VIRGINIA BRAIN & SPINE CENTER

NEUROLOGICAL SURGERY
Phone (540) 450-0072
Fax (540) 450-0074
James B. Chadduck, MD
Allan H. Fergus, MD
Patrick D. Ireland, MD
Steven R. Schopick, MD
Lee A. Selznick, MD
Tamela S. Catlett, NP-C
Amanda L. Hahn Simmons, NP-C
Julie B. Henderson, NP-C
Alison K. McNeill, NP-C
Racheal A. Valcour, NP-C

PAIN MANAGEMENT
Phone (540) 450-2339
Fax (540) 450-2333
N. Scott Ashcraft, DO
Michael J. Poss, MD
Christy A. Andrews, NP-C
Brian A. Lapp, PA-C

1818 AMHERST STREET · WINCHESTER, VA 22601 · WWW.VABRAINANDSPINE.COM

Dear Patient,

We have received your information from your physician referring you to Neurosurgery. Enclosed is the Virginia Brain and Spine Center new patient packet for the Neurological Surgery Department. Please complete **ALL** of the information that is requested and **bring it with you to your appointment.**

Please bring the following information with you to your appointment:

- **Insurance card(s), Photo I.D., Co-payment if applicable**
- **A list of the medications that you are currently taking**
- **Any imaging films and the corresponding reports that you were instructed to bring**

We realize that the content of information being received at your appointment can be very detailed and dealing with pain can be very distracting, however we encourage you to bring someone to the appointment to assist you.

If you are unable to keep your appointment, please telephone us at 540-450-0072 at least 24 hours in advance. **Please arrive 15 minutes early to *ALL* appointments so we can get you checked in.** Arrival more than 15 minutes past your appointment time will result in your appointment being rescheduled.

If you should have any questions, please feel free to contact our office at (540) 450-0072. Thank you very much for choosing our practice for your neurological surgery needs.

Directions from North Traveling South:
•Take I-81 South
•Take Exit 317
•Turn Right onto Route 37 South
•Take Route 50 (Winchester Romney) Exit
•Turn Left onto Amherst Street
•After Third light make a U-Turn, then turn Right into VBSC

Directions from South Traveling North:
•Take I-81 North
•Take Exit 310
•Turn Left onto Route 37 North
•Take Route 50 (Winchester Romney) Exit
•Turn Right onto Amherst Street
•After the Second light make a U-Turn, then turn Right into VBSC

APPOINTMENT INFORMATION

Appointment Date: _____ Your Provider: _____

Appointment Time: _____ Please Arrive By: _____

PATIENT INSTRUCTIONS

Thank you for choosing our physicians at Virginia Brain and Spine Center, Inc. for your health care needs. We are committed to providing the very best medical care and treatment. The following is a description of some of our practice policies and guidelines for patients. Please read this before your first appointment.

MEDICATION MANAGEMENT: Virginia Brain and Spine Center does not provide narcotic medication management services to our patients. If you require narcotic medication management please consult your primary care to obtain a referral that will better suit your needs.

PRESCRIPTIONS: All medication refills are done during working hours on Monday through Thursday only. You may have your pharmacy call directly to request a medication refill. Please allow two working days for the prescription to be processed. If you need a new written prescription, please allow 5-7 business days for the prescription to be processed. We are unable to refill prescriptions after hours so allow enough time before your prescription runs out. There is a $10 recovery fee for all prescriptions that are sent via certified mail.

MISSED APPOINTMENTS: Please notify us as soon as possible if you are unable to keep a scheduled appointment. We appreciate a minimum of 24 hours notice so that we can use this time for someone else who is waiting for an appointment. Abusive missed appointments may result in your dismissal as a patient.

RESCHEDULING: As a surgical practice, emergency situations arise that may result in the physician being called away to the operating room. As a result, your appointment may need to be delayed or rescheduled. We will do our best to notify you in order to give you the opportunity to reschedule before arriving for the appointment. During these times we appreciate your patience and understanding.

MEDICAL RECORDS: To obtain copies of your medical records you must sign a Medical Release form. There is also a small fee of $10.00 plus $0.50 per page. These fees, set forth by Virginia State law, must be paid in full before your request will processed. Please allow 5-10 business days for processing. Fees are subject to change without notice.

FORMS: Forms, including, but not limited to, disability or worker's compensation, will be filled out at the physician's discretion. The fee for completion of these items is $5 per form. All fees must be paid in full before the forms will be produced. Please allow 5-10 business days for processing.

EMERGENCIES: If you have a health care emergency then call 911. If you need to speak with a physician after hours then call the Winchester Medical Center operator at 540-536-8000 and ask to have the physician on call paged. For routine questions and concerns or for prescription refills, please call our office at 540-450-0072 for Neurosurgery Department and 540-450-2339 for Pain Management Department. If your call is not immediately answered by our staff then please leave a message and your call will be returned in order of priority within 24 hours.

NEEDLE STICK POLICY: I authorize any physician, hospital, or medical care facility to provide all my medical history and treatment to Virginia Brain and Spine Center. I authorize Virginia Brain and Spine Center, Inc., to test my blood for hepatitis and for the AIDS virus, if in their opinion, an employee of Virginia Brain and Spine Center, Inc. has suffered an exposure incident as a result of my treatment defined by the Occupational Safety and Health Administration. A law was enacted in 1989 and amended in 1993 which authorizes health care providers to test their patients for HIV, Hepatitis B and C antibodies when the health care provider is exposed to the body fluid of a patient in a manner which may transmit these antibodies. Pursuant to this law, in the event of such exposure, you will be deemed to have consented to such testing and to the release of the test results to the health care provider who may have been exposed. You will be informed prior to your blood being tested for HIV, Hepatitis B or C antibodies. The testing will be explained and you will be given the opportunity to ask any questions.

MEDICAL STAFF PHONE DIRECTORY: A directory of phone numbers is included below if you need to reach members of our medical staff quickly. We try to return phone calls within 48 hours (please note we are closed on all major holidays and weekends). If you are unsure which number you should dial but still need to reach our office, you can call 540-450-0072.

Neurosurgery Triage/Nurse: 540-771-2297
Secretary for Dr. Chadduck: 540-771-2292
Secretary for Dr. Fergus: 540-771-2293
Secretary for Dr. Selznick: 540-771-2294
Secretary for Dr. Schopick: 540-771-2295
Secretary for Dr. Ireland: 540-771-2296
Neurosurgery Referral Clerk: 540-771-2298
Pain Management Referral Clerk: 540-771-2299
Medical Records: 540-450-0072 x2353

Medical Assistant for Christy Andrews, NP: 540-771-2306
Medical Assistant for Brian Lapp, PA: 540-771-2307
Medical Assistants for Dr. Poss & Dr. Ashcraft: 540-771-2304
Patient Financial Counselor for Dr. Poss, Lapp PA-C, Dr. Fergus: 540-771-2286
Patient Financial Counselor for Dr. Ashcraft, Andrews NP-C, Dr. Chadduck, Catlett NP-C: 540-771-2300
Patient Financial Counselor for Dr. Schopick, McNeil NP-C, Dr. Selznick, Hahn-Simmons NP-C, Dr. Ireland, Henderson NP-C: 540-771-2305

FINANCIAL POLICY

The following is a statement of our Financial Policy, which you must read, agree to and sign, prior-to treatment. Our Financial Policy applies to all service rendered by our physicians and staff whether inpatient or outpatient.

Practice Payment Policy Guidelines:

- **Patients/(guardians) are financially responsible for all charges, regardless of third-party involvement.**
- **Full payment is due at time of services, unless prior insurance billing arrangements have been made.**
- **Patients with insurance will be required to pay all 'out-of-pocket' financial obligations at time of service.**
- **We accept: Cash, Check, Bank Debit Card, the following credit cards: Visa / Master Card / Discover.**
- **Practice will bill non-par insurance as a courtesy to the patient. The carrier should pay the practice and in the event that the carrier pays the patient, the patient must turn funds over to the practice in 5 business days.**

Patient Responsibilities and Financial Policies:

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes – name, address, phone, insurance coverage, etc. – you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage, Benefits and Referral Requirements: Your health insurance is a contract between you and your health insurance plan(s). Patients are responsible for understanding their health insurance coverage(s), benefits and referral requirements to receive diagnostic and therapeutic services from our physicians. Patients are responsible for securing the necessary written Referrals, Pre-authorizations or Pre-certifications from your primary care physician or health plan prior-to services rendered. If we have not received the necessary authorizations prior-to your appointment, the appointment will be rescheduled. Please present your Insurance ID card to our staff upon registration for each office visit.

Self-Pay Patients: Patients without insurance coverage are expected to pay for services received in full at time of service, unless a satisfactory payment agreement has been arranged with our billing manager prior-to services being rendered.

Patient with Private Insurance / Medicare / Medicaid Coverage: Our physicians participate with the Medicare and Medicaid Programs, and with most major insurance companies. We will file claim(s) to your insurance provided you authorize the 'assignment of benefits' below for payment directly to our practice. For participating insurance plans, the practice will accept payment based on contractual agreements. For plans that we do not participate (i.e., there is no contractual agreement), the practice will expect full payment from the patient at time of service. Any coverage or payment dispute is a matter between the insurance policyholder and the insurance company.

Patient Payment Agreement:

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, coinsurance, co-payment, or services deemed as "non-covered" by my insurance carrier at the time of service. If my insurance has not paid on my account in 60 days, the outstanding services will become my responsibility for immediate payment (unless Medicare and Medicaid). Should any balances arise due to insurance co-payments, co-insurance, deductibles, termination of coverage, non-payment at time of service and/or any other reason, I agree to pay all charges within 30 days of notice. I understand that if I fail to pay outstanding balances or make payment arrangements within 75 days, the amount due will be considered delinquent and subject to outside collection action. I further understand that delinquent accounts will be assessed a 1.5% interest charge per month (18% APR), and the possible dismissal of the patient from our care. If my account is forced to 'collections', I agree to pay all collection costs, including, but not limited to, court costs, attorneys and any other costs incurred for the collection of this debt fees equal to 40% of the amount owed, and accrued interest charges to date. I agree to pay a $25.00 returned check fee. Copies of my medical records can be obtained with advanced notice in accordance with §8.01-413 of the Code of Virginia, with charges not to exceed $0.50 per page for the first 50 pages and $0.25 per page thereafter, in addition to a $10.00 handling fee plus postage expense. The completion of special forms or reports has a minimum charge of $25.00 for each form. Fees are subject to change without notice.

Participating Insurance Plans:

- Aetna (excludes Aetna Medicare)
- Anthem BC/BS Virginia
- BC/BS PPO
- Cigna (excludes Cigna Connect)
- Healthsmart (Grant, PEIA)
- Medicaid-Virginia (Neurosurgery only)
- Medicare (includes Humana and Railroad)
- Optima/Community Health
- Physician Services-4 Most
- POMCO
- United Healthcare PPO (Options PPO and OneNet PPO networks)
- Virginia Health Network
- Virginia Premier (Neurosurgery only)
- Workers Comp-Virginia and West Virginia only

If we do not participate with your commercial plan, you will be financially responsible for our services provided to you. It is your responsibility to contact your insurance company before your appointment to verify if a preauthorization, precertification, or a referral is required. We will file your claim(s) to your insurance company based on the information that you provide our office at the time of service. If you do not have this information, you will be financially responsible for your visit. If you have any questions regarding payment, deductible, or other benefits, please contact your insurance company directly.

Patient's Full Name (First – Middle – Last)	Sex: M ☐ F ☐	Patient's Birth Date	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Mailing Address City State Zip		Cell Phone: Home Phone:	Patient's Social Security #
Physical Address (If different from above)		City, State	Zip
Responsible Party Name *Relationship?* →	☐ Self ☐ Spouse ☐ Parent	Resp Party's Birth Date	Responsible Party's SSN
Responsible Party Address ☐ *Same as Patient* City State Zip Drivers License State: Number:			Preferred method of contact ○ Text ○ E-Mail
Emergency Contact Name:		Emergency Contact Phone Number:	
Name of Employer Business Phone:		E-Mail Address:	

Medicare Beneficiary Lifetime "Signature on File": I request that payment of authorized Medicare benefits be made on my behalf to Virginia Brain and Spine Center, Inc. for any services furnished me by physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents information to determine benefits payable for services rendered.

_____ _____

Patient / Beneficiary Signature Date

Private Insurance and Workers Compensation Authorization for Assignment of Benefits and Information Release: I, the undersigned, authorize payment of medical benefits to Virginia Brain and Spine Center, Inc. for any services furnished me by the physician. I authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I understand that I am financially responsible for any amount not covered by my contract.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Authorization & Assignment of Insurance Benefits: I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of specific medical or other protected health information, whether manual, electronic or telephonic. I authorize the Practice to apply for benefits for services rendered to myself or minor child under any health insurance policies providing benefits and do hereby also assign and authorize payment of benefits from my insurance company to the Practice (including benefits payable under Title XVIII of the Social Security Act and/or any other governmental agency.) I irrevocably authorize all such payments to the Practice. I authorize the Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my benefits.

In consideration for medical service rendered, I acknowledge receiving notice of the Patient Instructions and Financial Policy and agree to pay for said medical services according to the terms and to follow patient instructions. My signature below indicates that I have read and agree to the policies.

_____ _____

Patient / Responsible Party / Guardian Signature Date

Consent for Release and Use of Confidential Information and Acknowledgement of Notice of Privacy Practices

I hereby give my consent to Virginia Brain and Spine Center, Inc. to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in my private health record.

I acknowledge the review and/or receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information. I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

I understand that I have the right to request that the practice restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Due to HIPPA Privacy Act, we are not permitted to release information regarding your care. If you wish to grant your permission, please list below the person(s) that we may speak with on your behalf. Please be aware those listed below will be given full access to your Private Health Information.

_____ _____ _____

(1) Name, Relationship to Patient (2) Name, Relationship to Patient (3) Name, Relationship to Patient

□ Office staff may leave messages regarding treatment on phone number:_____

□ I do not want my information used for marketing or fundraising purposes.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

Patient Intake Form

Patient Name ____ **Date** ____
Date of Birth ____ **Age** ____
Race_________________ **Ethnicity**______________ **Preferred Language**__________________
Referring Doctor ______________________________________ **Doctor Phone#** ______________________________

Chief Complaint: Please check all those that apply to today's visit

Brain	Neck/Arm/Hand	Left	Right	Back/Leg/Foot	Left	Right
☐ Headache	☐ Neck Pain			☐ Back Pain		
☐ Seizure						
☐ Dizziness	☐ Arm Pain	☐	☐	☐ Leg Pain	☐	☐
☐ Vision Loss						
☐ Hearing Loss	☐ Arm Numbness	☐	☐	☐ Leg Numbness	☐	☐
☐ Tumor						
☐ Trauma	☐ Arm Weakness	☐	☐	☐ Leg Weakness	☐	☐

☐ Other:____

Allergies: Please check any allergies to medications that apply **or here ☐ if none**.
☐ Pencillins
☐ Other: ____

Past Medical/Surgical History: Please check all that apply **or here ☐ if no to all**.

☐ Heart Disease	☐ Neck Pain	☐ Back/Neck Surgery
☐ Lung Disease	☐ Back Pain	☐ Heart Surgery
☐ Diabetes	☐ Stroke	☐ Pacemaker
☐ Blood Pressure	☐ Cancer	☐ Heart Stents
☐ Ulcers	☐ Other____________	☐ Other_______________

Diagnostic Studies: Please check studies done related to this visit **or here ☐ if none.**

	Date	Location
☐ MRI	_______________	________________________
☐ CT	_______________	________________________
☐ EMG/Nerve Study	_______________	________________________
☐ Arteriogram	_______________	________________________
☐ Other:_______________	_______________	________________________

Medications
Name/Dose/Frequency

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
______(May continue on back)______.

Review of Systems: Please check any symptoms you have recently experienced **or here ☐ if no to all.**

General:
☐ Fever
☐ Infection
☐ Weight Loss
☐ Weight Gain
☐ Other: _______________

Heart/Vascular
☐ Chest Pain
☐ Palpitations
☐ Exercise Intolerance
☐ Other: ______________

Chest/Lungs
☐ Cough
☐ Wheezing
☐ Short of breath
☐ Other:______________

Abdomen/Intestines/Liver
☐ Abdominal Pain
☐ Nausea/Vomiting
☐ Diarrhea
☐ Constipation
☐ Other: ____________

Musculoskeletal/Other
☐ Joint Pain
☐ Muscle Pain
☐ Easy bleeding/bruising
☐ Other: ____________

Urinary/Bladder
☐ Incontinence
☐ Retention
☐ Urinary Frequency
☐ Other: _____________

Family History: Please check significant medical conditions in your immediate family members **or here ☐ if none.**

☐ Heart Disease	☐ Stroke	☐ Diabetes
☐ Lung Disease	☐ Cancer	☐ High Blood Pressure
☐ Other:________________________		

Social History:
Occupation: ___________________ Retired? ☐Yes ☐No Do you drink alcohol regularly? ☐Yes ☐No
Do you smoke? ☐ Smoker ☐ Former Smoker ☐ Never How Often? ☐ Currently smoke some days ☐ Currently smoke every day

Patient Portal Access

Patient Portal Access is the all-in-one personal health record and patient portal that lets you access your health information. You will have 24/7 online access from any computer, smartphone, or tablet. You will be able to view test and lab results, send and receive secure online messages, request Rx refills, cancel appointments, and receive email care reminders. You can also download the free portal app at your Apple or Android store (enter FollowMyHealth in the search field).

Complete this form in its entirety and you will then receive an email from Follow My Health with instructions on setting up your personal Patient Portal Access account. You must register your new account from a computer only, you cannot create an account on a tablet or smartphone. After your account is created, you will be able to access your account from any device (computer, smartphone, or tablet). **Please complete this form if you have a valid email address, as we cannot submit your request without it.**

First Name:_____

Last Name:_____

Birth Date:_____

Last Four of SSN:_____

Valid Email Address (Please Print Clearly): _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 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.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about

criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Virginia Brain and Spine Center, 1818 Amherst St. Winchester, VA 22601. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have 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 information is kept by or for our office.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

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. You may obtain a copy of this notice at our web site, www.vabrainandspine.com

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Amy Maynard, Office Manager. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

You may contact our office at:

Virginia Brain and Spine Center, 1818 Amherst St. Winchester, VA 22601 or by calling 540-450-0074.

Agreement for Treatment at Virginia Brain and Spine Center

Patient: _____ Date: _____

This form is used with all patients at Virginia Brain and Spine Center to set basic boundaries for the use of controlled substances, or pain medications, to treat pain. We do this to protect your access to pain medications and your doctor's ability to use them to control your pain. Certain pain medications have the potential for abuse or misuse, and we have a responsibility to minimize such occurrences. We also have a moral, ethical, and legal responsibility to uphold local, state, and federal laws which govern these medications.

We are also responsible for periodically measuring your progress toward treatment plan goals which may also include physical therapy, psychotherapy, or behavioral medicine. We are also responsible for determining whether there are accepted medical reasons for you to continue using pain medications as part of your treatment plan. We do not intend for this agreement to suggest that you have a problem using pain medications. We use this form routinely and believe it is a necessary component of quality medical care.

**********The following terms only apply to those patients who are being prescribed narcotic pain medication by our office.**

Statement of Accountability Terms

Review this list of promises carefully, as we expect you to keep them. Following the list of promises is a space for your signature. When you sign this document, you are telling us that you (1) read it, (2) understand it, (3) agree to its terms, and (4) understand the possible consequences if you fail to keep your promises.

I, _____, promise:

1. I am seeing Virginia Brain and Spine Center for pain management and/or surgical reasons. If I go to another doctor for a pain complaint, I will tell my physician at Virginia Brain and Spine Center immediately.

2. I will show up for all scheduled appointments and treat my doctor and his staff with respect.

3. I will give my doctor and his staff complete and honest information about my (a) pain relief levels, (b) activity level (function), (c) any side effects I experience while using my pain medications, and (d) how much and how often I use my pain medications. I will do this at every office visit and whenever I talk with my doctor or his staff on the telephone or in writing.

4. I will fill my pain medications only at _____ Pharmacy. If I decide to change pharmacies, I promise to tell my doctor or his staff within one business day of the change.

5. I will not change (decrease or increase) the amount of pain medication I take without first obtaining my doctor's permission.

6. I will tell my doctor if my dentist prescribes me any medication for dental-related pain.

7. I will tell my doctor if another doctor issues me a prescription for *any medication.* I understand it is important to report this information to my doctor because some medications may not work well with my pain medications and could cause me harm.

8. I will tell my doctor if I experience new medical conditions or pain problems.

9. I will not share, sell, or allow others to take or use my pain medication. I will be careful about how I store my pain medication and I will keep it in a safe place, away from animals, children, and others.

10. I will seek immediate help if I have a medical emergency. If I go to the emergency room for any reason, I promise to tell my doctors about this event within 24 hours of my visit to the emergency room. If I cannot tell my doctor about my emergency room visit, I give my consent to my doctor to speak with my family members and any health care provider participating in my care about these issues. I also give my consent to the emergency room to release documentation related to my emergency medical treatment.

11. I will give a blood or urine sample if my doctor asks me for one. I understand my doctor will use the results of a blood or urine test to decide whether I am taking my pain medication and whether there is a medical reason to discontinue the use of my pain medication.

12. I will write down all facts related to the loss of my pain medication or prescriptions, if asked by my doctor. I understand my doctor has complete discretion whether to replace my pain medications or prescriptions.

13. I will not drive a vehicle or operate equipment or heavy machinery while using my pain medications.

14. I understand that it is my responsibility to report my use of medication to my employer if I am required to do so.

15. I will participate in a recovery program for chemical/substance abusers if requested to do so by my doctor. If I do not keep this promise, I understand my doctor may change my treatment plan and discontinue the use of pain medications. Alternatively, I understand my doctor may decide to discharge me from his medical care.

16. I understand that using controlled substances and drinking alcohol could harm me or others. I agree to talk to my doctor about the issue of drinking alcohol and taking any medications he prescribes to me at the time I receive any prescriptions. I understand my failure to disclose the use of alcohol to my doctor may result in a modification of my treatment plan to one that does not include controlled substances or discharge from the practice.

17. I will continue with or begin participating in a recovery program if I have a history of chemical or substance abuse. I understand that use of illicit substances such as cocaine, marijuana, amphetamines, or heroin is sufficient grounds for discharge from this practice.

18. My doctor will manage my postoperative pain for 14 days after a surgical procedure. At which time if I still require pain medication I will contact my primary care physician or agree to be evaluated by Pain Management.

19. *Female patients:* I am not pregnant to the best of my knowledge and will use appropriate birth control while taking pain medications. If I become pregnant while taking pain medications, I understand that it may cause severe medical problems including death to my unborn child and I will report the pregnancy immediately to my doctor. I agree not to breast feed while I am taking pain medications, as the medication passes through my breast milk to my child and could cause severe medical problems including death.

Consequences of My Failure to Keep My Promises

I understand that if I fail to keep any of my promises in this document, or if I have misrepresented any fact, my doctor may decide to safely take me off my pain medications, as medically appropriate to do so, and continue treating my pain with non-drug treatments. I also understand that my doctor may decide to discharge me from his medical care. I also understand that it is a crime to give false information in attempt to obtain controlled substances.

Signatures and acknowledgement of copy received

Provider: _____ Date: _____

Patient: _____ Date: _____

Family member/caregiver: _____ Date: _____