Pain & Spine INSTITUTE

General and Financial Policy

Our Mission: At Pain & Spine Institute, we offer a multidisciplinary evaluation/treatment for acute and chronic pain syndromes, as well as cancer pain. Our goal is to achieve maximum pain relief for the greatest length of time possible and to facilitate the return to a normal productive life.

Office Hours: Monday – Friday 8:00am – 5:00pm

Appointments: Please call during regular clinic hours. If you are unable to keep your scheduled appointment, please let the office know as far in advance as possible. If you call to cancel with less than 24 hours' notice, you may be subject to a cancellation fee of $35 and if you No Show for your scheduled appointment you will be charged $50. If you No Show or Cancel your appointment 3 times or more, you will be discharged from our practice. It is the responsibility of the patient to be at your scheduled appointment, reminder communication is a courtesy. If you are late for your appointment, you will be asked to reschedule.

Appropriate Conduct: We have a zero-tolerance policy for any patient who behaves inappropriately to staff, other patients, or providers. You will be discharged from our clinic immediately.

Medical Forms: Pain & Spine Institute management charges a flat fee of $25 prior to completion (you may be subject to an FCE test before any forms will be filled out), which applies to forms that need to be completed and signed by the provider. Forms will only be received during a scheduled appointment with the provider and can take up to 7 to 10 days business days to be completed.

Financial Policy: All patients should provide accurate and complete personal and insurance information prior to being seen by the provider. All applicable co-pays and personal balances are due at the time of service. We accept Cash, Personal Checks, Visa, Master Card, and American Express.

Insurance: We participate in many insurance plans, please read, and understand your insurance policy. It is your responsibility to know what your policy covers. Always have your insurance card available for each visit. Some insurances require a referral or prior authorization from a primary care provider. It is your responsibility to obtain this information prior to your visit.

Usual and Customary Rates: With market research, we charge reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any remaining balances.

Returned Checks: For checks returned to us for non-sufficient funds by your bank, you will be charged a $35 fee.

Insurance Denials: If any date of service is denied by the insurance carrier for ineligibility or no referral, the remaining balance will be turned over to patient responsibility.

Insurance Non-payment: If a claim is 45 days old and there has not been a response from the insurance carrier, the balance due will be turned over to patient responsibility for payment.

Delinquent Accounts: If your account is delinquent by more than 90 days, you will receive a letter and a call from our billing department notifying you that a payment is due before you can schedule any further appointments. If a payment or a payment plan is not made, your account will be turned over to a collection's agency.

I have read and understand Pain & Spine Institutes General and Financial Policies.

Patient Name:_____

Patient Signature:_____ Date:_____

Pain & Spine INSTITUTE

Contract for Controlled Substance Medication Prescriptions

We are committed to doing all we can to treat your pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of pain and related conditions, all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper controlled substance use.

1. All controlled substances have a potential for dependency and abuse.

2. All controlled substances must come from a Pain & Spine Institute provider unless specific authorization is obtained for an exception. If controlled substances are obtained from an unauthorized health care provider, the incident may be reported to primary physician and other authorities.

3. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies our office must be informed. Pharmacy Name:_____Phone:_____

Address: _____

4. The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for the purpose of maintaining accountability.

5. I may not share, sell, or otherwise permit others including spouse or family members to have access to these medications.

6 Unannounced urine or serum toxicology screens may be requested, and my cooperation is required. Presence of unauthorized substances may result in my discharge from our practice.

7. I will consume no amounts of alcohol in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal drugs. I agree to help myself by trying to change my behavior to include a healthier lifestyle including stopping smoking, diet, weight control and exercise.

8. Medication may not be replaced if they are lost, stolen, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. My report narrating what happened is not enough.

9. If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived, and these authorities may be given full access to our records of controlled substance administration.

10.Medications are to be taken as directed. I will not increase medication myself. Early refills will not be given. Renewals are based on keeping scheduled appointments. I will not phone for prescription refills; however, I will call to schedule an appointment for that refill.

11.In the event I am arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.

12.It is understood that failure to adhere to these policies may result in immediate cessation of therapy with controlled substance prescribing by this physician and our practice.

13.I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand, and accept its terms.

Patient's full name _____

Patient's signature_____ Date: _____

Pain & Spine INSTITUTE

CONSENT FOR THE USE AND DISCLOSURE OF HEAL TH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS ACCORDING TO HIPAA LAWS

I, _____, understand that as part of my health care, Pain and Spine Institute originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
- You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
- We agree to provide patients with access to their records in accordance with state and federal laws.
- You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request
- We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment, or health care operations.

I understand that Pain and Spine Institute is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the code of Federal Regulations.

I further understand that Pain and Spine Institute reserves the right to change their notice and practice and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Pain and Spine Institute change their notice, they will send a copy of any revised notice to the address I've provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient Name: _____

Patient Signature:_____ Date:_____

Pain & Spine INSTITUTE

NOTICE OF PRIVACY PRACTICES

Effective Date: *08/09/2021*

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.

Section A: Who Will Follow This Notice?
This Notice describes *Pain-Spine Institute's* (hereafter referred to as 'Provider') Privacy Practices and that of:

Any workforce member authorized to create medical information referred to as Protected Health Information (PHI) which may be used for purposes such as Treatment, Payment, and Healthcare Operations. These workforce members may include:

- All departments and units of the Provider.
- Any member of a volunteer group.
- All employees, staff, and other Provider personnel.
- Any entity providing services under the Provider's direction and control will follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for Treatment, Payment or Healthcare Operational purposes described in this Notice

Section B: Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the Provider. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated or maintained by the Provider, whether made by Provider personnel or your personal doctor.

This Notice will tell you about the ways in which we may access, disclose and exchange medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Make easily available to you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect.

Section C: How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, health care students, or other Provider personnel who are involved in taking care of you at the Provider. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different departments of the Provider also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the Provider who may be involved in your medical care after you leave the Provider, such as family members, clergy or others we use to provide services that are part of your care.

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

- **Healthcare Operations.** We may use and disclose medical information about you for Provider operations. These uses and disclosures are necessary to run the Provider and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many Provider patients to decide what additional services the Provider should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, health care students, and other Provider personnel for review and learning purposes. We may also combine the medical information we have with medical information from other Providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning a patient's identity.

- **Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the Provider.

- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

- **Health & Related Benefits and Services.** We may use and disclose medical information to tell you about health & related benefits or services that may be of interest to you.

- **Emergencies.** We may use or disclose your medical information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your consent. If this happens, we will try to obtain your consent as soon as we reasonably can after we treat you.

- **Communication Barriers.** We may use and disclose your health information if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

- **Facility Directory.** We may include certain limited information about you in the Facility Directory while you are a patient of the Provider. This information may include your name, location in the Provider, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The Provider Directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the Provider and generally know how you are doing.

- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care and we may also give information to someone who helps pay for your care, unless you object and ask us not to provide this information to specific individuals, in writing. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the Provider. We will

almost always generally ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the Provider.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **E-mail Use.** E-mail will only be used for communications with you following this organization's current policies and practices and with your permission. The use of secured, encrypted e-mail is encouraged.

- **Notice of Privacy Practices (NPP) Distribution.** The Privacy Rule requires a covered entity that maintains a web site providing information about the covered entity's services or benefits to prominently post its NPP on its web site.

  When we first delivery health care service to an individual electronically, such as through e-mail, or over the Internet, we may send an electronic NPP automatically and contemporaneously in response to the individual's request for service.

  We may e-mail an NPP to an individual if the individual agrees to receive an electronic NPP (although the individual always retains the right to receive a paper copy of the NPP upon request).

  We will make the latest notice (i.e., the one that reflects any changes in privacy policies) available at our office or facility for individuals to request to take with them, and post it in a clear and prominent location at the facility.

Section D: Special Situations

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

  - to prevent or control disease, injury or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
  - to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a

subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

    - in response to a court order, subpoena, warrant, summons or similar process.
    - to identify or locate a suspect, fugitive, material witness, or missing person;
    - about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - about a death we believe may be the result of criminal conduct;
    - about criminal conduct at the Provider; and
    - in emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

- **Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the Provider to funeral directors as necessary to carry out their duties.

- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Section E: Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

- **Right to Access, Inspect, Copy and Direct Copies to be Sent.** You have the right to access and inspect or have copies of your record of the medical information that may be used to make decisions about your care, with a few exceptions. Copies may be requested for yourself or you may opt to have them sent to any party you wish. Such access, inspection or copies will be provided to you in a timely manner, typically not more than 30 days after you make the request. Usually, this includes medical and billing records, but may not include psychotherapy notes.

- If we maintain your information electronically you may request a copy of your records via a mutually agreed upon electronic format. If we fail to agree upon an electronic format for delivery of electronic copies, we will provide you with a paper copy for your records. This organization will comply with all Health Information Portability and Accountability Act (HIPAA) and 21st Century Cures Act rules. These rules assist our patients and their personal representatives with access, disclosure and exchange of their electronic health information.

- If you request a copy of the information in either paper or electronic format, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

- We may deny your request to provide access to inspect and copy medical information in certain very limited circumstances. If you are denied access to medical information, in some cases, you may request that the denial be reviewed. Another licensed health care professional chosen by the Provider will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information, we have about you is incorrect or incomplete, you may request us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Provider. In addition, you must provide a reason that supports your request.

- We may deny your request for an amendment if; it is not in writing or does not include a reason to support the request or for other reasons. Typical reasons for denial of an amendment request include if you ask us to amend information that:

    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical information kept by or for the Provider;
    - Is not part of the information which you would be permitted to inspect and copy; or
    - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an 'Accounting of Disclosures'. This is a list of the disclosures we made of medical information about you. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically, if available). The first list you request within a 12-month period will be complimentary. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. We require that any requests for use or disclosure of medical information be made in writing. In some cases we are not required to agree to these requests, however if we do agree to them we will abide by these restrictions. We will always notify you of our decisions regarding restriction requests in writing.

  You have the right to request, in writing, a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to whom you want the limits to apply, for example, disclosures to your spouse.

  You also have the right, which we may not refuse (except as listed below), to restrict use and disclosure of your medical information about a service or item for which you have paid completely out of pocket, for payment (e.g., your insurance company) and operational (but not treatment) purposes, if you have completely paid your bill for this item or service. We are not required to accept your request for this type of restriction until you have completely paid your bill (zero balance) for this item or service or if the request is contrary to any law. We are not required to notify other healthcare providers of these types of restrictions, that is your responsibility.

- **Right to Receive Notice of a Breach.** We are required to notify you under the HIPAA rules by first class mail or by e-mail (if we offered and you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or hard copy or e-mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Section F: Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to the Provider for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current Notice in effect.

Section G: Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Provider or with the Secretary of the Department of Health and Human Services; http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

To file a complaint with the Provider, contact the individual listed on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you believe you have been subject to information blocking you may file a complaint with the office of the Inspector General (OIG).

Section H: Other Uses of Medical Information

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

Revised Date: July 21, 2021.

If you have any questions about this Notice of Privacy Practices ('Notice'), please contact:
Privacy Officer: Amy King Compliance Officer / HIPAA Privacy Officer Email: amy@dxtxpas.com

ACKNOWLEDGEMENT OF RECEIPT

Notice of Privacy Practices

Printed Patient Name: _____

Patient Birth Date: _____

I hereby acknowledge that I have reviewed the HIPAA Notice of Privacy Practice document.

_____ _____
Signature of patient or patient's representative/parent Date

_____
Printed name of patient or patient's representative/parent

_____
Relationship to patient