Interventional Spine & Pain Rehabilitation Center, ltd

Last Name:_____Frist:_____Middle:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Age:_____ SSN:_____

Employer:_____ Job Title:_____

Referring:_____ Family Doctor:_____

Marital Status:_____Spouse's Name:_____

Children under 18 and ages_____

Phone:_____ Email:_____

EMERGENCY CONTACT INFORMATION

Name:_____Relationship:_____Phone_____

All professional serves rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage or absence thereof. It is customary for the patient to pay for services when rendered unless arrangements with another party have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize *Interventional Spine & Pain Rehabilitation Center, ltd* , (ISPROC), BBF ltd, Dr M.F. Stretanski and/or any dBA thereof, to furnish information to insurance carriers concerning my illness, diagnoses and treatments and I hereby assign the physician (Dr Michael F. Stretanski) all payment for medical service rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature:_____date:_____

Contacts with whom Dr Stretanski and/or his office designees may discuss my case or payments, in addition to my Emergency contact

#1_____ #2_____

#3_____ #4_____

Please note that we will not be able to discuss your care with any persons not listed above. This includes billing questions, payments and refill issues. Make sure to list anyone who might need to call.

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PATIENT PROTECTED HEALTH INFORMATION

Consent to use for purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by ISPROC for the purpose of diagnosing or providing treatment to me, obtaining payment for healthcare bills, assisting in potential prior authorization for medication in isolation from the rest of my care, and the conduct healthcare operations of ISPROC. I understand that diagnosis or treatment of me by the physicians of ISPROC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction, in writing, as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. ISPROC is not required to agree to the restrictions that I may request, however if ISPROC agreed in writing to a restriction that I request, then the restriction is binding on ISPROC and its physicians.

I have the right to revoke this consent, in writing, at any time, except to the extent that ISPROC has taken action in reliance on this consent and understand that I may then be accountable for additional processing fees and fees for services not covered or paid due to lack of clinical information. I understand that Healthcare organizations are *mandatory reporters* and HIPPA does not apply when a crime has been committed.

My "Protected Health Information" means health information, including demographic information, collected from me and created or received by my physician, or another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This is protected information relates to my past, present or future physical or mental health or condition and identifies me as there is a reasonable basis to believe the information may identify me.

I understand I have the right to review ISPROC's Notice of Privacy Practices prior to signing this document. The ISPROC Notice of Privacy Practices has been provided to me, the Notice of Privacy Practices describes the types and uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of ISPROC, BBF or their representatives. The Notice of Privacy Practices also describes my rights and ISPROC's duties with respect to my protected health information.

ISPROC reserves the right to change the privacy practices that are described in the Notice of Privacy practices to coincide with state, federal law and/or compliance issues with SAMSA, pharmacy, medical board or other compliance or certifications or to reflect common trends in office practices. I may obtain a revised Notice of Privacy Practices by requesting one in writing and one will be provided or I will be referred to an electronic version, at the time of the next visit or two business days – whichever is longer.

X_____ Date_____.

Patient or Patient representative

_____.

Description of Patient's Representative Authority (ie – Parent, Spouse or Power-of-Attorney)

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Patient Financial Policy and Office Policy Disclosure page 1 of 2

On arrival please sign in at the front desk and present your current insurance card. Driver's license or state ID may be required under Ohio law. Please be sure to inform us of any changes in contact information.

Co pays are due at the time of service. This is required by your insurance company. ISPROC does NOT have any legal right to waive Co-Pay or patient portion of insurance.

Insurance claims are submitted on behalf our patients, however, the agreement to pay for medical services in a contract between the insurance carrier and yourself. Limitations and exclusions may exist. In and out of network benefits may differ. Patients are ultimately expected to understand how their insurance works. Patient financial responsibility portions, co pays and deductibles are set by the insurance company – not ISPROC. You may need to do considerable work and assist in getting your insurance company to pay for services rendered.

Secondary Insurance- We file secondary insurance claims are as a courtesy. If your secondary insurance has not paid within 60 days of our filing, then you will automatically be held responsible for balance of unpaid charges.

Third Parties: We do not bill third parties. Lawful third party payment may be accepted by prior written arrangement. Statements are provided as proof of payment or statement of unpaid balances. Credit cards in the name of individuals who are not present with a photo ID cannot be run.

Workers Compensation authorization must be obtained, usually by C-9 form prior to being seen for any active BWC claim. Patients must obtain the BWC claim number, phone number, name address and billing information for the MCO prior to visit.

Payment is accepted in the form of cash, debit cards, cashier's check, credit cards (VISA) or personal checks. We do not accept Discover. There will be a $35.oo charge for "non-sufficient funds"

Medical Records take considerable time and effort to process. Requests are processed M-Thurs in the order in which they are received and upon receipt of payment.

There is a standard **$ 20.oo fee** for prescription refills needing to be called into the pharmacy, written for pick-up which could have been taken care of at the time of office visit. This applies to all established patients on chronic medications or chronic medications needing to be taken over by ISPROC, ltd

There is a standard **$100.oo** (One Hundred Dollars) fee for no show/no call or cancellation less than 24 hours prior to appointment.

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Patient Financial Policy and Office Policy Disclosure page 2 of 2

There is a standard **$250.oo fee (**Two Hundred and Fifty) for no show/no call for Procedural Appointments or cancellation less than 24 hours prior to appointment or for cancellation of procedures after prior-authorization has been obtained.

There is a standard **$50.oo (Fifty dollars)** fee for all non-clinical paperwork such as FMLA, Jury Duty excuses, disability paperwork. This includes Worker's Compensation papers. Payment is due in full prior to form completion

There is no additional fee for Letter's of Medical Necessity, parking placards, procedural or medication prior authorization or peer-to-peer reviews with insurance companies or networks that are required for imaging studies, medication authorizations or treatment authorizations.

Rational decisions are made under reasonable circumstances regarding the waiver of fees.

All controlled substances, including tramadol, require a written "wet-ink" prescription and cannot be called into or electronically sent to a pharmacy. Absolutely no controlled-substances are available and there will be no discussion of controlled-substances other than at the time of face-to-face visit with the doctor.

Differences do exist between treatment options available through third-party reimbursements. Many common practices and procedures or treatments available without delay for one patient may be considered "experimental" or simply not covered by another plan. Other times treatments may be covered but reimbursed at only a small percentage of the cost of the treatment and are technically not available through the plan/network. Every possible effort to assist in processing insurance claims will be made but it is not possible to explain/predict what any insurance company or reviewer will decide on any given day surrounding payment for services rendered or authorizations requested. Any and all treatment not covered by your insurance, such as elective, cosmetic or alternative treatments, will be disclosed as such prior to performing treatment.

Collection of Bad Debt: ISPROC is forced to make use of a third part collection agency. Unpaid patient responsibility is turned over to collections after a second notice if no arrangements are made. We bend over backwards to work with patients on this matter, but if there is no response to billing, we have no choice under our third part insurance contracts other than to pursue debt. Once turned into collections, no appointment will be scheduled and no paperwork will be processed until reconciliation of the debt.

X_____ Date_____.

Patient or Patient representative, noting page 1 and 2 of disclosure

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INSURANCE DECLARATION

If you have an authorized BWC claim and prior C-9 authorization for the visit,

Or, if you are motor vehicle and arrangements have been made regarding motor vehicle case or personal injury case,

Or if you are a cosmetic patient, a Suboxone client, or an FAA pilot Medical Exam then this insurance declaration does not apply.

Otherwise you must declare that

- The issues for which I am being seen are NOT related to a motor vehicle accident.
- The issues for which I am being seen are NOT related to an active Worker's Compensation Claim.
- The issues for which I am being seen are not going to be opened as a Worker's Compensation Claim
- The issues for which I am being seen today are NOT related to a personal injury claim and I am not and will not be a plaintiff in a lawsuit and relating the issues for which I am seeking care.

I understand that I will not have the option to change my mind later and I understand that it is potentially Insurance Fraud to present a private insurance, Medicare or Medicaid for a motor vehicle, personal injury or Worker's Compensation Claim, or to knowingly present expired/cancelled insurance information. I "hold harmless" Dr Stretanski, ISPROC and/or its representatives in any such fraud claim or the reporting thereof. I understand that I am responsible to know how my insurance works and that my insurance may take money back, even years later, and that I will be financially accountable for bills related to services rendered if it becomes evident at a later date that there is an active personal injury, BWC, motor vehicle or other non-covered or uninsured case.

X_____ Date_____.

Patient or Patient representative