DESERT INTERVENTIONAL SPINE CONSULTANTS

2023 PATIENT UPDATE PACKET:

Patient's Name:_____ SS#:_____
First MI Last

Date of Birth: _____ Gender: _____ Single: ☐ Married: ☐ Widow: ☐ Divorced: ☐ Separated: ☐

Race: ☐ American Indian/Native American ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Pacific Islander ☐ White ☐ Other/Refuse

Email: _____

Street Address:_____ City/State/Zip_____

Primary Phone #:_____ Secondary Phone #:_____

Employer:_____ Employer Phone:_____

PRIMARY CARE PHYSICIAN & Phone Number:_____

Pharmacy Name (Crossroads) and Phone Number:_____

SPOUSE INFORMATION:

Spouse Name:_____ Date of Birth:_____

Spouse's Employer:_____ Employer Phone:_____

EMERGENCY CONTACT:

Name:_____ Relationship To Patient:_____

Phone Number:_____

WORKERS COMPENSATION INFORMATION:

YES / NO Insurance Name:_____

Date of Injury:_____ Claim #:_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD & PHOTO ID FOR COPYING):

****THIS SECTION MUST BE COMPLETED****

Primary Insurance:_____ Phone Number:_____

>>>Primary Insured's Name:_____ Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

Secondary Insurance:_____ Phone Number:_____

>>>Primary Insured's Name:_____ Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

- *I hereby authorize the payment of medical benefits to Desert Interventional Spine Consultants, LLC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.*
- *I further agree to pay all collections costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.*
- *I hereby authorize Desert Interventional Spine Consultants, LLC to release any medical information necessary to complete and process my insurance claims.*
- *I authorize Desert Interventional Spine Consultants, LLC to treat me and use my personal information for healthcare operations.*

X_____

Patient Signature (If a Minor, Responsible (Insured's)Party Signature) **Date**

DESERT INTERVENTIONAL SPINE CONSULTANTS

AUTHORIZATION TO RELEASE HEALTH INFORMATION:

Please fill #1 and sign, this form will remain in your chart in case you are hospitalized or visit an UC and we need to obtain your medical records.

1. I authorize Desert Interventional Spine Consultants to obtain the health information of the individual named below:

Patient Name:_____ Date of Birth: _____

Address: _____

Phone Number: _____

2. I authorize the information to be disclosed to and used by the following individual or organization:

Name: **Desert Interventional Spine Consultants, LLC** City/State: **Gilbert, Arizona**
1410 W Guadalupe Rd, Bldg. 4, Ste 125
Zip Code: **85233** Phone #: **480-838-1914** Fax #: **480-838-9434**

For the purpose of: **Medical Evaluation and Treatment**

3. The type and amount of information to be disclosed is as follows: (specify dates where appropriate)

☐ Copy of Complete Medical Records ☐ X-ray Films

☐ X-ray/CT scan/ MRI Reports ☐ MRI/CT Scan Films

☐ Laboratory Reports ☐ Psychological or Psychiatric Conditions

From: _____ **DOS:** _____

Fax: _____

PURPOSE OF DISCLOSURE: *We may use and disclose your medical records only for each of the following purposes:*
(1) Treatment, (2) Payment, and (3) Health care operations.
We may also create and distribute de-identified health information by removing all references to individually identifiable information.

REVOCATION RIGHTS: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by sending a written notice of revocation to Releaser. I understand that the revocation will become effective upon receipt by Releaser. Any health information disclosed by Releaser pursuant to this Authorization, before the effective date of the revocations is not subject to revocation.*

Patient's Signature: _____ Date: _____

DESERT INTERVENTIONAL SPINE CONSULTANTS

BILLING POLICY:

The following sets forth the general billing policy of Desert Interventional Spine Consultants. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide to Desert Interventional Spine Consultants, the accurate billing information at the time of check-in and to notify this office of any changes to this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services bring rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a **$35** NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

- I understand that the office will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior to any elective surgery that I may have. I further understand that it is the policy to collect the deductible and/or coinsurance prior to scheduling my elective surgery. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on: 1) anticipated surgery to be performed and 2) current information provided to clinic by my insurance carrier.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/deductibles) and I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.

- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I understand that any outstanding balances must be **paid in full** prior to my next appointment. Any balances not satisfied could results in appointment cancellations.

- ***PLEASE BE ADVISED: Notice for cancellation of office visits and procedures, must be given 24 hours in advance. A $50 fee will be assessed for office cancellations and, $75 fee for procedure same day cancellations/no show.***

My signature below confirms that I have read these billing policies and my financial obligation as pertaining to this office.

Legal Signature: _____

Date: _____

DESERT INTERVENTIONAL SPINE CONSULTANTS

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My office is required by federal regulation, known as the HIPAA Privacy Rule, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. The office will not disclose your health information except as described in this Notice.

The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

OUR COMMITMENT TO YOUR PRIVACY:
The office is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized that these laws are complicated, but we must provide you with the information.

WHO HAS ACCESS TO THIS INFORMATION?
Any person or persons who designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for my services has access to your Protected Health Information.

Entities such as Governmental Oversight agencies, Judicial and Administrative Proceeding, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:
We release your information on to those who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:
You have the right to inspect your Protected Health Information. You also have the right to amend any errors you may find in your records.

DISCLOSURE AND CONSENT:
I have been given the opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risk of non-treatment, the procedures used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I authorize Desert Interventional Spine Consultants to leave detailed information regarding my care at the phone number listed on my demographics and the email I provided.

Please name all person(s) we can contact and/or discuss your medical information:

Name:_____ **Relationship:** _____

DOB: _____ **Phone Number:** _____

****If you need to add any more people use the bottom of the page, please include name, phone and relationship****

I hereby understand and accept the above criteria:

Patient / Other Responsible Person Signature: _____

Printed Name: _____ Date: _____

OPIOID AND CONTROLLED SUBSTANCES CONTRACT

I understand that the treatment I receive from Desert Interventional Spine Consultants includes opioid and/or other sedative medications. I understand and agree to the following while receiving these drugs:

I understand that the goals of prescribing these medications are to increase my activities at home and/or work and decrease pain symptoms and behavior within the time specified in my treatment plan.

I understand that opioid medications are not the only part of my treatment plan, but agree to follow other parts of my treatment program including physical therapy, behavioral pain management, injections etc.; as necessary.

I will not attempt to obtain any opioid or sedative medications from any source other than this clinic. If I require emergency treatments requiring controlled substance use, I will notify Desert Interventional Spine Consultants, the next working day.

I understand that I must schedule monthly appointments for medication renewals. Renewals are contingent on keeping scheduled appointments. No opioid medications will be refilled over the phone.

I understand that I am only to take the medications as prescribed and, all medication changes have to be discussed during office visits, not via phone.

I understand that lost or stolen medications and/or prescriptions will not be replaced. I am responsible for my own medications and it is my responsibility to verify that prescriptions are filled correctly and that the medication supply will last until my next scheduled appointment.

I understand that I must return all unused narcotic medications in the event of medication changes.

I agree to use a single pharmacy for dispensing controlled substances, and provide Desert Interventional Spine Consultants with the name and phone number of that pharmacy. I will inform this office of, any changes to my overall pharmacy/health condition at check in at my next appointment.

I agree to urine drug screens to monitor drug usage, and monthly pill count.

I agree for an outside laboratory to be used for clinical urine drug testing services and I understand that my insurance may be billed for services rendered. I understand that I am responsible for any co-pays, deductibles, or other fees that my insurance provider deems my responsibility.

When taking prescribed opioids, it is crucial to strictly avoid the use of illicit drugs. Illicit substances can interact unpredictably with opioids and pose significant health risks.

To avoid potential risks and harmful interactions, alcohol is to be avoided while consuming opioids.

CAUTION: OPIOID MEDICATIONS MAY CAUSE DROWSINESS. USE CARE WHEN OPERATING A CAR OR MACHINERY. FEDERAL LAW PROHIBITS ALTERATIONS OF PRESCRIPTIONS OR DIVERSION OF THESE DRUGS TO ANY OTHER PERSON!!!!

My signature below confirms that I understand and agree to all of the above requirements to obtain opioid and/or sedative medications from Desert Interventional Spine Consultants. LLC and failure to comply may result in discontinuation of care and discharge from the facility.

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Physician Signature: _____Date: _____