NASA Spine Institute
R. Eric Santos, M.D., P.A.
Dr. Kim Garges . , M. D., P.A.

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctor's, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: in emergency situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctor's/specialists) with whom we may share your information:

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is the best phone number for us to contact you? WK HM CELL OTHER

Phone number: _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. Is it OK for such message to include details (such as diagnosis and medication information) at this number? _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Print name of Patient or Legal Representative Relationship to Patient

NASA Spine Institute
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General Acceptance of Liability

I, _____, fully understand that it is the responsibility of
Please print full name
the patient and/or guarantor to provide proper billing information. I also understand I will be fully responsible for office visits, x-rays, diagnostic studies and surgery that are not covered by my insurance company.

If my insurance company requires a referral, I understand it is my responsibility to provide R. Eric Santos, M.D. / Kim J. Garges . M.D. and staff with that referral for proper billing. If the office of R. Eric Santos, M.D ./ Kim J. Garges , M.D. does not receive a referral at the time of my appointment, I will be responsible for payment for the office visit and treatment(s) for all services rendered. It will be my responsibility to file a claim with my insurance company for reimbursement.

I have read and understand this acceptance of liability.

_____ _____
Signature of Patient and/or Guarantor Date

_____ _____
Representative of
R. Eric Santos, M.D., P.A.
Kim Jeffrey Garges M.D. Date

NASA Spine Institute
R. Eric Santos, M.D., P.A.
Kim J. Garges , M.D., P.A.

Acknowledgement of Review of
NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices for R. Eric Santos, M.D., / Kim J. Garges, M. D. P.A. which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document. ******If patient is 17 years or younger a parent or guardian must sign this form******

_____/_____/_____

_____ _____
Patient Name (please print full name) Signature of Patient

_____ _____
Printed Name of Parent/Guardian Signature of Parent/Guardian

Relationship to Patient: _____

Patient DOB: _____ Patient SS#: _____

_____ _____/_____/_____
Printed Name of R. Eric Santos, M.D./ Kim Garges , M.D. Staff Date

_____
Signature of R. Eric Santos, M.D. / Kim Garges M.D. Staff

FOR CLINIC USE ONLY:
If patient refuses to sign acknowledgement of "Notice of Privacy Practices"

Dr. R. Eric Santos and his staff have made the following good faith efforts to obtain the above referenced individual's written acknowledgement of the NOTICE OF PRIVACY PRACTICES. Please give explanation below as to why the written acknowledgement was not obtained (If given by patient).

Explanation:

_____

_____

_____