Sports & Spine Pain Management

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

* The educational pamphlet entitled "Notice of Privacy Practices" provides information about how Sports and Spine Pain Management may use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HPAA).

* Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen you will receive a revised copy either by mail, or in person.

* You have the right to request restrictions on how your protected health information may be used or disclosed or treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

*By signing below, you acknowledge receipt of our **Notice of Privacy Practices**.*

RELEASE OF MEDICAL INFORMATION FOR COORDINATION OF CARE

I, hereby authorize Sports and Spine Pain Management to release medical information to my referring physician, primary care doctor, case manager and any other individual involved in my medical care for the sole purpose of facilitating my treatment. Sports and Spine Pain Management may also obtain my medication history for the purpose of continued treatment. I understand that my medical information is confidential and that I have a choice to request that my physician not share my medical records with any of the above individuals. Should I choose to exercise this right, I will provide in writing to my physician any of the individuals involved in my care whom I do not wish to receive my medical records. I agree that a copy of this release may be used in place of the original.

I am aware that I may request that this Release of Medical Information may be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to those terms.

MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our service. To better serve all of our patients, we require a 24 hour notification should you need to cancel or reschedule your appointment. Should you miss, or reschedule your appointment with less than a 24 hour notice, you will be charged $50.00, and payment will be due at the time of your next appointment. Your insurance company does not cover fees for missed appointments.

AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications and other information pertinent to our patients' care. In this event with your signed authorization we would discuss such information to a person you designate. Please complete the section below:

I hereby authorize Sports and Spine Pain Management to discuss any information required in the course of my examination or treatment (when I cannot be reached by phone) to the following designated person(s)

Name of Designee:_____ Phone Number: _____
Relationship to Patient: _____

Name of Designee:_____ Phone Number: _____
Relationship to Patient: _____

☐ None **I agree to all of the above**

_____ _____
Patient or Legal Guardian Signature Date

This form shall expire one year from the date of signature

RELEASE OF MEDICAL INFORMATION FOR BILLING PURPOSES

I, hereby authorize Sports and Spine Pain Management to release medical information to Medicare, my employer's Benefits Department, or my other insurance company for the sole purpose of obtaining payment for my medical care. Although medical information is confidential, many carriers require medical documentation prior to payment for services. I understand that only information pertaining to obtaining payment for my care will be released. I agree that a copy of this release may be used in place of the original.

I am aware that I may request this Release of Medical Information to be revoked at any time by providing the physician's office with a dated and signed letter. I have read and agree to these terms.

NOTICE OF FINANCIAL INTEREST

Federal regulations require that we inform you that the physicians below have a financial interest in The Center for Pain Management, ASC, LLC and/or the ASC Development Company, LLC. An interest in this facility enables them to have a voice in the Administrative and Medical Policy of this healthcare institution. This involvement helps us ensure the finest quality surgical care for their patients.

Sports & Spine Pain Management, LLC

PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility or all charges incurred for services rendered. I understand that I will be required to pay co-payments, amounts applied to deductibles, and balances of bills not paid in accordance with the benefits of my current insurance policy. If I am unable to make payment in full for my medical treatment within 30 days, I agree to make payment arrangements.

I hereby authorize payment for all medical insurance benefits which are payable under the terms of my insurance policy, to be paid directly to Sports and Spine Pain Management, or it's designates for services rendered. I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that it is my full responsibility that any third party which I direct Sports and Spine Pain Management to bill, in the event of non-payment for whatever reason in accordance with the benefits of my current insurance policy, I will pay immediately. It is further agreed that in the event I fail to pay upon demand, should my account be referred to an outside collection agency and or attorney, I accept full responsibility to pay all collection costs not to exceed 30% and interest of 1.5% per month not to exceed 18% per annum and reasonable court costs.

I have received information on Bill Of Rights and Advanced Directives and agree to all of the above.

_____ _____

Patient or Legal Guardian Signature Date

This form shall expire one year from the date of signature

LATE ARRIVAL POLICY

The appointment time you are given is when you are expected to be in the exam room or operating room. We require that new patients come in 30 minutes early, and established patients 15 minutes early to complete paperwork. If you do not arrive 15 minutes early, you may not have enough time to complete the necessary paperwork. Arriving late means not arriving 15 minutes prior to the appointment time. Appointment reminders are automatically generated 3 days prior to your appointment time. By signing below you agree to receive these appointment confirmation calls by our automated call system.

It is the policy of Sports and Spine Pain Management that Patients are to arrive on time. Patients who arrive late for visits or procedures cannot expect or demand to be seen. Other Patients who have arrived on time expect to be seen at their allotted appointment time. Many appointments are scheduled only for 15 minutes. Arriving late by even five minutes will affect the schedule. We have a limited number of Exam Rooms and only one Operating Room. Due to this, seeing one late Patient will make the schedule run late for the rest of the day. This is not considerate to the other Patients who have arrived on time.

There are many things that can occur to make a Patient late: i.e. car trouble, traffic, parking, etc. We understand that this can happen, but need you to understand we cannot change the schedule for the rest of the day to accommodate any of these reasons.

If you arrive late for any reason, please check in at the front desk. The Practice Manager or Office Manager will check the schedule for the day and, if possible, offer you another available time the same day. For example, if another Patient has cancelled or re-scheduled an appointment and there is an unexpected slot available, you will be offered the open time slot. If one is not available, an appointment on a different day will be offered to you. Please remind the staff if your medication will run out prior to this new appointment date.

We specifically ask all new Patients to arrive 30 minutes early and follow-up Patients to arrive 15 minutes early.

There may be times when we run late. This is due to some unforeseen Patient clinical need that we must accommodate. We respect our patient's time and will do all that we can to be on schedule.

_____ _____

Patient or Legal Guardian Signature Date

PATIENT CONSENT FORM

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their parents' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

We want you to know, as our patient, that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, n order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that Have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and financial complications. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rules". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Print Name	Signature	Date

☐ I hereby authorize Sports & Spine Pain Management to access my Medication History