Action **S**pine **A**nd **P**ain **C**enter
57 Baker Boulevard,
Akron, Ohio 44333
Phone: (330) 6661400

PATIENT DEMOGRAPHICS

First Name _____ Last _____ MI _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ /_____ /_____ SS Number _____
Home Phone _____ Cell Phone _____
Work Phone _____ Employer _____
Marital Status _____ Spouse's Name _____
Spouse Date of Birth _____ /_____ /_____ Spouse SS Number _____ - _____- _____

E-Mail Address _____
Race _____ ☐ Refuse to Report Primary Language Spoken _____
Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Refuse to Report
May we leave a message on your phone (s) for appointments? ☐ Yes ☐ No
May we leave a message with another resident at the home? ☐ Yes ☐ No
Emergency Contact _____ Relationship _____
Phone Number _____
Referring Physician Name _____ Phone Number _____
Physician Address _____ City _____ Zip _____

Date of last visit _____

Primary Insurance Company _____ Phone _____
ID Number _____ Group Number _____
Policy Holder _____ DOB _____/_____/_____
Relationship _____

Secondary Insurance Company _____ Phone _____
ID Number _____ Group Number _____
Policy Holder _____ DOB _____/_____/_____
Relationship _____

I hereby permit Action Spine And Pain Center (ASAP) to release any information acquired in the course of my examination or treatment required to process this claim or as required by my insurance carrier for utilization management purposes. If I am insured through military insurance, it may be necessary to release my records to the MTF (Military Treatment Facility) and I also permit any release of records for their purposes.

I hereby agree to pay any and all co-pays, deductibles, amounts over UCR, and/or excluded charges exceeding payments from insurance with whom ASAP does not accept assignment with, and/or any and all co-pays and deductibles with those they do.

I hereby request my insurance carrier to pay on my behalf insurance benefits to ASAP for services rendered. I understand this authorization will be effective until revoked in writing. I understand that if necessary, credit bureau reports may be obtained. ASAP cannot be responsible for collecting my insurance claim nor negotiating a settlement on a disputed claim. ASAP fees are not established by insurance companies. I am responsible for my account.

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FINANCIAL POLICY

Co-payments:

All co-payments are to be paid prior to service, in accordance with your health insurance policy. We appreciate your understanding and cooperation with this policy. If you do not have your copy with you at the time of service, you will be asked to reschedule. There will be a charge for NSF checks of $45.

Account Balances:

Your balance is due in full upon receipt of your monthly statement. This includes your co-insurance, deductibles and other services not covered by your health insurance. There will be a charge for NSF checks of $45. If a balance is not paid in full or payment arrangements have not been made, your account will be sent to an outside collection agency. If this is done, there is an option that you will be discharged from the practice for non-payment on your account.

Pre-existing Condition and Precertification:

It is your responsibility to notify us of any pre-existing clause on your policy. If your insurance policy has a pre- existing clause on it, please note that you will be responsible for all charges incurred. It is your responsibility to know if precertification is required for services and to know if services are a covered benefit under your policy. If services are considered investigational and/or they are non-covered benefit, please note that you will be responsible for all charges incurred.

BWC (Bureau of Worker's Compensation)

If you choose not to use BWC for your medications, you will be responsible to pay for the urine drug screens you receive. If you choose to use BWC for medication, BWC may authorize payment for the urine drug screens.

The State of Ohio requires that all Pain Clinics monitor their patients via urine or blood drug screening. The requirement is also listed in your Pain Agreement the urine drug screen is not optional if you remain a patient in a pain management clinic.

Self-Pav Patients:

If you do not have health insurance or if our doctors do not participate with your insurance, payment in full is expected at the time of service prior to being seen. Partial payment is due at time of scheduling your initial consult which is non-refundable. There will be a charge for NSF checks of $45.

We do not accept Motor Vehicle Insurance. We do not accept starter checks.

We are happy to work with you in every way possible to assess individual patient's financial situations. If you have any questions, please contact our billing office at (330) 208-2720.

The Billing Office Hours are Monday—Friday 10:00 am to 4:00 pm. Please call with any questions during these times.

Please sign below to signify your receipt and understanding of the above Financial Policy.

Patient Signature _____ Date _____

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THERAPEUTIC AGREEMENT FOR CONTROLLED SUBSTANCES

Both the Action Spine And Pain Center staff (the physicians and staff) and I (the patient), have a common treatment goal: To improve my ability to function and/or work. In consideration of that goal, I am being treated with potent medications. Examples are narcotics, tranquilizers and /or barbiturates. These medications are considered controlled substance medications and their use is closely controlled and monitored by local, state and federal agencies. These medications are highly effective when taken as directed under medical supervision, but they also have potential for misuse and abuse. Also, these medications have the potential for various side effects and these will be explained prior to treatment.

I have been fully informed by the Action Spine And Pain Center physicians and staff about psychological dependence (addiction) to controlled substance. If this happens, I will follow my physician's guidance and participate in any treatment programs prescribed, which may include detoxification, psychological counseling and medical treatment. Failure to comply will result in discharge from Action Spine And Pain Center.

I agree to abide by the following conditions:

1. A baseline drug screen completed on the first clinic visit.

2. I agree that all controlled substance medications and prescriptions shall be prescribed only by my ASAP physician.

3. Obtaining other controlled medications from any other individual or physician without informing ASAP will be considered a violation of this agreement. The only exception is medications prescribed while I am admitted in a hospital.

4. I will take the medications as directed, no more and no less. If I use up my medication sooner than prescribed, I understand that they will not be replaced before my next scheduled visit and my pain may return.

5. I know that some patients may develop tolerance, which is the need to increase the dose of the medication to achieve the same effect in terms of pain relief. I also understand that as a result of other treatment modalities or the natural course of my disease process, my pain may decrease. Therefore, my medication doses will have to be adjusted (increase/decrease) as deemed appropriate by my physician. I will not adjust the medication by myself.

6. I understand that if I stop taking the medications abruptly, this may be dangerous and lead to withdrawal symptoms. If the medication needs to be discontinued, I will do so gradually and only under medical supervision.

7. I am responsible for my controlled substance medications. If the medications or prescriptions are lost, misplaced, stolen or disappear for any reason, we are not responsible for the replacement. You must contact the ASAP staff regarding the loss of your prescription or medication immediately. A police report is required for replacement of lost or stolen medications but replacement is at the physician's discretion.

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8. I am responsible for keeping track of the amount of medications remaining and obtaining refills at my scheduled officevisits.

9. I agree to help myself by trying to change my behavior towards a healthier lifestyle including; stop smoking, using only legal drugs that have been prescribed to me by my physician, use of alcohol only in moderation as permitted by my physician, diet and weight control, adherence to physical therapy (as directed) and exercise. I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

I understand that if I violate any of the above conditions, my controlled substance prescriptions and /or treatment at ASAP may be terminated immediately. If the violation involves obtaining controlled substances from another individual, as described above, the incident will be reported to my primary physician, local medical facilities and in some cases, other authorities. The ASAP also retains the right, at its sole discretion, to release a person from the program at anytime.

Patient Signature: _____

Witness Signature: _____

Date: _____

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PAIN AGREEMENT

I, _____ Qatient name) commit Action Spine And Pain Center's program. My initials below indicate my understanding of the following:

• I agree to a drug screen at any time at the discretion of my physician. I[around positive (or illegal substances, positive (or medications not prescribed to me or negative for medications that have been prescribed, mv ohvsician has the right to immediately dismiss me from the program.

_____(Int)

• I will show up for all recommended treatments and tests.

_____ (Int)

• I will comply with my program's attendance policy and may be dismissed from the program if I have multiple missed appointments.

_____(Int)

• I understand that if I have three (3) no show appointments I may be dismissed from the program.

_____ (Int)

• If I am unable to make my appointment, I will call and cancel within 24 hours. I may be charged for a missed appointment.

_____ (Int)

• I understand on my first consult that I may not be given a prescription.

_____ (Int)

• I will follow the physician's prescription regime as prescribed. If receiving medications, I will adhere to the Agreement for Controlled Substances.

_____ (Int)

• I understand that I may be asked to bring in my medications for a pill count at any time during the program.

_____ (Int)

• I understand that it is my responsibility to make sure that I do not run out of my medications prior to my next scheduled office visit.

_____ (Int)

• I understand that narcotics cannot be prescribed over the phone. I understand that no prescriptions will be issued if I have not had an office visit within the last 30 days.

_____ (Int)

• I will notify the Action Spine And Pain Center's staff of any changes to my insurance, demographics (address, phone number)

_____ (Int)

• I will not be abusive or aggressive in language or behavior to the Action Spine And Pain Center's staff.

_____ (Int)

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Pharmacy Name: _____

The phone number to my pharmacy is: _____

• I agree that I will use ONLY the pharmacy I have listed above for my prescriptions.

_____ (Int)

• Should I have to change pharmacies, I will contact the staff 72 hours before I request a new pharmacy to be called and used for my prescriptions.

_____ (Int)

I have read the above **patient commitment agreement with Action Spine And Pain Center's program.** I have **initialed all statements.** I understand that if I fail to comply with the **commitments that I am making,** I will be discharged **from the Action Spine And Pain Center's program.**

Name:_____ Date: _____

Address: _____

City/State/Zip: _____

Home Phone:_____ Work:_____ Cell:_____

Date of Birth:_____/_____/_____

SS #: _____

Patient Signature:_____ Date: _____

Witness:_____ Date: _____

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57 Baker Boulevard,
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Phone: (330) 6661400

Name: _____

Date of Birth: _____

Privacy Statement

This notice describes how medical **information about** you may be used and disclosed and how you can get access to this information. Please review carefully. You will be given a copy of this notice.

Patient Health Information: Under federal law, your patient health information is protected and confidential. This information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. Your health information includes payment, billing, and insurance information.

How we use your Health Information: We use health information about you for treatment, to obtain payment, and for health care operation including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances we may be required to use or disclose the information without your permission.

Examples of Care, Payment, and Health Care Operations: Treatment: We will use and disclose your health information to provide your medical treatment. For example, nurses, physicians, and other members of your treatment team will record and use it to determine your care. We may also disclose information to other health care providers who are helping in your treatment, to pharmacist filling your prescriptions and family members helping with your care. Payment: We will disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain your records of payment. Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including the administration of records, evaluate the quality of treatment, and to asses outcomes.

Special Use: We may use your information to contact you with appointment reminders. We may also contact you to provide information about different treatment options.

Other uses and Disclosures: We may use or disclose health information about you for other purposes. Subject to certain requirements, we are permitted for the following purposes: Required by Law: We may be required by law to report gunshot wounds, suspected abuse, suspected neglect, or similar events. Research: We may use or disclose information for approved medical research. Public Health Activities: As required by law, we may disclose vital statistics, disease, information related to recalls of products, and similar information to health authorities. Health Oversight: We may disclose information to assist in investigations and audits, and eligibility for government programs. Judicial Proceedings: We will disclose information in response to subpoena or court order. Law enforcement purposes: We may disclose information subject to certain restrictions. Workers Condensation: We may release information about your workers compensation or other programs providing benefits for work related injuries or illness. Military or Special Government Functions: If a member of the armed forces, we will release information as military authorities command, correctional facilities, or for national security.

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Continuation of Privacy Statement

Death: We must report information regarding deaths to the coroner, medical examiner, funeral directors, and organ donation. Serious Threat to Health and Safety: We may share information when needed to prevent a serious threat to your health, safety and the public.

Individual Rights: You have the following rights with your information. Request Restrictions: You may request restrictions on some uses of this information, although we are not required to agree with this request. Confidential Communications: You may request that we communicate with only you. You may request a special address, or phone number. Inspect and Obtain Copies: In most cases you have the right to look and receive a copy of your information. Amend Information: If you believe there are errors in your information, or information is missing, you may request it corrected and information added. Accounting of Disclosure: You may request a history of the disclosure of the information about you for reasons OTHER than treatment, payment, or operations.

Our Legal Requirement: We are required to provide you this notice, protect your information, and abide by the terms of this notice.

Changes in Privacy Practice: We may change these terms at any time. We will change our notice to reflect the terms that we change. We will also post the terms changes in our waiting room. You may request a copy of this notice, and or the changes at any time. You may contact the Center Director below to answer any questions.

Complaints: If you have a complaint that may reveal we have violated this privacy statement, or do not agree with a decision that we made in regard to your information, please contact the Center Director below. You may also contact the US Department of Health and Human Services. The person below may provide you with the correct address upon request.

Contact Person:

57 Baker Boulevard,

Akron, Ohio 44333,

Phone :- (330) - 6661400

Patient Signature:_____ Date: _____

Witness:_____ Date: _____

Action Spine And Pain Center
57 Baker Boulevard,
Akron, Ohio 44333
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Name: _____
Date of Birth: _____

NOTIFICATION IN THE CASE OF BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

I PURPOSE

The Health Information Technology for Economic and Clinical Health (HITECH) Act requires that in the event Covered Entity discovers a breach of unsecured protected health information, Covered Entity must notify each patient whose unsecured protected health information has been, or is reasonable believed to have been, accessed, acquired, used or disclosed as a result of such breach. In order to protect the privacy of our patients' protected health information and to comply with federal law, this policy is adopted to assist Covered Entity in determining whether a breach has occurred, and in the event a breach has occurred, in providing notification of such breach. This policy only applies to unsecured protected health information.

II DEFINITIONS

Breach: The acquisition, access, use, or disclosure of protected health information in a manner not permitted under the HIPAA Privacy Rule, which compromises the security or privacy of such information.

For the purpose of this definition, compromises the security or privacy of the protected health information means poses a significant risk of financial, reputational, or other harm to the individual. A use or disclosure of protected health information in a Limited Date Set that does not include the identifiers listed at §164.514(e)(2), date of birth, and zip code does not compromise the security or privacy of the protected health information.

The term breach does not include:

1. Any unintentional acquisition, access, or use by a workforce member or person acting under the authority of Covered Entity or a business associate, made in good faith and within the scope of his/her authority provided such information is not further used or disclosed in a manner not permitted under the HIPAA Privacy Rule.
2. Any inadvertent disclosure from an authorized individual at Covered Entity to another authorized individual at Covered Entity provided such infofllation iS hot further used or disclosed in a manner not permitted under the HIPAA Privacy Rule.
3. a disclosure of protected health information where Covered Entity has a good faith belief that the unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

Unsecured Protected Health Information: Protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issues on the HHS website (see Exhibit A, attached).

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EXHIBIT A

HHS Guidance Specifying the Technologies and Methodologies that Render Protected Health Information Unusable, Unreadable, or Indecipherable to Unauthorized Individuals*

Protected health information (PHI) is rendered unusable, unreadable, or indecipherable to unauthorized individuals if one or more of the following applies:

(a) Electronic PHI has been encrypted as specified in the HIPAA Security Rule by "the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key" and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools should be stored on a device or at a location separate from the data they are used to encrypt or decrypt. The encryption processes identified below have been tested by the National Institute of Standards and Technology (NIST) and judged to meet this standard.

(i) Valid encryption processes for data at rest are consistent with NIST Special Publication 800-111, Guide to Storage Encryption Technologies for End User Devices.

(ii) Valid encryption processes for data in motion are those which comply, as appropriate, with NIST Special Publications 800-52, Guidelines for the Selection and Use of Transport Layer Security (TLS) Implementations; 800-77, guide to IPsec VPNs; or 800-113, Guide to SSL VPNs, or others which are Federal Information Processing Standards (FIPS) 140-2 validated.

(b) The media on which the PHI is stored or recorded have been destroyed in one of the following ways:

(i) Paper, film, or other hard copy media have been shredded or destroyed such that the PHI cannot be read or otherwise cannot be reconstructed. Redaction is specifically excluded as a means of data destruction.

(ii) Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.

*Guidance dated 8/24/09. HHS must update this guidance annually.

Patient Signature _____ Date _____

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Patient Rights and Responsibilities

Rights

- ☐ The right to quality care and treatment
- ☐ The right to know the names of those treating you
- ☐ The right to respectful safe care and treatment free of abuse and harassment the right to participate in decisions concerning care and treatment
- ☐ The right to confidentiality of records and communications, and access to them
- ☐ The right to information privacy regarding your diagnosis, treatment options, and the potential outcomes of the treatment
- ☐ The right to refuse a treatment, as permitted by law. You can refuse treatment and still receive alternate care
- ☐ The right to detailed information regarding service fees and charges the right to express spiritual and cultural beliefs
- ☐ The right to redress a grievance
- ☐ The right to appropriate assessment and management of pain

Responsibilities

I. The patient is responsible to provide accurate and complete information related to their health, reporting perceived risks in their care, and unexpected changes in their health.

II. The patient is responsible for notifying the office when unable to keep scheduled appointments, and provides health care insurance information, when health care insurance changes.

III. The patient is responsible for their actions if they refuse treatment and or fail to follow their plan of treatment as recommended by the physician.

IV. The patient is responsible for being respectful and considerate of other patients and organizational personnel.

V. The patient is responsible to ask questions when they do not understand about their care or what they are supposed to do.

These rights and responsibilities outlined the basic concepts of service for Action Spine And Pain Center. If you believe that at any time one or more of the statements have not been met with your care, please ask to speak to a Supervisor or the Director. We will make every attempt to understand your complaint and concern. We will correct the issue you have if it is within our control, and you will receive a written response.

Patient Signature:_____ Date: _____

Witness:_____ Date: _____