
**Center for Spine Interventions**

| Today's date: | Primary Care Physician: |
|---|---|

## PATIENT INFORMATION

| Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid |
|---|---|---|---|---|---|

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Home phone no.: ( ) | Cell phone no.: ( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

**Referred to clinic by (please check one box):** ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Other

Email address:

## INSURANCE INFORMATION

(Please give your insurance card and Photo ID to the receptionist.)

Is this patient covered by insurance? ❑ Yes ❑ No

| Name of primary insurance: | Subscriber's name: | Birth date: / / | Group no.: | Policy no.: | |
|---|---|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

## IN CASE OF EMERGENCY

| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Cell phone no.: ( ) |
|---|---|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

*Patient/Guardian signature* *Date*

Center for Spine Interventions

## FINANCIAL POLICY

Thank you for choosing Center for Spine Interventions as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at the time of service

*Regarding Insurance*

We participate on most insurance plans. Read and understand your insurance policy. Your policy is a contract between you and the insurance carrier. Read it, understand it and ask questions. DO NOT ASSUME YOUR POLICY AUTOMATICALLY COVERS EVERYTHING. Even different policies form the same insurance company can have different requirements. It is YOUR responsibility to know what your policy covers and what it does not. Always carry your insurance card with you. You will need it for all office visits and may need it in case of an emergency. Some insurance carriers require we verify your coverage for each office visit. Without this information, we may have to reschedule your appointment, or you may have to pay at time of service. Some carriers require a referral or prior authorization from your primary care provider. It is YOUR responsibility to obtain this referral. IF **YOU DO NOT HAVE A REFERRAL OR PRIOR AUTHORIZATION, YOU WILL BE RESPONSIBLE FOR PAYMENT OR WE WILL RESCHEDULE YOUR APPOINTMENT.**

*Usual and Customary Rates*

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

*Past Due Accounts*

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

*Returned Checks*

For checks returned to us for non-sufficient funds by your bank, we will charge a $39.00 fee.

*Insurance Denials*

In the event that any date of service is denied by the insurance carrier for ineligibility or no referral, the remaining balance will be turned over to patient responsibility.

*Insurance Non-payment*

If a claim is forty-five (45) days old and there has been no response from the insurance carrier, the balance due will be turned over to patient responsibility for payment.

Please contact our Billing Department if you have any questions or concerns at (678) 813-2741

**I have read the Financial Policy. I understand and agree to the Financial Policy.**

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Signature | Date |

Center for Spine Interventions

**Consent to Treatment and Other Acknowledgements**

By reading and signing this document, I , the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medications, anesthesia, medical services, and surgical or diagnostic procedures (including but not limited to the use of lab and radiographic studies) as ordered or approved by me attending physician(s), or any healthcare professional assigned to my care by my attending physician(s), and I acknowledge and consent to the following:

1. INDEPENDENT CONTRACTORS: Center for Spine Interventions may utilize independent contractors for office, outpatient or inpatient treatment/procedures. These include, but are not limited to, surgical assistants, physical therapist, and consulting and referral physicians. Healthcare professionals that are independent contractors are not agents or employees of Center for Spine Interventions and are responsible for their own actions. I understand that Center for Spine Interventions shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by my physician(s).
2. VALUABLES: Center for Spine Interventions assumes no responsibility for, and I hereby release Center for Spine Interventions from liability for, loss or damage to any of my personal property while on the premises and/or receiving treatment.
3. AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF THIRD-PARTY PAYMENTS: I hereby expressly authorize Center for Spine Interventions and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying my medical care. I authorize and direct all payors to pay all benefits due for sure care directly to Center for Spine Interventions and all professionals (including independent contractors) providing for such care, and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to Center for Spine Interventions and the third-party payor signed and dated by me: however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.
4. PAYMENT FOR SERVICES: In return for services to be provided by Center for Spine Interventions, I promise to pay for services rendered by Center for Spine Interventions to me or for my benefit. If the services I receive from Center for Spine Interventions are covered by a third-party payor, Center for Spine Interventions may elect to bill and accept payment from such third party. I will pay the portion of these bills which the third-party payor determines are my responsibility. In the cases of services which I agree to receive but which are not covered by the third party, I will pay the amount due upon receipt of services. If no third party is involved in paying for my services, I agree to pay in full for such services at the time the services are received.
5. AUTHORIZATION AND RELEASE FOR PHOTOGRAPHS: I authorize and release Center for Spine Interventions and its employees and agents to take photographs, videos, x-rays, and/or other photographic, electronic or other images of me and to use them as may be medically appropriate. Such images may be used for educational or other purposes as necessary and appropriate. These images may be maintained as a permanent part of my medical record. I understand and

acknowledge that Center for Spine Interventions may use cameras for security and patient monitoring, and patient confidentiality will be maintained for all such images.

6. NO GUARANTEE OF RESULTS: Center for Spine Interventions physicians and healthcare professionals cannot guarantee any specific result(s) of any examinations, treatment, procedure or medical care. I release Center for Spine Interventions, its physicians and healthcare professionals from any liability for any accident or injury that is not directly caused by the negligence of Center for Spine Interventions or its employees.
7. During the course of my care and treatment, I understand that various types of examinations, test, diagnostic or treatment procedures ("procedures") may be necessary. These procedures may be performed by physician(s), nurses, technicians, physician assistants, or other healthcare professional. While routinely performed without incident, there may be material risk associated with these procedures. If I have any questions concerning these procedures, I will ask my physician(s) to provide me with additional information. I also understand my physician may ask me to sign additional Informed Consent documents relating to specific procedures.
8. I understand that the healthcare professionals involved in my care will rely on my documented medical history, as well as other information provided by me, my immediate family, or others having information about me, in determining whether to perform or recommend procedures. I agree to provide accurate and thorough information regarding my medical history and any conditions or events which may impact medical decision-making.

By signing this document, I certify that I have read and understand its contents and that information provided by me is accurate and complete (including insurance information and current eligibility for benefits). A copy of this documentation may be utilized the same as the original.

A copy of this document may be utilized the same as the original

Patient/Authorized Representative: _____

Patient printed name here: _____

Date: _____

If not signed by the patient, please indicate relationship to the patient on the line provided:

_____

Center for Spine Interventions

## Narcotic Agreement and Prescription Refill Policy

- I agree to allow 48 hours for prescription refills.
- I understand that prescription refills requested after 4:00pm will not be received until the next business day.
- I understand that a follow-up visit may be required from my physician in order to obtain a refill.
- I agree to take all medication exactly as instructed. I am NOT allowed to change the dosage amounts or alter the time schedule of taking the medication without first speaking to my physician.
- I understand that narcotics and non-narcotics medications will NOT be phoned in after hours or on the weekends.
- Patients may be terminated from the practice for noncompliance in the taking of their medications. In order to ensure compliance, Center for Spine Interventions reserves the right to perform random drug screen monitoring on patients who require prescription narcotic medication over an extended period of time, as required by law.
  Refusal to cooperate with drug screen likewise will constitute a basic for termination from the practice.
- Center for Spine Interventions will NOT refill prescriptions that have been lost or misplaced.
- I must keep all appointments as recommended.
- I will not give away, trade or sell medications.
- The following are specific (but not exclusive) grounds for immediate termination from the practice: 1) Obtaining narcotics from any other physician while under Center for Spine Interventions care. 2) Altering or forging of a prescription. ***This is a felony and will be reported.***
- I am aware that most of the manufacturers of drugs used to treat chronic pain recommend against the operation of heavy equipment, which includes driving a motor vehicle. I am aware that if I choose to drive a vehicle I could be charged with a DUI.
- I will not combine any narcotic medications with the consumption of alcohol.
- I understand that only one pharmacy may be used for filling my prescriptions. My pharmacy's name and location is:

  _____

  _____ (Please notify us if your pharmacy changes) Pharmacy #_____

I have read, understand and agree to the policies above. I understand that if I do no sign this document, my physician may refuse to prescribe narcotic medication to treat my pain. I acknowledge having been provided a document entitle Controlled Substance Agreement and Informed Consent Form and I have a right to a paper copy upon request and have had the opportunity to ask questions and receive answers to my satisfaction.

Patient Name: _____ (Please Print) Date of Birth: _____

Patient Signature: _____ Date: _____

Center for Spine Interventions

**Privacy Notice Acknowledgement**

**Document of good Faith**

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been to obtain a written acknowledgement of this. However, acknowledgement has not been obtained because:

____ Patient refused to sign the Privacy Notice Acknowledgement

____ Patient was unable because: _____

____ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

____ Other reason, describe: _____

_____ _____ _____

Employee's name printed Employee's Signature Date

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**Authorization to Release Protected Health Information**

I, _____, hereby authorize Center for Spine Interventions to release my protected health information to the following: (Please check and provide the NAME or specific entities to which your protected health information may be given.)

____ Family members or friends: (please give name)

_____

____Other:

_____

There may be instances that your healthcare that your healthcare provider may wish to communicate some aspects of your protected health information via electronic means, either to you and/or another healthcare provider that may be consulted regarding your care or treatment. Center for Spine Interventions cannot guarantee privacy for e-mail communications over the Internet. I understand and accept this risk and will allow Center for Spine Intervention to communicate my PHI electronically.

_____ Yes _____ No

This authorization shall be in effect until plan of care is complete.

_____ _____ _____

Patient / Representative Name Patient / Representative Signature Date