



SPINE WORKS INSTITUTE™
COMPREHENSIVE SPINE CARE

****If your injury is a result of an auto accident or work injury,
please stop and see the front desk****

Date: _____

LAST NAME: _____ FIRST: _____ MI: _____ SSN: _____

STREET ADDRESS: _____ DOB: _____

CITY: _____ STATE: _____ ZIPCODE: _____ SEX: MALE FEMALE

MAIN PHONE # _____ SECONDARY # _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

RACE AMERICAN INDIAN OR ALASKA NATIVE ASIAN NATIVE HAWAIIAN BLACK OR
AFRICAN AMERICAN WHITE HISPANIC PACIFIC ISLANDER OTHER

EMERGENCY CONTACT: _____ PHONE # _____

PRIMARY CARE PHYSICIAN: _____

PRIMARY INSURANCE: _____ GUARANTOR NAME: _____

GUARANTOR DOB: _____ GUARANTOR SSN: _____ MALE FEMALE

ADDRESS: _____

ID NUMBER: _____ GROUP #: _____

SECONDARY INSURANCE: _____ GUARANTOR NAME: _____

GUARANTOR DOB: _____ GUARANTOR SSN: _____ MALE FEMALE

ADDRESS: _____

ID NUMBER: _____ GROUP #: _____

I give my consent for Spine Works Institute to perform any and all examinations, tests, treatment, and urine specimen procurement, and any other reasonable measures we deem necessary to diagnose and treat my condition.

Patient/Guardian Signature

Date

FINANCIAL POLICY

This financial policy contains important information about billing and payment for our professional services. It outlines your responsibility as the patient and our responsibilities with regards to billing and payment for our services.

- Our practice participates with many health insurance companies. Our business office will submit the claim for any service rendered to a patient who is a member of one of these plans. It is the patient's responsibility to provide us with current insurance information and to confirm that our doctor is participating in their insurance plan at the time of service. The burden of proof is the patient's responsibility and not the physician's responsibility.
- Claims will be submitted to the Primary and Secondary insurance carriers only. If you have a Tertiary carrier it will be the patient's responsibility to submit the claim for any additional payment needed.
- It is the patient's responsibility to ensure that any required authorization or referral for treatment is provided prior to the visit. In the absence of a required authorization or referral the patient's visit may be rescheduled or the patient may be personally responsible for payment of services rendered.
- There is a \$50 administrative fee for completion of medical forms or copies of medical records.
- There will be a financial fee of \$50 for each returned for insufficient funds.
- A \$50 fee will be charged for appointments not canceled 24 hours in advance or no showed, it is your responsibility to keep up with your scheduled appointments.
- Payment for professional services can be made with cash, check, credit or debit card.

INSURANCE & INSURANCE COLLECTIONS

Your insurance policy is a contract between you and your insurance company. If your insurance has not paid your account in full within 60 days the balance of your account will be due. It is the patient's responsibility to make sure the insurance reimburses the physician for services rendered. Unresolved balances may be placed with an outside collection agency. In the unfortunate situation where accounts are sent to a collection agency or attorney for non-payment, patients are responsible for collection fees, attorney fees, service charges, and accruing interest in addition to the unpaid balance. Once an account has been placed for collections, future appointments may not be made until you balances are paid. Life threatening emergency care will still be rendered.

COPAYS AND CO-INSURANCE

Office visit copay are due at time of service. If your office visit is applied to your deductible or co-insurance we will collect an estimated patient responsibility based on the current insurance fee schedule, there can be no exceptions due to contracting and compliance rules and regulations. You may incur additional charges after your claim has been processed by your insurance company. If you are unable to pay your copayment or co-insurance your appointment will be rescheduled, NO exceptions.

MEDICARE

As a participating provider, we will bill your Medicare carrier. You are responsible for deductible and 20% co-payment and we must collect each visit.

SECONDARY INSURANCE

Having more than on insurance DOES NOT necessarily mean that your services are covered at 100%. Secondary insurances will pay as a function of what your primary carrier pays. We will bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

INTEREST

We reserve the right to charge interest in the amount of 12% as provided by state law for unpaid balances over 30 days. This monthly finance rate is subject to change without notice, but will not exceed rates allowed applicable law.

NO WARRANTY OR GUARANTEE

I understand that no warranty or guarantee has been made to me as a result or cure.

ASSIGNMENT OF BENEFITS

I, the undersigned, certify that I (or my dependents) have insurance coverage with the insurance information provided by me and assign directly to Spine Works Institute all insurance benefits, if any, otherwise payable me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Physician to release all information necessary to secure the payment benefit. I authorize the use of this signature on all insurance submissions.

SIGNATURE OF PATIENT

PRINT NAME

DATE

Who to Contact

I hereby give permission to Spine Works Institute to disclose and discuss any information related to my medical conditions to/with the following:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ I do not wish to give permission for additional family members, relatives or close personal friends to have access to any information regarding my medical conditions

How to Contact

I wish to be contacted in the following manner:

Home Telephone:

_____ Okay to leave message with detailed information

_____ Leave message/voicemail with call back number only

Work Telephone:

_____ Okay to leave message with detailed information

_____ Leave message/voicemail with call back number only

Cell Phone:

_____ Okay to leave message with detailed information

_____ Leave message/voicemail with call back number only

Written Communication:

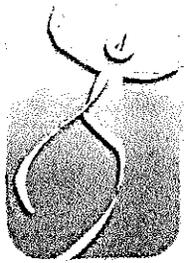
_____ Okay to leave message with detailed information

_____ Leave message/voicemail with call back number only

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that the request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information. THIS IS NOT A REQUEST TO RELEASE MEDICAL RECORDS.

Signature of Patient

Date



SPINE WORKS INSTITUTE™

COMPREHENSIVE SPINE CARE

Clinic Policy Agreement for Controlled Substance Prescriptions

"Controlled Substance Agreement"

The purpose of this Clinic Policy and Agreement for Controlled Substance Prescriptions ("Agreement") is to prevent misunderstanding about controlled substances that you are or will be taking. This is to help both you and your physicians comply with the laws regarding controlled pharmaceuticals/substances. In addition, the following cautions should be understood:

- Overuse or over dosage of pain medication can result in lethal side effects, including decreased ability to breathe and death.
- If pregnant, narcotics should be continued only with the approval of the patient's obstetrician/gynecologist.
- Narcotics may impair one's ability to drive and operate heavy machinery.
- Daily use of narcotics can lead to tolerance and physiological dependence.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this agreement.

I will use the medication(s) exactly as directed by my physician. My physician will specify the amount and frequency of medication refills.

I agree that I will voluntarily submit to a blood or urine test when requested by Dr. Joshua Hay to determine my compliance with my program of pain control medication and to determine medication levels. I understand that if I refuse to comply, I will not receive any prescriptions for controlled substances. I understand that if I test positive for illegal substances, treatment for chronic pain may be terminated.

I will not use any controlled medications, including opioids, narcotics, sedatives, stimulants, or anti-anxiety medications prescribed by or obtained from any other physician or source unless Dr. Joshua Hay

is fully informed of their use. In the event of an emergency that requires me to receive medications in the ER or hospital, I will inform Dr. Joshua Hay of this.

I understand that my physician will periodically review my process, and if the medication(s) are not improving my quality of life/functioning or are causing adverse effects they may be discontinued. I understand that I must keep my appointments with my doctor or the medication(s) may be discontinued or I may be discharged from the practice.

I further understand that my physician may request that I meet with a Psychologist or Psychiatrist periodically as indicated while in treatment with Dr. Joshua Hay.

I will not use any illegal controlled substances, including marijuana, cocaine, methamphetamine, ecstasy ECT.

I will safeguard my pain medication from loss, theft, diversion, or use by others. I understand that my prescription(s) and my medication(s) are exactly like money. If either are lost or stolen, they may NOT BE REPLACED.

I agree that refill requests of my prescriptions for pain medicine will be made available only at the time of an office visit or during regular office hours. No refills will be available during evenings, weekends, holidays or when Dr. Joshua Hay is not available. No prescriptions will be mailed to the patient or pharmacy.

I agree to use _____ Pharmacy, located at _____

Telephone number _____, for filling prescriptions of all my pain medications.

I authorize Dr. Joshua Hay and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize Dr. Joshua Hay to provide a copy of this Agreement to my pharmacy upon my request. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I understand that if I break or do not comply with this Agreement, my doctor may stop prescribing these controlled substances/pharmaceuticals, may taper of the medicine, as necessary, to minimize withdrawal symptoms, and/or may refer me for treatment through a drug dependence treatment program/specialist. I also understand that I may also be entirely discharged from Dr. Joshua Hay's practice for breaking or failing to comply with this Agreement.

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and making this Agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.
2. I have never been involved in the sale, illegal possession, misuse/diversion or transport of controlled substance(s) (narcotics, sleeping pills, nerve pills, or painkillers) or illegal substances (marijuana, cocaine, heroin ECT.).
3. No guarantee or assurance has been made as to the results that may be obtained from chronic pain treatment. With full knowledge of the potential benefits and possible risks involved, I consent to chronic pain treatment, since I realize that it provides me an opportunity to lead a more productive and active life.
4. I have reviewed the side effects of medication(s) that may be used in the treatment of my chronic pain. I fully understand the explanation regarding the benefits and the risks of these medication(s) and I agree to the use of these medication(s) in the treatment of my chronic pain.

A copy of this Agreement will be provided to me.

Patient's signature/date

Dr. Joshua Hay signature

Patient's printed name

Witness/Date