ALLSPINECARE
Your Spine Surgery Specialist

Dear Patient:

Thank you for choosing All Spine Care and trusting us with your care. We would like to take the opportunity to explain the policies of our office. Please review all the items presented.

All calls after our business hours will be sent to directly to our answering service. Please contact our answering service after hours for EMERGENCY CALLS only. This would include fever, changes with your surgical incision or increased pain, NO medication refills will be done under any circumstance through our answering service.

Please allow 24-48 hours for all prescription refills. To help facilitate these requests, please leave your first and last name, the name of the requested medication, your birth date and the pharmacy phone number in your message. Under no circumstance will medication refill requests be taken after our business hours or over the weekend.

All routine calls will be returned within 24 hours, in the order in which they were received.

If we have ordered imaging studies for you, (X-Ray, MRI or CT scans) it is your responsibility to bring the written reports as well as the disks to your follow-up visit. Unfortunately, we may have to reschedule your appointment if we do not have all of the appropriate information for your evaluation.

Please feel free to contact us if you have any questions.

Sincerely,

All Spine Care

I have read and understand the above-mentioned policies.

_____ _____

Patient Signature, Guardian, or Personal Representative Date

Notice of Privacy Practices

** This notice describes how your health information may be used and disclosed, and how you can access this lease review carefully. **

The Health Insurance Portability and Accountability Act require us to continue maintaining your privacy to give you this notice and to follow the terms of this notice. This law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to transfer copies of your health to another practice. We will mail your files for you.

You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.

You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (727) 474-7411.

Please review and initial next to each space and sign below:

Acknowledgement of Receipt of Notice of Privacy Practices

____ I acknowledge that I was provided a copy of the HIPAA Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

Please review and initial next to each space and sign below:

Treatment Agreement

____I agree to comply with my treating physician whether by surgical or non-surgical means. I understand that if I do not follow my doctor's instructions concerning my care and treatment, less than optimal results may occur.

Release of Information

____ Private Health Information to any and all of my insurance carriers, their third party payors and claim reviewers until the claim is resolved. For the purpose of treatment, I also allow treating physicians.

Patient Financial Policy

1. You must inform the office of all personal (home address, phone numbers, etc...) and/or insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges denied.

2. Your payment for office services are due at the time of service. We will accept VISA, MasterCard, American Express, Discover and cash or check.

3. Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you with an assignment of benefits if we participate with your carrier. You are agreeing to have your insurance company pay the doctor directly.

4. Please honor our 24 reschedule notice. At the discretion of our provider, you may be charged a no show fee of $35.00.

5. We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will require you to pay the co-pay/co-insurance/deductible at the time of service. Your upfront portion will be calculated based on your insurance benefit/limits and our negotiated fee agreement with your carrier.

6. Not all services are a "covered" benefit in all insurance policies, some plans even impose a waiting period before covering services (pre-existing). In the event your health plan determines a service to be "not covered/pre-existing," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.

7. Pre-scheduled Surgical procedures require pre-payment. Your deductible/coinsurance/co-pay for this procedure is due prior to the pre-operative appointment. For additional services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.

8. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Any payment exceptions will be agreed upon in writing.

9. PAST DUE accounts are subject to collection proceeding. All fees including, but not limited collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office.

10. There is a service fee of $35.00 for all returned checks. Upon an NSF or CLOSED ACCOUNT occurrence, all future remittances will need to be in other forms of payment ie cash or credit card. Restitution, if applicable will be requested from the State's Attorney's office.

11. **Accident or Auto Injury Patients:** It is our goal to offer our services to a wide range of patients and understand that some patients may require our care due to injuries sustained, at least in part, by the negligence of third parties. We attempt to bill any insurance available to you including Personal Injury Protection through your automobile insurer where applicable, your health insurance carrier AND we will refrain from collecting any unpaid or non-covered services until you have concluded your claim permitting a signed agreement is entered into. In return, it is your obligation to provide us with the name and contact information of any insurer you wish to have billed as well as your policy and/or claim number at the time of your initial visit. If you fail to provide us with that information, your insurance will not be billed and you will be responsible for the full payment of all charges incurred and to the extent allowed by law. You also understand that any services which are not paid or covered by any insurer will remain your personal responsibility regardless of the outcome of any claim you may have pending against other parties. At the conclusion of any such claim, it is your responsibility to contact our facility, or instruct your legal representative to contact our facility, to inform us that the claim has been concluded and to arrange final payment for the charges incurred.

During the pendency of any claim for which you have retained legal counsel, we will refrain from collection efforts but strongly encourage you to make payment arrangements for any balance remaining after the payment of insurance benefits to the extent you are financially able. It is your responsibility to inform us of the name and contact information of your legal representative at the time of your initial visit. You are also responsible to notify us of any change in your legal representation within ten (10) days of the change. In the event that you are no longer represented by legal counsel, we will initiate collections efforts within ten (10) days of notification. In the event you have any balance at the conclusion of your claim but do not recover enough to pay the balance, you remain personally liable for the balance and we will commence collection efforts sixty (60) days after the conclusion of your claim if other arrangements to pay the balance have not been made. Balances incurred for our services remain your responsibility regardless of whether the treatment rendered by our physicians or in our facilities are deemed unrelated to the incident giving rise to your claim by any first or third-party insurance carrier, judge, jury, arbitrator, or other finder of fact. You understand and acknowledge that you are freely choosing to receive treatment by our physicians or in our facilities and that you have not been made any promises or received any inducements to incur the expenses of such treatment based upon the outcome of any pending claim you have.

_____ (Initial) **I DO NOT WISH** to use my health insurance for treatment at All Spine Care.

Patient's Name:_____

Signature of Patient/Guardian:_____ Date: _____

Authorization of Payment

____ I hereby assign all Medical benefits director to All Spine Care for the payment of any services rendered. I also authorized release of medical records necessary to process my health claims. I fully understand that in the event my insurance company does not pay for the services I received; I will be financially responsible for payment.

Completion of forms

The completion of informational/insurance forms represents an administrative service to our patients above and beyond the provision of medical care. Recent changes in health care have resulted in the tremendous increase in the volume of information requests to our practice. The time and effort involved in providing this detailed information results in significant costs especially when multiplied over the large number of patients our practice services. The refusal of insurance companies and requesting agencies to cover the costs requires us to institute a policy of charges for the completion of forms. The cost to complete any forms will be $35.00. Please allow 7-10 business days to have the forms completed.

Patient's Name:_____

Signature of Patient/Guardian:_____ Date: _____

Patient Information

Patient's Name: _____ Date of Birth _____/_____/_____

Social Security number: _____ () Male () Female

Address:

_____

_____

Home number (____) _____-_____ Cellphone number (____) _____-_____

Email: _____

Primary Insurance: () Medical _____ () Auto () Workman's comp

Accident related? () Auto () Workman's comp Date of accident: _____

Attorney name: _____ Phone number: (___) ____-_____

Subscribers Name:_____ Subscribers date of birth: ___/___/___

Group number:_____ Policy ID/Claim number:_____

Payer address: _____

_____

Adjuster name:_____ Phone number: _____

Secondary Insurance: _____

Subscriber Name:_____ Subscribers date of birth: ___/___/___

Group number:_____ Policy ID number:_____

Payer address: _____

_____

Adjuster name:_____ Phone number: _____

Please have your insurance card(s) and photo ID ready.

_____ _____

Signature of Patient/Guardian Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Please Print) Patient Name: _____

Social Security Number: _____ Date of Birth: _____

- I hereby authorize All Spine Care to release any information in my chart to any medical practitioner, doctor, hospital, or medical institution/facility to which I may be referred to assist with my care.

- The protect health information may be disclosed to:

  _____
  _____
  _____

- Additionally, I authorize All Spine Care to obtain any medical information from any medical practitioner, doctor, hospital, or medical institution/facility to assist in my care.

_____ _____

Signature of Patient, Guardian, or Personal Representative Date