Relief
SPINE & PAIN CENTER

Patient Information

Today's Date: _____

First Name: _____ Last Name: _____ Date of Birth: _____

Gender: _____ Address: _____ City/State/Zip: _____/____/_____

Emai: _____ Mobile Phone: _____ Home Phone: _____

Primary Care Provider (PCP): _____ PCP phone number: _____

Referring Physician: _____ Referring Provider's Phone: _____

Emergency contact name/Phone: _____/_____ Relationship**:** _____

Insurance Information

Primary Insurance: _____ Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance: _____ Subscriber Name: _____ Subscriber DOB: _____

Subscriber ID: _____ Group Number: _____

If Applicable choose one

[ ] Workers Compensation Insurance [ ] Motor-Vehicle Accident Insurance [ ] Personal Injury

Insurance Name: _____ Insurance Phone: _____ Date of Injury: _____

Insurance Address: _____ City/State/Zip: _____/_____/_____

Employer at the time of injury: _____ Claim#: _____

Adjuster's Name: _____ Adjuster's Phone: _____ Email: _____

How did you find us

[ ] Google [ ] Facebook [ ] Friend [ ] Billboard [ ] Referred by MD [ ] Website [ ] News media

[ ] Other: _____

Opioid Risk Tool (ORT)

Instructions: Please mark "Yes" or "No" for each question, depending on if it applies to you.

No.	Question	Yes	No
1	Has there been a family history of alcohol abuse?	[ ]	[ ]
2	Has there been a family history of illegal drug use?	[ ]	[ ]
3	Has there been a family history of recreational drug use?	[ ]	[ ]
4	Has there been a personal history of alcohol abuse?	[ ]	[ ]
5	Has there been a personal history of illegal drug use?	[ ]	[ ]
6	Has there been a personal history of recreational drug use?	[ ]	[ ]
7	Are you aged between 16 - 45 years?	[ ]	[ ]
8	Has there been a history of preadolescent sexual abuse?	[ ]	[ ]
9	Has there been a personal history of Attention Deficit Disorder (ADD or ADHD), bipolar, or schizophrenia?	[ ]	[ ]
10	Has there been a personal history of depression?	[ ]	[ ]

Patient Health Questionnaire-9 (PHQ-9) Over the last 2 weeks, how often have you been bothered by any of the following issues? Please check the response that best describes your experience.

Question	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, like reading the newspaper or watching TV	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

Clinic use (score): _____

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g., yard work) and errands or favors for other family members (e.g., driving the children to school).

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non- paying jobs as well, such as that of a housewife or volunteer.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g., taking a shower, driving, getting dressed, etc.)

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Life- Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping, and breathing.

No Disability 0 ☐. 1 ☐. 2 ☐. 3 ☐. 4 ☐. 5 ☐. 6 ☐. 7 ☐. 8 ☐. 9 ☐. 10 ☐. Total Disability

Pain Disability Index Total: _____
(For clinic use)

Authorization for Release and Use of Health Information

Patient Information:

Name:	
Date of Birth:	
SSN#:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	

Authorization:
I hereby authorize Relief Spine and Pain Center to release my health information which may include records related to drug abuse, child abuse, AIDS, alcoholism, or mental illness.

Information to Release:

- Complete Medical Record (Specify dates of service): From: _____ To: _____
- Partial Medical Record (Specify details and dates): _____
- Billing Records for the date of service/requested record: _____

Recipient Information:

- Name: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone Number: _____
- Fax Number: _____

Purpose of Disclosure (check applicable):

- Personal request
- Specialist visit
- Travel purposes
- Attorney
- Disability
- Changing doctor
- Other: _____

Process for Release:

- Fax: _____
- Mail to patient.
- Mail to individual named above.

Administrative Service Fees and Requirements:

- A fee is required for the completion of patient forms, which must be paid in advance.
- Please allow up to ten (10) working days for the completion of these forms.
- For copying chart notes or records, the fees are as follows: a $5.00 search fee plus $1.00 per page for the first 25 pages, and $0.50 per page thereafter.

Expiration of Authorization (choose one):

- This authorization will automatically be renewed every 12 months unless I notify the Clinic in writing.
- This authorization will expire on _____ (insert expiration date or event).

Right to Revoke Authorization: I understand that I may revoke this authorization at any time by submitting a written revocation to Relief Spine and Pain Center. I understand that revocation will not affect any actions taken before the receipt of my written revocation.

Re-Disclosure: I understand that if my health information is disclosed to a party not bound by federal privacy regulations, it may no longer be protected by these regulations.

Fees: I acknowledge that state and federal laws permit a fee for copying medical records, and I will be responsible for any such fees.

Refusal to Authorize Use and/or Disclosure: If I refuse to sign this authorization for purposes related to worker's compensation, Relief Spine and Pain Center may decline to treat me if the treatment is solely for creating health information for a third party.

Release and Waiver: I waive any privilege concerning my health information for the purposes of this release and indemnify Relief Spine and Pain Center, along with its staff, from any liabilities or claims that may arise from this release.

Acknowledgment:

I have read and understand these policies and agree to abide by their guidelines.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
Legal Representative	Relationship to Patient

Request for Release of Medical Records

Patient Information:

Name:	
Date of Birth:	
SSN#:	
Address:	
City:	
State:	
Zip Code:	
Phone Number:	

Clinic/Hospital/Health Care Provider (Who has the information you want released):

- Name: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Phone Number: _____
- Fax Number: _____

Authorization:
I hereby authorize Relief Spine and Pain Center to request/receive my health information from the above Health care provider which may include records related to drug abuse, child abuse, AIDS, alcoholism, or mental illness.

Information to Release:

- Complete Medical Record (Specify dates of service): From: _____ To: _____
- Partial Medical Record (Specify details and dates): _____
- Other (Specify): _____

Expiration of Authorization (choose one): This authorization will automatically be renewed every 12 months unless I notify the Clinic in writing.

Right to Revoke Authorization: I understand that I may revoke this authorization at any time by submitting a written revocation to Relief Spine and Pain Center. I understand that revocation will not affect any actions taken before the receipt of my written revocation.

Re-Disclosure: I understand that if my health information is disclosed to a party not bound by federal privacy regulations, it may no longer be protected by these regulations.

Fees: I acknowledge that state and federal laws permit a fee for copying medical records, and I will be responsible for any such fees.

Refusal to Authorize Use and/or Disclosure: If I refuse to sign this authorization for purposes related to worker's

compensation, Relief Spine and Pain Center may decline to treat me if the treatment is solely for creating health information for a third party.

Release and Waiver: I waive any privilege concerning my health information for the purposes of this release and indemnify Relief Spine and Pain Center, along with its staff, from any liabilities or claims that may arise from this release.

Acknowledgment:
I have read and understand these policies and agree to abide by their guidelines.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
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General Consent for Care and Treatment

As a patient, you have the right to detailed information about your medical condition and any necessary surgical, medical, or diagnostic procedures. This knowledge enables you to make informed decisions about your treatment options, understanding all associated risks and benefits. Currently, no specific treatment plan has been recommended. This consent form is designed to authorize necessary evaluations to identify the best treatment plan for any conditions diagnosed.

Scope of Consent:
This document authorizes the conduct of reasonable and necessary medical examinations, tests, and treatments by our healthcare professionals. By signing this form, you acknowledge that:

1. This consent is ongoing and will remain in effect even after a specific diagnosis has been made and treatment has been recommended.
2. You agree to receive treatment at this facility and any satellite offices that are under the same ownership.

Rights and Communications:

- You may withdraw your consent at any time by submitting a written notice.
- You retain the right to discuss any proposed treatment plans with your physician, including the objectives, potential risks, and benefits of any tests or treatments.
- We strongly encourage you to ask questions and express any concerns you might have about recommendations made by your healthcare provider.

Voluntary Participation:
I voluntarily request the designated physicians, mid-level providers (such as Nurse Practitioners, Physician Assistants, or Clinical Nurse Specialists), and other healthcare providers as necessary, to perform reasonable and necessary medical examinations, tests, and treatments for the condition that has led me to seek care at this facility. Should further testing or more invasive procedures be advised, I understand that additional consent forms will be provided for my review and signature.

Acknowledgment:
I have read and understand these policies and agree to abide by their guidelines.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
Legal Representative	Relationship to Patient

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address(s) below to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care organizations.

I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it's bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Printed Name | Date of Birth (MM/DD/YYYY)

Signature of Patient (or Legal Representative for Patient) | Date

Legal Representative | Relationship to Patient

Financial and Payment Policies

Overview and Agreement:
Please review the following policies carefully and ask any questions you may have. A copy of this agreement will be provided upon request. By signing below, you acknowledge that you understand and agree to comply with these policies.

Insurance Coverage:

1. **Participating Insurance Plans:** We participate in most insurance plans, including Medicare. If you are not insured by the plan we work with, full payment is expected at each visit. For patients with a plan, we accept but without an up-to-date insurance card, payment in full is required at each visit until coverage can be verified.

2. **Insurance Responsibility:** It is your responsibility to understand your insurance benefits. Contact your insurance company directly with any questions about your coverage.

Payments at Time of Service:

1. **Co-payments and Deductibles:** All co-payments and deductibles must be paid at the time of service as required by your insurance contract. Failure to collect these payments can be considered fraud, and it is essential to uphold the law by making these payments promptly.

2. **Non-Covered Services:** Be aware that some services may not be covered by your insurance plan or may not be considered reasonable or necessary by insurers, including Medicare. For services not covered by insurance, full payment of 100% of the charges is required unless prior arrangements have been made.

Proof of Insurance and Claims Submission:

1. **Documentation Required:** All patients must complete our patient information form and provide a copy of a valid driver's license and current insurance card to verify insurance at the first visit.

2. **Claims Assistance:** We will submit your claims and assist you as much as reasonably possible to get your claims paid. Your insurer might request specific information from you directly, and it is your responsibility to comply. You are responsible for the balance of your claim whether or not your insurance pays.

Account Management:

1. **Payment for Services:** For insured services, we require an estimated payment of approximately 20% of the total anticipated charges or the specific co-payment dictated by your insurance. For uninsured services, full payment is necessary unless prior arrangements are made.

2. **Returned Checks:** A handling fee of $25.00 will be charged for any returned checks.

3. **Collection of Unpaid Accounts:** If your account must be sent for collection, you will be responsible for all fees involved in that process.

4. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make appropriate updates to your account. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

5. **Late Payments:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay for your account in full. Partial payments will not be accepted unless otherwise negotiated. Unresolved balances may lead to account referral to a collection agency and potential discharge from our practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Appointment Policy:

Missed appointments not canceled within a reasonable time frame will incur a charge. These charges are your responsibility and will be billed directly to you. Please help us serve you better by keeping your scheduled appointments.

Acknowledgment:

I have read and understand these policies and agree to abide by their guidelines.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
Legal Representative	Relationship to Patient

OPIOID MEDICATION AGREEMENT

By signing at the end of this document, you acknowledge your understanding and commitment to comply with the guidelines for safe and responsible use of opioid medications prescribed for pain management.

Please read each statement carefully:

1. **Complete Medical Disclosure:** I will provide a thorough medical history, including previous treatments for pain, any history of substance use disorder, and any relevant medical, psychiatric, or legal history.

2. **Adherence to Prescribed Dosage:** I will not alter my medication dosage unless explicitly authorized by my physician. Unauthorized changes may result in discontinuation of the medication and/or termination from the practice.

3. **Non-Distribution of Medication:** I will not share, sell, or borrow medications. Violation of this policy may lead to discontinuation of the medication and/or termination from the practice.

4. **Secure Storage of Medication:** I agree to securely store my medication to prevent theft or misuse by others.

5. **Sole Provider Agreement:** Relief Spine and Pain Center will be the exclusive provider of my pain medication unless otherwise coordinated with another healthcare provider.

6. **Appointment Compliance:** I will attend all scheduled appointments as determined by my physician which will occur at least once every 4 to 6 weeks. Failure to attend scheduled appointments without proper notice may lead to discontinuation of the medication and/or termination from the practice.

7. **Drug-Seeking Behavior:** I will avoid any behavior indicative of drug-seeking, such as using illegal drugs, excessive alcohol consumption, or frequent requests for early refills.

8. **Drug Testing and Medication Compliance**: I agree to provide urine and/or saliva samples upon request at any time, without prior notification, to detect the use of non-prescribed medications, illicit drugs, and to confirm the use of prescribed medications. Additionally, I will comply with random pill counts as requested by the physician, without prior notification.

9. **Treatment Evaluation and Continuation**: I understand that if my physician deems it unsuitable to continue my current medication, they may choose to cease treatment at their discretion. In this scenario, I may be referred to a detoxification program or an addiction specialist for additional support.

10. **No Weekend or Holiday Prescriptions:** Prescriptions for controlled substances will not be issued on weekends, holidays, or outside of regular office hours.

11. **Lawful Use of Medication:** I will use the medication solely for its intended medical purpose as directed by my physician.

12. **Legal Cooperation:** I authorize the clinic to cooperate with any legal and pharmacy boards, including city, state, or federal law enforcement agencies and this state's Board of Pharmacy, in the investigation of any potential misuse, sale, or other diversion of my medication. I also authorize the clinic to provide a copy of this agreement to the pharmacy.

13. **Handling of Medications in Special Circumstances:** Should there be any negative reactions or if the medication does not work as intended, I agree not to dispose of the medication independently. Instead, I will return the medication to the clinic for verification through a pill count before receiving any further prescriptions.

14. **Pregnancy Notification:** I will notify the clinic immediately if I become pregnant or plan to become pregnant while taking these medications.

15. **Vehicle Operation:** I will not operate vehicles or heavy machinery if I feel impaired by the medication, and I agree not to operate a motor vehicle if I feel mentally impaired while using controlled medications. Additionally, I will abstain from alcohol use while on controlled medication.

16. **Medication Termination:** I understand that the use of narcotic medication may be terminated immediately if I fail to comply with these terms.

Consent to Treatment with Opioid Medications:

The use of narcotic/opiate pain medications carries various risks, such as sleepiness and drowsiness, which may affect reaction times. Patients are advised to exercise caution and avoid activities that require full alertness, such as driving. While undergoing treatment with these medications, appropriate contraceptive measures are recommended.

Furthermore, patients should be aware of potential complications associated with narcotic medication use. These include tolerance (requiring higher doses for the same pain relief), physical dependence (experiencing withdrawal symptoms upon abrupt cessation), and the risk of addiction, characterized by loss of control over use, compulsive use, and continued use despite negative consequences on one's social, physical, or psychological health.

Having read and discussed the information provided, if you fully understand the risks and guidelines associated with opioid medications and agree to comply with this agreement, please sign below. If you have any doubts or further questions, discuss them with your physician before signing.

Pill Count Policy:

At Relief Spine & Pain Center, we are committed to minimizing the potential for drug misuse among our patients. To support this commitment, we have established a Pill Count Policy in conjunction with our Urine Drug Screening (UDS) policy.

Policy Implementation:

Providers may request a random pill count for patients under the following circumstances:

1. **Inconsistent Urine Drug Screens (UDS):** Any discrepancies noted during routine UDS may trigger a pill count.
2. **External Allegations:** Should there be allegations from any source regarding a patient's misuse of their medication, a pill count may be requested.
3. **Suspicious Behavior:** Observations of behavior that suggest misuse of medications will also warrant a pill count.
4. **Prescription Drug Monitoring Program (PDMP) Alerts:** Alerts received via PDMP indicating prescriptions from multiple providers may lead to a pill count.

Procedure and Documentation:

When a patient is brought in for a random pill count, all pertinent details must be meticulously documented in the patient's medical chart. On request, the patient has 3 hours to bring in opioid medication to be counted by our staff. Bring the medication in its original bottle given by the pharmacy. It is the patient's responsibility to have a working phone number that is checked regularly for messages. Please note that missing the phone call is not a valid excuse for missing a pill count.

- **If the pill count is correct:** This will be noted in the chart, and the patient will continue to receive care at Relief Spine & Pain Center.
- **If the pill count is inconsistent and the patient lacks a reasonable explanation:** The physician may use their discretion to discontinue the physician-patient relationship. In such cases, the patient will be provided with a list of recommended Pain Management Providers and Substance Abuse Treatment Programs available in the area.

Patient's Agreement:

I agree to abide by the rules and conditions stated. I consent to random and scheduled substance screenings and understand that any breach of this contract may result in my doctor ceasing to prescribe these medications. I also consent to share my prescription information with relevant parties and understand no guarantees about outcomes are provided.

Preferred Pharmacy: _____

Pharmacy Contact Number: _____

Patient Signature: _____

Date and Time: _____

Witness Signature: _____

Date and Time: _____

Provider Confirmation:

I confirm that I have provided the patient with educational materials regarding the use of opioid medications and have thoroughly discussed potential risks and alternatives. The patient understands and agrees to the terms outlined.

Provider Signature: _____

Date and Time: _____

Notice of Privacy Policies

Effective Date: May 11, 2024

Introduction: This Notice of Privacy Practices ("Notice") describes how Relief Spine and Pain Center, LLC may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI.

Our Responsibilities: Relief Spine and Pain Center, LLC is required by law to:

- Maintain the privacy of your PHI.
- Provide you with this Notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Accommodate your reasonable requests to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, a revised Notice will be available upon request, in our office, and on our website.

Uses and Disclosures of PHI: Your PHI may be used and disclosed as follows:

- **Treatment:** We will use and disclose your PHI to provide, coordinate, or manage your medical treatment and any related services.
- **Payment:** Your PHI will be used, as needed, to obtain payment for your health care services.
- **Healthcare Operations:** We may use or disclose your PHI to support the business activities of our practice.
- **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- **Communication with Family:** Health professionals may disclose to a family member, other relative, or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.
-

Your Rights: You have the following rights regarding the PHI we maintain about you:

- **Right to Inspect and Copy:** You can inspect and copy PHI that may be used to make decisions about your care.
- **Right to Amend:** You can ask us to amend your information if you believe it is incorrect or incomplete.
- **Right to an Accounting of Disclosures:** You can request an accounting of disclosures where such disclosures were not made for treatment, payment, or healthcare operations.
- **Right to Request Restrictions**: You can request a restriction on the use or disclosure of your PHI.
- **Right to Request Confidential Communications:** You can request that we communicate with you in a certain way or at a certain location.
- **Right to a Copy of This Notice:** You may ask for a copy of this Notice at any time.

Changes to this Notice: We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. We will post a copy of the current notice in our facility.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with us or with the Secretary of Health and Human Services. To file a complaint with us, contact our Privacy Officer. All complaints must be in writing.

Contact Information: For more information or to file a complaint, please contact:
Privacy Officer, Relief Spine and Pain Center, LLC
Address: 1403 Old Waterworks Road SW, Fort Payne, AL 35968
Phone: 256-646-7246

Acknowledgment:
I have read and understand these policies and agree to abide by their guidelines.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
Legal Representative	Relationship to Patient

PRACTICE POLICIES

Identification Verification: At every appointment, you are required to present valid photo identification along with your insurance details, including primary and secondary insurance cards if applicable. It is your responsibility to keep us updated on any changes to your personal or insurance information.

Referral and Authorization Requirements: Some insurance plans may require a referral from your primary care provider or pre-authorization for procedures. If required and deemed necessary by your provider, please allow 7-10 business days for processing. Opting for services without prior authorization may result in personal financial responsibility for those services.

Payment of Co-pays and Deductibles: All co-pays and deductibles are due at the time of service as mandated by your insurance agreement.

Charges for Accessing Medical Records: A fee may be charged to cover the cost of copying and sending medical records, which includes supplies, labor, and postage if mailed.

Administrative Fees for Non-Clinical Forms: A $50 fee is required in advance for the completion of non-medical forms such as jury duty excuses, Family Leave Act applications, and others. Please allow 7-10 business days for form completion.

Appointment Timeliness Policy: You are required to arrive on time for your appointments. Late arrivals may result in rescheduling or waiting for an available opening. Delays can occur due to emergencies or complex patient needs, impacting scheduled times. Habitual lateness may lead to dismissal from our practice.

Appointment Rescheduling: Please notify us at least 24 hours in advance if you need to reschedule your appointment.

Missed Appointment Policy: Missing an appointment without 24-hour notice incurs a $50 charge for office visits and $100 for procedure visits. Multiple missed appointments may lead to dismissal from our practice.

Payment for Returned Checks: A $25 fee will be imposed for any returned check, and subsequent checks will not be accepted.

Self-Pay Patients: Patients without insurance or those not covered by a participating plan are required to pay at the time of service: $200 for new patient visits and $150 for follow-ups. This policy also applies to liability and workers' compensation cases, with no acceptance of attorney letters or contingency payments.

Exclusions: We do not treat patients with pending legal cases including motor vehicle accidents, workers' compensation claims, or those who have engaged legal representation concerning medical conditions. We also do not conduct disability evaluations or issue disability approvals.

Accepted Payment Methods: We accept major credit cards, checks for amounts under $200, money orders, and cash.

Medication Refill Policy: At Relief Spine & Pain Center, we are committed to managing your treatment plan with the highest level of care. Ensuring that you have continuous access to your prescribed medications under safe and regulated conditions is a key part of our commitment.

1. **Prescription Agreement:** Patients must have a signed and current opiate prescribing agreement in place. This is to ensure safe and monitored use of pain management medications.
2. **Regular Appointments:** To qualify for refills, patients must be seen regularly by their physician. For controlled substances, monthly evaluations are typically required. These regular visits allow us to assess the effectiveness of your treatment and make any necessary adjustments.
3. **Toxicology Screenings:** As mandated by law, patients on certain medications must undergo periodic toxicology screenings. These screenings are crucial for ensuring safety and compliance with your treatment plan.
4. **Processing Time:** Medication refill requests typically require 24 to 48 hours to process. We strive to handle all requests promptly; however, unforeseen delays can occur, especially when dealing with insurance companies.
5. **Prior Authorizations:** If a medication requires prior authorization, our staff will initiate this process on your behalf. While we provide this service to facilitate timely access to medications, please be aware that the review period is controlled by your insurance provider, which typically takes up to three days after our submission**.**
6. **Restrictions on Refill Timing**: Refills for narcotics and certain controlled substances are not processed on Weekends or after regular business hours. This policy is in place to ensure that all prescriptions are handled during business hours, allowing for proper oversight and communication with the pharmacy.
7. **Emergency Refills:** We understand that emergencies happen; however, medication refills are generally not considered emergencies. If you find your medication running low, please contact us during business hours well in advance to avoid gaps in your medication therapy.
8. **Communication with Pharmacies:** If you need a refill, please have your pharmacy send a refill request to our office directly. This standardizes the process and helps prevent errors. We will review and respond to these requests during our normal business hours.

By signing below, you acknowledge and agree to adhere to these policies, understanding that they are put in place to ensure the safe and effective use of medication under the care of Relief Spine and Pain Center.

Acknowledgment:

I have read and understand these policies and agree to abide by their guidelines.

Patient's Printed Name	Date of Birth (MM/DD/YYYY)
Signature of Patient (or Legal Representative for Patient)	Date
Legal Representative	Relationship to Patient