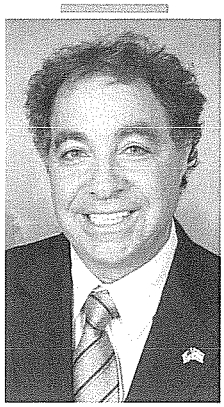
LARRY FISHMAN, M.D.



ADDRESS:
427 South Parsons Avenue, Suite 110
Brandon, Florida 33511
(813) 653-2770

PERSONAL:
Married
Born December 12, 1952, Philadelphia, Pennsylvania

UNDERGRADUATE:
1970-1974
A.B. Degree, University of California, Berkeley

GRADUATE EDUCATION:
1975-1979
M.D. Degree, Universidad Autonoma de Guadalajara

FIFTH PATHWAY:
1980-1980
University of California, Irvine

POST-GRADUATE EDUCATION:
1980-1982
Neurological Surgery, Mayo Graduate School of Medicine

1982-1985
Residency, Mayo Clinic Neurosurgery

1985-1988
Neurosurgery, Medical College of Pennsylvania

PRIVATE PRACTICE:
1988-1989
Orlando Neurosurgical Associates, Orlando, Florida

1989-Present
427 South Parsons Avenue, Suite 110, Brandon, Florida

1991-Present
Director of Neurological Surgery, HCA Brandon Hospital

Former Assistant Clinical Professor, Division of Neurosurgery
University of South Florida College of Medicine

2004-2009
Chairman, Peer Review, Brandon Regional Hospital

2008 - Jan. 2010
Chairman, Department of Surgery Brandon Regional Hospital

PUBLICATIONS:
Fishman, L. and Marsh, W.R.
Prolonged Bleeding Time Associated With Moxalactam Administration
Neurosurgery, 14: 735-736, 1985

SPEAKER:
The Upper Mississippi Basin Chapter of AANN, October, 1984
Hydrocephalus: Pathophysiological Process and Surgical Intervention

American Society of Neuroimaging 10th Annual Meeting, March, 1987
Correlative Neuroimaging of Superior Sagittal Sinus Thrombosis

CERTIFICATIONS:
1984, Passed Part 1 of American Board of American Board of Neurological Surgery Exam
1993, Board Certified

ACTIVE STAFF:
HCA Brandon Hospital
South Bay Hospital
South Florida Baptist Hospital
Memorial Hospital, Tampa
Tampa General Hospital

SOCIETIES & ORGANIZATIONS:
Member of the Congress of Neurological Surgeons
The Florida Neurological Society
The American Academy of Neurological Surgeons
Hillsborough County Medical Association
American Medical Association
Florida Medical Association
Southern Medical Association
International Association of Minimally Invasive Surgery
Joint Section on Neurotrauma and Critical Care
Joint Section Cerebrovascular Surgery
Cleveland Clinic Associate Affiliation

NEUROLOGICAL SURGERY

Larry Fishman, M.D., P.A.
Diplomate of the American Board of Neurological Surgery

Dear New Patient:

Dr. Fishman and his staff would like to welcome you to our office.

As a way to begin our association with you, we have prepared this welcome packet. It both provides you with necessary information and gives us an opportunity to ask you important questions by means of several forms included here.

Included in this welcome packet is a patient information brochure that will guide you through most of our policies. You will learn about scheduling, the doctor's office hours, how to contact us in case of an emergency, how to renew prescriptions, and how billing works in our office.

Also included are several forms for you to fill out. We send them to you with the intention that it may be more comfortable for you to complete them at home. Please take your time with all of these, especially the medical history form. This information is important to the doctor when he formulates your treatment plan.

Please bring all xray films with you, i.e., MRI, CT scan, myelograms, and plain spine films. If you fail to bring in your xrays, we will have to reschedule your appointment for another day.

You will need to bring in all your insurance information including your insurance card. If you are an HMO patient you must bring in your referral with you. In the instance that your primary doctor says they will fax it to us, please call our office the day before to make sure we have your referral. We will not call your primary doctor for the referral and without it, the doctor cannot and will not see you. In the event this visit is covered under workman's compensation, please make sure your claims adjustor calls us to authorize the visit; the doctor cannot see you until this call has been placed to us.

When you come into the office for your first visit, please bring the forms in this welcome packet completed as thoroughly as possible.

If you have any questions or need more information about our office, please feel free to call our office.

Dr. L. Fishman and staff

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NEUROLOGICAL SURGERY

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OFFICE HOURS:

Our office staff is in the office Monday through Friday from 8:30 a.m. until 5:00 p.m.

SCHEDULING:

The doctor sees patients on Monday from 9:00 a.m. until 11:00 a.m. and then again from 1:30 p.m. until 4:00 p.m. On Wednesdays, he sees patients from 9:00 a.m. until 11:00 a.m. On Fridays, he sees patients from 8:00 a.m. until 2:00 p.m.

HOW TO CONTACT US WITH AN EMERGENCY:

Call our office phone number (653-2770). One of the staff will answer the phone during normal business hours. Let them know your name, the nature of your emergency and phone number where you are at. They will give you a call back with further instructions once they have spoken to the doctor and he has told them how to address the situation. After hours, there is a live answering service who will answer the phone. Please give them your name, the emergency you are having and a phone number where Dr. Fishman can return your call. The service will then call Dr. Fishman and relay him the information. In turn, the doctor will call you and give you further instructions on how to take care of the emergency.

PRESCRIPTIONS:

Call our office during normal business hours and ask for a renewal on your medication. Please make sure you have the pharmacy name, number and the name of the medication ready when you call. All of these calls need to be taken care of during normal business hours. **Please do not call the office after hours or on weekends for medication. The doctor will not call in any medications during this time.**

BILLING:

Co-payments and deductibles must be made in the office upon arrival. We will file the insurance claim ourselves. If your insurance denies the claim, you will be sent a bill for that amount. If you do not have a referral with you and your insurance requires you have one, you will either have to reschedule or pay for the visit yourself.

427 South Parsons Avenue, Suite 110 • Brandon, Florida 33511 • (813) 653-2770

Welcome To Our Office

Your Name: _____ Today's Date: _____
First Middle Last

Home Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Length of Employment: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: ( ) _____ Birthdate: _____ Age: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Length of Employment: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

Name of Spouse: _____ Birthdate: _____ Age: _____
Occupation: _____ Social Security Number: _____
Employer: _____ Length of Employment: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____
Employer's Telephone: ( ) _____

In the Case of an Emergency, Contact: _____ Relationship: _____
Home Phone: ( ) _____ Work Phone: ( ) _____

How did you learn about Neurological Surgery, Larry Fishman, MD? _____
Referred By: Dr. _____

Insurance Information

Patient's Name: _____ Today's Date: _____
First Middle Last

[Primary]
Name and Address of Company: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group #: _____ Policy ID #: _____
Effective Date of Coverage: _____

[Secondary]
Name and Address of Company: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group #: _____ Policy ID #: _____
Effective Date of Coverage: _____

Our office will file insurance for your procedure charges only, office visits are payable on the day you are seen. Please remember you are responsible for all fees, regardless of insurance coverage.

Method of Payment: ___ Cash ___ Check ___ MasterCard or VISA

Signature of Patient or Legal Guardian: _____ Date: _____

I authorize the release of any medical information necessary to process this claim.

Signed: _____
(patient or authorized person)
Date: _____

I authorize payment of medical and procedure benefits to Neurological Surgery, Larry Fishman, MD.

Signed: _____
(insured or authorized person)
Date: _____

Medical History (page one)

Name (Please print in ink throughout this form) Date

We ask that you complete this form to help the doctor determine your diagnosis and treatment plan. Please be very specific.

1. Are you right or left handed?

2. What kind of symptoms are you having?

3. How long have you had these symptoms? (Be specific about onset.)

4. Do you have any numbness, tingling or weakness in your arms or legs? (Please describe.)

5. Please circle any of the following treatments you have tried to relieve your symptoms:

physical therapy	bed rest	pain medication
reduction of activity	muscle relaxants	back brace
anti-inflammatory medications	exercise program	heat
cervical or lumbar traction	massage therapy	TENS unit
chiropractic treatment	pain control clinic	oral steroids
work-hardening program	steroid injections	cervical collar
hydrotherapy	ultrasound	others:_____
		_____

6. Circle previous tests done

plain xrays CT scan MRI NCV
myelogram EMG angiogram EEG other_____

7. Have you ever had any brain or spine surgery? If so, please give dates and reasons.

8. Please list ANY past operations you have undergone. Please give dates if you remember them.

A. E.
B. F.
C. G.
D. H.

Medical History (page two)

Name (Please print in ink throughout this form) Date

9. Please list ANY medication ALLERGIES.
A. C.
B. D.
Are you allergic to IODINE?

10. List all current medications.

11. Do you take ASPIRIN, MOTRIN, IBUPROFEN, NAPROSYN, RELAFEN, ALEVE, ADVIL, or any other anti-inflammatory medicine? Please list. Do you take COUMADIN (WARFARIN) or any other blood thinners?

12. Do you have heart disease, hypertension, diabetes or lung disease? What medications, if any, do you take?

13. Do you smoke? If so, how much?

14. Do you drink alcohol? If so, how much? What kind?

15. Please name any physicians that you have seen about your current medical problem or any similar problem.

16. Has anyone in your family ever had the same or similar problem? (Please list who and what type of problem.)

17. If your symptoms are related to any injury, please mark the box below indicating the type of injury. **Date** of injury:_____
□auto injury □personal injury □work-related injury
□other _____
Describe the accident and injury **completely.** If work-related, please tell why.

18. Are you working now? What are the physical requirements of your job? (Describe what you do physically during your work day.)

Medical History (page three)

Name (Please print in ink throughout this form) Date

19. Specifically, what amount and kind of lifting, if any, are you required to do?

20. Do you have any medical work-related restrictions? (Please describe.)

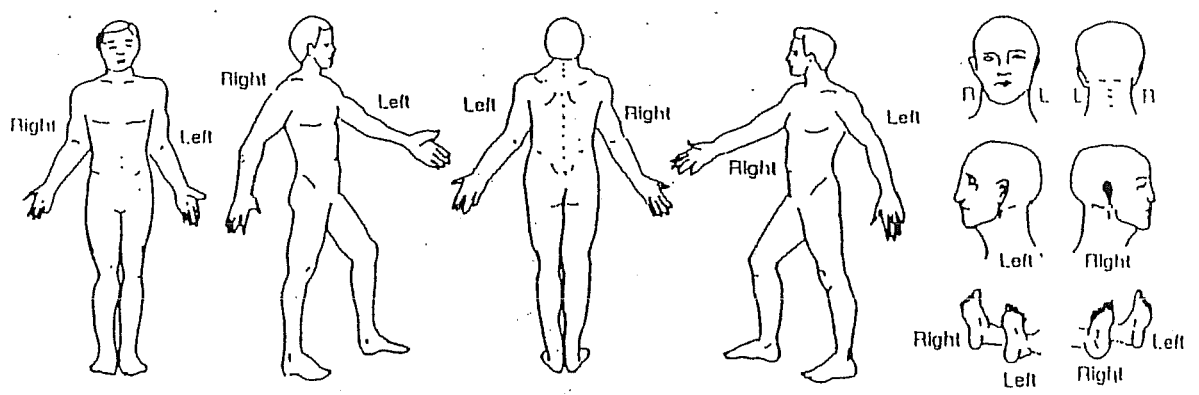
21. If you stopped working because of symptoms related to this injury, when did you stop working?

22. Why did you stop working?

23. Please state your height and weight.

24. Are you contacting an attorney(s) to help you in litigating a personal injury, auto accident, or Worker's Compensation suit? If yes, please give attorney's or attorneys' name(s), address, and phone number.

Please mark you areas of pain in the below figures.



NEUROLOGICAL SURGERY

Larry Fishman, M.D., P.A.
Diplomate of the American Board of Neurological Surgery

DISCLOSURE TO FAMILY/FRIENDS

_____ I do not want Larry Fishman, M.D. to disclose any information concerns my care or treatment by Provider to individuals without my express Written consent or legal authorization.

_____ I authorize Larry Fishman, M.D. to disclose information related to my care and treatment to the following named individual(s).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

The authorization provided for above is subject to the following limitations or restrictions.

_____

_____

_____

_____

_____
Patient Name (Printed)

_____ _____
Signature of Patient or legal guardian Date

_____
Witness

NEUROLOGICAL SURGERY

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PATIENT-PHYSICIAN CONTRACT

We are now in a new era of Health Care Reform - intended to help patients. Sadly, these reforms do not include any "Lawsuit Reforms" that would dramatically reduce costs for patients and also promote a better environment for patients and their physicians. In a recent nationwide poll[1] 83% of the nation's electorate wanted Congress to address the medical malpractice system as part of the Health Care Reform plan. We wish Congress had taken action implementing reforms that both doctors and patients could support. And the majority of patients agree. Congress missed the opportunity. Because of that we have taken action with the single goal of enhancing the relationship between patients and the physician.

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's right to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country—claims that are driving up insurance rates and impacting court decisions for the patients who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follow the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.
We demonstrate this commitment to you with our signature on this form.

WHAT WE ARE ASKING YOU TO DO

We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness(es) if you are dissatisfied with your medical care and decide on legal action.
We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

Signature _____ Date _____

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NEUROLOGICAL SURGERY

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PRESCRIPTION DRUG POLICY

The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from Dr. Fishman, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amounts, with clear instructions.

Prescription drugs have potential for abuse and are regulated closely by the state and federal agencies. Certain more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We will accept **NO** excuses for their loss, theft and will not order replacements. We will not prescribe them if you are using them other than exactly prescribed or receiving them from another source. We expect you to notify our office if you change drug stores, so that the order at the first store may be cancelled.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you will need a refill, please call our office with the name of your pharmacy and pharmacy phone number 24-48 hours prior so that we will have ample time to ask Dr. Fishman and then call your medication into your pharmacy.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR) or the local police.

If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

Patient signature/Patient Guardian Date

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NEUROLOGICAL SURGERY

Larry Fishman, M.D., P.A.
Diplomate of the American Board of Neurological Surgery

PRIVACY PRACTICE

1. You have the right to request restrictions on the use and disclosure of your medical records/information; however Dr. Fishman is not required to agree to restrictions not guaranteed by law. You will be informed if Dr. Fishman will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communications.
3. You have the right to inspect and copy your medical records. (Dr. Fishman is entitled to charge you a reasonable fee related to the cost of copying your records.)
4. You have the right to seek to amend your medical records, and if Dr. Fishman does not agree with your request, to note your objection in the medical record.
5. you have a right to receive an accounting (list) of disclosures of your medical records/information made by Dr. Fishman. (Except for those disclosures that are made to you or with your specific authorization that fall within the scope of Dr. Fishman's "health are operations or disclosures made for payment or treatment purposes.)
6. You have the right to receive a paper copy of this notice.

Dr. Fishman is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices. Patients will be provided with revised notices, as appropriate.

If a patient believes that his or her privacy rights have been violated, the patient may complain to Dr. Fishman, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Dr. Fishman, please write or call us with the details. Dr. Fishman will not retaliate in any way against a patient for making a complaint.

If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated person: Rena Lee

Dr. Fishman reserves the right to change its privacy practices and to make its new policies effective for all protected health information that Dr. Fishman maintains. If such changes are made, Dr Fishman will issue an updated "Notice to Patients".

Please acknowledge receipt and review of this notice by signing below.

Name of Patient (print) Date

Signature of Patient or Lawfully Authorized Representative

427 South Parsons Avenue, Suite 110 • Brandon, Florida 33511 • (813) 653-2770

FINANCIAL POLICY

DR. LARRY FISHMAN, M.D., P.A.

The following information is provided to avoid any misunderstanding or disagreement concerning Dr. Fishman's Financial Policy.

* Prompt payment allows us to control costs. Outstanding accounts cost both of us time and money, therefore, all patients will be required to establish financial arrangements for payment of their accounts.

*** Worker's Compensation patients: As long as your care is determined to be W/C there is no financial responsibility due from you. Until, you either reach MMI (Maximum Medical Improvement) and your W/C carrier determines you are responsible for co-payments for services rendered to you. Or if your claim is controverted or denied the balance will be your responsibility and the financial policy will apply to your account.**

* It should be mentioned that your insurance coverage is an agreement between you and your insurer. As a courtesy our practice will bill your insurance carrier for a period of sixty days. It will then be your responsibility to remit payment for any unpaid claim(s) by your carrier as well as any and all charges not covered by your carrier or deemed over Usual and Customary charges.

***All Copays and Deductibles / patient percentages are due at the time of service and three days prior to scheduled surgery date.**

*** All Appointments not cancelled within 24 hours of your scheduled appointment will be assessed a $25.00 missed appointment fee, which is payable by the Patient.**

*** Our office does not accept Third Party Liability - Payment is patient's responsibility.**

*** If your carrier requires Authorization, this is your responsibility to obtain for your appointments. You will also need your Insurance Card so a copy can be made for your chart.**

* Each month you will receive a monthly statement for services, which is due and payable within 30 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

* All patients refusing to remit payment after final notice has been sent without pending insurance or other financial arrangements, will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished. All patients will be required to sign a written legal agreement with our practice. All accounts are subject to being forwarded to a Collection Agency and Credit Bureau as well as any and all additional costs occurred in collecting the debt (attorney fees).

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Our practice firmly believes that a good Doctor/patient relationship is based upon understanding and open communications. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your account.

If you have any questions concerning our policy or need assistance, please contact us immediately.

_____ _____

(Patient / Legal Guardian) ***(Date)***