Expert Pain Physicians

Pain & Spine Wellness Center

NEW PATIENT INFORMATION AND POLICES

Welcome to Expert Pain Physicians, LLC. As part of our new patient intake process, we are providing you with the following information and polices.

1. **MISSED APPOINTMENT & LATE ARRIVAL POLICY**
2. **RELEASE OF INFORMATION, FINANCIAL & MEDICAL POLICIES**
3. **NOTICE OF PRIVACY PRACTICES**
4. **AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**
5. **HIPAA CONSENT FORM**

Please read these documents carefully, and should you have any questions regarding their content, please contact one of our staff members.

By signing below, I acknowledge receipt of the above policies listed in 1-3 above and agree to abide by the terms and conditions of each policy. I have signed and submitted an AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION and a HIPAA CONSENT FORM.

_____ **Date**_____

Patient Name/Guardian (if under 18) (please print)

X_____

Signature

EXPERT PAIN PHYSICIANS, LLC NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED BY EXPERT PAIN PHYSICIANS AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how Expert Pain Physicians may use and disclose your protected health information ("PHI") for treatment, payment or healthcare operations and other purposes that are permitted or required by law

1. PROTECTED HEALTH INFORMATION. PHI is any information which identifies you and includes demographic information and information that relates to your past, present, or future physical or mental health or condition and related health care services. Your PHI may be used and disclosed by Expert Pain Physicians and its staff and others outside of its office that are involved in your care and treatment for the purpose of providing care and treatment to you, to pay your healthcare charges, to support the operation of Expert Pain Physicians, or any use required by law.

2. TREATMENT. Expert Pain Physicians will use and disclose your PHI to provide, coordinate, and manage your care and treatment. This includes coordination or management of your care with a third party such as a physician to whom you have been referred to ensure the physician has the necessary information to properly diagnose or treat your condition.

3. PAYMENT. Expert Pain Physicians may use your PHI as needed to obtain payment for your care and treatment. This includes, but is not limited to, obtaining approval for certain treatment or equipment that may require that relevant PHI be disclosed to your health plan to obtain approval for such treatment or equipment.

4. EXPERT PAIN PHYSICIAN OPERATIONS. Your PHI may be used, as needed, to support business activities of Expert Pain Physicians. Examples of these activities are quality assessment, accreditation, and employee review. As necessary, you may be contacted to inquire of your status.

5. DISCLOSURE WITHOUT YOUR AUTHORIZATION. Expert Pain Physicians may disclose your PHI without your authorization as required by law. Examples include, but are not limited to, Food and Drug Administration requirements, legal proceedings, law enforcement criminal activity, workers' compensation, and abuse and neglect.

6. PATIENT RIGHTS. Disclosure of PHI can only be made with your consent or as allowed by the Heath Insurance Portability and Accountability Act of 1996 ("HIPAA"). You have the right to request in writing a copy of your medical records if you pay the cost to copy and mail your record. You also have the right to restrict Expert Pain Physicians from disclosing all or any part of your PHI by making a request in writing to Expert Pain Physicians stating the specific restriction and to whom you want the restriction to apply. Expert Pain Physicians is not required to abide by the restriction requested by you if it believes it is in your best interest to permit use and disclosure of your PHI.

You also have the right to receive communications by alternative means or at an alternative location and receive a summary of the disclosures of PHI, if any, made by Expert Pain Physicians. You have the right to inspect and copy your PHI, to obtain a copy of your record and information about you and that you be contacted in a specific way. If you believe there is incorrect information in your record, you have the right to request an amendment to the record, and if your request is denied, the right to file a statement of disagreement.

If you believe Expert Pain Physicians has violated these rights, you can contact us or file a complaint with the U.S. Department of Health and Human Services for Civil Rights by calling 1-877-696-6775 or visiting www.hhs.gov./ocr/privacy/hippa/complaints. Expert Pain Physicians will not retaliate against you for making a complaint.

Other disclosures of your PHI will only be made with your consent unless otherwise required by law. You may revoke your consent at any time, in writing, except to the extent Expert Pain Physicians has made a disclosure in reliance indicated in your authorization.

MISSED APPOINTMENT & LATE ARRIVAL POLICY

Expert Pain Physicians' goal is to provide courteous and timely service. This requires all patients to provide timely notification when an appointment cannot be kept and to timely arrive for their scheduled appointment. Your compliance with these policies is appreciated.

Rescheduled or Missed Appointment Policy

By scheduling a follow up visit or making an appointment for an operative procedure, you are agreeing to abide by the policies of Expert Pain Physicians. Should you need to cancel or reschedule an appointment, you must provide Expert Pain Physicians at least twenty four hours' notice of your need to miss or reschedule your appointment.

In the event you fail to cancel your appointment upon twenty four hours' notice or fail to appear for your appointment, and you were scheduled for a clinic visit, you agree that Expert Pain Physicians may charge you Fifty Dollars ($50) for failing to timely cancel of appear for your scheduled appointment. If you were scheduled for an operative procedure and fail to provide twenty four hours' notice of cancellation or appear for your scheduled appointment, you agree Expert Pain Physicians may charge you Two Hundred Dollars ($200) for failing to timely cancel or appear for your appointment. Payment of these charges is required prior to your next appointment.

Your insurance carrier will not cover the charges for failing to timely cancel an appointment or missing an appointment.

Late Arrival Policy

The appointment time you are given is the anticipated time you will be called to the exam room or operating room.

Expert Pain Physicians requires that patients making a return visit arrive fifteen (15) minutes prior to their scheduled appointment to complete necessary paper work. Patients scheduled for an operative procedure must arrive thirty (30) minutes prior to their appointment if they require sedation and fifteen (15) minutes prior to their scheduled appointment if they do not require sedation.

If you arrive late for any reason, please check in at the front desk. The staff will check the schedule for the rest of the day and, if possible, offer you another available time the same day. If an appointment is not available for that day, an appointment on a different day will be offered. Please remind the staff if your medication will run out prior to a new appointment date.

There may be times when your appointment runs late. This is due to unforeseen clinical responsibilities that must be accommodated. Expert Pain Physicians respects your time and makes every effort to see you as scheduled.

Release of Information, Financial, & Medical Policies

Assignment of Benefits:
I hereby assign all medical and surgical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, or any other health/medical plan, to issue payment directly to Expert Pain Physicians for services provided to myself and/or my dependents. I acknowledge that I am responsible for any amount not paid by my insurance carrier(s).

Authorization to Release Information - For Billing Purposes
I hereby authorize Expert Pain Physicians to release my or my dependents medical information to Medicare, my employer's benefits department, or my insurance carrier(s) for the purpose of obtaining payment for medical care. I understand that only information pertaining to obtaining payment for care and treatment will be released, and I agree that a copy of this Release of Information, Financial & Medical Policies ("this Release") may be used in place of the original.

Authorization to Release Information - For Coordination of Care
I hereby authorize Expert Pain Physicians to release medical information to my referring physician, primary care doctor, case manager, and/or any other individual involved in my care for the purpose of facilitating treatment.

I understand that my medical information and that of my dependents is confidential and acknowledge that I have the right to request that Expert Pain Physicians not disclose medical records or medical information to the above individuals. Should I choose to exercise this right, I will provide written notice to Expert Pain Physicians identifying those individuals involved in my care and treatment who are not authorized to receive copies of medical records or disclosure of medical information. My written notice must be signed and dated.

Privacy Practice Notice
I have reviewed Expert Pain Physicians Notice of Privacy Practices that was provided to me. I acknowledge that notice describes how Expert Pain Physicians safeguards my protected health information and explains my rights and responsibilities for the privacy of the medical care and treatment provided. The Notice of Privacy Practices states that Expert Pain Physicians reserves the right to change its terms. Should the terms change, I will receive a revised Notice of Privacy Practices by mail or in person when I next have an appointment. By signing below, I acknowledge receipt of the current Notice of Privacy Practices.

Payment for Medical Services
All charges for medical care and treatment provided are payable at the time of service unless other arrangements have been made in advance with the business office. Necessary forms will be completed to file for insurance payment. I hereby acknowledge my financial responsibility for all charges incurred for care and treatment provided. I acknowledge that I will be responsible for and required to pay co-payments, deductible amounts, and any balance not paid pursuant to the terms of my current insurance policy. If I am unable to make payment in full for my treatment within thirty days, I agree to call the Expert Pain Physicians billing office and make arrangements for payment. I certify that the information I have reported regarding my insurance coverage is correct. I authorize Expert Pain Physicians to verify insurance coverage and benefits allowed under my policy. I acknowledge that non-payment for any reason by my insurance carrier will obligate me to pay for my treatment in full upon receipt of a statement for care and treatment. I further acknowledge the filing of insurance claims is a courtesy Expert Pain Physicians provides its patients, but all charges are my responsibility from the date care and treatment is provided. In the event my account is turned over to an outside collection agency, I agree to be responsible for a late fee of thirty percent of the balance owed and/or all attorney fees and costs incurred to collect my unpaid balance.

Authorization to Discuss Information with Designated Person
It is often difficult to reach a patient to discuss appointments, medications, and other information pertinent to care. By signing this Release, I grant Expert Pain Physicians permission to discuss such information with the person I have designated below or to leave a message on my voicemail.

Consent to Examination and Treatment
By signing below, I acknowledge that I understand the terms of this Release of Information, Financial & Medical Policies and that I have signed voluntarily. I acknowledge that I was advised of the availability of assistance and/or an interpreter to help me understand the terms and conditions of this release and that I declined such assistance.

IF MINOR CHILD AS PATIENT:
I acknowledge my dependent can receive care and treatment as necessary in the event I am unable to accompany him or her to daily treatment. I am aware that a parent or legal guardian must be present for examination and evaluation by the professional staff and for any report of findings or treatment.

My signature below authorizes the physicians of Expert Pain Physicians, with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me or my dependent as considered necessary.