Dear Patient:

We appreciate having you as a patient of Scott C. Kutz, MD. As a physician, nurse, or office personnel, it is our desire to provide you the best possible medical care. You may have questions regarding our clinic policies, and this letter is designed to answer some of your questions.

To help us assist you in getting an online Face2Face meeting with Dr. Kutz, please give us the following information.

PLEASE NOTE: We apologize in advance for any extra effort that you are required to go through to get us your information. However, it is a federal requirement that your information and medical history be protected by a special encrypted technology. This is why it is required for you to save this completed form to your computer and then attach it to an email and send it to us through our special HIPAA secure email server at https://sendsafe.to/info@mintmedicalgroup.com.

PATIENT OFFICE INFORMATION

PATIENT'S NAME:_____ **DATE OF BIRTH:** ____/_____/_____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:**_____

HOME #: (_____**)**_____**-**_____ **CELL #: (**_____**)**_____**-**_____ **WORK #: (**_____**)**_____**-**_____**xt.**_____

EMAIL ADDRESS: _____ **OTHER #: (**_____**)**_____**-**_____

PRIMARY CARE PHYSICIAN: _____**PHONE #: (**_____**)**_____**-**_____

MEDICATION ALLERGIES: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO. NAME: _____**PHONE #: (**_____**)**_____**-**_____

CLAIMS ADDRESS: _____

INSURANCE POLICY HOLDER: _____ **RELATION:** _____

POLICY HOLDER'S SOCIAL SECURITY #: _____**-**_____**-**_____ **DATE OF BIRTH:**_____/_____/_____

SECONDARY INSURANCE CO. NAME: _____PHONE #: (_____)_____-_____

CLAIMS ADDRESS: _____

INSURANCE POLICY HOLDER: _____ RELATION:_____

POLICY HOLDER'S SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

The above information is true to the best of my knowledge. I have read the office policies provided and understand them fully. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize MINT, Inc. or my insurance company to release any information required to process my claims.

_____ _____

SIGNATURE
(Typing your name is sufficient for this form)

DATE

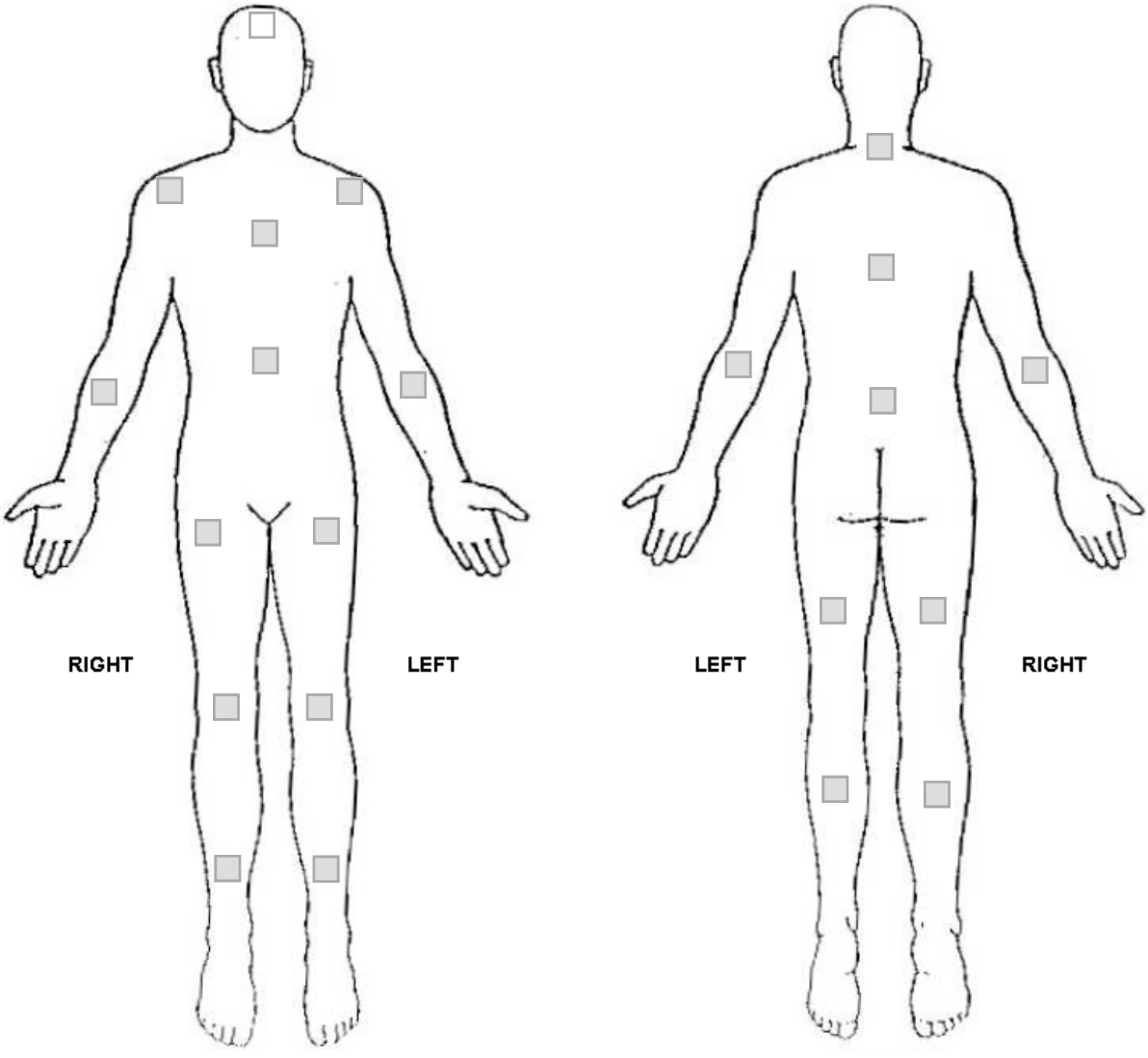
Again, when you have filled out as much as you can, save your form to your computer and then attach it to an email to https://sendsafe.to/info@mintmedicalgroup.com. You will be notified that we have received your form. Your information will be transmitted through our HIPPA compliant secure messaging system.

MINT
Minimally Invasive Neurosurgery of Texas

WHERE IS YOUR PAIN NOW?

Mark the areas on your body where you feel the described sensations. Please use the appropriate symbols. Include all affected areas.

ACHES	^^^^^ ^^^^^ ^^^^^	**NUMBNESS**	0 0 0 0 0 0 0 0 0 0 0 0	**PINS & NEEDLES**	- - - - - - - - - - -	**BURNING**	XXXX XXXX XXXX	**STABBING**	/ / / / // / / / // /



FRONT **BACK**

5425 Spring Creek Pkwy. Ste 133, Plano, TX 75024 ● 972.244.3491 ● 972.535.2180

Scott C Kutz, MD
Neurosurgeon

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.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At MINT, Inc. (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name, address and claims information. We use this information to provide service to you, to process your claims and to bring your health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information, we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We will take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why – information is shared

We limit who receives information and what type of information is shared.

* Sharing *information within **the Practice***. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

* sharing *information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

* *Other*. Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us – whether it's at our office, over the phone or through the Internet.

Scott C Kutz, MD
5425 Spring Creek Pkwy.
Ste. 133
Plano, TX 75024
972-244-3491

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE FORM INSTRUCTIONS

A physician with a direct patient relationship with an individual is not required to obtain the consent of the patient prior to using protected health information (or disclosing it to third parties) for purposes of carrying out treatment, payment or health care operations. While the modifications to the final Privacy Rule reduced the necessity for a mandatory consent form, it provided for an acknowledgement of receipt of a Notice of Privacy Practices. This consent form accomplishes that purpose. A consent form should be signed prior to or during initial paperwork for each new patient and as soon as possible for existing patients. This form does not require a witness; however, we recommend that the form be witnessed whenever possible as it may help prevent misunderstandings at a future date.

REFERENCE

Policies & Procedures: Permitted Uses and Disclosures without Authorization.
Minimum Necessary Use and Disclosure of Protected Health Information.
Uses and Disclosures of PHI by and for Personal Representatives, Minors and Deceased Incidental Uses and Disclosures

MINT
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Scott C. Kutz, MD
Neurosurgeon

Patient Consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the provision of healthcare services, MINT, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must: agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

_____ _____

PATIENT'S NAME PRINTED DATE

_____ _____

PATIENT'S PRINTED NAME IS THE SAME AS HIS OR HER SIGNATURE SOCIAL SECURITY # (FOR ID PURPOSES ONLY)