Alabama Spine and Pain
Pavan Telang, MD

541 West College Street, Suite 2000
Florence, AL 35630
Phone 256-712-2422
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Authorization, Consent, Release Statements; Insurance, Financial & Other Policies

ASSIGNMENT, CONSENT & RELEASE:
I the undersigned hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician/Alabama Spine and Pain, LLC to submit claims for benefits, for all services rendered or to be rendered, without obtaining my signature on each and every claim submitted and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and other health plans directly to Alabama Spine and Pain, LLC. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Recognizing the need for health care, the patient or his representative consents to services rendered as ordered or instructed by the doctor including medical or surgical treatment, laboratory tests or X-ray examinations. I further authorize Alabama Spine and Pain, LLC to furnish protected health information to my agents, attorney or any insurer, compensation carrier, healthcare facility, welfare agency or any healthcare provider for reasons of financial assistance or continuity of medical care. The patient consents to photographs taken for reference or official use only. This authorization will remain in effect until revoked by me in writing.

MEDICARE AUTHORIZAITON:
I request that payment of authorized Medicare benefits be made on my behalf to Alabama Spine and Pain, LLC for any services rendered to me by that physician/group. I authorize any holder of medical information about me to release to HCFA and its agents any information needed to determine these benefits or the benefits payable for related service. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA 1500 form, or elsewhere on approved claim forms or on electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned claims, Alabama Spine and Pain, LLC agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductibles are based upon the charge determination of Medicare.

INSURANCE, FINANCIAL & OTHER POLICIES:

We welcome the opportunity to discuss any aspect of these policies.

- To ensure the accuracy of your personal information, you are required to update and fill this form on your first visit of each year
- It is your responsibility to give us complete and accurate information regarding your coverage and to keep us updated, in writing, of changes. If your insurance coverage changes, we require that a photocopy of BOTH sides of the card be sent to us IMMEDIATELY. Should a service be rendered and subsequently denied because you failed to provide accurate insurance information, you will be responsible for the total charge and/or any penalty imposed upon.
- It is your responsibility to contact your insurance company to verify eligibility, benefit limitations, co-payment obligation and whether the doctor participates in your plan. Although we may obtain pre-certification if needed, payment is dependent on aforementioned.
- Patients without insurance, or on Spend Down plans, are expected to pay in full at time of service.
- By federal law and/or contract, we are required to collect co-payment. Your insurance company requires any co-pay due be paid at the time of service.
- All deductibles and coinsurance, including the annual Medicare deductible, are due and payable in full at the time of the first billing.
- You are responsible for obtaining any necessary referral from your primary care physician prior to the visit at Alabama Spine and Pain, LLC.
- Alabama Spine and Pain, LLC will not file a secondary claim more than twice. You will be billed for any amount due and you should seek reimbursement from your plan directly.
- Should your health plan request information from you, you are expected to reply promptly or you will be responsible for the entire charge since the plan suspends all reimbursement for pending claims until you reply.
- Balances due are to be paid in full upon receipt. For your convenience we accept credit and debit cards.
- Balances older than 120 days will automatically be sent to a collection agency unless a payment plan has already been established.
- If this account is assigned to a collection agent or attorney for collection and/or suit, Alabama Spine and Pain, LLC may be entitled to reasonable attorney’s fees and costs of collection.
- There is a $30 charge for returned checks.
- There is a pre-paid charge for additional accounting, forms to be filled, records to be copied, and special reports. Allow 5 business days for services to be done.

- There is a $25 charge for missed appointments and cancellations less than 48 hours in advance except in cases of severe weather or unusual circumstances.
- Prescriptions WILL NOT be refilled when office is closed and/or your chart is not available. Please call between 9 am and 2 pm on weekdays.
- WE MUST have the prescription number and pharmacy phone number when you call us. Allow 48 hours for processing.
- It is necessary for you to fill out certain forms at each visit because we are required by law to document every aspect of your visit in writing.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you immediately of any changed in my status or the above information.

I agree to the above and acknowledge receipt of the insurance, financial & other policies:

NOTICE OF PRIVACY PRACTICES

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

OUR RESPONSIBILITIES UNDER HIPAA

In the course of providing health care we generate, collect and share health-related information pertaining to our patients. Traditionally that information was kept confidential by ethical traditions and a patchwork of regulations that vary by State. We have certain responsibilities regarding that information due to Congressional enactment of HIPAA, the Health Insurance Portability and Accountability Act. Under HIPAA, all information in your medical record along with associated billing and payments plus other related demographic data which can be traced back to you as an individual is considered PHI (Protected health Information). This Notice explains how we use and disclose medical information about you and inform you of your rights to access and control that information.

PROTECTED HEALTH INFORMATION USES AND DISCLOSURES

The following are examples of the types of uses and disclosures of your PHI that might occur. Some are more likely to happen than others, some may never happen. These examples are neither exhaustive nor an indication of what we intend to do. They are simply examples of the types of uses and disclosures that could be made by our medical practice without your permission as allowed by HIPAA.

Medical Treatment – We use previously given medical information about you to provide you with current or prospective medical treatment or services. Therefore, we may and most likely will disclose medical information about you to doctors, nurses, technicians, medical students, hospital personnel and surgery center personnel who are involved in taking care of you. For example, a doctor to whom we refer you for ongoing or further care may need your medical record. Different areas of the Practice also may share medical information about you including your records, prescriptions, requests of lab work and x-rays. We may also discuss your medical information with you to recommend possible treatment options or alternatives that may be of interest to you. We also may disclose medical information about you to people outside the Practice who may be involved in your medical care after you leave the Practice, this may include your family members or other personal representatives authorized by you or by a legal mandate (a guardian or other person who has been named to handle your medical decisions, should you become incompetent.)

Payment – We may use and disclose medical information about you for services and procedures so that they may be billed and collected from you, an insurance company, or any other third party. For example, we may need to give your health care information about treatment you received at the Practice to obtain payment or reimbursement for the care. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment to facilitate payment of a referring physician or the like.

Health Care Operations – We may use and disclose medical information about you so that we can run our Practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other medical practices 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 who the specific patients are.

We may also use or disclose information about you for internal or external utilization review and/or quality assurance to business associates for purposes of helping us to comply with our legal requirements, to auditors to verify our records, to billing companies to aid us in this process and the like. We shall endeavor at all times when business associates are used to advise them of their continued obligation to maintain the privacy of your medical record.

Appointment and Patient Reminders – We may ask that you sign in writing at the Reception Desk a "Sign In" log on the day of your appointment. We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, email otherwise and may involve the leaving of a message via email, on an answering machine or voice mail, or otherwise could potentially be received or intercepted by others.

Emergency Situations – In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

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Research – Under certain circumstances we may use and disclose medical information about you for research purposes regarding medications, efficiency of treatment protocols and the like. All research projects are subject to an approval process which evaluates a proposed research project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We will obtain an Authorization from you before using or disclosing your individually identifiable health information unless the authorization requirement has been waived. If possible, we will make the information non-identifiable to a specific patient. If the information has been sufficiently de-identified, an authorization for the use or disclosure is not required.

Required by Law – We will disclose medical information about you when required to do so by federal, state or local law.
To Avert Serious Threat to Health or Safety – We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific 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.
Research, Death & Organ Donation – We may use or disclose your PHI in limited circumstances for research purposes. When necessary, we must disclose PHI to a coroner, medical examiner, funeral director or to an organ procurement organization for them to carry out their duties.
Worker's Compensation – We may release medical information about you for Worker's Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Oversight of Health and Public Policy – We disclose PHI to federal, state and local health and government agencies that oversee activities authorized by law. These include audits, investigations, inspections, licensure and determination of your eligibility for services. These activities may be necessary for the government to monitor the health care system, public programs, its contractors and entities subject to civil rights laws. For example, we must disclose PHI to the US Department of Health and Human Services for purposes of determining whether we are in compliance with federal privacy laws.

Monitoring Public Health Risk and Safety – As required by law, we may disclose your PHI to public health authorities, the Food and Drug Administration or entities that receive information for the purposes of 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
- 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.

Investigative, Government & Security Activities – We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and national security. These activities are necessary for the payer, the government and other regulatory agencies 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, or other public civil or criminal proceeding, we may disclose your PHI in response to a court order, summons, warrant, administrative order, grand jury subpoena, discovery request or other lawful process to the extent requested.
Law Enforcement and Criminal Activity – We may disclose PHI to a law enforcement official concerning a suspect, fugitive, material witness, crime victim or missing person, or to protect against fraud and other illegal activities. We may also do so when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or who has escaped from lawful custody. In the case of inmates or other persons in lawful custody, we may disclose PHI to law enforcement officials or correctional institutions that are responsible for their care.
Changes to this Notice – We reserve the right to change this notice at any time. 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 may receive from you in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, top-center, the date of the last revision and effective date. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.
Complaints – If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our Compliance Officer who will direct you on how to file an official complaint. All complaints must be submitted in writing, and all complaints shall be investigated without repercussion to you. **You will not be penalized for filing a complaint**.
Disclosures and Uses of PHI with your Written Permission – We will not disclose your PHI for any purpose not previously referenced in this notice without first obtaining your written authorization. When we need your permission, you may grant it by signing an authorization form. You may later revoke it in writing, except to the extent an action, use or disclosure was already performed as a result of your prior authorization.

Business Associates - Companies who provide services to our Practice who may have access to our patient's PHI will be required to sign a Business Associate Agreement protecting the Practice from PHI disclosures without authorization. An example of a business associate would be a medical transcription service.

YOUR RIGHTS AS OUR PATIENT

Access to Your Health Information – You have the right to inspect and obtain copies of your PHI that may be used to make decisions related to our care for you, generally within 30 days. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.
To inspect and copy your PHI, you must submit your request in writing to our Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying and mailing.
We may deny your request to access and disclose in certain very limited circumstances, such as when disclosure would reasonably endanger you or another person. If you are denied access to medical information, you may request that the denial be reviewed.
Right to Amend – If you feel that the medical information we have about you in your records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the Practice maintains your medical record.
To request an amendment, your request must be submitted in writing to the Compliance Officer, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. If we believe that the PHI is already accurate and complete, we will deny your request. We will likely deny requests for amendment to any PHI that was not created by us (unless you provide reasonable evidence that the person or entity that created the information is no longer available to make the amendment).
We cannot grant requests to amend PHI, which is not kept by the practice or which is not part of the PHI that you are permitted to inspect.
As part of your access right, you have the right to authorize and later revoke in writing the use or disclosure of your PHI to anyone for any purpose with limited exceptions.
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 to others.
To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back. We will notify you of any 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 health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care (a family member or friend). For example, you could ask that we not use or disclose information about a particular treatment you received. Your request must be made in writing and (1) state what information is to be limited (2) to whom the restriction applies and (3) if the restriction applies to use, disclosure or both.
We are not required to agree to these additional restrictions, but if we do, we will comply with your request except in cases of emergency or when we are otherwise required to disclose the information by law.
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 time. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail messages, or the like.
To request confidential communications, you must make your request in writing. 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 us to contact you.
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.
THE NAME OF OUR COMPLIANCE OFFICER CAN BE OBTAINED FROM THE RECEPTIONIST AT OUR OFFICE TELEPHONE NUMBERS.

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment

CONTROLLED SUBSTANCE AGREEMENT

Pain management may take the form of different criterion and is dependent upon each patient's individual needs. On occasion after a thorough review of the patient's medical history, failure of conservative, medical and surgical management, it may be determined that the patient requires controlled substances (opioid medication) for effective pain management.

Controlled Substances may be prescribed for treatment; however, these medications introduce the possibility of abuse or misusage. As a result of this information, the policies provided below are in accordance with the physician's determination to initiate and maintain prescription of controlled substances for effective pain regulation.

1) You will maintain scheduled visits to ALABAMA SPINE AND PAIN as directed by your prescribing Physician.

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2) You will follow prescription orders and take your medication at the rate directed by your prescribing Physician.

3) You will keep safe these medications in a secure location. **YOUR MEDICATION WILL NOT BE REPLACED FOR ANY REASON IF MISSING OF DISPOSED OF.**

4) Any modification to your medication regime must be made in person through an appointment with your prescribing Physician.

5) Your prescribing Physician has the liberty to contact your dispensing pharmacy or additional Heath Care Professionals providing you care and disclose/obtain information concerning your treatment.

6) **Under no circumstances will you distribute or sell your medication to another individual.**

7) It may be required that your prescribing Physician have original prescription containers for **pill counts** accompany you at your scheduled office visits to ensure compliance with your medication regime.

8) Your prescribing Physician **WILL NOT** authorize a premature refill of medication under any circumstance.

9) Continuation of medication may require combination treatment with other criterion, such as lifestyle changes, physical therapy, aquatics, etc.

10) Your prescribing Physician may request an unanticipated urine toxicology test **URINE DRUG TEST** at any point during your treatment to ensure compliance with your medication regime. ***Your physician will make arrangements for termination of treatment and initiate a medication cessation schedule in the event that you refuse testing of this nature.*** A recommendation for a review for an addictive complication may be requested if any substances are detected that have not been authorized by your Health Care providers.

11) While actively participating in a treatment regime with controlled substances; you will not consume or use illegal substances of any kind (examples of such substances are marijuana, ecstasy, crystal meth, cocaine, ketamine, or heroin). ***Your prescribing physician will make arrangements for termination of treatment and initiate a medication cessation schedule in the event that you are abusing illegal substances.***

12) You will notify Alabama Spine and Pain immediately if you are prescribed pain medication of any kid from another Health Care Provider. Additionally, you will not pursue additional medication from another Health Care Provider without disclosing that you are currently under an active pain management regime.

I the patient, have reviewed the policies of this agreement in addition to **page CONTROLLED SUBSTANCE RISKS, COMPLICATIONS, & INFORMATION**. I understand that a copy of this legal document is available in the office, on the website (www.alabamaspineandpain.com), patient portal and available upon written request.

CONTROLLED SUBSTANCE RISKS, POSSIBLE COMPLICATIONS, & INFORMATION

Upon initiating pain management through a controlled substances treatment regime, please be aware that there are risks, possible complications, and information that you will need to review.

In the prescribing of any controlled substance, there is the possibility of a physical dependence. In the event that the patient develops a tolerance to the medication prescribed, the medication may begin tot become less effective in combatting the patient's pain levels.

- YOU ARE NOT RECOMMEDED TO COMPLETE THE FOLLOWING TASKS WHILE ACTIVELY TAKING OPIOIDS:
  - Consuming Alcohol
  - Operating Heavy Machinery
  - Operating a Motor Vehicle
  - Participating in a situation that requires full awareness

- **POSSIBLE COMPLICATIONS**
  - Tolerance / Physical Dependence
  - Anaphylactic / Allergic Reaction
  - Disorientation
  - Respiratory Depression
  - Bowel Obstruction / Constipation / Problematic Urination
  - Withdrawal Phenomena : Signified by elevated pulse and blood pressure, heart palpitations, and diaphoresis
  - Birth defects or fetal physical dependency
  - Lowered Testosterone

- **ADDITIONAL INFORMATION**

- **Precautions**
  - Caution in the young and the elderly patients
  - Caution in patients with other pre-existing medication conditions
  - Patients that are pregnant or may become pregnant
  - Patients prescribed to anticoagulants
  - Patients prescribed to medications that cause Central Nervous System depression or prescribed to some form of a sedative
  - Patients on multiple medications