AIPC
ADVANCED INTERVENTIONAL PAIN CLINIC
A Prospira PainCare Center of Excellence

BILLING / ASSIGNMENT OF BENEFITS AGREEMENT

Thank you for choosing to be treated at Advanced Interventional Pain Clinic. Our office is happy to file all insurance, as we are members of numerous medical plans. Our billing service will provide monthly statements with updated account status. **A balance may exist if:**

1. Insurance payment is pending
2. Checks were sent directly to the patient.
3. Plan does not cover charges in full (e.g. co-pays, deductibles, and co-insurance.)
4. Deductible has not been previously met.

BY LAW, we MUST BILL all patients for any balance remaining after insurance has been paid. Please do not hesitate to call the billing department at (407)622-7246 if you have any questions, or if prior arrangements have been made regarding your balance.

We ask for your cooperation in promptly paying any unpaid balances and in forwarding any insurance checks to our office.

I have read the above billing policy and procedures of Advanced Interventional Pain Clinic and fully understand the aforementioned.

Your signature at the conclusion of this agreement confirms that you have read and fully understand the right of confidentiality and the limits to that right, as well as our fee policy.

I, the undersigned Patient, have and do assign all rights and benefits of insurance of any and all applicable personal injury protection, medical payments and/or insurance to the Advanced Interventional Pain Clinic and/or its affiliates and subsidiaries for services and/or supplies to the undersigned Patient and covered by Personal Injury Protection (P.I.P) Coverage, Worker's Compensation or other insurance coverage under my policy, in accordance with *Florida State Statute* §627.736. I have read the information herein and it is true to the best of my knowledge and belief

This Assignment includes, but is not limited to, all rights to collect benefits directly from the insurance company for services that I have received and all rights to proceed against the insurance company obligated to provide benefits, including legal suit. If for any reason the insurance company fails to make payments of benefits to which I am due. Specifically, this assignment includes the right to collect payment for the reasonable costs incurred in accordance with *Florida State Statute* §627.736.

I understand that if my insurance or any other payor fails to pay for the services rendered at Advanced Interventional Pain Clinic, its subsidiaries or affiliates that I personally guarantee payment. If collection action regarding my outstanding balance occurs I agree to reimburse the Advanced Interventional Pain Clinic for attorney's fees and costs, court costs and prejudgment interest in the amount of 11% per annum.

I hereby instruct the insurance carrier that in the event the subject's medical benefits are disputed for any reason, including medical relatedness, reasonableness and/or necessity, that the amount of benefits claimed by Advanced Interventional Pain Clinic is to be set aside and not disbursed until the dispute is resolved. I further instruct the insurance carrier to notify the provider immediately of any dispute as to payment so that he/she/it may exercise their legal rights. I have read the information herein and it is true to the best of my knowledge and belief

Patient's Signature: _____ Date _____

Witness: _____ Date _____

FOR OFFICE USE ONLY

Physical therapy billing: _____ Waived except for deductible and co-pays
_____ Not waived

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____
Last First Middle
Patient's Address: _____ City _____State _____ Zip _____
Home/Business Phone _____ Cell Phone: _____ E-Mail: _____

PERSON OR ENTITY TO RELEASE INFORMATION

☐Name: _____
Address: _____
Phone: _____
Fax: _____

PERSON OR ENTITY TO RECEIVE INFORMATION

☐ **Advanced Interventional Pain Clinic**

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed)

____ Complete Medical Record ___Office Notes ___ Lab Reports
____ Procedure Reports ___ Surgery Records ___ Billing Records
_____ Other (Specify)

DATES OF SERVICE: _____

PURPOSE: ___ Changing Physicians, ___ Personal Copy to Patient, ___ Attorney, ___ Insurance.
___ Workman's Compensation, ___ Other _____

This authorization will expire on _____. (If no date specified, this authorization shall expire 1 year after date signed.)

CHECK AND INITIAL BELOW:

___ I DO, ___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS related conditions**, and all medical records and clinical information relating thereto. *(Initials of individual giving authorization)* _____.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**. (*Initials of individual giving authorization)* _____.

___ I DO, ___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment. *(Initials of individual giving authorization)* _____.

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and/or information.

_____ _____
Signature of Patient or Patient's Representative Witness

_____ _____
Relationship to Patient Date
(if applicable, attach document of guardianship or Power of Attorney)

(9/09)

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CONSENT TO OBTAIN MEDICATION HISTORY

Advanced Interventional Pain Clinic has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. You benefit from this information sharing by enabling us to reconcile your medications more easily thereby preventing any undesired drug interactions.

To provide this service, Advanced Interventional Pain Clinic securely connects to a patient's medication history data stored in the databases of community pharmacies and pharmacy benefit managers. Advanced Interventional Pain Clinic then presents that data to prescribers through software from a certified vendor. The prescriber is required to obtain all necessary patient consents prior to electronically accessing a patient's medication history. Please rest assured that we will treat this shared information, like all other Protected Health Information, with the utmost due care, as HIPAA requires.

Please carefully read the information carefully before making your decision.

I GIVE CONSENT to access my electronic medication history in connection with providing me any health care services, including emergency care.

I DENY CONSENT to access my electronic medication history for any purpose, *even in a medical emergency*.

_____
Print Name of Patient

_____
Signature of Patient or Patient's Legal Representative

_____
Date

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Prescription Program at Advanced Interventional Pain Clinic

Advanced Interventional Pain Clinic offers Electronic Prescription Prescribing (EPP). EPP allows us to send your medication refills electronically to your Pharmacy. This means no more waiting for your prescriptions to be filled.

Please fill in the blanks below with your Pharmacy information and return the form to our front office.

Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone Number: _____

Patient Name: _____
(Please print)

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Pharmacy Name: _____

Phone Number: _____

Address: _____

Crossroads: _____

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HIPAA NOTICE OF PRIVACY PRACTICES. 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. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT OUR COMPLIANCE OFFICER. (877) 539-9068

This notice describes our privacy practices and that of:

- Any physician or health care professional authorized to enter information into your medical chart.
- All departments and units of our facilities.
- All employees, staff and other office personnel.
- All these individuals, sites and locations follow the terms of this notice. In addition, these individuals, sites and locations may share medical information with each other or with third party specialists for treatment, payment or office operations purposes described in this notice.

We create a record of the care and services you receive at our facilities which we need to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our facilities. The terms "information", "health information" or "medical information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.
We are required by law to:

- Maintain the privacy of your Protected Heath Information
- Provide you this notice of our legal duties and privacy practices with respect to your Protected Heath Information;
- Follow the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests.

The main reasons for which we may **use** and **disclose** your Protected Health Information are to evaluate and process any requests for coverage and claims for benefits you may make, or in connection with other health-related benefits or services that may be of interest to you. The following describes these and other use and disclosures, together with some examples:

- **For Treatment**. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to our office personnel who are involved in taking care of you at one of our facilities or elsewhere. We also may disclose medical information about you to people outside our facilities who may be involved in your care after you leave one of our facilities, such as family members or others we use to provide services that are part of your care, provided you have consented to such disclosure. These entities include third-party physicians, hospitals, nursing homes, pharmacies or clinical labs with whom the office consults or makes referrals.

- **For Payment**. We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about procedures you receive at one of our facilities so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

- **For Health Care Operations**. We may use and disclose medical information about you for your internal operations. These uses and disclosures are necessary to run our facilities and make sure that all of our patients receive quality care. For example, we may use medical information about you to review our treatment and services

and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services one of our facilities should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff and other office personnel for review and learning purposes.

- **Individuals Involved in your Care or Payment for your Care**. We may release medical information about you to a friend or family member who is involved in your medical care, provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Where Required by Law or for Public Health Activities**: We disclose Protected Health Information when required by federal, state or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases, or providing Protected Health Information to a governmental agency or regulator with health care oversight responsibilities. We may also release Protected Health Information to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death.

- **To Avert a Serious Threat to Health or Safety**: We may disclose Protected Health Information to avert a serious threat to someone's health or safety. We may also disclose Protected Health Information to federal, state or local agencies engaged in disaster relief as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.

- **For Health-Related Benefits or Services**: We may use Protected Health Information to provide you with information about benefits available to you under your current coverage or policy and in limited situations, about health-related products or services that may be of interest to you.

- **For Law Enforcement or Specific Government Functions**. We may disclose Protected Health Information in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons or similar process. We may disclose Protected Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as Part of a Regulatory or Legal Proceeding**. If you or your estate is involved in a lawsuit or a dispute, we may disclose Protected Health Information about you in response to a court or administrative order. We may also disclose Protected Health Information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the Protected Health Information requested. We may disclose Protected Health Information to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.

- **Disclosures of Workers' Compensation.** We may, without your authorization, disclose information in your Medical Record to the extent that disclosure is authorized by, and necessary to comply with, laws relating to workers' compensation.

- **Privacy and Security of Health Information.** We will not use or disclose your health information for marketing purposes, sell your health information, or, in most cases, use or disclose any psychotherapy notes without your authorization. We are required by law to notify you following a breach of your unsecured Protected Health Information.

- **Other Uses of Protected Health Information**: Other uses and disclosures of Protected Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization

or that of your legal representative. If we are authorized to use or disclose Protected Health Information about you, you or your legally authorized representative may revoke that authorization in writing, at any time, except to the extent that we have taken action relying on the authorization or if the authorization was obtained as a condition of obtaining your Health Insurance coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information we Maintain About you:

The following are your various rights as a consumer under HIPAA concerning your Protected Health Information:

- **Right to Inspect and Copy Your Protected Health Information**. In most cases, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you. To inspect and copy Protected Health Information, you must submit your request in writing to the applicable administrator listed above. We will normally respond to your request within 30 days of receipt unless the information to which you request access is located off site, in which case, it may take us up to 60 days to respond. If for some reason we are unable to respond within the time frames just stated, we will, prior to the expiration of the 30-day or 60-day period, notify you in writing why we are unable to respond and the date by which we will respond. In no case will our response be given later than 30 days after the expiration of the date that it would have been due had we not given notice.

  To receive a copy of your Protected Health Information, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of Protected Health Information will not be made available for inspection and copying. This includes psychotherapy notes; and also includes Protected Health Information collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your Protected Health Information or we may deny your request with respect to only some of the information in your Medical Record. If your request is denied, you will be notified in writing why we denied the request. That same notice will also explain to you your rights to request a review of that denial and how to exercise those rights. Finally, we will also advise you how you may make a complaint to us or to the Secretary of the Department of Health and Human Services. If your request is denied only in part, we will provide you with access to the remaining information in your Medical Record. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

- **Right to Amend Your Protected Health Information**: If you believe that your Protected Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Protected Health Information while it is kept by or for us. You must provide your request and your reason for the request in writing, and submit it to the applicable administrator listed above. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend Person Information that: is accurate and complete; was not created by us unless the person or entity that created the Protected Heath Information is no longer available to make the amendment; is not part of the Protected Health Information kept by or for us; or is not part of the Protected Health Information which you would be permitted to inspect and copy. Our response regarding such request will follow the same procedures set forth above for accessing your records. The same complaint procedures should also be following in the event your request to amend your records is denied.

- **Right to an Accounting of Disclosures**: You have the right to request a list of the disclosures we have made of Protected Health Information about you. This list will not include disclosures made for treatment, payment, health care operations, for purposes of national security, made to law enforcement or to corrections personnel, or made pursuant to your authorization or made directly to you. To request this list you must submit your request in writing to the applicable administrator listed above. Your request must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). We

will respond to your request for an accounting within 60 days after receipt unless we notify you in writing prior to the expiration of the 60-day period why we are unable to respond within that time frame and specify the date on which we will respond, which will not be later than 90 days after receipt of your request. The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on Protected Health Information we use of disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it in all circumstances**, except in the case of a disclosure restricted to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and the Protected Health Information pertains solely to a health care item or service for which you, or the person other than the health plan on your behalf, has paid the covered entity in full. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing to the applicable administrator listed above. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on Protected Health Information uses or disclosures that are legally required, or which are necessary to administer our business.

- **Right to Request Confidential Communication**: You have the right to request that we communicate with you about Protected Health Information in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the applicable administrator listed above and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact us at Florida Pain and Rehab Associate, LLC, c/o Privacy Officer, 880 Holcomb Bridge Road, Building C Suite 200, Roswell, GA 30076 or call (877) 539-9068. All complaints must be submitted in writing or by calling our Complaint Hotline (877) 539-9068. You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at Florida Pain and Rehab Associate, LLC, c/o Privacy Officer, 880 Holcomb Bridge Road, Building C Suite 200, Roswell, GA 30076 (877) 539-9068.

ADDITIONAL INFORMATION:

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for Protected Health Information we already have about you as well as any Protected Health Information we receive in the future. If we do make such changes, we will post a copy of the revised notice in the reception area of all our facilities and in other areas of our facilities where we provide health care services. You may obtain a copy of the current notice by calling our Compliance Officer at (877) 539-9068 and requesting a copy, or by requesting a copy from any of our health care professionals with whom you have contact.

Other Uses of Medical Information: Other uses and disclosures of medical information not covered by this notice that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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Effective – 9/23/2013
Revised 9/17/2013 SJ

Effective – 9-23-2013

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

_____
Please print your name here.

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain an acknowledgment
- We were not able to communicate with the patient. (Please provide specific details)
- Other (Please provide specific details)

_____

_____

_____ _____
Employee's signature Date

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal, not state, law.

Revised 9/17/2013

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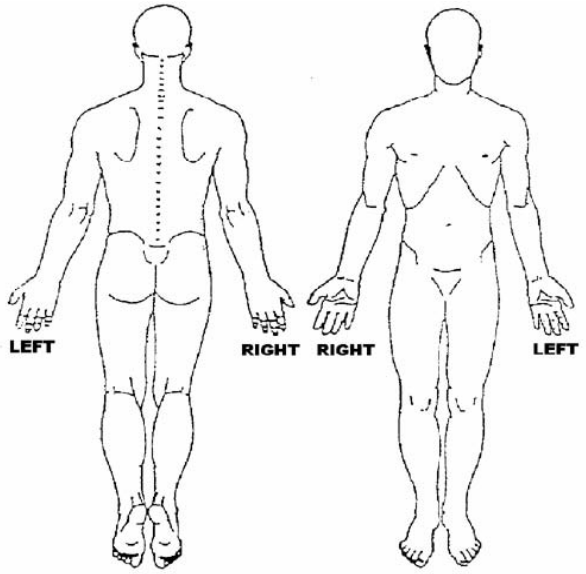
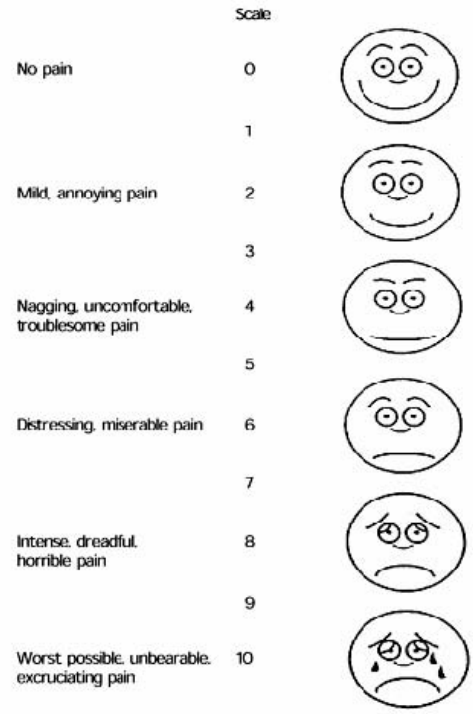
PAIN & DIFFICULTY ASSESSMENT



Please mark the appropriate region using the scale to the right.



ACTIVITY	AMOUNT				MODIFICATION ASSISTANCE
	NONE	MUCH	SOME	N/A	
Dressing					
Grooming					
Brushing Teeth					
Combing Hair					
Shaving					
Toileting after Care Wiping					
Bathing					
Hand Function					
Holding Objects					
Carrying Objects					
Lifting Objects from Floor					
Lifting Objects Overhead					
Difficulty Transferring					
Getting on/off the Toilet					
Getting into/out of the following:					
Bed, Chair, Bathtub, Shower, Car					
Walking (ambulation)					
Other Activities					
Shopping, Cooking, Driving, Laundry, Gardening & Sleeping					

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Pain Management Agreement

Patient Name: _____ Chart #: _____

I understand, accept, and agree to the following terms and conditions in order to receive care for the treatment of pain at Advanced Interventional Pain Clinic *(place your initials next to each statement)*:

_____ I understand that my provider and I will work together to find the most appropriate treatment for my chronic pain. I understand the goals of treatment are not to eliminate pain, but to partially relieve my pain in order to improve my ability to function. Chronic opioid therapy is only one part of my overall pain management plan.

_____ I understand that my provider and I will continually evaluate the effect of opioids on achieving the treatment goals and make changes as needed. I agree to take the medication at the dose and frequency prescribed by my provider. I agree not to increase the dose of opioids on my own and understand that doing so may lead to the treatment with opioids being stopped.

_____ I understand that the common adverse effects of opioid therapy include constipation, nausea, sweating, itchiness of the skin, confusion or other changes in mental state or thinking ability, and problems with coordination or balance. Drowsiness may occur when starting opioid therapy or when increasing the dosage. I agree to refrain from driving a motor vehicle or operating dangerous machinery until such drowsiness disappears.

_____ I will not seek opioid medications from another physician for the treatment of my pain. Regular follow-up care is required and only my provider will prescribe these medications for my chronic pain for me at scheduled appointments.

_____ I will attend all appointments, treatments and consultations as requested by my providers. I will attend all appointments and follow pain management recommendations.

_____ I will not give or sell my medication to anyone else, including family members, nor will I accept any opioid medication from anyone else. I agree to be responsible for the secure storage of my medication at all times. If my medications are stolen, I will report this to police and my provider and will produce a police report of this event if requested to do so.

_____ I understand that if my prescription runs out early for any reason (for example, if I lose the medication or I take more than prescribed), my provider may not prescribe extra medication for me. I may have to wait until the next prescription is due and that my provider will not be available to prescribe medication during evenings and weekends. I understand that my provider will not provide me with refills by phone or at night or on weekends, and that it is my responsibility to call my doctor at least five business days in advance of running out of medications.

_____ I understand that using or attempting to use a forged or falsified prescription will result in the immediate discharge from the practice, and notification of the appropriate law enforcement agencies

_____ I understand that the use of other medications can cause adverse effects or interfere with opioid therapy. Therefore, I agree to notify my provider of the use of all substances, including marijuana, alcohol, medications not prescribed for me (tranquilizers), and all illicit drugs.

_____ I agree to periodic unscheduled drug screens.

_____ I understand that I may become physically dependent on opioid medications, which in certain patients may lead to addiction. I agree that if necessary, I will permit referral to addiction specialists as a condition of my treatment plan.

_____ I understand that my failure to meet any of the requirements of this agreement may result in my provider choosing to stop writing prescriptions for me. In this case, my doctor may choose to taper my medications over a period of several days, as necessary, to avoid withdrawal symptoms. If this is not deemed to be viable option, I understand that I may be discharged and may be provided with a 30 day supply of medication for use while I find a new physician to provide me with medical care. I understand that withdrawal from medications will be coordinated by my provider and may require specialist referrals.

_____ I hereby agree that my provider has the authority to discuss my pain management with other health care professionals and my family members when it is deemed medically necessary in the provider's judgment.

_____ My providers may obtain information from State controlled substances databases and other prescription monitoring programs. I authorize my providers and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine. I authorize my provider to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

_____ To the best of my knowledge, I am not pregnant at this time. I understand that opioids are considered dangerous to a fetus. I will do everything possible to avoid getting pregnant while taking these medications unless otherwise approved by my provider.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

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PATIENT CANCELLATION/NO-SHOW POLICY ACKNOWLEDGEMENT

I understand that Advanced Interventional Pain Clinic has a cancellation/no-show policy, and that I will be charged for any appointment I cancel or miss with less than 24 hours notice. Cancellations are reserved for emergencies only, and require a minimum of a 24 hour notice. All cancellations are to be rescheduled to ensure continuity of care. Any arrival 15 minutes or more after the scheduled start time of your appointment will be considered a cancellation/no-show.

I understand that the Advanced Interventional Pain Clinic does not overbook patients, my appointment time is set aside specifically for me. Thus the Advanced Interventional Pain Clinic reserves the right to charge a fee of $50.00 for each scheduled appointment that is cancelled with less than 24 hours notice, as well as for no-shows. I also understand that I may be discharged from the care of Advanced Interventional Pain Clinic if I cancel with less than 24 hours notice, or no-show, more than 3 times within any 6 month period.

I also understand that I will not be seen until any outstanding cancellation/no-show fees have been paid in full and that any self-pay fees are non-refundable.

By signing below, I understand and agree to the above policy.

Patient Name (Print):_____

Patient Signature: _____

Provider Signature: _____

Date: _____

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PATIENT RIGHTS AND RESPONSIBILITIES

DISCLOSURE OF OWNERSHIP
Dr. Cherian Sajan does have a financial interest in this facility.

PATIENT RIGHTS:

The patient has the right to:

- Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information should he/she so desire.
- Exercise these rights without regard to sex, cultural, economic, education, religious background, physical handicap, or the source of payment for care.
- Considerate, respectful and dignified care, provided in a safe environment, with protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Access protective and advocacy services or have these services accessed on the patient's behalf.
- Appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Be advised that the physician's above have a financial interest in the facility.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Be informed of the facility's policy and state regulations regarding advance directives and be provided advance directive forms if requested.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of source of payment.
- Receive upon request, full information and necessary counseling on the availability of known financial resource for his /her care, including information regarding facilities discount and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his /her health care.
- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before medical records can be made available to anyone not directly concerned with their care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record per federal guidelines.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: whom to contact to file a grievance, and that he/she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Complaint Helpline.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trails. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medial record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate of thereof of the continuing healthcare requirement following their discharge from the facility.
- Be informed if Medicare eligible, upon request and in advance of treatment, whether the health care provider or health care facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

PATIENT RESPONSIBILITIES:

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over the counter products and dietary supplements or prescriptions), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of

nurses and other health professionals as they carry out the physician's orders.

- The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition.
- The patient is responsible for providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours.
- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- The patient is responsible for his/her actions should you refuse treatment or not follow your physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled prior to surgery or other services.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible to inform the facility about the patient's advance directives.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

ADVANCE DIRECTIVE NOTIFICATION:

In the state of Florida, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute Power of Attorney that authorize others to make decisions on their behalf based on the patient's expressed wishes when the patient is unable to make decisions or unable to communicate decisions. The Advanced Interventional Pain Clinic respects and upholds those rights.

However, unlike in other medical settings, the facility does not routinely perform "high risk" procedures. Most procedures performed in this facility are considered to be of minimal risk. Of course, no procedure is without risk. You will discuss the specifics of your procedure with your physician who can answer your questions as to its risks, your expected recovery, and care after the procedure.

Therefore, it is our policy, regardless of the contents of any Advance Directive or instructions from a health care surrogate or attorney-in-fact, that if an adverse event occurs during your treatment at this facility, we will initiate resuscitative or other stabilizing measures and transfer you to an acute care hospital for further evaluation. At the acute care hospital, further treatments or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Healthcare Power of Attorney. Your agreement with this facility's policy will not revoke or invalidate any current health care directive or health care power of attorney.

If you wish to complete an Advance Directive, copies of the official state forms are available at our facility or you may obtain a copy via the website:

http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf

If you do not agree with this facility's policies, we will be pleased to assist you in rescheduling your procedure.

If a patient is adjudged incompetent under the state's laws, the rights of the patient are exercised by the person appointed and /or the legal representative designated by the patient under Florida law to act on the patient's behalf. The Facility will accept a Court Appointed Guardian, Dual Power of Attorney, or a Health Care Surrogate.

PATIENT COMPLAINT OR GRIEVANCE

- If you have a problem or complaint, please speak to the receptionist or your care giver. We will address your concern(s) promptly.
- If necessary, your problem or complaint will be advanced to our corporate office for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.
- If you are not satisfied with the resolution of the facility, you may contact: (877) 539-9068 to speak with our Compliance Officer.

Patient complaints or grievances may be filed through the State of Florida Consumer Services Unit at 1-888-419-3456 (Press 2) or write to the address below:

If you have a complaint against a health care professional and want to receive a complaint form, call Consumer Services Unit at 1-888-419-3456 (Press 2) or write to the address below:

Department Of Health
Consumer Services Unit
4052 Bald Cypress Way, Bin C75
Tallahassee, Florida 32399-3275

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Complaint Helpline.
Call the Medicare Beneficiary Helpline at: 1-800-844-0795

BY SIGNING THIS DOCUMENT, I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY, READ AND UNDERSTAND ALL OF ITS CONTENTS:

By: _____ **Date:** _____
(Patient /Patient Representative Signature)