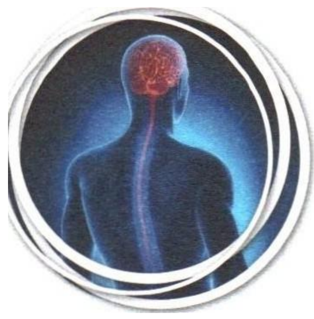


Scott P. Leary, M.D.

Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
- Complex Spine Surgery
- MIS: Minimally Invasive Spine Surgery
- MIS: Alternatives to Fusion
- MIS: Alternatives to Surgery
- Artificial Disc Replacement
- Stem Cell Therapy
- Correction of Spinal Deformity
- Correction of Scoliosis
- Outpatient Kyphoplasty
- Cervical Spine Disease
- Lumbar Spine Disease
- Skull Base Surgery
- Endoscope Assisted Surgery
- Acoustic Neuroma
- Brain Tumors
- Cerebral Aneurysms
- Stereotactic Radiosurgery
- Pituitary Adenoma
- Trigeminal Neuralgia
- Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

Dear Patient:

You have scheduled an appointment with the office of Scott P. Leary, M.D. and Tracy M. Sebastian, PA-C, welcome to our practice! Please feel free to go onto our website at www.scottlearymd.com where you can meet the staff, find our location and read other patients' stories.

We will be happy to bill your health insurance. Please bring your insurance card(s) and photo ID so that we may make a copy of it for our files.

Please be sure to bring the **actual films on disc** of any x-ray studies, MRIs, CTs, etc. Please make sure to bring their corresponding report as well. The provider will review the imaging with you during your visit.

We have included driving directions to help you locate us, however, it is best to input our address into your navigation system (in your vehicle or on your smartphone) to get most accurate directions. Our address is 7625 Mesa College Drive, Suite 305A, San Diego, CA 92111.

Park anywhere you can find an open spot in our parking lot. If you have a handicap placard, we have designated handicapped parking spots throughout the parking lot.

We are located on the 3rd floor of the 3-story building. Once you exit the elevators, on the 3rd floor, our check-in desk will be all the way on the left-hand side. Our front desk person, Andrea, will be there to greet you.

Please make sure to have all your new patient paperwork completed before arriving to your appointment. There will be additional paperwork to complete once you arrive and we don't want you to be late for your first meeting with Dr. Leary.

If you have any questions, you can contact us at 858-223-2100.

We look forward to seeing you on your appointment date.

Sincerely,
Dr. Leary, Tracy and Staff

From the North
1-805 South
Take the 1-805 South
Take the Balboa Avenue East/CA-274 E exit, EXIT 21.
Keep right to take the Balboa Avenue/CA-274 ramp.
Merge onto CA-274/Balboa Avenue
Turn right onto Convoy Street
Convoy Street becomes Linda Vista Road
Turn left onto Mesa College Drive
7625 MESA COLLEGE DRIVE is on the right.

1-5 South
Take the 1-5 South
Merge onto the 1-805 South.
Keep left to take 1-805 South via EXIT 31.
Take the Balboa Avenue East/CA-274 E exit, EXIT 21.
Keep right to take the Balboa Avenue/CA-274 ramp.
Merge onto CA-274/Balboa Avenue.
Turn right onto Convoy Street.
Turn left onto Mesa College Drive.
7625 MESA COLLEGE DRIVE is on the right.

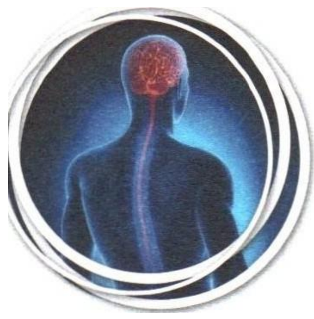
1-163 South
Take the 1-163 South.
Exit Genesee Avenue .
Turn right onto Genesee.
Turn right on to Linda Vista Road.
Turn right onto Mesa College Drive.
Turn right into the first driveway.
7625 MESA COLLEGE DRIVE

From the South
1-805 North
Take the 1-805 North.
Take the Kearny Villa Road/Mesa College Drive exit, EXIT 20A.
Keep left to take the Mesa College Drive ramp.
Turn left onto Kearny Villa Road.
Kearny Villa Road becomes Mesa College Drive.
Make a U-turn at Linda Vista Road onto Mesa College Drive.
7625 MESA COLLEGE DRIVE is on the right.

1-5 North
Take the 1-5 North toward San Diego.
Merge onto CA-163 North via EXIT 16A toward Escondido.
Take the Genesee Avenue West exit, EXIT 513.
Turn right onto Genesee Avenue.
Turn right onto Linda Vista Road.
Turn right onto Mesa College Drive.
7625 MESA COLLEGE DRIVE is on the right.

From the East
Take the 1-8 West.
Merge onto I-805 North via EXIT 68 toward Los Angeles.
Take the Kearny Villa Road/Mesa College Drive exit, EXIT 20A.
Keep left to take the Mesa College Drive ramp.
Turn left onto Kearny Villa Road.
Kearny Villa Rd becomes Mesa College Drive.
Make a U-turn at Linda Vista Road onto Mesa College Drive.
7625 MESA COLLEGE DRIVE is on the right.

From the West
Take the 1-8 East
Merge onto CA-163 North via EXIT 16 toward Escondido.
Take the Genesee Avenue West exit, EXIT 5B.
Turn right onto Genesee Avenue.
Turn right onto Linda Vista Road.
Turn right onto Mesa College Drive.
7625 MESA COLLEGE DRIVE is on the right



Scott P. Leary, M.D.
Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Controlled Substance/Narcotic Agreement

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

This agreement is between the patient and the prescribing provider; Scott P. Leary, M.D. and Tracy M. Sebastian, PA-C. By signing a contract for narcotic administration, the patient has indicated that they understand the discussion about the use of narcotic medications, including side effects, and is agreeable to start this treatment under the terms set by this medical office. It is agreed that narcotic medication will be given by Dr. Leary and/or Tracy Sebastian on a regular basis to the patient **ONLY** if the following terms are met:

1) I will take medications only as prescribed. I will not exceed the prescribed dose even if I perceive it to be necessary. **No early refills will be given.**
2) I am fully responsible for the safe keeping of my medication. Lost or stolen medications will not be replaced.
3) I will never share my medication with others.
4) I will not use illicit drugs or abuse alcohol.
5) No narcotic prescriptions will be refilled after hours or on weekends.
6) I will not drive a vehicle or use dangerous equipment while taking my pain medications. I am aware that if I have narcotics in my system while operating a vehicle **I** may be subject to a DUI.
7) I am aware that narcotic medications are addicting.
8) I am aware the narcotic medications can cause constipation which can lead to bowel obstruction.
9) I am aware that suddenly stopping these medications may be dangerous.
10) I understand that **I** will not receive any other narcotic medications from any other provider(s) while receiving narcotic medications from this office.
11) I fully understand the explanations regarding the benefits and the risks of this method of treatment. I agree to the use of narcotic medication in treatment of my pain.

This has been fully explained to me and I understand the terms. I have had the opportunity to ask questions and received acceptable answers. **I agree to the terms of this contract.**

Date: ______________________

Patient Printed Name: ______________________________________

Patient Signature: ____

Witness Printed Name: _____________________________________

Witness Signature: ____

Notice of Privacy Practices

Scott P. Leary, M.D.
SENTA Medical Clinic
Division of Neurological Surgery
7625 Mesa College Drive, Suite 305A
San Diego, CA 92111
Privacy Officer, Office Manager, 858-223-2100

Effective Date: April 14, 2003

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. We use a billing service to obtain this payment. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. From time to time we may release your information to a collection agency or attorney for the purpose of collecting past due accounts.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information, which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers and health plans who participate in Imperial County Physician's Medical Group, Imperial Valley Family Care Medical Group, Scripps Physicians, Sharp Reese-Stealy Medical Group, Sharp Community Medical Group, Community Health Group, Sharp Health Plan, Sharp Advantage, and for any health care operations activities of Southern California Physicians Managed Care Services, Center for Healthcare, Sharp, or Medicare or Medi-Cal Managed Care plans. From time to time your medical information may be disclosed in the Tumor Board or Skull Base Surgery Rounds at Alvarado Hospital Medical Center/SDRI. We may use and disclose medical information about you with Alvarado Hospital, Alvarado Surgery Center, Sharp Memorial Hospital, Sharp Chula Vista Hospital, Sharp Coronado Hospital, Scripps Memorial Hospital, Sharp Grossmont Hospital, Grossmont Plaza Surgery Center, Grossmont Surgery Center, and the Gamma Knife Center. Our contract affiliations with the

health plans, medical groups, hospitals, and surgery centers listed above may change from time to time. To verify our current affiliations please contact our Privacy Officer at the phone number listed at the beginning of this notice.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. The information left with the message will be limited to the minimally necessary information needed for this purpose.

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in

response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

16. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

17. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

18. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all

reasonable requests submitted in writing which specify how or where you wish to receive these communications. We reserve the right to accept or reject your request, and will notify you of our decision.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Practices will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy of any amended Notice of Privacy Practices at each appointment. We will request an acknowledgement from you confirming your receipt of our Notice of Privacy Practices. We will also post the current notice on our website, when the website becomes active.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Department of Health and Human Services.

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice of Privacy Practices

Scott P. Leary, M.D.
SENTA Medical Clinic
Division of Neurological Surgery
7625 Mesa College Drive, Suite 305A
San Diego, CA 92111
Privacy Officer, Office Manager, 858-223-2100

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

❑ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Signed: ____________________________________ Date: ____________________________

Print Name: ________________________________ Telephone: _______________________

Date of Birth: ____________________________

If not signed by the patient, please indicate:

Relationship:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient:

____

Medical Information Release Form

(HIPAA Release Form)

Name: ___________________________________ Date of Birth: _____ I____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse _______________________________________

[ ] Child(ren) _______________________________________

[ ] Other ____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: ________________

If unable to reach me:

[ ] you may leave a detailed message

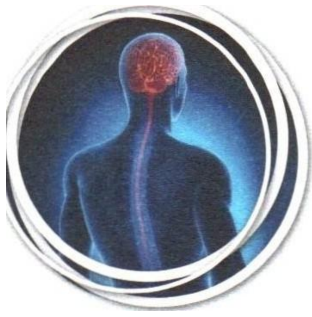
[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is *(day)* ______________________ between *(time)*_________

Signed: ____ Date: ___/___/_____

Witness: ____Date: __ / __ / _____



Scott P. Leary, M.D.
Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

ELIGIBILITY GUARANTEE

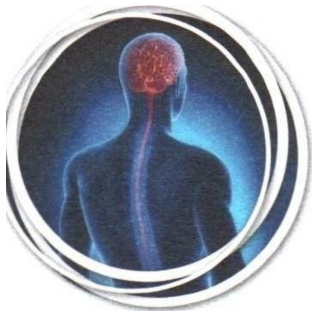
I ______________________________, hereby certify that
Name of Patient

I am eligible for ______________________________ ,
Health Pan

Effective ______________________________ . I understand that if the above is not true or if I am not eligible under the terms of my Health Plan Agreement, I am liable for all charges for services rendered. Also, if the above is not trye, I agree to pay in full for all services rendered within 30 days of receiving a bill from the above noted provider.

____
Signature of Patient/Member

____
Subscriber Number/Social Security Number



Scott P. Leary, M.D.

Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

To My Patients:

During the course of your treatment, you may require additional imaging studies. You may be referred to SMI Imaging Center for these studies. Please be aware that I own a financial interest in the aforementioned facility. There are other facilities available in our medical community where the same procedure(s) can be performed, and you have the option to use one of these alternate facilities. You will not be treated any differently by me regardless of the facility at which you choose to be treated.

Thank you for your understanding.

Scott P. Leary, M.D.

__________________________ __________________

Patient Signature Date

____

Print Patient Name

Alternate Facilities:

Imaging Healthcare

UCSD Imaging Facilities

Regents MRI

Name:______________________________ **Date:**____________________

PATIENT CONFIDENTIAL MEDICAL HISTORY FORM

Scott P. Leary, M.D.

Please answer ALL questions. If you do not understand the question or know the answer, write "?" in the space. Use the back of this form if additional space is needed to list your answers.

Nature of Complaints:____

General Health

Height: __________ **Weight:** __________

Do you smoke? **Y/N/Quit**. If yes, how many packs/day/how long? __________ If you quit, what year?__________

Alcoholic Beverages/Day:__________ Coffees/Day: __________ Teas/Day: __________

Do you have any medication allergies? **Y/N**. If yes, please list:________________________________

What types of allergic reaction did you have?________________________________

Past Medical History-Do you have or have you ever had any of the following major illnesses?

Asthma	**Y/N**	COPD/Emphysema	**Y/N**	High Blood Pressure	**Y/N**	Spinal Trauma	**Y/N**	Urinary Tract Infection **Y/N**
Bleeding Disorder	**Y/N**	Diabetes Type _____	**Y/N**	High Cholesterol	**Y/N**	Stroke	**Y/N**	**Other:**
_________Cancer	**Y/N**	Heart Disease	**Y/N**	Kidney Disease	**Y/N**	Thyroid Disorder	**Y/N**	

Family History-Do any of your family members have or had any major illnesses? If none, please write none.

Family Member:	**Illness/Condition:**

Surgical History- If none, please write none. Use the back of this form if additional space is needed.

Name of Surgery:	**Name of Surgeon:**	**Date of Operation: (MO/YR)**

Current Medications- If none, please write none. Use the back of this form if additional space is needed.

Name of Medication:	**Dose of Medication (e.g. 10 mg):**	**Frequency (e.g. 1/day):**

Do you take aspirin? **Y/N** Do you take fish oil? **Y/N** Do you take any other types of bloodthinners? **Y/N**

If yes, please list:____

Do you have or have you ever had:

Abnormal bleeding or anemia	**Y/N**	Difficulty climbing stairs	**Y/N**
Hypertension	**Y/N**	Ulcer or Gastritis	**Y/N**
Weight Loss	**Y/N**	Difficulty swallowing	**Y/N**
Fits/Convulsions/Seizures	**Y/N**	Numbness	**Y/N**
Double vision	**Y/N**	Paralysis	**Y/N**
Sudden vision loss	**Y/N**	Diabetes	**Y/N**
Decreased hearing	**Y/N**	Stroke	**Y/N**
Shortness of breath	**Y/N**	Heart Surgery	**Y/N**
Loss of memory	**Y/N**	Chest Pain	**Y/N**
Mental Illness	**Y/N**	Alcohol/Drug Addiction	**Y/N**
Metal in Body	**Y/N**	Claustrophobia	**Y/N**
Pacemaker or Defibrillator	**Y/N**	Implanted Device or Battery	**Y/N**

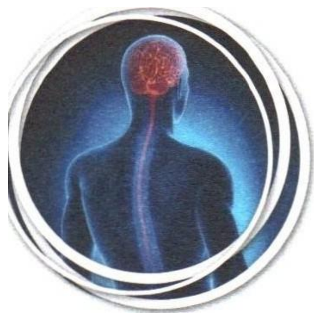
To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the medical office of any changes in medical status.

Patient (or Legal Guardian) Signature:______________________________ **Date:** ____________________

Patient Name: **Date:**

Please check one of the boxes for each type of conservative therapy listed below. If you check either "Yes" or "No" for effectiveness, then please also enter a month and year that you started the therapy and either enter "current" or a month and year (i.e., 02/17-present, 02/17-10/17, etc.) in which the therapy ended.

Type of Therapy	Effective? Yes	Effective? No	Not Applicable (NA)	Duration (Mo/Yr-Mo/Yr)	Additional Details
Acupuncture					
Chiropractic Therapy					
Physical Therapy					
Traction					
Ice/Heat Therapy					
Behavioral Therapy					
Guided Imagery/Meditation					
Weight Loss/Nutrition Therapy					
Braces or Orthotics					
Electrical Stimulators					
TENS Unit					
Non-Invasive Decompression					
Spinal Injections					
Trigger Point Injections					
Stem Cell Injections					
LIST ALL SPECIFIC MEDICATIONS TAKEN IN ADDITIONAL DETAILS COLUMN:					
NSAIDS (Advil, Ibuprofen, Naproxen, etc.)					
Tylenol (Acetaminophen)					
Narcotic Medications (Vicodin, Norco, Percocet, Tramadol, etc.)					
Muscle Relaxer Medications (Flexeril, Soma, Baclofen, etc.)					
Nerve Pain Medications (Lyrica, Gabapentin, etc.)					
Antidepressant Medications (Effexor, Lexapro, Paxil, etc.)					
Anti Anxiety Medications (Ativan, Valium, Xanax, etc.)					
Medications - Other - Please list					
Other Unlisted Therapies - Please list					



Scott P. Leary, M.D.
Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

CONSENT TO PARTICIPATE IN A TELEMEDICINE APPOINTMENT

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

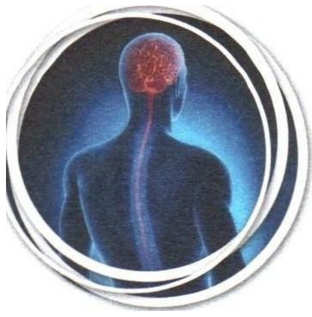
Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me.
2. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.
4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
   (1) omit specific details of my medical history/physical examination that are personally sensitive to me.
   (2) ask non-medical personnel to leave the telemedicine examination room: and or
   (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me telemedicine consultation.
6. In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the Doxy.me video conference connection.
7. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify: * That I have read or had this form read and/or had this form explained to me * That I fully understand its contents including the risks and benefits of the procedure(s). * That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Signature: ______________________________ Date: __________________

Patient Printed Name: ______________________________



Scott P. Leary, M.D.

Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

How to check-in as a Telemedicine patient

To meet with Dr Leary/Tracy for your visit you will need to follow these directions:

1. Turn on your computer/smart phone
2. Open your browser of choice:
   a. Chrome
   b. Safari
   c. Firefox
3. Make sure your webcam/camera and microphone are working – please go through the Test Bot to confirm your camera, speaker and microphone are working properly.
4. Make sure you are in a calm quiet room/area where you are free from distractions, can talk loud and openly and are able to listen about your current health condition without others around you listening to your medical issues. Examples would include:
   a. Bedroom
   b. Bathroom
   c. Closed office space
5. Make sure all incisions/wounds can be viewed during your visit. Please have all dressings off and area ready to be exposed. This may require the assistance of another person.
6. Please have all the above in place and be ready for your visit at least 5 minutes before you are scheduled to start your visit.
7. Please remember, we cannot connect for you, you must connect with us.

To "check-in" for your visit:

1. Your appointment date and time is: Date: Time:
2. Type the following provider's room address into your web address bar: https://doxy.me/drscottleary
3. Enter your name where prompted, then click "Check -In
4. You are now in your provider's waiting room. Wait for your provider to start the call

Note: If you have trouble checking in to your provider's room, contact support@doxy.me

Scott Leary, M.D.
7625 Mesa College Drive Suite 305A San Diego CA 92111
Phone: 858-223-2100
Fax: 858-223-2101

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: ________________________________ Birthdate: _________
Last First Middle

I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: ________________________________
Address of Provider: ________________________________
____
Phone: ____________________ Fax: ____________________

Person to use or receive the health information:

Name: Dr. Scott Leary
Address: 7625 Mesa College Dr Ste. 305A
San Diego, CA 92111
Phone: 858-223-2100 Fax: 858-223-2101

Purpose: I understand that the specific purpose of this Authorization is: (if you do not want to explain the purpose, write "at the request of the individual")

____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

___ All of my health information that the provider has in his/her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other

mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.
___ All of my health information described above except for the following:
____

___ Only the following records or types of health information:
____
(insert dates of treatment, types of treatment or other designation)

Term: This authorization will remain in effect for one (1) year from the date this authorization is signed.

Redisclosure: I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have a right to receive a copy of this authorization from my health care provider.

Photocopy: A photocopy, fax or electronic copy of this authorization

shall be considered as effective and as valid as the original.

____________________________________ _______________
Signature Date

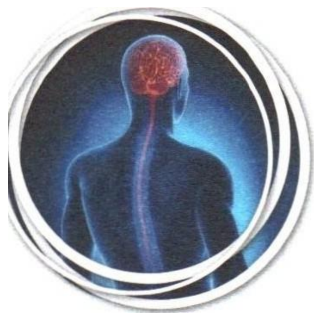
__________________________ __________________________
Print Name Witness Signature

If individual is unable to sign this Authorization, please complete the information below.

____________________________________ _______________
Signature of Personal Representative Date

__________________________ __________________________
Legal Relationship Witness Signature

Name: ____
(please print)



Scott P. Leary, M.D.
Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

Notice of Appointment No Show or Late Cancellation Policy

At Dr. Scott Leary's office, we are dedicated to providing excellent patient care. When we schedule appointments, we set aside time and professional resources to meet the individual needs of our patients, including time for a one-on-one consultation. When a patient fails to show up for an appointment, or to cancel within 24 hours of the appointment, our valuable resources are idle. More importantly, a patient care opportunity is missed.

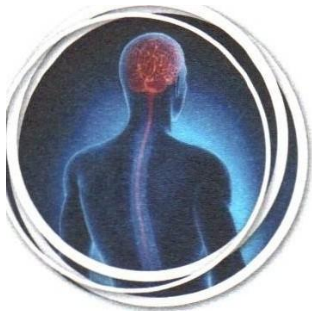
We understand that there are occasions when a patient must miss an appointment due to unforeseen circumstances or a scheduling conflict beyond his or her control. In this event, we ask that you call our office and cancel your appointment within 24 hours of the scheduled visit. This courtesy allows my office staff to schedule another patient who is also in need of medical care. For your convenience, you may reschedule an appointment at (858) 223-2100.

Please call us at (858) 223-2100 at least 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 12:00 p.m. on Friday.

If prior notification is not given, you will be charged $75 for the missed appointment.

Please sign below to consent to these terms.

__________________________________ ______________
Patient Signature Date



Scott P. Leary, M.D.
Diplomate, American Board of Neurological Surgery
Fellowship Trained, Complex Spine Surgery
Minimally Invasive Spine Surgery
Artificial Disc Replacement
Stereotactic Radiosurgery
General Neurosurgery

Scott P. Leary, M.D.
Tracy Sebastian, PA-C

7625 Mesa College Drive
Suite 305A
San Diego, CA 92111
(858) 223-2100
FAX (858) 223-2101
www.scottlearymd.com

Services
Complex Spine Surgery
MIS: Minimally Invasive Spine Surgery
MIS: Alternatives to Fusion
MIS: Alternatives to Surgery
Artificial Disc Replacement
Stem Cell Therapy
Correction of Spinal Deformity
Correction of Scoliosis
Outpatient Kyphoplasty
Cervical Spine Disease
Lumbar Spine Disease
Skull Base Surgery
Endoscope Assisted Surgery
Acoustic Neuroma
Brain Tumors
Cerebral Aneurysms
Stereotactic Radiosurgery
Pituitary Adenoma
Trigeminal Neuralgia
Workers' Compensation

A member of:
SENTA Neurosurgery:

Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Alois Zauner, M.D.

Tracy Sebastian, PA-C
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Deborah Frantz, PA-C

Neurology
Ian M. Purcell, M.D. PhD
Monali Patel, M.D.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

It can be found at https://openpaymentsdata.cms.gov.

Acknowledgement of Receipt of Open Payments Database Notice
Scott P. Leary, MD
7625 Mesa College Drive, Suite 305A
San Diego, CA 92111

I hereby acknowledge that I received a copy of the Open Payments Database Notice.

Signed______________________________ Date___________________________

Print Name ______________________________ DOB______________________