



Release of Information & Financial Policy

Release of Information and Medical Records

You authorize Premier Pain & Spine, LLC (PPS) or his/her designee(s) to release and disclose such medical records, information, and documentation as may be necessary or appropriate to process insurance claims and to obtain payment on your behalf. You also authorize the release of information acquired during your examination or treatment and all information pertaining to your history and progress in your case. This includes any alcohol or drug abuse data that may be protected by Federal Regulations - 42CFR Part 2. You agree that a photocopy of your original authorization shall be considered equally authentic.

You authorize the following family members or others whom may be involved in coordinating your care.

Name	Relationship
_____	_____
_____	_____

Marketing and Communications

You authorize and release the use and/or disclosure of medical information and reviews for marketing and communications. Protected Health Information could be used or disclosed as a story in a PPS publication (print or electronic). Protected Health Information could also be disclosed to the news and media. Please initial if you decline: _____

Regarding Insurance

We cannot bill your insurance company unless you provide us with your insurance information and any special claim forms required by your insurance company. We accept assignment of insurance benefits. That means your insurance will pay us directly the amount due based upon your benefit coverage. By signing this form, you authorize assignment of your benefits to PPS for treatment and related services. However, we do require, as your insurance benefits require, payment of co-pays, co-insurance, and deductibles at the time of service. Your insurance policy is a contract between you and your insurance company. Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. The federal government agency that administers the Medicare and Medicaid programs, has determined that except for certain circumstances, the discounting or waiving of a patient's co-pay or deductible is unlawful. Additionally, under the new HIPAA regulations, we are now not allowed to discount or waive patient's co-pays or deductibles as outlined by benefit plans offered by other third party payers. You are responsible for payment unless we are a participating provider for your insurance company.

Please know your benefits.

Please be aware that only your insurance company can tell you if the services provided are covered under your benefit plan. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. In the event that your account is turned over to an outside collection agency, you will be responsible for an additional 25% of the balance owed and/or all the attorney fees and costs incurred to collect the unpaid debt.

Those Insurance Plans in which we are a Participating Provider

If your insurance requires a referral, it is your responsibility to obtain a referral and always have a current one on file. All co-pays and deductibles are due at the time of treatment. Prior to seeking payment from you, we will work with these plans to obtain payment. After insurance pays we will send you a bill in the mail, if you do not pay your copay, you will be charged an administrative fee of \$5 every month that it is not paid. In the event that your insurance coverage changes to a plan in which we are not a participating provider, refer to the paragraph below.

Those Insurance Plans in which we are NOT a Participating Provider

If your insurance company has not paid your account in full within 45 days of the billed date, the balance is your responsibility. Your assistance in collection from your insurance company may be required. If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment. If you do not have a referral to one of our providers, you will be asked to pay for the visit in full at the time of service or to reschedule the visit in order for you to obtain the required referral.

Patient Balances

Patients are responsible for full payment at the time of service if not covered by some other third party such as Medicare or Commercial Insurance. In order to continue to provide unparalleled pain intervention, we ask that our patients keep current in addressing balances.

- Balances up to \$250 must be paid in full prior to appointment
- Outstanding balances over \$251 require approval from our Billing Manager at (847) 519-4701 ext 111.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is a protective measure safeguarding patient privacy and confidentiality. By signing this agreement, I acknowledge that I have received information pertaining to my rights as covered under the Health Insurance and Portability and Accountability Act of 1996. Your bill of rights/privacy policy is available at every front desk if you would like to read it.

Same Day Appointments

As we are not a walk-in clinic, we do require patients to make an appointment at least 24 hours prior to their intended appointment date. If you are requesting to be added on to our schedule same day, we will do our best to accommodate your request. Please be aware that there will be a fee for a same day add on appointment that must be paid day of appointment.

Same day add on follow up: \$30.00 Same day add on procedure: \$50.00

Patient No-Show & Late Arrival Policy

At PPS, we strive to meet and exceed expectations of all our patients and we are dedicated to providing you with the best care and services possible. We also strive to meet your needs by providing appointment times that best fit your schedule. Time is specifically reserved for you on our schedule when you make your appointment. When sufficient notice is not given to cancel or reschedule your appointment, it does not give us enough time to contact another patient who could come to clinic during your assigned time. This results in other patients not getting the care they need, when they need it. Because of the great need for our services and extensive waiting list, we have implemented the following No-Show and Late Arrival Policy. PPS policy states that 3 or more no-shows in a year's time is considered excessive. Patients who have no-showed 3 appointments within the preceding year have met grounds for dismissal from clinic. Patients are required to arrive 15 minutes prior to their appointment time for follow up appointments and 30 minutes prior to their appointment time for procedures. If you do not arrive at your arrival time, you may be canceled and asked to reschedule.

Patients who no show or cancel within 24 hours of appointment time are subject to the following fees:

\$30 for a follow up

\$50 for a procedure

\$100 for larger procedures (Spinal Cord Stimulator Trial, Kyphoplasty, Discogram, Stem Cell)

Code of Conduct

In an effort to provide a safe and healthy environment for staff, visitors, patients and their families, PPS expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

The following behaviors are prohibited:

- Possession of firearms or any weapon
- Physical assault, arson or inflicting bodily harm
- Throwing objects
- Raising voice to the level of disrupting other patients or interfering with office procedure
- Making verbal threats to harm another individual or destroy property
- Intentionally damaging equipment or property
- Making menacing gestures
- Attempting to intimidate or harass other individuals
- Making harassing, offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication
- Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or sexuality

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Premier Pain & Spine, LLC Care Team

Thank you for Choosing PPS for your pain management needs. We are constantly striving to provide you with the utmost in patient care. Our practice is divided into Care Teams. Each Care Team consists of a physician, a physician assistant, a nurse practitioner, and medical assistants, who collaborate on your case to provide exceptional care. Most follow up visits will be managed by either the physician assistant (PA) or the nurse practitioner (NP). The PA or NP will always discuss your case personally with the physician and all changes will be verified with them. Although we always try to honor a specific request for providers, we cannot always accommodate all requests. Specific requests may result in significantly increased wait times. All of our providers offer exceptional care and can address your pain.

Controlled Substance Informed Consent

The purpose of this informed consent is to give you information, including the risks and benefits, about the medications you may be taking for pain. A member of the Premier Pain & Spine, LLC medical staff may prescribe you federally controlled substances such as opioids (Vicodin/Norco/etc.) or benzodiazepines (Valium/Xanax/etc.), sometimes called narcotics, for intractable pain. This decision was made because your condition warrants necessity or other treatments have not helped your pain.

By signing this document, you are confirming that you have read this consent in its entirety, that your questions have been answered, and that you have full understanding of the risks and benefits of using controlled substances to treat pain and improve function.

- I am aware that addiction is characterized as a strong desire or sense of compulsion to take the drug; Difficulties in controlling drug-taking behavior in terms of its onset, termination, or levels of use; A physiological withdrawal state when drug use is stopped or reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms; Evidence of tolerance, such that increased doses of the drug are required in order to achieve effects originally produced by lower doses; Progressive neglect of alternative pleasures or interests because of drug use, increased amount of time necessary to obtain or take the drug or to recover from its effects; Persisting with drug use despite clear evidence of overtly harmful consequences, such as harm to the liver, depressive mood states or impairment of cognitive functioning.
- I understand that physical dependence is a normal, expected result of using these medicines for an extended period of time. I understand that physical dependence is **NOT** the same as addiction. I am aware that physical dependence means that if my pain medicine use is markedly decreased or stopped, I will experience a withdrawal syndrome. Characteristics of opioid withdrawal include, but not limited to: Sweating, runny nose, yawning, feeling hot and cold, abdominal cramps, nausea, vomiting, diarrhea, tremor, insomnia, restlessness, anxiety, increased heart rate, increased blood pressure and dilated pupils. I am aware that opioid withdrawal is uncomfortable but not immediately life threatening.
- I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. If it occurs, increasing doses does **NOT** always help and may cause undesirable side effects. Tolerance or failure to respond well to opioids may cause my doctor to choose another form of treatment.
- I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medication will not provide complete pain relief.
- **(Males Only)** I am aware that chronic opioid use has been associated with low testosterone levels. This may affect my mood, stamina, sexual desire and physical / sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.
- **(Females Only)** I am aware that chronic opioid use has been associated with low testosterone, progesterone and estrogen levels. This may affect my mood, stamina, sexual desire and physical / sexual performance. I understand that my doctor may check my blood to see if my hormone levels are normal. If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and my pain management doctor to

inform them. I am aware that, should I carry a baby to delivery while taking these medications, the baby will be physically dependent upon opioids. Birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking opioid pain medications.

I have read the above consent (or it has been read to me). I understand the topics, instructions, warnings, cautions, benefits and risks stated. I have had a chance to have all of my questions regarding this treatment option answered to my satisfaction and understanding. By voluntarily signing the last page of this agreement, I give my consent for the treatment of my pain with opioid pain medicines, if I so choose under the guidance of my physician. I have read the above policies (or it has been read to me). I have had a chance to have all my questions answered to my satisfaction and understanding.

Controlled Substance Agreement

The purpose of this agreement is to assure that you and your physician comply with all state and federal regulations concerning the prescribing of controlled substances. The physician's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of the treatment depends on mutual trust and honesty in the physician/patient relationship.

I agree to participate in a program of Pain Management with the Physicians of Premier Pain & Spine, LLC. I may be provided with controlled substances, while actively participating in the Pain Management Program, only if I adhere to the following regulations:

- I will **ONLY** receive controlled substances from Premier Pain & Spine, LLC
- I will use the medications within the parameters given by Premier Pain & Spine, LLC staff.
- Any evidence of drug hoarding, acquisition of any opiate medications or adjunctive controlled substances from other physicians (which includes emergency rooms), unauthorized dose escalation or reduction, loss of prescriptions, or failure to follow the Controlled Substance Agreement may result in **TERMINATION** of the doctor/patient relationship.
- I will **NOT** call the office for early refills. I will be given a prescription for enough medication to last from appointment to appointment.
- I understand that I will be responsible for coordinating travel around my medication refill schedule.
- I understand I will **NOT** receive replacements for lost, stolen or destroyed medications.
- I am solely responsible for keeping my pain medication in a safe and secure place, such as a locked cabinet or safe. I am expected to protect my medications from loss or theft. Stolen medications should be reported to police and to my physician immediately.
- **NO** medications will be called in after normal business hours.
- I will inform my physician of all medications I am taking, including herbal remedies, since opioid medications can interact with over-the-counter medications and other prescribed medications, especially cough syrup that contains alcohol or codeine.
- If required, I will return any opioid medications and adjunctive medications prescribed by my physician in the original bottles.
- I may not give or sell my medications to any other person, under any circumstance. If I do, I may endanger that person's health. It is also against the law.
- I am aware that my reflexes and reaction time may be delayed when taking opioid analgesic medications. I will **NOT** take part in any activity that may be considered dangerous to me or someone else if I feel drowsy or am not thinking clearly. Such activities include, but are not limited to: Operating heavy equipment or motor vehicles, working in unprotected heights or being responsible for another individual who is unable to care for himself/herself.
- I understand that the use of alcohol and opioid medications is contraindicated and dangerous.
- I am aware the development of addiction is much more common in persons with family or personal history of addiction. Therefore, I agree to provide my doctor with a complete and honest personal and family drug history to the best of my knowledge.
- I understand that controlled substances play a small role in the treatment of my pain condition and I am willing to participate in other integral modes of pain treatment including, but not limited to: Procedural-based treatments such as injections, physical therapy, occupational therapy, pain psychology, cognitive behavioral therapy, group

counseling/therapy, biofeedback, adjuvant (other) pain medications, chiropractic and other holistic forms of treatment. If **NO** effort is made to continue these other forms of treatment, the physician reserves the right to stop prescribing controlled substances.

- I **AGREE** and understand that my physician reserves the right to perform random or unannounced urine/saliva drug testing. If requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my doctor may change my treatment plan, including safe discontinuation of my opiate medications when applicable, or complete **TERMINATION** of the doctor/patient relationship. The presence of non-prescribed drug(s) or illicit drug(s) [cocaine, marijuana, etc.] in the urine/saliva can be grounds for **TERMINATION** of the doctor/patient relationship. Urine drug testing is not forensic testing, but is done for my benefit as a diagnostic tool and in accordance with certain legal and regulatory materials on the use of controlled substances to treat pain.
- I **AGREE** to participate in a drug detoxification program if prescribed by a member of the Premier Pain & Spine, LLC staff.
- I **AGREE** to allow my physician to contact any healthcare professional, family member, pharmacy, legal authority, or regulatory agency to obtain or provide information about my care or actions, *if my physician feels it is necessary*.
- I **AGREE** to a family conference or a conference with a close friend or significant other, *if my physician feels it is necessary*.
- Should notice of **TERMINATION** occur, I agree to obtain an alternate source of physician care within **thirty (30) days**.
- Should violation of this agreement occur, I will consider **thirty (30) days** adequate notice for termination of controlled substances.
- I will **NOT** seek controlled substances from Premier Pain & Spine, LLC staff if I decide to discontinue participation in the Pain Treatment Program.

The above agreement has been explained to me by my provider. I agree to its terms. I understand that failure to comply with any of the agreement requirements is a breach of the contract, which may subject me to immediate termination from the practice. This controlled substance agreement is not applicable if you already have an existing medication contract with an outside provider. If at any time a member of the Premier Pain and Spine medical staff elects to begin prescribing you a controlled substance, this agreement will begin to take effect immediately.

URINE MEDICATION SCREENING

Ultimately, urine medication screening is a useful tool in pain management that provides valuable objective information to assist clinicians with critical insight to custom tailor treatment and improve outcomes.

Why Urine Medication Screening?

- Improve patient safety
- Ongoing medication monitoring is part of every patient's customized treatment plan
- Detection of medications that may result in a drug to drug interaction or reaction
- Patient education of medications
- Federal and state regulators recommend formal monitoring during the course of treatment
- All new patients are screened during initial consult

Premier Pain & Spine, LLC is committed to providing you the safest and most effective treatment for your overall health and well-being. If you have any questions or concerns, please ask for a member of our medical staff and we will gladly assist you.

I have read the above consents (or it has been read to me). I have had a chance to have all of my questions regarding this treatment answered to my satisfaction and understanding. By voluntarily signing this form, I give my consent for the treatment of my pain with opioid pain medicines, if clinically warranted.

Patient's Name: _____

Date of Birth: _____

Patient's Signature: _____

Date: _____

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