## Consent to Treat

I _____ (patient name) give permission for **Upstate Hand Center** to give me medical treatment.

I allow **Upstate Hand Center** to file for insurance benefits to pay for the care I receive.

I understand that:

- **Upstate Hand Center** will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

## Notice of Privacy Acknowledgement

We keep a record of all healthcare services we provide to you. You may ask to see and receive a copy of those records at any time. Any errors you discover on said records, you may request for correction to be made. If it is found to be in fact an error, corrections to those records will be made.

We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information by contacting our Privacy Office Administrator. Our Notice of Privacy describes in more detail how your health information may be used and disclosed and how to access your information.

By your signature below, you consent to treatment and acknowledge receipt of this Notice of Privacy Practices.

_____ _____

Patient's Signature: Date:

# UPSTATE HAND CENTER

**Patient Name:** _____

## FINANCIAL POLICY

**PLEASE READ ALL INFORMATION AND ACKNOWLEGE BY SIGNING BELOW**

1. We ask that you present your insurance card at each visit. It is your responsibility to provide us with correct information to bill your insurance.
2. If you have a change of address, telephone number, or employer, please notify the receptionist
3. Deductibles, co-payments or charges for non-covered services are due at the time of service. We accept cash and major credit cards.
4. You are expected to provide payment for previous balances or balances sent to collection prior to your office visit. If you are unable to pay your balance in full, contact the office at (864)308-8668, or talk to the receptionist to set up a payment agreement.
5. If your plan requires prior authorization, you must obtain the authorization prior to your visit at Upstate Hand Center.
6. SELF-PAY PATIENTS: Patients with no insurance are expected to pay at the time of service. A discount is offered for payment in full at the time of service. If you can't pay in full, a payment agreement must be made, prior to seeing the doctor.
7. **No show and missed appointments. If you do not give 24 hours' notice prior to cancellation, or rescheduling, you will be charged a $50.00 No-show/rescheduling fee. When an appointment is scheduled with the doctor, time is specially allocated for you. We ask as a courtesy phone call to cancel your appointment 24 hours in advance.**

Remember, whether you do or do not have insurance, you are ultimately responsible for payment of your charges. If you have any questions regarding our financial policy, please contact the office at (864)308-8668.

I have read and have a full understanding of the financial policy of Upstate Hand Center.

***Signature:*** _____ ***Date:*** _____

**_Upstate Hand Center_**
1650 Skylyn Drive Suite 380
Spartanburg, SC 29307

**(864)308-8668**

**Pain Management Agreement**

I voluntarily request that my physician treat my painful conditions. I hereby authorize and give my consent to prescribe controlled medications as an element in the treatment of my pain. It has been explained to me that these medication(s) may include opioid/narcotic drug(s), which can be harmful if taken without medical supervision. I agree with the following terms:

1.I understand that I am being treated by Upstate hand Center ( henceforth referred to as UHC) and I agree to actively participate in all treatment as recommended and to keep all appointments as scheduled.

2.I will use controlled substances only as directed by UHC medical staff and will refrain from using any illicit drugs while on these medications and/or **I will notify UHC staff that I am under a separate pain management agreement and will not receive narcotics from this practice.**

3.I will receive controlled substances only from the UHC medical staff, except in the case of a medical emergency. I agree to inform my other doctors that I am receiving these medications and request that.

4. I agree to UHC informed of all medications that I am taking.

5. I understand that the most common side effects that could occur in the use of the medications in my treatment may include but are not limited to: constipation, nausea, vomiting, excessive drowsiness, itching, urinary retention( inability to urinate), orthostatic hypotension ( low blood pressure), arrhythmias, depression, impairment of reasoning and judgment, respiratory depression ( slow or no breathing), impotence, low testosterone levels, tolerance to medication (s), physical and emotional dependence or even addiction and death.

6. I understand that controlled substances may cause physical dependence and that sudden withdrawal may cause symptoms such as abdominal and muscle cramps, sweats, chills, nausea and vomiting. In rare cases it may cause death.

7. **In order to prevent loss of my pain medication, I will keep them in a safe place. If my pain medications or prescriptions are lost or stolen or otherwise not available to me, I understand that the prescription for pain medications will NOT be replaced without a police report.**

8. I will NOT give, sell, lend or in anyways provide my pain medications to any other person.

9. I understand that there will be NO early refills on my pain medications.

10. I understand that medication refill requests are only accepted 8:00-5:00 pm. Monday -Thursday and Friday 8:00 -12:00 pm. NO MEDICATIONS OR REFILL REQUESTS WILL BE TAKEN DURING NIGHTS, WEEKENDS OR HOLIDAYS. I also understand that it is my responsibility to anticipate the need for refills and make refill requests in a timely manner, allowing up to 3 business days.

11. I agree not to operate a vehicle, automobile, machinery or any potentially hazardous device while impaired by medications. I will not hold UHC or its employees responsible for any accidents, injuries, damages or loss, resulting from engaging in any of these activities while taking pain medications.

12. I understand that if I am pregnant, controlled substances may have adverse effects on the fetus. FOR FEMALE PATIENTS: I agree to notify UHC if I become or intend to become pregnant.

13. I agree to submit to unannounced drug testing to include urine, hair and blood tests. If drugs not prescribed for me, or excessive or low levels of drugs prescribed for me are found in any blood, hair or urine, all pain medications will be stopped, and I may be discharged from UHC. I also agree to submit to pill counts if requested .

14. If my pain is not controlled or my level of function with drug therapy does not improve to the satisfaction of my physician, I understand that pain medication may be discontinued, and alternative treatments will be used.

15. If my doctor recommends, I will see a specialist for addiction treatment, or other pain management.

16. I certify that I am not currently using illegal drugs or abusing prescription medication (s) and I am not undergoing treatment for substance dependence ( addiction) or abuse.

17. I **agree to fill my medications only at the pharmacy listed below:**

**Name:** _____

**Address:** _____

**Telephone Number:** _____

**I have read and understood all of the above terms. I have had the opportunity to ask questions about these terms of treatment and all of my questions have been answered to my satisfaction. I agree to abide by the terms and provisions in this agreement and understand that failure to do so may lead to termination of treatment.**

**SIGNATURE:**

_____ _____

**PATIENT:** **DATE:**