Scott P. Leary, M.D.
Peter R. Schultz, MSN, FNP-BC

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 Clinic
Division of Neurological
and Spinal Surgery

Neurosurgery
Scott P. Leary, M.D.
Sanjay Ghosh, M.D.
Jeffrey S. Schweitzer, M.D., Ph.D.
Vikram Udani, M.D.
Alexa Smith, M.D.
Peter R. Schultz, MSN, FNP-BC
Amanda W. Gumbert, PA-C
Felix M. Regala, PA-C
Ashley Ryan, PA-C
Gage Lambert, PA-C

Otolaryngology/Head & Neck Surgery
Perry T. Mansfield, M.D.
Michael J. O'Leary, M.D.
Brian H. Weeks, M.D.
R. Stuart Weeks, M.D., Emeritus
Jeffrey Lin, PA-C
Jeannine Shively, PA-C

Neurology
Ian M. Purcell, M.D., Ph.D.

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

This agreement is between the patient and the prescribing provider; Scott P. Leary, M.D. and Peter Schultz, MSN, FNP-BC. By signing a contract for narcotic administration, the patient has indicated that he/she understands 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 Peter Schultz, MSN, FNP-BC 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 full 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 Signature: _____

Patient Printed Name: _____

Witness Signature: _____

Printed Witness Name: _____

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: __ / __ / _____

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Neurological & Spinal Surgery

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ELIGIBILITY GUARANTEE

I _____, hereby certify that
Name of Patient

I am eligible for _____
Health Plan

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 true, 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

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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 cooperation.

Scott P. Leary, M.D.

_____

Patient Signature Date

_____

Print Patient Name

Alternate Facilities:
Imaging Healthcare
UCSD Imaging Facilities
Regents MRI