North American Spine & Pain
404 Creek Crossing Blvd
Hainesport, NJ 08036
P 609-845-3988
F 609-288-6078
www.naspacmd.com

NEW PATIENTS MAY NOT BE PRESCRIBED OPIOIDS DURING THEIR FIRST VISIT DEPENDING UPON THE OUTCOME OF YOUR INITIAL ASSESSMENT

Date: _____

Name: _____ DOB: _____
Last First M

Address: _____
Street City State Zip Apt Number

Primary Phone: _____ **Secondary Phone:** _____

Email Address: _____

Sex: ☐Male ☐Female **Race:** _____ **Age:** _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow

Current Employment Status: Please check one:

☐Full Time ☐Part-time ☐ Unemployed ☐ Retired ☐ Disability

Name of Employer: _____

Address: _____

Phone Number: _____

Primary Insurance: _____ ID#_____ Group#_____

Subscriber Name: _____ DOB: _____ SS #: _____

Secondary Insurance: _____ ID#_____ Group# _____

Subscriber Name: _____ DOB: _____ SS #: _____

Prescription Insurance: _____ID#: _____ RX BIN#_____

Referring Physician: _____**Primary Care Physician:** _____

What is the main problem for which you are seeking treatment?

_____

How long have you had your current pain problem? _____ Years _____Months

Onset of Pain: How did your current pain problem start (**Check one**):

Injury at work: _____ Injury, not at work: _____ Motor vehicle accident: _____

Illness, non-injury: _____

 Workers Comp: _____
 Auto Insurance: _____

Policy # _____

Claim Number: _____

Date of Injury: _____ What state did the accident / incident occur in? _____

Adjuster Name: _____ Phone: _____ Fax: _____

Attorney Name: _____ Phone: _____ Fax: _____

Severity of Pain: In general, over the past month, the intensity of my pain has been (**Circle one**)

Mild Moderate Moderate – Severe Severe

Timing of Pain: How often do you have your pain (Check one):

☐Constantly (100% of the time) ☐Near Constantly (60 to 95% of the time)

☐Intermittently (30 to 60 % of the time) ☐Occasionally (less than 30% of the time)

Pain/ Symptom Quality: How would you describe your pain? (Please check all that apply)

☐ Burning ☐Pressure-like ☐Sharp ☐Shooting ☐Cutting ☐Throbbing☐ Cramping

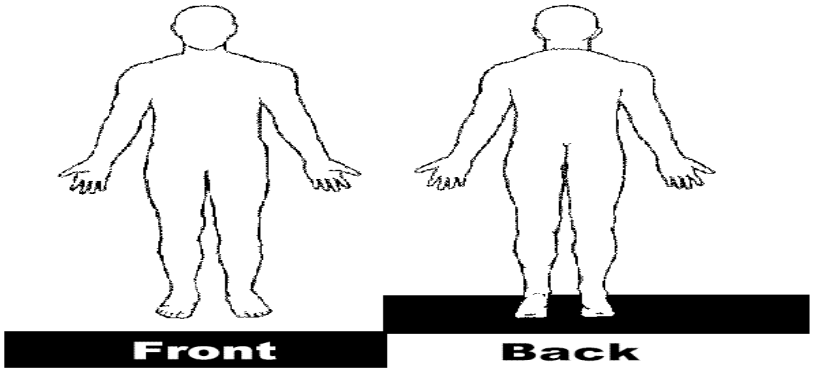
☐ Dull/Aching ☐ Other (describe) _____

Associated with pain, I feel the following: ☐ Numbness ☐ Pins and needle

I have weakness in my:

- ☐ Upper extremities
- ☐ Lower extremities
- ☐ Dropping Objects
- ☐ Falling
- ☐ Loss of bladder or bowel control, if so explain_____
- ☐ Other: _____

Pain Location: Please mark the locations (s) of your pain on the diagrams below with an "x". If whole areas are painful, please shade I these areas.



Relieving and Aggravating Factors: How do the following affect your pain? (Please Check on for each item)

	Decrease	No Change	Increase
Lying Down			
Standing			
Sitting			
Walking			
Exercise			
Relaxation			
Bowel Movement			
Coughing/Sneezing			

Activities and Your Pain:

Does your pain limit your ability to walk? ☐ Yes ☐ No
How long can you sit? ☐ None ☐ 30 Minutes ☐ 1 Hour ☐ 2> Hours
How long can you stand? ☐ None ☐ 30 Minutes ☐ 1 Hour ☐ 2> Hours
To assist with walking, I use a: ☐ Cane ☐ Walker ☐ Wheelchair No assistance Device

Are you **not able** to perform any of the following daily activities? (**Check all that apply**)

☐ Going to work ☐ performing household chores Doing yard work or shopping

☐ Socializing with friends ☐ participating in recreational activities

Previous Pain Treatment: Please check all that apply

☐ Surgery	☐ Nerve block/Injection	☐ Epidural Steroid Injection	☐ Physical Therapy
☐ Exercise	☐ TENS	☐ Heat Treatment	☐ Ice Treatment
☐ Psychotherapy		☐ Biotherapy	
☐ Chiropractic Manipulation		☐ Brace/Traction	

Current Medications: List ANY medications you are currently taking:

Medication Name	Dose	Frequency

Pharmacy Name, Location, and Phone Number:

_____

Allergies: Please indicate the names of any medication to which you are allergic:

_____

What type of reaction did you have?

_____

Are you allergic to contrast dye used for X-ray? Yes No

Prior Medications:

Opioids:	**Anti-depressants:**	**Muscle Relaxants:**
☐ Hydrocodone	☐ Prozac	☐ Soma
☐ Opana/ Opana ER	☐ Zoloft	☐ Skelaxin
☐ Codeine	☐ Effexor	☐ Flexeril
☐ Fentanyl	☐ Pristiq	☐ Baclofen
☐ Dilaudid/ Exalgo	☐ Wellbutrin	☐ Zanaflex
☐ Methadone	☐ Paxil	☐ Robaxin
☐ Oxycodone (Percocet) Valium(Diazepam)		☐
☐ Tramadol		
☐ Nucynta		

All other medications:

NSAIDS/ Tylenol:	**Anti-Anxiety**	**Nerve Pain:**
☐ Tylenol	☐ Klonopin	☐ Neurontin
☐ Asprin	☐ Xanax	☐ Tegretol
☐ Motrin	☐ Valium	☐ Amitriptyline
☐ Naproxen	☐ Ativan	☐ Lyrica
☐ Indocin		☐ Cymbalta
☐ Celebrex		☐ Savella
☐ Toradol		
☐ Mobic		
☐ Ibuprofen		

Additional medications: _____

Past Surgical History: Please list the approximate date and surgery:

_____

_____

_____

Family History: Please specify any medical or psychiatric conditions common in your family who suffers with these ailments:

_____

_____

_____

Social History:

Have you ever been a smoker? ☐ Yes ☐ No If so, how often? _____ For how many years did you smoke? _____ Tobacco use? (Circle one) Light/Moderate/Heavy
Do you drink alcohol? ☐ Yes ☐ No If yes, How often? _____ Do you have a history of alcoholism? ☐ Yes ☐ No ☐ Current Problem
Have you ever abused prescription drugs? ☐ Yes ☐ No ☐ Current Problem
Cocaine or Intravenous substance abuse? ☐ Yes ☐ No ☐ Current Problem

Review of Symptoms: Please check all items you feel are applicable to you:

☐ Recent significant weight gain/ loss		
☐ Fever	☐ Dizziness	☐ Nausea
☐ Double or blurry vision	☐ Difficulty swallowing	☐ Vomiting
☐ Constipation	☐ Diarrhea	☐ Genital Pain
☐ Chest Pain	☐ Memory Loss	☐ Wheezing
☐ Heart palpitations	☐ Shortness of breath	☐ Rash
☐ Seizures	☐ Diabetes	☐ Adrenal Disease
☐ Joint stiffness	☐ Muscle Weakness	☐ Hypothyroidism
☐ Hyperthyroidism	☐ Difficulty walking	☐ Decreased range of motion
☐ Loss of consciousness	☐ Easy or excessive bruising	☐Easy or excessive bleeding
☐ Difficulty urinating		
☐ Swelling (specify) _____		
☐ Pain in extremity (specify) _____		
Any additional information:		

Past Medical History: Check all that apply

☐ Hypertension ☐ Coronary Artery Disease ☐ Angina or Chest Pain ☐ Heart Attack

☐ Diabetes ☐ Asthma or Wheezing ☐ Emphysema ☐Kidney Disease

☐ Liver Disease ☐Stroke ☐ Seizure or Epilepsy ☐ Bleeding Problem

☐ Depression ☐ Anxiety ☐ Thyroid Disease ☐ HIV

☐ Hepatitis C

☐ Arthritis – specify location: _____

☐ Cancer – specify location: _____

☐ Other: specify: _____

Psychological Treatment:

Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including pain?

☐ Yes, treated for? _____ ☐No

Have you ever considered/ planned/ attempted suicide? ☐Yes ☐No
If so, when? _____

Sleep Disturbances:

Do you have difficulty sleeping? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Are you tired upon awakening? ☐ Yes ☐ No

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DISCLOSURE OF FINANCIAL INTEREST

State requirements and the Centers for Medicare & Medicaid Services requires that we disclose to patients a physician's financial interest in an ambulatory surgical center or other health center to which the physician refers his or her patients. The following physicians have a 100% financial interest in North American Spine and Pain locations throughout New Jersey, Delaware and Pennsylvania:

Dr. Abhijeet Rastogi, MD
Dr. Kieran Slevin, MD

Please sign below to acknowledge that you have been informed of the ownership interest in the above entities:

PATIENT'S NAME (Please Print)_____ DATE_____

PATIENT'S SIGNATURE _____

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PAYMENT FOR MEDICAL SERVICES

I hereby assume financial responsibility for all charges Insured for services rendered as allowed under state and/or federal law. I understand that I may be required to pay co-payments, amounts applied to deductibles and balances of bills not paid in accordance with the benefits of my current insurance policy if allowable. If I am unable to make payment in full for my medical treatment within 30 days, I agree to call the business office and make payment arrangements.

I hereby authorize payment for all medical Insurance benefits, which are payable under the terms of my insurance policy, to be paid directly to North American Spine & Pain or designated for services rendered. In the event that I receive such payment, I agree to deliver same to North American Spine & Pain within 10 days of receiving same.

I certify that the information I have reported regarding my insurance coverage is correct. I authorize the doctor's office to verify insurance coverage and benefits allowed in accordance with my insurance company's policy.

I understand that in the event of non-payment, if I direct any third party to bill North American Pain & Spine, it is my full responsibility, in accordance with the benefits of my current insurance policy to pay immediately.

It is further agreed that in the events I fail to pay upon demand, should my account be referred to an outside collection agency and/or attorney, I accept full responsibility to pay all collection costs not to exceed 30% of the amount then due with interest of 1.5% per month and not to exceed 18% per annum and reasonable court cost and reasonable attorney's fees. I also agree that any action commenced to collect my account shall be brought in Burlington County, New Jersey.

× _____ × _____

Patient or Legal Guardian Signature Date

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MISSED APPOINTMENT POLICY

Please be aware that by scheduling an initial consultation with our physicians, you are agreeing to abide by the billing policies of our practice. To better serve all our patients, we require a 24-hour notification should you need to cancel or reschedule your appointment. Should you miss or reschedule your appointment with less than 24-hour notice, you may be charged 35$ for office visits and 65$ for procedures. This payment will be due at the time of your next appointment. Your insurance company does not cover missed appointment fee. therefore it may be your responsibility to pay it.

× **Initials:** _____ × **Date:** _____

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NOTICE OF PATIENT PRIVACY RIGHTS

This notice describes how medical information about you may be used and disclosed and how you can access to this information. Please review it carefully.

Copy of Your Medical Records: You can get an electronic or paper copy of your medical record and other health information we have about you, usually within 30 days of your request. We do charge a reasonable fee based upon state law limits. Please ask the receptionist for information on our fees.

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

Request Confidential Communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address to maintain your privacy. We will say "yes" to all reasonable requests. We will also obtain that information from you today.

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

Whether or How We've Shared Your Information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask which includes who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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

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

You Can File a Complaint If You Believe Your Rights Have Been Violated: You can complain if you feel we have violated your rights by contacting our Compliance/Privacy Officer by calling (609) 845-3988 or contact any of our offices and you will be directed to them. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.**

Your Choices: For certain health information, you can tell us your choices about what we share. In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care OR Share information in a disaster relief situation**.** If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, however, we never share your information unless you give us written permission: 1. Marketing purposes or 2. Sale of your information.

Our Uses and Disclosures: We typically use or share your health information to treat you; to run our practices, improve your care, and contact you when necessary. We can use and share your health information to bill and get payment from health plans and other entities so they can pay for you. We are allowed or required to share your information for the public good, such as public health and research and only if we meet the conditions in the law before we do so. For more information please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues: We can share health information about you for certain situations such as: Preventing disease; Helping with product recalls; Reporting adverse reactions to medications; Reporting suspected abuse, neglect, or domestic violence; and Preventing or reducing a serious threat to anyone's health or safety

To Do research: We can use or share your information for health research but only within the law.

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

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when someone dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you: For workers' compensation claims; For law enforcement purposes or with a law enforcement official; With health oversight agencies for activities authorized by law; For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our offices, and on our web site.

Effective Date: 4/26/18

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RELEASE OF MEDICAL RECORDS

Authorization for Use or Disclosure of Protected Health Information

1. **Authorization**

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. **Effective Period**

This authorization for release of information covers the period of healthcare from:

A. □ _____ to _____.

OR

B. □ all past, present, and future periods.

3. **Extent of Authorization**

A. □ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse, other pertinent information unless excluded (see below)).

OR

B. □ I authorize the release of my complete health record with the exception of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Genetic Testing Results
□ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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

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

× _____
Signature of patient or personal representative

× _____
Printed name of patient or personal representative and his or her relationship to patient

× Patient Initials: _____ × Date: _____

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Patients Rights

1. The patient has the right to receive considerate and respectful care.

2. The patient has the right to know the name of the physician responsible for coordinating his/her care.

3. The patient has the right to obtain information from his or her physician in terms that can be reasonably understood. Information may include, but is not limited to his or her diagnosis, treatment, prognosis, and medically significant alternatives for care or treatment that may be available. When it is not medically advisable to share specific information with the patient, the information should be made available to an appropriate person in his or her behalf. When medical alternatives are to be incorporated into the plan of care, the patient has the right to know the name of the person(s) responsible for the procedures and/or treatments.

4. The patient has the right to obtain the necessary information from his or her physician to give informed consent before the start of any procedure and/or treatment. Necessary information includes, but is not limited to, the specific procedure and/or treatment, the probable duration of incapacitation, the medically significant risks involved, and provisions for emergency care.

5. The patient has the right to expect this accredited ambulatory surgery facility will provide evaluation, services and/or referrals as indicated for urgent situations. When medically permissible, the patient or designated support person(s) will receive complete information and explanation about the need for and alternatives to transferring to another facility. The facility to which the patient is to be transferred must first have accepted the patient for transfer.

6. The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his or her action.

7. The patient has the right to obtain information about any financial and/or professional relationship that exists between this facility and other health care and educational institutions insofar as his or her care is concerned. The patient has the right to obtain information about any professional relationships that exist among individuals who are involved in his or her procedure or treatment.

8. The patient has a right to be advised if this accredited ambulatory surgery facility proposes to engage in or perform human experimentation affecting his or her care or treatment. The patient has the right to refuse to participate in research projects.

9. The patient has the right to every consideration for privacy throughout his or her medical care experience, including but not limited to, the following. Confidentiality and discreet conduct during case discussions, consultations, examinations, and treatments. Those not directly involved in his or her care must have the permission of the patient to be present. All communications and records pertaining to the patient's care will be treated as confidential.

10. The patient has the right to expect reasonable continuity of care, including, but not limited to the following. The right to know in advance what appointment times and physicians are available and where. The right to have access to information from his or her physician regarding continuing health care requirements following discharge.

11. The patient has the right to access and examine an explanation of his or her bill regardless of the source of payment.

12. The patient and designated support person(s) have the right to know what facility rules and regulations apply to their conduct as a patient and guest during all phases of treatment.

Patient Responsibilities

It is the patient's responsibility to participate fully in decisions involving his or her own health care and to accept the consequences of these decisions if complications occur.

It is the patient's responsibility to follow up on his or her physician's instructions, take medications when prescribed, and ask questions that immerge concerning his or her own health care.

It is the patient's responsibility to provide name of support person in case of emergency, and have this support person available when advised to do so.
Direct any care concerns or complaints to:

The Compliance Officer: Melinda Tobin, Phone: (856) 942-1187: Email:mtobin@naspacmd.com

And the Office of the Medicare Beneficiary Ombudsman Phone: 1-800-MEDICARE (1-800-633-4227) Website:http://www.medicare.gov/claims-andappeals/medicare-rights/get-help/ombudsman.html

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Dear Patient:

Although we will submit all necessary information to your insurance company for timely reimbursement, your insurance company may send insurance payments (checks) directly to you. However, we will be submitting both a signed limited power of attorney and an assignment of benefits on your behalf which will require them to send the checks to us for payment of your treatments.

Payments sent to you for our treatments, whether from primary or secondary insurance companies, are required to be used to pay outstanding charges to North American Spine & Pain.

If you receive a check, either deposit the insurance check and send us a personal check or forward the insurance check to us as soon as possible.

You will remain financially responsible for all outstanding charges should you choose to keep the check.

Thank You.

North American Spine & Pain

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ASSIGNMENT OF BENEFITS & LIMITED POWER OF ATTORNEY

Assignment of Benefits Form & Release

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

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

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

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

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

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

I authorize the release of any information pertinent to my case to any insurance company, adjuster, and/or attorney involved in this case. I authorize NASPAC to be my personal representative, which allows it to: (1) submit any and all appeals when my insurance company denies me benefits to which I am entitled; (2) submit any and all requests for benefit information from my insurance company; and (3) initiate formal complaints to any state and/or federal agency that has jurisdiction over my benefits; and (4) initiate and defend any litigation on my behalf.

I understand and agree that I am responsible for full payment of the total charges if my insurance company has refused to pay 100% of my benefits based on billed charges within ninety days of any and all appeals or requests for information. Should my account be referred to an attorney or outside agency for collection, I agree to pay NASPAC reasonably attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the maximum rate not more than 30% interest per anum. I understand and agree that fines levied against my insurance company will be paid to NASPAC for acting as my personal representative.

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

_____

Print Patient Name

_____

Patient Signature

Date _____/_____/_____

CONSENT FOR COMMUNICATING PATIENT HEALTH INFORMATION BY VOICEMAIL OR EMAIL

I understand that members of the North American Spine & Pain team will at times need to contact me.

□ I DO give permission to North American Spine & Pain to leave a message with relevant medical information on my □ Home Phone □ Cell Phone □ Work Phone and/or □ Email regarding communication of my medical care such as instructions related to treatment, clinical, billing and/or appointment needs.
□ I DO NOT give permission to North American Spine & Pain to leave a message on my home phone, cell phone, work phone, or email regarding communication of my medical care such as instructions related to treatment, clinical, billing and/or appointment needs. I understand that selecting this option may result in delayed communication of pertinent information treatment related details, appointment confirmations, billing communications, or call backs. I understand that I will be responsible to follow up to obtain this information.
List below any individual(s) whom you authorize access to your medical information and/or authorize us to leave a detailed message regarding all aspects of your medical care, financial history, or other information pertinent to your treatment, payment or our operations
Name: _____Relationship to Patient _____ **Contact Number: _____Email: _____**
Name: _____ Relationship to Patient: _____ **Contact Number: _____Email: _____**
I understand that I may change and/or revoke this authorization at any time by notifying North American Spine and Pain in writing by completing an updated form. This authorization expires upon written notice.
Patient Signature: _____ **Date:_____**
If patient is under 18 and not an emancipated minor, a parent/guardian name and signature required: I attest that I am the parent or legal guardian of the minor named above, they are not an emancipated minor, and I have the legal authority to execute the above release. Name:_____ Date:_____

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CONTROLLED SUBSTANCE AGREEMENT

I, _____ phone# (_____)_____, have read and understand the following agreement. I agree to abide by it if I am placed on time contingent or as needed controlled substances. I have been fully open with my pain management physician and have revealed any history of previous substance abuse and all currently prescribed medication by other physicians.

1. Medications will be taken as directed by my physician. I will have enough medication to last until my next visit. If I run out of medication PRIOR to my next appointment, NO ADDITIONAL MEDICATION CAN BE AUTHORIZED.

2. I understand that I need to have a monthly appointment with my physician or nurse practitioner for medication management. I further understand that refill issues will only be discussed by phone on Mondays and Thursdays in an urgent situation. Phone calls will not be returned on refill issues other days of the week. Refills are NEVER made over the weekends.

3. I understand that controlled substance prescriptions general CANNOT be phoned or faxed to a pharmacy. All prescriptions **must** be filled in the state of New Jersey.

4. I understand that controlled substance prescriptions are MY responsibility. If anything happens to my prescriptions (lost, stolen, flushed down the toilet, etc.), I am personally responsible. Under such circumstances, prescriptions will not be rewritten or reordered.

5. I understand that I am to obtain ALL of my prescriptions for controlled substances only from North American Spine & Pain while under their care. I will notify my pain physician if I receive a controlled substance from any other physician or source. If I violate this and obtain a controlled substance from any other source, or if I give or sell any controlled substance or prescriptions, then I have violated this agreement.

6. If it appears to the physician that there are no demonstrable benefits to my daily function or quality of life from the controlled substance, I will gradually taper my medications as prescribed by the physician. I will not hold North American Spine & Pain or any staff member of North

American Spine & Pain liable for problems caused by misuse, abuse, or discontinuance of controlled substances.

7. I will inform my physician immediately if I develop serious side effects, or to an emergency room due to pain, or if I become pregnant, because if I am of childbearing age, I could give birth to a child physical dependent upon a controlled substance. These issues will be reviewed with my pain management physicians.

8. I understand that if I develop another pain condition (toothache, abdominal pain, etc.) this does not allow me to self-increase my medications. I will see my local doctor, disclose all medication that I am taking and inform North American Spine & Pain of any additional medication that have been ordered prior to taking them.

9. Signs of addiction and psychological dependence will be interpreted as a need for weaning and detoxification.

10. I agree to submit to a urine and / or blood screen to document appropriate blood levels of prescribed analgesics and to detect the use of non-prescribed medication at any time.

I understand that I may be discharged from North American Spine & Pain for any positive result for illegal drugs, for a urine sample that has a temperature reading below 90 degrees, for refusing to give a urine sample when requested or for not showing up at designated off-site lab in the allotted amount of time I am given to arrive there.

×_____
Initials

11. There is risk of excessive sedation when controlled substances are combined with sedatives, hypnotics or depressants such as alcohol. Therefore, I agree to avoid concurrent use of such non-prescribed substances.

12. I recognize that chronic pain represents a complex problem which may benefit from physical therapy, psychotherapy and behavioral modifications strategies to secure increased functioning and improved coping skills. I also recognize that my active participation is extremely important, I will actively participate in ALL aspects of the Pain Management Program and / or any recommendations that I am given for additional treatment.

13. I understand my pain management physician may need to discuss my care with family members or other physicians. I will allow such communication but only with my prior consent and as long as it maintains the confidence of my doctor – patient relationship.

14. I understand that I may be randomly contacted and requested to engage in a pill counting procedure. I will be given 24 hours to present myself to the practice with all of my prescribed controlled substances from the practice or I may be asked to do so prior to my next visit without

prior notice. If I am unable to present myself to the practice within 24 hours as asked, I will present to the nearest pharmacy within 24 hours and follow the instructions provided to me by the medical staff contacting me.

14. I understand that my insurance company will be billed for any testing which North American Spine & Pain feels is necessary in conjunction with my care. If my insurance company does not pay for drug screens or other testing, I will be responsible to pay for these myself, directly to the lab I am assigned if it is appropriate under my payor obligations.

I fully understand that if I do not abide by the above paragraphs, then I may (at my pain physician's discretion) no longer receive any type of controlled substance medication from North American Spine & Pain. I understand that if I have a problem or questions with any of the above paragraphs, I can make an appointment to discuss this with my physician and receive clarification.

×Date: _____

×Patient Name: _____

×Patient Signature: _____

×Witness Signature: _____

×Physician Signature: _____

……

×Employee Signature: _____

I hereby certify that I on the patient's request, have read this contract to the patient as stated above and a copy was given to the patient.

ADVANCED DIRECTIVE

New Jersey law mandates that all health care facilities ask each of their patients whether they have an advance directive (which is sometimes also referred to as a "living will"). At North American Spine and Pain, we have made this question part of the admission process. In addition, we request that if you have an advance directive, **bring a copy of it to North American Spine and Pain prior to or at your next scheduled appointment.**

An advance directive is used by an individual to indicate a voluntary, informed choice of accepting, rejecting, or choosing among alternative courses of medical treatment and allows the individual to give written instructions to those caring for him or her, indicating the type of health care he or she would wish to receive or to reject in the event he or she becomes unable to express these decisions.

There are two different types of advanced directives:

1. **A Proxy Directive** – This is a document in whereby a competent, adult designates a trusted relative or friend to make health care decisions on his or her behalf when he or she is unable to make these decisions.
2. **An Instruction Directive** – In this document, a competent adult provides written instructions concerning the type of medical treatment he or she wants or does not want performed for him or her under what circumstances.

A brochure containing information about advance directives is available from the Division of Aging, if you wish to receive the brochure, please make your request to:

State of NJ
Division of Human Services
The Division of Aging
101 South Broad Street
CN 807
Trenton, New Jersey 08625

PLEASE SEND OR BRING A COPY OF YOUR ADVANCE DIRECTIVE TO NORTH AMERICAN SPINE AND PAIN PRIOR TO YOUR SCHEDULED APPOINTMENT.

Patient Consent for My Provider to File a Complaint/Appeal/Grievance on my Behalf with my Health Insurance Plan

Provider Name:	Provider Plan ID Number:
Provider Address:	
Description of services that may be appealed:	Date(s) services were provided:

I agree to allow North American Spine and Pain to file a complaint/appeal/grievance on my behalf with the following health plan: _____ if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own complaint/appeal/grievance concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file a complaint/appeal/grievance, or stops grieving my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file a complaint/appeal/grievance on my behalf.

Print Patient Name:	Patient Date of Birth:	Health Insurance Company:
Patient Address:		Patient Insurance ID Number:
Patient Signature:		Signature Date:

The above-named enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:	
Print Representative Name:	Relationship to the Patient:
Representative Signature:	Signature Date:

Print Witness Name:	Witness Signature:	Signature Date:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICES

I hereby acknowledge that North American Spine and Pain has provided me with a HIPAA Notice of Privacy Practices and acknowledge that they may use and disclose my health information for HIPAA authorized purposes, such as the purpose of treating me, obtaining payment for services rendered to me, and performing routine healthcare operations and services.

I also acknowledge that I have been provided with the opportunity to determine alternate means of communication by voicemail and electronic notices. I have also been provided the opportunity to determine what information I would like precluded from disclosure as my right and whom North American Spine and Pain can disclose my information to as my choice, which will include information up to and including protected health information (PHI).

I hereby also acknowledge that I was offered and accepted written information concerning Advanced Directives. I have also signed a limited power of attorney to allow the assignment of my benefits to North American Spine and Pain in order for them to receive direct payment from my insurance carrier for my treatment where necessary.

I acknowledge that I agree bring or provide for an escort to take me home on the day of a procedure.

I have also received and accepted information on my rights as a patient (Patient Rights).

× _____ × _____

Patient or Legal Guardian Signature Date

_____

Printed Patient Name or Legal Guardian