Please review and update the information below to the best of your ability

Patient Registration PLEASE PRINT

CURRENT PATIENT INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

City: _____ State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Sex (please circle): **M** **F**

Date of Birth: _____

Social Security No.: _____

Patient email: _____

Primary Care Provider:_____

Referring Provider:_____

Guarantor Information (to whom statements are sent)

Name: _____

Address: _____

City: _____ State: _____

Relationship to patient: _____

Date of Birth: _____

Social Security No.: _____

Phone: ( ) _____ - _____

Emergency Contact Information

Name:

Relationship:

Phone:

Mobile Phone:( ) _____ - _____

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)

Last Name:

First Name:

Middle Name:

Address:

City: State: Zip:

Date of Birth: Sex (please circle): **M** or **F**

Employer Name:

Policy Information

Patient's relationship to policy holder:

ID/Certification #

Policy/Group #

Employer address:

Secondary Insurance Information

Insurance Plan Name:

Policy Holder Name:

Policy ID #

Policy Group #

Initial: _____ Yes or _____ No I hereby consent to the use of the Prospira PainCare Portal via the internet to communicate with THE SPINE CENTER OF SOUTHEAST GEORGIA, L.L.C., to access my health records, to request or reschedule appointments, to view and update personal information, to request prescriptions, to receive test results, to read patient education material, to view statements, to pay bills, and to access related services and content.

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **A fee for no shows may apply**
- **I authorize my provider's office to contact me by telephone including artificial, prerecorded, or automated calls. This includes but is not limited to appointment reminders, collection and emergency notification calls. If the telephone number that I am providing is a mobile telephone number, I consent to receive the above indicated calls and text messages on this mobile telephone number. I understand I maybe charged by my wireless carrier.**

Signed_____ **Date:**_____

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

Current Medication List

***PLEASE INCLUDE ALL PRESCRIPTION MEDICATIONS,**
OVER THE COUNTER MEDICATIONS, SUPPLEMENTS, AND VITAMINS*

PAIN MEDICATIONS			
Medication	*Dosage*	*Frequency*	*Prescribed by*
1.			
2.			
3.			
4.			
ANTI-INFLAMMATORIES			
1.			
2.			
3.			
BLOOD THINNERS			
1.			
2.			
ALL OTHER MEDICATIONS			
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

By signing this document, I attest that the above medications are a complete and accurate list of all medications I have been prescribed and that I am currently taking.

_____ _____

Patient's signature Date

Name: _____

INITIAL ASSESSMENT FORM

DOB: _____

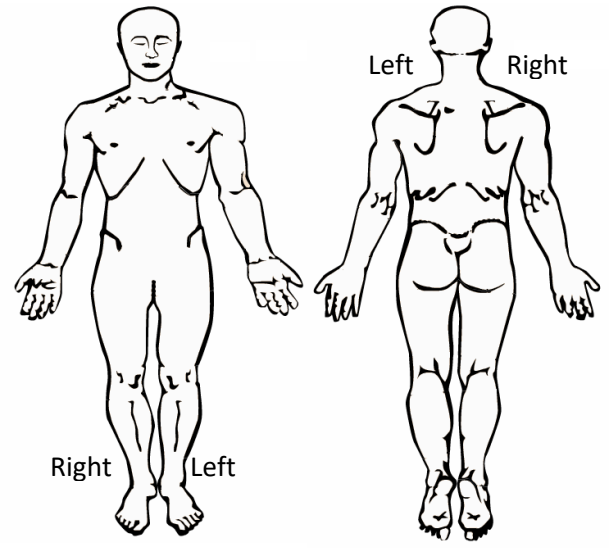
BP: _____/_____ HR: _____

Wt: _____ Ht: _____

Date: _____

Temp: _____

Location of pain: Please **shade** your area of pain



Please check what describes your pain:

☐ aching ☐ throbbing ☐ dull ☐ sharp ☐ stabbing
☐ shooting ☐ burning ☐ other:_____

Please check if you have associated symptoms*:*

☐ numbness ☐ tingling ☐ muscle spasm ☐ weakness
☐ bowel or bladder incontinence ☐ pins and needles

What worsens your pain? ☐ coughing ☐ straining ☐ standing
☐ bending ☐walking ☐ sitting ☐ driving ☐ touch
☐ cold ☐ Other: _____

What makes your pain better? ☐ rest ☐ cold ☐ warmth
☐sitting ☐ standing ☐ medication
☐ Other:_____

Indicate the one NUMBER between 0-10 that best describes your pain:

No pain *moderate pain* *severe pain* *unbearable*

0 1 2 3 4 5 6 7 8 9 10

_____ Pain at its worst _____ Pain at its least

_____ Average pain _____ Pain now

History of present illness: Is your injury ☐ work related or ☐ auto accident? Date of injury _____ State injury occurred _____

Describe the incident: _____

_____

_____

Review of systems

General
- ☐ fatigue
- ☐ fever
- ☐ weight loss/gain

Eyes
- ☐ vision loss

Head/Ears/Nose/Throat
- ☐ hearing loss
- ☐ nose bleed
- ☐ sore throat

Cardiovascular
- ☐ chest pain
- ☐ palpitations

Respiratory
- ☐ cough
- ☐ shortness of breath

Gastrointestinal
- ☐ vomiting blood

Genitourinary
- ☐ loss of bladder control

Musculoskeletal
- ☐ joint pain/swelling
- ☐ spasms
- ☐ weakness

Skin
- ☐ color changes

Neurological
- ☐ paralysis
- ☐ seizures

Psychiatric
- ☐ depressed mood
- ☐ hallucination

Endocrine
- ☐ elevated blood sugar

Hematology/Lymphatic
- ☐ bleeding
- ☐ bruising

Previous treatment

Did you have previous pain management? With who? _____ Treatments: _____

Did you have injections? ☐ No ☐ Yes, if so any relief? _____

Did you have any alternative therapies: ☐ chiropractor ☐ acupuncture ☐ physical therapy ☐ Other_____
If so any relief? _____

Relative surgical history

☐ Back surgery ☐ Neck surgery ☐ Spinal cord stimulator ☐ IT Pain pump ☐ Defibrillator/Pacemaker

☐ Other: _____

Current medications _____

_____

Blood thinners ☐Aspirin ☐Plavix ☐Warfarin ☐Lovenox ☐Pradaxa ☐Ticlid ☐Pletal

Previous pain medication

☐ Vicodin☐ Percocet ☐ Dilaudid ☐ Oxycontin ☐ Oxycodone ☐ Fentanyl

☐ Suboxone ☐ Methadone ☐ MS Contin ☐ Other: _____

Medication allergies

☐ No known drug allergies ☐ Betadine/Iodine ☐ Contrast dye ☐ Latex ☐ Medication allergies: _____

Past medical history (please check all that apply)

☐ AIDS/HIV ☐ Diabetes ☐ Cancer: _____ ☐ Hepatitis B / C ☐ Heart Disease
☐ Bleeding Disorder ☐ Stroke/Mini-Stroke ☐ Multiple Sclerosis ☐ Liver Disease ☐ Kidney Disease
☐ COPD ☐ Stomach/Intestinal Ulcers ☐ High Blood Pressure ☐ Obstructive Sleep Apnea ☐ Other: _____
☐ Alcoholism ☐ Previous Addiction ☐ Drug Abuse ☐ Bipolar Disorder ☐ Generalized Anxiety Disorder

Family history

Is your Mother living? ☐Yes ☐ No If no, age deceased_____cause of death_____
Is your Father living? ☐Yes ☐ No If no, age deceased_____cause of death_____

Family history related conditions

☐ arthritis ☐ cancer ☐ ankloysis spondylosis ☐ other_____
☐ back pain ☐ Multiple Sclerosis ☐ osteoporosis

Occupation

☐ employed ☐ currently unemployed ☐ disabled☐ retired Position (former/current):_____

Physician Notes Only

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

PATIENT CANCELLATION/NO-SHOW POLICY ACKNOWLEDGEMENT

I understand that The Spine Center 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.

The Spine Center 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 The Spine Center 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: _____

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

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 The Spine Center of Southeast Georgia *(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

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

CONSENT FOR TREATMENT

I do hereby consent to treatment of my condition by the staff of The Spine Center. I also certify that no guarantees or assurances have been made to me as to the results that may be obtained as a result of procedures, treatment and/or techniques used by The Spine Center. I further understand that while I am being assessed and/or treated at The Spine Center will not be held responsible for any injury sustained outside of its immediate physical premises.

_____ Date: _____

Patient's Signature

_____ Date: _____

Alternate Signature (if patient cannot sign)

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

Assignment of Benefits Form & Release
The Spine Center of Southeast Georgia

I, the undersigned, hereby authorize the assignment of the benefits and rights available to me under my insurance plan with the insurance company listed on the copy of the current insurance card I have provided to The Spine Center of Southeast Georgia (hereinafter "Spine Center") for medical services and care provided to me by the Spine Center. I hereby authorize payment be made directly to the Spine Center for all my covered health insurance benefits from all Third Party payers, including my employer in the event of a Worker's Compensation case. I further understand that I am financially responsible for services denied as non-covered. I certify that the insurance information I have provided to the Spine Center is true and accurate and that I am responsible for keeping said information updated. I am fully aware that having health insurance does not absolve me of my responsibility to ensure that the charges for the professional services and care rendered to me by the Spine Center (hereinafter "charges") are paid in full. I also understand that my insurance company may not pay at 100% of the amount of the charges and that I may be responsible for any and all charges not paid to the Spine Center by my insurance company, including any portion paid and not applied to in-network benefits for any out-of-network services. **I agree to pay the full amount of any and all charges pursuant to the Spine Center's scheduled rates, copies of which are available to me upon request prior to treatment.**

I authorize the Spine Center to release (1) information necessary to secure payment of benefits and/or (2) records of any treatment or examination rendered to me to other medical providers. This information may relate to (a) age; (b) medical history, condition, and/or care; (c) physical and/or mental health; (d) occupation; (e) income; (f) avocations; (g) driving records; and/or (h) other personal characteristics. This authorization extends to information on the use of alcohol, drugs and/or tobacco; the diagnosis and/or treatment of HIV infection and other sexually transmitted disease(s); and the diagnosis and/or treatment of mental illness.

I authorize the Spine Center to submit claims on my behalf to my insurance company. I fully agree and understand that the submission of a claim does not absolve me of my responsibility to ensure that all charges are paid in full. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

I irrevocably designate, authorize and appoint the Spine Center as my true and lawful attorney-in-fact. This power of attorney is provided for the limited purpose of receiving all payments due under my insurance plan on account of medical services and care rendered or to be rendered to me by the Spine Center. I hereby confirm and ratify all actions taken by my attorney-in-fact pursuant to the authority granted herein. I authorize my insurance company to assign and transfer any and all of my applicable plan benefits and rights to the Spine Center, including the right to receive any applicable plan documents and remedies and to pursue appeals and/or litigation on my behalf. This authorization includes any rights due me permissible under state and federal laws and is valid for a period of one year.

I instruct and direct my insurance company to pay the Spine Center directly. This includes any event where the Spine Center may be Out of Network. I understand that under ERISA, I have the right and authority to direct where payment for services rendered is sent. If my current policy prohibits direct payment to the Spine Center; under my rights per state and federal ERISA regulations, I instruct and direct my insurance company to provide SPD documentation stating such non-assignability clause to me and the Spine Center. Upon proof of non-assignability, I instruct my insurance company to make the check out to me and mail it directly to the Spine Center for the professional and/or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges. I agree and understand that any funds I receive from my insurance company for services and care rendered by the Spine Center will be immediately signed over and sent directly to the Spine Center. If my insurance company sends a check for payment directly to me, I agree to immediately deliver the check to the Spine Center, as I understand that the Spine Center has the right to immediate possession of the check.

This is a direct assignment of my rights and benefits under my insurance policy. I have agreed to pay any balance of the charges over and above any such insurance payment. I authorize the Spine Center to receive any checks from my insurance company on my account, endorse them for deposit, and deposit and apply the proceeds toward payment on my account. I further authorize the Spine Center to deposit checks received on my account when made out to me.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case. I authorize the Spine Center to be my personal representative, which allows it to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled; (2) submit any and all requests for benefit information from my insurance company; and (3) initiate formal complaints to any state and/or federal agency that has jurisdiction over my benefits.

I understand and agree that I am responsible for full payment of the total charges if my insurance company has refused to pay 100% of my benefits based on billed charges within ninety days of any and all appeals or requests for information. Should my account be referred to an attorney or outside agency for collection, I agree to pay to the Spine Center reasonably attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the maximum rate of 1½ percent per month under O.C.G.A. § 7-4-16, or the highest legally available rate, whichever is higher. I understand and agree that fines levied against my insurance company will be paid to the Spine Center for acting as my personal representative.

I authorize the Spine Center and its associates to provide medical care and treatment to me by today's standards. Any action stemming from this Assignment of Benefits Form & Release shall be instituted, prosecuted, and maintained in Glynn County, Georgia. A photocopy of this Assignment of Benefits Form & Release shall be considered as effective and valid as the original. If any part or provision of this Assignment of Benefits Form & Release should be held void or invalid, the remaining provisions shall remain in full force and effect.

_____

Signature of Patient/Guarantor Date

_____

Signature witnessed by Date

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

E-Prescribe Program at the Spine Center

The Spine Center 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.

All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change pharmacies, our office must be informed.

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: _____

The Spine Center of Southeast Georgia
A PROSPIRA PAINCARE CENTER OF EXCELLENCE

PATIENT RIGHTS AND RESPONSIBILITIES

DISCLOSURE OF OWNERSHIP
Dr. Christopher Bovinet 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.

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- 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 Georgia, all patients have the right to participate in their own health care decisions and to make Advance Directives or to execute a 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 Spine Center 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:

https://aging.georgia.gov/documents/georgia-advance-directive-health-care

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 Georgia 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 Georgia Department of Community Heath at 1-800-878-6442 or File a Complaint Form or write to the address below:

GA Dept of Community Health
Healthcare Facility Regulation
Complaint Intake
2 Peachtree Street, NW
Suite 31-447
Atlanta, Georgia 30303

If you have a complaint against a health care professional and want to receive a complaint form, call GA Composite Medical Board at (404) 656-3913 or write to the address below:

GA Composite Medical Board
Enforcement Unit
2 Peachtree Street, NW
Suite 31-447
Atlanta, Georgia 30303

All Medicare beneficiaries may also file a complaint or grievance with the Medicare Beneficiary Complaint Helpline.
Call the Medicare Beneficiary Helpline at: 1-800-633-4227

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)

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

HIPAA Authorization for Use and Disclosure of Protected Health Information

1. I hereby authorize The Spine Center to use and/or disclose the protected health information about me described below ("**PHI**") to _____.

2. The PHI that may be used and/or disclosed is _____ _____.

3. The PHI may be used and/or disclosed for the following purpose: _____ _____.

4. This authorization shall remain in effect until: _____.

5. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this form.

6. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time, except to the extent that The Spine Center has acted in reliance upon it, by sending written notification to: _____.

7. I understand that I have the right to refuse to sign this authorization.

8. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

_____	_____
Signature	Date
_____	_____
Name	Relationship or Authority of Personal Representative (if applicable)*

*This may be signed by a legal representative of the individual, only if the individual is a minor or an incompetent, or the beneficiary or personal representative of a deceased individual.

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

Your Information. Your Rights. Our Responsibilities.

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 DEPARTMENT. (877) 539-9068

YOUR RIGHTS

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Treat you
- Run our organization

- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll

provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us, to file a complaint with us, please contact us at Prospira PainCare, 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 can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 877-696-6775.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all Protected Health Information we 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 or by requesting a copy from any of our health care professionals with whom you whom you have contact.

The Spine Center of Southeast Georgia

A PROSPIRA PAINCARE CENTER OF EXCELLENCE

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.