	□	□	□	□	□	□	□	□	□
Sensitivity to bright lights	□	□	□	□	□	□	□	□	□	□
Problems remembering things	□	□	□	□	□	□	□	□	□	□
Difficulty paying attention	□	□	□	□	□	□	□	□	□	□
Difficulty finding the right word to say or expressing thoughts	□	□	□	□	□	□	□	□	□	□
Difficulty understanding things	□	□	□	□	□	□	□	□	□	□

Symptoms	How **often** have you had this symptom?					**How much** has this symptom bothered you?				
	None of the time 0	A little of the time 1	About half of the time 2	Most of the time 3	All of the time 4	Symptom not present 0	Mild 1	Moderate 2	Severe 3	Very severe 4
Only can focus on one thing at a time	□	□	□	□	□	□	□	□	□	□
Unable to focus vision and attention	□	□	□	□	□	□	□	□	□	□
Loss of depth perception	□	□	□	□	□	□	□	□	□	□
Slowness of thought	□	□	□	□	□	□	□	□	□	□
Absent-mindedness or forgetfulness	□	□	□	□	□	□	□	□	□	□
Bladder problems	□	□	□	□	□	□	□	□	□	□
Irritable bowel problems	□	□	□	□	□	□	□	□	□	□
Nausea	□	□	□	□	□	□	□	□	□	□
Feeling unsteady on your feet, like you might fall	□	□	□	□	□	□	□	□	□	□
Shortness of breath or trouble catching your breath	□	□	□	□	□	□	□	□	□	□
Dizziness or fainting	□	□	□	□	□	□	□	□	□	□
Irregular heart beats	□	□	□	□	□	□	□	□	□	□
Losing or gaining weight without trying	□	□	□	□	□	□	□	□	□	□
No appetite	□	□	□	□	□	□	□	□	□	□
Sweating hands	□	□	□	□	□	□	□	□	□	□
Night sweats	□	□	□	□	□	□	□	□	□	□
Cold limbs (e.g. arms, legs, hands)	□	□	□	□	□	□	□	□	□	□
Feeling chills or shivers	□	□	□	□	□	□	□	□	□	□
Feeling hot or cold for no reason	□	□	□	□	□	□	□	□	□	□
Feeling like you have a high temperature	□	□	□	□	□	□	□	□	□	□
Feeling like you have a low temperature	□	□	□	□	□	□	□	□	□	□
Alcohol intolerance	□	□	□	□	□	□	□	□	□	□
Sore throat	□	□	□	□	□	□	□	□	□	□
Tender/sore lymph nodes	□	□	□	□	□	□	□	□	□	□
Fever	□	□	□	□	□	□	□	□	□	□
Flu-like symptoms	□	□	□	□	□	□	□	□	□	□
Some smells, foods, medications, or chemicals make you feel sick	□	□	□	□	□	□	□	□	□	□

MULTIDIMENSIONAL FATIGUE INVENTORY

Please rate your level of -agreement with each of the following statements:

1----------2----------3----------4----------5----------6----------7

Yes, That is true — **No, that is not true**

	1	2	3	4	5	6	7
I feel fit.							
Physically I feel only able to do a little.							
I feel very active.							
I feel like doing all sorts of nice things.							
I feel tired.							
I think I do a lot in a day.							
When I am doing something, I can keep my thoughts on it.							
Physically I can take on a lot.							
I dread having to do things.							
I think I do very little in a day.							
I can concentrate well.							
I am rested.							
It takes a lot of effort to concentrate on things.							
Physically I feel I am in a bad condition.							
I have a lot of plans.							
I tire easily.							
I get little done.							
I don't feel like doing anything.							
My thoughts easily wander.							
Physically I feel I am in an excellent condition.							

Karnofsky Performance Scale

Please mark the percentage that best describes your activity status

100% Totally well; no concerns about fatigue. You can think clearly and do several things at once. You can exercise to your maximum potential without any problems.

90% Energy good but you feel fatigued after hard exercise.

80% You feel well with respect to your energy but must monitor your energy through the day. Your thinking is good but not quite clear. Tasks are easy and you can still do multiple tasks at once. You are fatigued after moderate exercise. Full time work is possible for most.

70% Your overall energy is OK but everything you do is much more difficult and your energy is easily shifted. Your thought processes are much slower and more difficult and memory is poor. Exercise tolerance is poor and any strenuous exercise will make you feel unwell while light activity is tolerable. You can achieve a full day (8 hours) of tasks, but it requires a high degree of effort. You are too tired to do anything additional such as socializing. Full time work is possible only if you do not have to do any household tasks, errands or childcare. Part time work is possible for most.

60% You are able to complete 1/2 day of tasks and feel tired during it. Your thinking and memory are poor. You must rest at some point in the day. Even with rest, there is no part of the day in which you feel normal with respect to energy or can think clearly. Part time work is possible only if hours are flexible to coincide with your energy peaks and you do not have to do any household tasks, errands or childcare.

50% Your energy only allows you to do about 3 tasks per day (2-3 hours of activity). Your energy is easily drained. Thought processes are difficult. Your exercise tolerance is poor; walking up stairs is difficult.

40% You can only perform 2 light tasks per day. Physical exercise is not tolerable. Your thought processes are very slow and your memory is poor.

30% You can only perform one light task per day, any extra physical movement makes you feel unwell. You have difficulty reading and writing.

20% You are unable to perform any daily tasks; even going to the bathroom is tiring. The most physical exertion you can manage is to sit in a chair for short periods. Emotions are very unstable and fluctuate without warning.

10% You are in bed for most of the day and you have zero tolerance for anything extra. You are frequently too exhausted to even eat.

BRIEF PAIN INVENTORY

Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain, other than these everyday kinds of pain during the past 24 hours?	□Yes □ No
Would you consider your pain to be widespread and occurring in more than one spot on your body?	□Yes □ No

	With **0** being ***no pain*** and **10** being the ***worst pain*** you can imagine, please choose the number that best describes your level of pain in **the past 24 hours**.										
	0	1	2	3	4	5	6	7	8	9	10
Pain at its **worst**											
Pain at its **least**											
Pain on the **average**											
Pain you have **right now**											

Do you take any medications or receive any treatments for your pain? If so, write the treatments or medications you are taking or receiving for your pain in the box to the right.	
In the past 24 hours, how much relief have pain treatments or medications provided? 0% is no relief and 100% is complete relief	%

	With 0 being does not interfere and 10 being completely interferes, choose the one number that describes how, during										
	0	1	2	3	4	5	6	7	8	9	10
General activity											
Mood											
Walking ability											
Normal work											
Relations with other people											
Sleep											
Enjoyment of life											

GENERAL HEALTH QUESTIONNAIRE (SF-36)

In general, would you say your health is:				
□ Excellent	□ Very Good	□ Good	□ Fair	□ Poor

Compared to one year ago, how would you rate your health in general **now**?				
□ Much better	□ Somewhat better	□ Same	□ Somewhat worse	□ Much worse

The following items are about activities you might do during a typical day. Does your health now limit you in these activities and if so, how much? Check the appropriate box

	Yes limited a lot	**Yes limited a little**	**No not limited at all**
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	□	□	□
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	□	□	□
Lifting or carrying groceries	□	□	□
Climbing **several** flights of stairs	□	□	□
Climbing **one** flight of stairs	□	□	□
Bending, kneeling, or stooping	□	□	□
Walking **more** than a mile	□	□	□
Walking **several** blocks	□	□	□
Walking **one** block	□	□	□
Bathing or dressing yourself	□	□	□

*During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	**No**
Cut down the **amount of time** you spent on work or other activities	□	□
Accomplished less than you would like	□	□
Were limited in the **kind** of work or other activities	□	□
Had **difficulty** performing the work or other activities (for example, it took extra effort)	□	□

*During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	**No**
Cut down the **amount of time** you spent on work or other activities	□	□
Accomplished less than you would like	□	□
Didn't do work or other activities as **carefully** as usual	□	□

During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?				
□ Not at all	□ Slightly	□ Moderately	□ Quite a bit	□ Extremely

How much **bodily pain** have you had during the **past 4 weeks**?					
□ None	□ Very Mild	□ Mild	□ Moderate	□ Severe	□ Very Severe

During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?				
□ Not at all	□ A little bit	□ Moderately	□ Quite a bit	□ Extremely

*These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.*
*How much of the time during the **past 4 weeks:***

	All of the time	**Most of the time**	**Good bit of the time**	**Some of the time**	**A little bit of the time**	**None of the time**
Did you feel full of pep?	□	□	□	□	□	□
Have you been a very nervous person?	□	□	□	□	□	□
Have you felt so down in the dumps that nothing could cheer you up?	□	□	□	□	□	□
Have you felt calm and peaceful?	□	□	□	□	□	□
Did you have a lot of energy?	□	□	□	□	□	□
Have you felt downhearted and blue?	□	□	□	□	□	□
Did you feel worn out?	□	□	□	□	□	□
Have you been a happy person?	□	□	□	□	□	□
Did you feel tired?	□	□	□	□	□	□
During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?	□ All of the Time	□ Most of the time	□ Some of the time	□ A little of the time	□ None of the time	

How TRUE or FALSE is each of the following statements for you.

	Definitely true	**Mostly true**	**Don't know**	**Mostly false**	**Definitely false**
I seem to get sick a little easier than other people	□	□	□	□	□
I am as healthy as anybody I know	□	□	□	□	□
I expect my health to get worse	□	□	□	□	□
My health is excellent	□	□	□	□	□

HAD SCALE

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.

This questionnaire is designed to help your doctor to know how you feel. Read each item and mark the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

I feel tense or "wound up":			**I feel as if I am slowed down**	
Most of the time			Nearly all the time	
A lot of the time			Very often	
Time to time, occasionally			Sometimes	
Not at all			Not at all	
I still enjoy the things I used to enjoy:			**I get a sort of frightened feeling like "butterflies" in the stomach**	
Definitely as much			Not at all	
Not quite so much			Occasionally	
Only a little			Quite often	
Hardly at all			Very often	
I get a sort of frightened feeling as if something awful is about to happen:			**I have lost interest in my appearance:**	
Very definitely & quite badly			Definitely	
Yes, but not too badly			I don't take so much care as I should	
A little, but it doesn't worry me			I may not take quite as much care	
Not at all			I take just as much care as ever	
I can laugh and see the funny side of things:			**I feel restless as if I have to be on the move:**	
As much as I always could			Very much indeed	
Not quite so much now			Quite a lot	
Definitely not so much now			Not very much	
Not at all			Not at all	
Worrying thoughts go through my mind:			**I look forward with enjoyment to things:**	
A great deal of the time			As much as ever I did	
A lot of the time			Rather less than I used to	
From time to time but not too often			Definitely less than I used to	
Only occasionally			Hardly at all	
I feel cheerful			**I get sudden feelings of panic:**	
Not at all			Very often indeed	
Not often			Quite often	
Sometimes			Not very often	
Most of the time			Not at all	
I can sit at ease and feel relaxed			**I enjoy a good book or radio or TV program:**	
Definitely			Often	
Usually			Sometimes	
Not often			Not often	
Not at all			Very seldom	

SLEEP ASSESSMENT QUESTIONNAIRE

PLEASE ANSWER EACH QUESTION BY CHECKING THE ONE ANSWER THAT FITS BEST

Over the past month, how often have you experienced the following……..

	Never	Rarely	Some times	Often	Always	Don't Know
1. Difficulty falling asleep?						
2. Sleeping for less than 5 hours?						
3. Sleeping more than 9 hours?						
4. Repeated awakenings during your sleep?						
5. Loud snoring?						
6. Interruptions to your breathing during sleep?						
7. Restlessness during your sleep (e.g. move your legs or kick)?						
8. Nightmares or waking up frightened or crying out loud?						
9. Waking up before you want to (i.e., getting less sleep than you need)?						
10. Waking up NOT feeling refreshed or thoroughly rested?						
11. Waking up with aches or pains or stiffness?						
12. Falling asleep while sitting (e.g., reading, watching t.v.)?						
13. Falling asleep while doing something (e.g., driving, talking to people)?						
14. Working shifts?						
15. Working night shifts?						
16. Irregular bed time and/or wakeup time during work or weekdays?						
17. Taking medication for sleep or nervousness?						

NOVA SOUTHEASTERN UNIVERSITY
Health Professions Divisions
Institute for Neuro Immune Medicine Health Care Centers

CONSENT AND AGREEMENT FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS
Please read the following information carefully. After you have read this Consent and Agreement for Treatment ("Agreement") please sign your name below to accept the terms of this agreement.

1. **Authorization for Routine Medical Treatment:** I hereby consent to such medical treatment for myself or my child which in the judgment of my health care provider may be considered necessary or advisable while a patient at Nova Southeastern University Inc., and it's health care providers, employees and agents ("NSU").

2. **Teaching Facilities:** I am aware that the NSU Institute for Neuro Immune Health Care Centers are teaching facilities, and as a result, medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

   I am aware that the NSU Student Medical Center does not involve medical residents, medical students, and other medical career students in my care and treatment. In addition, I am aware that should I access care and treatment at any other NSU Institute for Neuro Immune Health Care Center for any reason that medical residents, medical students, and other medical career students will be involved in my care and treatment under appropriate supervision of clinical faculty.

3. **Appointments and Cancellation Policy:** The clinic time of the medical resident and clinical faculty is scheduled by appointment. It is essential, that all appointments be kept promptly. When an appointment cannot be kept, the clinic must be notified at least 24 hours in advance. Patients that miss THREE (3) scheduled appointments may be DISMISSED from the NSU Institute for Neuro Immune Health Care Centers. In the event that you are dismissed, the NSU Institute for Neuro Immune Health Care Centers will be available for emergencies during the normal hours of operation for a period of 30 days from the date of the third missed appointment to provide you with ample opportunity to select a medical provider of your choice.

Patient/Representative's Initials _____

4. **Right to Discontinue Treatment:** The NSU Health Care Centers have the right to discontinue treatment. In such cases, the patient or patient's representative agrees to accept full responsibility for pursuing alternate professional medical care. A letter will be sent informing the patient or patient's representative that treatment is being discontinued. All records pertaining to the treatment and diagnosis of patients are the property of the NSU Health Care Centers. Records and X-rays will be duplicated upon written request with reasonable charge to the patient.

5. **Financial Agreement:** I hereby agree to pay usual and customary charges for all services provided by NSU to the patient, except those covered by insurance (which includes all commercial and government third party payors). I understand that I am personally responsible for payment for any non-covered services, health insurance deductibles and co-insurance. In the event that I fail to fulfill any of the obligations in this section, I agree to pay any and all collection costs incurred by NSU in the enforcement of this section.

6. **Risks of Treatment:** The students and/or residents under the appropriate supervision of clinical faculty at the NSU Institute for Neuro Immune Medicine Health Care Centers are available to answer any questions concerning the potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. In the Student Medical Center clinical faculty are available to answer any questions concerning potential risks and complications involved with specific procedures, and reasonable alternatives to the proposed treatment. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of my treatment.

7. **Laboratory Bills:** I understand the outside reference laboratory ("laboratory") will bill me directly for all laboratory tests performed by said laboratory. I understand that the fee schedule and/or cost for laboratory tests performed by NSU shall be available to the patient upon request.

8. **Patient Records:** I understand that all original records and diagnostic aids, such as x-rays, are the property of the NSU Health Care Centers. I understand that the NSU Health Care Centers will own the original records. I also understand that I may obtain copies of the records at a reasonable cost, upon written request, based upon established policies of the NSU Health Care Centers.

Patient/Representative's Initials _____

9. **Consent to Photograph:** I understand that photography, video recordings, other imaging and audio recordings ("images and/or recordings") may be recorded to document my care and treatment. I understand that the NSU Health Care Centers will own these images and/or recordings. I also understand that I may obtain copies of the images and/or recordings at a reasonable cost, upon written request, based upon established policies of the NSU Health Care Centers.

10. **Release of Information for Payment:** I hereby authorize and consent to NSU to release medical information to obtain payment as described in the NSU Privacy Notice. This authorization will include where applicable psychiatric, alcohol, drug abuse, and laboratory results of HIV Infection (Human Immune Deficiency Virus) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS). I authorize NSU to provide necessary information to the patient's insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay NSU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

11. **Change of Student/Resident/Clinical Faculty:** I understand that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member and/or student(s) or resident(s) actually are involved in performing the care and treatment. In addition, I understand at the Student Medical Center that at the time of the treatment, unforeseen circumstances may require changing which individual clinical faculty member is involved in performing the care and treatment.

12. **Information for Female Patients:** I have informed my doctor about my use of birth control pills. I have been advised that certain antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing conception and pregnancy. I have been advised that in addition to using my regular birth control pills that I will need to use and an additional alternative method of birth control while taking medications prescribed during my care and treatment.

13. **Medical History and Follow up:** I acknowledge that I have provided an accurate and complete medical and personal history, including antibiotics, drugs, or other medications I am currently taking as well as those to which I am allergic. I will follow any and all treatment and post treatment instructions as explained and directed to me and will permit the recommended diagnostic procedures, including x-rays.

Patient/Representative's Initials _____

14. **Assignment of Benefits:** I hereby irrevocably assign and transfer to NSU all right, title and interest in any benefits payable to which I may be entitled from all insurance companies, employee benefit plans, third party administrators and/or other person or entities financially responsible for my medical care and treatment rendered to me, my dependent or the insured by NSU. Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf to NSU. Where Medicaid benefits are applicable, I certify that I am a recipient of Medicaid benefits and request that said payment of authorized benefits be made on my behalf to NSU.

Patient/Representative's Initials _____

Release of Information for Treatment and Health Care Operations

By signing this form, I am consenting to the use and disclosure of my Protected Health Information ("PHI") for treatment and Nova Southeastern University's health care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the Nova Southeastern University Institute for Neuro Immune Medicine Health Care Centers ("NSU") will share patient PHI according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

NSU's Notice of Privacy Practices provides a more complete description of these uses and disclosures. I agree that I have the right to review the Notice of Privacy Practices prior to signing this consent. I acknowledge that I have done so. NSU reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained at the NSU Institute for Neuro Immune Medicine Health Care Centers.

I acknowledge and agree that the PHI that may be disclosed for treatment and health care operations purposes may include any or all of the following information concerning the patient: (i) any psychiatric or psychological information related to treatment of physical and/or mental illness; (ii) any information regarding drug abuse, chemical dependency or alcohol abuse; or (iii) any information regarding testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome ("AIDS"); human immunodeficiency virus ("HIV"); Sexually Transmitted Disease("STD"); Tuberculosis; Hepatitis; or other information as may be required for my treatment and health care operations.

I also consent to the release of any information to any and all business associates, regulatory and/or accrediting organizations as necessary to maintain licensure and accredited status. In addition, I consent to the release of any information to county, state or federal public health agencies, as required by law.

I understand that I have the right to request that NSU restrict how it uses or discloses the patient's PHI to carry out treatment and health care operations. However, I understand that NSU is not required to agree to the requested restrictions, but if it does, it is bound by such agreement.

I understand that I may revoke this consent in writing except to the extent that NSU has already made disclosures in reliance upon it. If I do not sign this consent, or if I later revoke it, NSU may decline to provide treatment to the patient.

Patient/Representative's Initials _____

I certify that I have read and understand the preceding Consent and Agreement for Treatment, and/or have asked and had answered to my satisfaction, any and all questions that I may have about same, by my treating student/resident or clinical faculty physician.

_____	_____
Patient or Patient Representative Signature	Date
_____	_____
Print Name of Patient or Patient Representative	Patient Date of Birth

_____
Description of Patient Representative's Authority

Confirmation of interpretation to Patient (if applicable)
If the patient does not read/understand English, it is the responsibility of the person who is authorized by him/her to ensure that the content of this consent form has been duly explained to him/her before he/she signs the form.

- The Patient does not read or understand English.
- I confirm that I understand the content of the consent form and I have interpreted and explained the content of the form to the patient so that he/se clearly understood what it meant before signing it.

_____	_____
Print Name of Interpreter	Relationship to Patient

_____
Signature of Interpreter

NOVA SOUTHEASTERN UNIVERSITY | NSU Florida

HIPAA Notice of Privacy Practices

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.

Purpose of this Notice

We are required by law to maintain the privacy of your protected health information. This notice applies to all records of the health care and services you received at Nova Southeastern University (NSU). This notice will tell you about the ways in which we may use and disclose your protected health information. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your protected health information.

I. Uses and Disclosures of Protected Health Information

NSU may use and disclose your health information, that is, information that constitutes protected health information (PHI) as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), for the purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. The following categories describe diverse ways that we use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information fall within the categories below.

A. Treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your PHI to a pharmacy to fulfill a prescription, to a laboratory to order a blood test, or to a home health agency that is providing care in your home. We may also disclose PHI to other health care providers who may be treating you or consulting with your health care provider with respect to your care. In some cases, we may also disclose your PHI to an outside health care provider for purposes of the treatment activities of the other provider.

B. Payment. Your PHI will be used, as needed, to bill and collect payment for your health care services. Your PHI may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. In addition, uses of PHI for payment purposes may also include certain communications to your health insurer to get approval for the treatment that we recommend. For example, if a hospital admission is recommended, we may need to disclose information to your health insurer to get prior approval for the hospitalization. We may also disclose protected information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for your services, we may also need to disclose your PHI to your insurance company to demonstrate the medical necessity of the services, or as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your case for the other provider's payment activities. We may release information to an outside agency for collection purposes.

C. Operations. We may use or disclose your PHI, as necessary, for our own health care operations in order to facilitate the func- tion of NSU and to provide quality care to our patients. Health care operations include such activities as

- Quality assessment and improvement activities;
- Employee review activities;
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision;
- Accreditation, certification, licensing, or credentialing activities;
- Review and auditing, including compliance reviews, medical reviews, legal services, and maintaining compliance programs; and
- Business management and general administrative activities.

In certain situations, we may also disclose patient information to another health care provider or health plan for their health care operations.

D. Other Uses and Disclosures. As part of treatment, payment, and health care operations, we may also use or disclose your PHI for the following purposes:

- To remind you of an appointment (appointment reminders may be communicated by mail or by leaving a message on the answering machine of a telephone number that you have provided);
- To inform you of potential treatment alternatives or options;
- To inform you of health-related benefits or services that may be of interest to you; and
- To provide refill reminders or otherwise communicate about a drug or biologic that is prescribed to you (our costs for sending these prescription-related communications may be subsidized by third parties).

E. To Business Associates. Sometimes it is necessary for us to hire outside parties (business associates) to help us carry out certain health care operations or services. These services are provided in our organization through contracts with the business associates. Examples include computer maintenance by outside companies, consultants and transcription of medical records. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we've asked them to do. Similarly, there are departments of NSU that provide services to us and may need access to your PHI to do their jobs. We

require business associates and other NSU departments to appropriately safeguard your information.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your PHI without your permission or authorization for a number of reasons including the following:

A. When Legally Required. We will use or disclose your PHI when we are required to do so by any Federal, State, or local law. Any use or disclosure under this section will comply with and be limited to the relevant requirements of any such law.

B. When There Are Risks to Public Health. We may disclose your PHI for public health activities and purposes. For example, public health activities generally include:

- To prevent, or control, disease, injury, or disability as permitted by law;
- To report disease, injury, and vital events such as birth or death as permitted or required by law;
- To conduct public health surveillance, investigations, and interventions as permitted or required by law;
- To collect or report adverse events and product defects or problems; to track FDA-regulated products; to enable product recalls, repairs, replacements, or look back to the FDA and to conduct post-marketing surveillance;
- To notify patients of recalls of products they may be using;
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition, as authorized by law;
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required, to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether the individual has a work-related illness or injury; and
- To report to a school about an individual who is a student or prospective student of the school if the PHI disclosed is limited to proof of immunization and the school is required by State or other law to have such proof of immunization prior to admitting the individual.

C. To Report Abuse, Neglect, or Domestic Violence. We may notify government authorities, including a social service or protective services agency, if we reasonably believe that a patient is the victim of abuse, neglect, or domestic violence. Although every person has a responsibility to report suspected abuse or neglect, certain occupations are required to do so. These occupations are considered "professionally mandatory reporters," for example, health professionals and mental health professionals. It is the responsibility of the professionally mandatory reporters to alert the proper authorities in the event a minor, elderly, or vulnerable adult patient is identified as a victim of alleged or suspected neglect or abuse including sexual abuse, and to comply with proper procedures for the reporting as required or authorized by law.

D. To Conduct Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

E. In Connection with Judicial and Administrative Proceedings. We may disclose your PHI in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process if we receive satisfactory assurance from the party seeking the information that either reasonable efforts have been made to ensure that you have been given notice of the request, or reasonable efforts have been made to obtain an order protecting the information requested.

F. For Law Enforcement Purposes. We may disclose your PHI to a law enforcement official for certain law enforcement purposes including:

- As required by law for reporting of a gunshot wound or other physical or life-threatening injury indicating an act of violence;
- Pursuant to court order, court-ordered warrant, subpoena, summons, or similar process;
- For the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
- Under certain limited circumstances, when you are or are suspected to be the victim of a crime;
- To a law enforcement official if NSU has a suspicion that your death was the result of criminal conduct;
- To report a crime in an emergency situation; and
- In the event a minor, elderly, or vulnerable adult patient is identified as a victim of alleged or suspected neglect or abuse including sexual abuse.

G. To Coroners, Funeral Directors, and for Organ Donation. We may disclose PHI to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorize by law, in order to permit the funeral director to carry out his or her duties. PHI may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

H. For Research Purposes. Under certain circumstances, we may use and disclose your PHI for research purposes. We also may retain samples from tissue, teeth or blood and other similar fluids normally discarded after a medical procedure for later use in research projects. All these research projects, however, are subject to a special review and approval process, by the institutional review board ("IRB"). This process evaluates a proposed research project and its use of PHI, trying to balance the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. In some cases, your authorization would be required. In other cases, it may not, where the review process determines that the project creates no more than a minimal risk to privacy, obtaining your authorization would not be practical and the researchers show they have a plan to protect the information from any improper use or disclosure. We may also disclose your PHI to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the health care center. If a research project can be done using health information from which all the information that identifies you (such as your name, social security number and medical record number) has been removed, we may use or release the data without special

approval. We also may use or disclose data for research with a few identifiers retained—dates of birth, treatment, and general information about the area where you live (not your address), without special approval. However, in this case we will have those who receive the data sign an agreement to appropriately protect it. In the event that you participate in a research project that involves treatment, your right to access health information related to that treatment may be denied during the research project so that the integrity of the research can be preserved. Your right to access the information will be reinstated upon completion of the project.

I. In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions. In certain circumstances, the Federal regulations authorize NSU to use or disclose your PHI to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and other law enforcement custodial situations.

K. For Worker's Compensation. We may release your health information to comply with worker's compensation laws or similar programs.

L. Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official under specific circumstances such as (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

III. Uses and Disclosures Permitted Without Authorization, but with Opportunity to Object

We may disclose your PHI to your family member(s), a close personal friend, or any other person identified by you, if the disclosure is directly relevant to the person's involvement in your care or payment related to your care. We can also disclose your information in connection with trying to locate or notify family member(s) or others involved in your care concerning your location, condition, or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgment, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your PHI as described.

IV. Uses and Disclosures Which You Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. We will apply special protections to psychotherapy notes and will not release such notes without your signed authorization unless they are being used by your treating provider, by mental health students under supervision of your treating provider or by NSU to defend a legal action.

We cannot use your information for marketing or sell your protected health information without your specific authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The Right to Inspect and Copy Your PHI. You may inspect and obtain a copy of your PHI that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that are used to make decisions about you.

To the extent electronic records are implemented, you do not have the right to actually inspect or access the electronic medical record system. If you request access to part of a designated record set that is maintained in electronic format the information will be printed on paper or downloaded to a compact disk ("CD") or other electronic format upon your request provided that we are able to readily produce the requested format.

Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to a law under which, you may not have the right to have a denial for access reviewed.

We may deny your request to inspect or copy your PHI if, in our professional judgment, we determine that the access requested is likely to endanger your life or safety or that of another person, that it is likely to cause substantial harm to another person reference within the information, or that the request was made by your personal representative and it is determined that the personal representative is reasonably likely to cause substantial harm to your or another person. You have the right to request a review of this decision.

To inspect or copy your medical information, you must submit a written request to the NSU Health Care Center/Clinic where you received services and direct the correspondence to the HIPAA Liaison. The contact information for that NSU Health Care Center/Clinic is attached to the notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us in complying with your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. The Right to Request a Restriction on Uses and Disclosures of Your PHI. You may ask us, in writing, not to use or disclose certain parts of your PHI for the purposes of treatment, payment, or health care operations. You may also request, in writing, that we do not disclose your health information 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 state the specific restriction requested and to whom you want the restriction to apply.

NSU is not required to agree to a restriction that you may request. We will notify you in writing if we deny your request to a restriction.

Although NSU is not required to agree to most restrictions, if you pay for health care services out of pocket in full and do not wish the services to be counted toward an insurance deductible you may request that the information related to these services not be included in any disclosures to a health plan. There may be circumstances where NSU has a legal requirement to submit a bill to health

plan and will be unable to provide services to you consistent with this request.

If NSU does agree to a requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. If one health care center/clinic agrees to a restriction, the restriction applies only to the facility that agreed, unless you submit the request to and receive written agreement to the restriction from the other health care centers/clinics at NSU. Under certain circumstances, we may terminate a restriction. You may request, in writing, a restriction by contacting the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services.

C. The Right to Request to Receive Confidential Communications from Us by Alternative Means or at an Alternative Location. You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We 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. We will not require you to provide an explanation for your request. Requests must be made, in writing, to the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services.

D. The Right to Request Amendment of Your PHI. You may request an amendment of PHI about you in a designated record set for as long as we maintain this information. If you believe that there is a mistake or missing information in our record of your PHI, you may request, in writing, that we correct or add to the record. In this written request, you must also provide a reason to support the requested amendment. We will respond within 60 days of receiving your request. We may deny the request in writing, if we determine that the PHI is: (1) correct and complete; (2) not created by us and/or not part of our records, or; (3) not permitted to be disclosed or inspected. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If we approve the request for amendment, we will change the PHI and so inform you. Requests for amendment must be directed to the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services.

E. The Right to Receive an Accounting. You have the right to request, in writing, an accounting of certain disclosures of your PHI made by NSU. This right applies to disclosures for purposes other than treatment, payment, or health care operations as described in this Notice of Privacy Practices. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made, in writing, to the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services. The request should specify the time period sought for the accounting. Accounting requests may not be made for periods of time dating more than six years prior to the date of the request. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The Right to Obtain a Paper Copy of This Notice. Upon request, we will provide a separate copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

G. Right to Receive Notice of Breach. We will give you written notice in the event we learn of a breach of unsecured protected health information. We will notify you as soon as reasonably possible but not later than sixty (60) days after the breach has been discovered.

VI. Our Duties

NSU is required by law to maintain the privacy of your health information and to provide you with this Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI that we maintain. We will post a copy of the current Notice of Privacy Practices in each of our health care centers/clinics. The Notice of Privacy Practices will contain under Section VIII the effective date. In addition, each time you register for services at NSU for treatment or health care services, you may request a copy of the current notice in effect.

VII. Complaints

You have the right to express complaints to NSU and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with NSU by contacting, in writing, the HIPAA Liaison at the NSU Health Care Center/Clinic where you received services. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

VIII. Effective Date.

This Notice was originally effective April 14, 2003.
Last updated May 2014.

Nova Southeastern University

NSU Health Clinics

HIPAA Notice of Privacy Practices—Contact Person

NSU's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the NSU Health Clinics HIPAA Liaison. Information regarding matters covered by this notice can be requested by contacting the HIPAA Liaison in writing. Complaints against NSU can be mailed to the HIPAA liaison by sending them to:

HIPAA Liaison

Nova Southeastern University
Division of Clinical Operations -NSU Health
3301 College Avenue
Fort Lauderdale, FL 33314
Attention: Jill Burgess

Telephone: (954) 262-4935

In addition, complaints against NSU may also be mailed to the Chief Privacy Office by sending them to the NSU Office of Privacy at:

Nova Southeastern University
Office of University Compliance
3301 College Avenue
Fort Lauderdale, FL 33314-7796
Attention: Chief Privacy Officer

Telephone: (954) 262-4302

NSU Health

HIPAA NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of the NSU Health Clinics HIPAA Notice of Privacy Practices.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print, and sign your name in the space below.

_____ _____

Personal Representative Name (Print) Personal Representative Signature

_____ _____

Relationship Date

FOR OFFICE USE ONLY

I have made a good faith effort to obtain a written acknowledgement of receipt of the NSU Notice of Privacy Practices. However, an acknowledgement was not obtained because:

- ❑ Patient refused to sign.
- ❑ Patient was unable to sign or initial because: _____
- ❑ Due to an emergency situation, it was not possible to obtain an acknowledgment.
- ❑ Other: _____

_____ _____

Employee Signature Date

Date: April 2003

Revision: May 2014 File in Patient Chart

NSU Health

Institute for Neuro Immune Medicine
Family and Friends Communication Designation Form

We respect the privacy of your health information. If you wish to grant permission for us to share your medical and billing information with a family member or friend involved in your care, which is not otherwise authorized by law to act on your behalf (e.g., a minor patient's parent), please specify below.

The Family and Friends Communication Designation Form pertains to limited verbal disclosures of Protected Health Information ("PHI") to persons directly involved in your treatment, for purposes of notifying such persons of a patient's current location, and general condition. It also applies to limited disclosures of PHI, which may be in printed, or other written formats, to such persons for the purposes of making appointments, receiving appointment reminders, and making billing or payment inquiries on behalf of a patient.

The Family and Friends Communication Designation Form does not apply to disclosures of health care information unrelated to your current condition, nor does it apply to the provision of copies of health records; in both cases, a written authorization must be provided by the you or your Personal Representative.

You are not required to grant this permission, and may revoke this permission by notifying the NSU Institute for Neuro Immune Medicine in writing of any changes to this form by contacting the Institute for Neuro Immune Medicine's HIPAA Liaison at:

Nova Southeastern University
Division of Clinical Operations - NSU Health
3301 College Avenue
Fort Lauderdale, FL 33314
Attention: Jill Burgess

Nova Southeastern University
Office of University Compliance
3301 College Avenue
Fort Lauderdale, FL 33314
ATTN: Privacy Officer

I give my permission to the NSU Institute for Neuro Immune Medicine to share the medical and billing information of:

_____ _____

Print Patient Name Date of Birth

Please provide the full names of these individuals, their relationship to you, and telephone number.

Individual's Full Name (Please Print)	**Relationship to Patient**	**Telephone #**

By my signature below, I hereby consent to and request that NSU communicate with the above listed individuals regarding my health care treatment and payment information as indicated. I agree that NSU may rely upon this information unless I change this form as set forth above.

Full Patient Name (Printed)	**Personal Representative Name (Printed) (if applicable)**
Patient or Personal Representative Signature	**Signature Date**

NSU Health **Institute for Neuro Immune Medicine**

Date Received – Official Use Only

Authorization for Use or Disclosure of Protected Health Information (PHI)

Patient Name (Last, First, Middle Initial):		
Patient Address:		
City	State:	Zip Code:
Telephone #:	Date of Birth	

I authorize release/disclosure of the patient's health records and information:

From the health care provider, physician, office, facility as listed below:	**To** the patient, personal representative, health care provider, physician, office, facility as listed below:
Name:	Name:
Address/City/State/Zip:	Address/City/State/Zip:
Telephone #:	Telephone #:
Health Care Provider Fax # (if applicable):	Health Care Provider Fax # (if applicable):
Attention:	Attention:

I authorize release/disclosure of the following health information during the term of this Authorization: (*Check all that applies):*

☐ Entire Medical Record
☐ Specific Date of Service ___/___/___
☐ Specific Date Range ___/___/___ to ___/___/___
☐ Billing Records (Specify date or date range) _____
☐ Records related to a specific injury with the following date (e.g., worker's compensation injury)
☐ Imaging/Radiology Films (Specify date or date range) _____
☐ Hospitalization (H & P, Consult, Tests, Surgical, Discharge Summary)
☐ Test Results (Specify: Lab, X-Ray, EKG, etc.) _____
☐ Therapy Notes (Specify: PT, OT, Speech, etc.) _____
☐ Other _____

The purpose of the disclosure is: (*Check all that applies):*

☐ Continuation of Care
☐ Legal
☐ Personal Reasons (at the request of the individual)
☐ Insurance
☐ Other _____

I understand that the above referenced health information may include information relating to 1) Sexually Transmitted Disease (STD), Human Immunodeficiency Virus (HIV), or Acquired Immune Deficiency Syndrome (AIDS); 2) Treatment of Alcohol, Drug, or Substance Abuse; 3) Mental or Behavioral Health or Psychiatric Care;.4) Genetic testing results and/or (5) Records created by non-NSU providers.

As such, I request that the following health information is **NOT** disclosed with the health information listed above.
*(Check all applicable boxes that should **NOT** be disclosed/released)*

☐ STD /HIV/ AIDS	☐ Alcohol /Drug, / Substance Abuse	☐ Mental or Behavioral Health or Psychiatric Care (NOT including Psychotherapy Notes)	☐ Genetic Data	☐ Records created by non-NSU providers

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Expiration of Authorization:

This authorization will remain in force and effect under the following conditions: (*check one preference*)

☐ From the date of this Authorization until the following date: ____/_____/_____

☐ Until the happening of the following expiration event: _____

If I do not specify an expiration date or event, then this Authorization will expire ninety (90) days from the date on which I sign the Authorization.

I understand that, as set forth in NSU's Notice of Privacy Practice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

Nova Southeastern University
Division of Clinical Operations - NSU Health
3301 College Avenue
Fort Lauderdale, FL 33314
Attention: Jill Burgess

- I understand my revocation will not apply to information already retained, used, or disclosed in response to this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that the clinic will not condition my treatment on whether I provide authorization for the requested use or disclosure.
- I understand that I have the right to:
  - Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
  - Refuse to sign this authorization.

I certify that this form has been fully explained to me, that I have read it, or had it read to me, and that I understand its contents.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

NSU Health Staff Use Only

Completed by: _____ (Print Full Name) Date completed: _____

Delivery method: ☐ FAXED TO HEALTHCARE PROVIDER ☐ MAILED ☐ IN PERSON ☐ E-MAILED TO THE PATIENT (ADDENDUM COMPLETE

File in Patient Chart
Date: April 2003
Revision: March 2012; October 2014; May 2015; July 2016; April 2017; October 2017; January 2022

Note: Only in the special circumstance where a Patient requests his/her medical record to be emailed directly to the Patient, the Patient's Personal Representative, or another person designated by the Patient above, then the attached addendum must be completed as well.

Nova Southeastern University (NSU)
Institute for Neuro Immune Medicine
Addendum to Authorization for E-Mail Communications

E-mail address (please print clearly – one letter per box):

Confirm e-mail address (please print clearly – one letter per box):

I request that the protected health information designated in the attached authorization be communicated via encrypted e-mail communication at the above listed email address, which I have confirmed to be accurate. I acknowledge and understand that e-mail communication may contain my personal and private medical information including, but not limited to, my name, address, date of birth, social security number, types and dates of health care services received, medication, insurance coverage information, and/or test results. I understand that the NSU Health Care Center and its health care providers are not responsible for the security of e-mail communications once they are received and stored at the email address listed above.

I understand that e-mail communications may not be secure, even if encrypted, and that the protected health information could include identifiers that could be intercepted and used maliciously for criminal purposes such as identity theft. I further understand that responses to the e-mail communication may not be encrypted or secure. Additionally, I understand that it is the policy of NSU that it may not exchange clinically relevant information with patients via email, **except if the Patient or the Patient's Personal Representative requests a copy of the patient's medical record via email, or as specifically permitted by NSU.**

As such, I understand that if the NSU Health Care Center receives an email from a patient that relates to his/her medical care, the NSU Health Care Center is responsible for notifying the patient that other than providing a copy of the requested medical record the NSU Health Care Center does not communicate clinical information by email, and that the patient should call the office to address the matter or make an appointment, as appropriate, or call 911 for any and all emergencies. With these understandings, I authorize NSU to communicate via email communications at the above listed email address.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority

Date: October 2014
Revision: May 2015

File in Patient Chart