HEADACHE & NECK PAIN INSTITUTE

THE HEADACHE & NECK PAIN INSTITUTE
PATIENT CONSENT TO TREAT AND DEMOGRAPHIC INFORMATION

Today's Date: _____ Patient's Name: _____

Date of Birth: _____ Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Male: _____ Female: _____ Telephone #: Daytime: _____ Evening:_____

Employer: _____ Phone #: _____ Full Time _____ Part Time _____

Person to contact in case of emergency: _____ Phone #: _____

Primary Medical Insurance Carrier: _____

Subscriber: _____ DOB: _____

Secondary Medical Insurance Carrier: _____

Subscriber: _____ Employer: _____ Relationship: _____ DOB: _____

Pharmacy: _____ Location: _____

Is your condition related to an accident? NO YES If yes, date of accident: _____

Type of accident: Auto Work Injury Other: _____

Name and phone number of employer if this is a work injury: _____

Name and phone number of work comp case manager: _____

Primary Care Physician: _____ Phone number: _____

Referring Physician: _____ Phone number: _____

CONSENT TO TREAT: I consent to the provision of health care services at Interventional Spine Associates of the Carolinas. I acknowledge that no guarantee has been made to me as to the results that may be obtained from this care. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider during each visit. I understand if special procedures are recommended, my heath care provider will discuss this with me and my additional consent will be required.

_____ _____
Signature of Patient Date

_____ _____
Authorized Signature Date

Relationship: _____
(Parent, Guardian)

_____ _____
Witness Date

THE HEADACHE & NECK PAIN INSTITUTE
A DIVISION OF PROVIDENCE ANESTHESIOLOGY ASSOCIATES
FINANCIAL POLICY

Thank you for choosing Interventional Spine Associates of the Carolinas as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policies please do not hesitate to ask our staff. We ask that all patients read and sign our policy prior to seeing a medical care provider.

A minimum deposit of $440.00 for new patients and $220.00 for established patients will be due at the time of service for all self-pay patients. These deposits will be applied to the services rendered, although there may be additional charges during the office visit that result in your receiving a billing statement. The visit level, necessary tests, and/or procedure are determined by the rendering provider during the appointment. The patient's portion of the charge after the insurance processing; including coinsurance, deductible, and/or balance on account is due upon notification. Co-pays are due at the time of service.

We accept assignment with most major insurance companies and participating provider plans. However, you must understand that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance.
2. If we do not participate with your insurance plan, you will be charged the $440.00/$220.00 minimum deposit upon check-in and your portion will be due as stated above.
3. All charges are your responsibility whether your insurance company pays or not.
4. If the insurance company does not pay your balance in full within 20 days, we ask that you contact the carrier to request prompt payment. Please inform our office of the carrier's response.
5. Returned checks and appointments cancelled less 24 hours in advance will be subject to $35.00 collection charge.
6. Unpaid balances over 60 days may be subject to referral to a collection agency. All applicable collection fees will be the patient's responsibility.
7. If you are having a procedure performed by one of our physicians in the Midtown Surgery Center or the Orthopedic Hospital, the Surgery Center will bill separately from ISA for facility charges.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Authorization to Release and Assign Insurance Benefits: I authorize release of any information required to act on any insurance claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original assignment. I hereby assign to Interventional Spine Associates of the Carolinas the medical and/or surgical benefit I am entitled from my insurance company(s) and/or Medicare and Medicaid.

This authorization is in effect for all future claims until I choose to revoke in writing.

I, the undersigned, understand and agree to the above Financial Policy. I understand that I am financially responsible for all charges incurred for my medical treatment. I have had the opportunity to ask and have my questions answered to my satisfaction.

_____ _____

Patient's Signature (or Authorized Signature) Date

_____ _____

Printed Name of Patient Relationship to patient if not patient

_____

Authorized Witness

PATIENT'S BILL OF RIGHTS AND PATIENT RESPONSIBILITIES

You have a right to:

- Develop a pain management plan with your physician.
- Have your plan and pain medication history taken.
- Ask how much pain to expect and how long it might last.
- Have your pain questions answered freely.
- Know what medication, treatment, or anesthesia will be given.
- Know the risks, benefits, and side effects of treatment.
- Know what alternative pain treatments may be available.
- Sign a statement of informed consent before any treatment.
- Be believed when you say you have pain.
- Have your pain assessed on an individual basis.
- Have your pain assessed using the 0 = no pain, 10 = worst pain scale.
- Ask for changes in treatments if your pain persists.
- Receive compassionate and sympathetic care.
- Receive prescribed medication on a timely basis.
- Refuse treatment without prejudice from your doctor.
- Seek a second opinion.
- See your medical records upon request.
- Include your family in decision making.
- Remind those who care for you that pain management is part of your diagnostic, medical, or surgical care.
- Receive and examine an explanation of your medical bill.

You have a responsibility to:

- Provide complete and accurate information, including medical history, medications, pain and pain relief methods.
- Ask questions about your care, pain and pain management, what you are expected to do, or a further explanation if you do not understand what you have been told.
- Follow the recommendations of your provider and/or physician. Ask questions if you are concerned or not able to follow directions.
- Understand and accept the outcome and consequence of deciding that you cannot follow the advice of your physician.
- Tell your care provider if you have an unexpected change in condition, side effects from medication, your pain is not relieved, or you feel that your care is not going the way you think it should.
- Respect other patients, staff, and property.
- Give accurate information about your demographic information and sources of payment or your bill.
- Pay your portion of the medical bill in a timely manner.
- Give us suggestions about your needs and expectations and how to we can improve care.

_____ Initials _____ Date

Privacy Practices and Release of Information

I have received or been offered and accepted/declined a copy of Interventional Spine Associates of the Carolina's Privacy Practices. I have had the opportunity to have any questions answered to my satisfaction regarding the privacy practices of the clinic.

_____ _____

Patient's Signature (or Authorized Signature) Date

Authorized Witness: _____

Authorization for Release of Information

Name of Patient _____ Date of Birth _____

_____ is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
❑ Voice Mail	❑ Results of lab tests/x-rays Other_____
❑ Spouse (provide name & phone number) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Parent (provide name & phone number) _____	❑ Financial ❑ Medical as follows:_____ _____
❑ Other (provide name & phone number _____	❑ Financial ❑ Medical as follows _____ _____

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

_____

Revised January 2010