PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Social Security No.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Employment Status: ___ Full time ___ Part time ___ Retired ___ Unemployed ___ Student

Employer/School: _____ Phone: _____

Emergency Contact/Release Medical Information: _____ Relationship: _____

Phone: _____

__ **I authorize SC Pain & Spine Specialists to leave messages including Personal Health Information on my voicemail.**

__ **I authorize SC Pain & Spine Specialists to contact me via email and text message with appointment reminders, review requests, & general healthcare information. You may receive messages from us, our affiliates, & 3rd-party vendors that perform services on our behalf. Messages sent to you via email & text are not confidential methods of communications & may not be secure. Your consent is not a condition of services. Message & Data rates may apply.**

Email address: _____ Cell number for text message: _____

INSURANCE INFORMATION

Primary Insurance: _____ Effective Date: _____

Address: _____ Phone: _____

Guarantor: _____ Relationship: _____

Group No.: _____ ID No.: _____ Subscriber Date of Birth: _____

Secondary Insurance: _____ Effective Date: _____

Address: _____ Phone: _____

Guarantor: _____ Relationship: _____

Group No.: _____ ID No.: _____ Subscriber Date of Birth: _____

Authorization for release of information and to pay insurance benefits: SC Pain & Spine Specialists, LLC is hereby authorized to release information to healthcare providers that have referred me to this physician or who may benefit from this information as they care for me in the future. I authorize release of medical information to my insurance carrier, their utilization management agency, my employer, or any other agency that may be assisting in payment for my care. In the event of hospitalization, I hereby assign payment to SC Pain & Spine Specialists, LLC for surgical and/or medical benefits otherwise payable to me.

_____ _____

Patient Signature (if parent of guardian, please indicate relationship to patient) Date

NEW PATIENT PAIN EVALUATION FORM

Name: _____ Date of Birth: _____ Age: _____

Place of Birth: City _____ State _____ Country _____ Height: _____ Weight: _____

Sex: Male Female Dexterity: R-Handed L-Handed

Who referred you to our office? _____ Who is your Primary Care Provider? _____

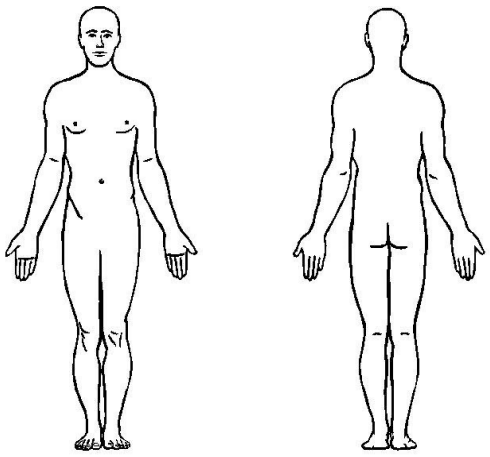
Practice: _____ Practice Address: _____

Phone No.: _____ Fax No.: _____

Where is your pain? _____

When did your pain start?_____

Please indicate your area of pain on the body diagram to the right. → → →



Please rate your pain level below using this scale:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Pain at its worst: _____ ***Pain at its best:*** _____

Current pain level: _____ Was there an injury or precipitating event? ☐ Yes ☐ No

If yes, please indicate **date of injury** and describe what happened: _____

_____

Describe the type of pain you have **all of the time**:

___ *aching* ___*burning* ___*shooting* ___*sharp* ___*stabbing* ___*dull* ___*cramping* ___*throbbing* ___*gnawing*

___ *sickening* ___*fearful* ___ *tearing* ___*tender* ___*other:* _____

Describe the type of pain that **comes and goes**:

___ *aching* ___*burning* ___*shooting* ___*sharp* ___*stabbing* ___*dull* ___*cramping* ___*throbbing* ___*gnawing*

___ *sickening* ___*fearful* ___ *tearing* ___*tender* ___*other:* _____

Where is the pain most present? _____

Does the pain radiate from the main area of pain? Yes No If yes, where? _____

Do you have any areas of numbness? Yes No If yes, where? _____ When did it begin? _____

Do you have any areas of weakness? Yes No If yes, where? _____ When did it begin? _____

Do you have any difficulty with bladder control? Yes No Bowel Control? Yes No

What makes your pain worse (activities or positions)? _____

What makes your pain better? _____

What are you currently taking for pain control? _____ Dosage/Frequency: _____

Patient Name: _____ **Date of Birth:** _____

Please list any other doctors you have seen for this problem: _____

Have you had any of the following studies? MRI CT scan X-ray Myelogram Date Performed:_____

Type of Exam (lumbar, cervical, brain, etc):_____ Facility: _____

Please check any therapies you have tried and indicate if they helped or not:

	Yes	No		Yes	No
☐ Nonsteroidal/anti-inflammatories (NSAID)	☐	☐	☐ Brace/Collar	☐	☐
☐ Physical Therapy	☐	☐	☐ Epidural steroid injections	☐	☐
☐ Oral steroids	☐	☐	☐ Chiropractic therapy/OMT	☐	☐
☐ Pain medication	☐	☐	☐ Tens Unit	☐	☐
☐ Muscle relaxants	☐	☐	☐ Surgery	☐	☐
☐ Other: _____	☐	☐			

Family Past Medical History:

Mother: _____ Living? Yes No Current age or age at death: _____

Father: _____Living? Yes No Current age or age at death: _____

Other history of family illness? Yes No If yes, please list: _____

Social History:

Single Married Divorced Widowed Children: Yes No If yes, how many? _____

Occupation:_____ Are you currently working? Yes No Full-time Part-time

Do you ***currently*** smoke? Yes No If yes, _____ pack(s) per day x _____ years

If no, did you ***previously*** smoke? Yes No If yes, _____ pack(s) per day x_____years Quit date: _____

Do you drink alcohol? Yes No If yes, _____ drinks per day? x _____ years

Do you ***currently*** use illicit drugs? Yes No Did you ***previously*** use illicit drugs? Yes No

If yes, Name of drug(s): _____

Military service? Yes No If yes, which branch? _____ Current Prior

Highest Level of Education : Grammar School High School College Degree: _____

For clinical staff only:

BP _____ P _____ R _____ O2 Sat. _____ T _____

CLINICAL SUMMARY:

Intake Clinician Signature:_____

REVIEW OF SYSTEMS

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Are you currently experiencing any of the following symptoms? Please check all that apply:

CONSTITUTIONAL	☐ Fever	☐ Weight Loss	☐ Fatigue
	☐ Night Sweats	☐ Difficulty Sleeping	
EYES	☐ Blurry Vision	☐ Double Vision	☐ Eye Dryness
	☐ Eye Pain	☐ Wears Glasses / Contacts	☐ Eye Redness
EAR, NOSE, THROAT	☐ Trouble Hearing	☐ Ringing in the Ear	☐ Vertigo (Spinning)
	☐ Ear Pain	☐ Hoarse Voice	☐ Slurred Speech
	☐ Trouble Swallowing		
CARDIOVASCULAR	☐ Chest Pain	☐ Irregular Heart Beat	☐ Fast Heart Beat
	☐ Limb Swelling	☐ Leg Pain with Walking	☐ Fainting
RESPIRATORY	☐ Trouble Breathing	☐ Chronic Cough	☐ Coughing up Blood
GASTROINTESTINAL	☐ Indigestion/Reflux	☐ Heartburn	☐ Abdominal Pain
	☐ Nausea	☐ Vomiting	☐ Bloody Stool
	☐ Diarrhea	☐ Constipation	☐ Excessive Thirst
GENITOURINARY	☐ Incontinence	☐ Painful Urination	☐ Blood in Urine
	☐ Have to Rush to Restroom	☐ Loss of Libido	☐ Erectile Dysfunction
	☐ Excessive Urination		
MUSCULOSKELETAL	☐ Muscle Pain	☐ Muscle Cramps	☐ Muscle Twitching
	☐ Loss of Muscle Bulk	☐ Neck Pain	☐ Back Pain
	☐ Joint Pain	☐ Joint Stiffness	☐ Joint Swelling
SKIN/INTEGUMENTARY	☐ Skin Rash	☐ Skin Discoloration	☐ Change in Sweating
	☐ Hair Loss	☐ Nail Changes	
NEUROLOGICAL	☐ Headaches	☐ Numbness	☐ Tingling
	☐ Weakness	☐ Tremors	☐ Clumsiness
	☐ Trouble Concentrating	☐ Trouble with Memory	☐ Blackouts
PSYCHIATRIC	☐ Feeling Depressed	☐ Feeling Anxious	☐ Hallucinations
	☐ Inappropriate Crying	☐ Inappropriate Laughing	☐ Loss of Enjoyment
	☐ Feeling Guilty/Worthless	☐ Suicidal Thoughts	
HEME/LYMPHATIC	☐ Abnormal Bleeding	☐ Abnormal Bruising	☐ Nose Bleeds
	☐ Lumps or "Swollen Glands"		
ENDOCRINE	☐ Heat Intolerance	☐ Cold Intolerance	

PAST MEDICAL/SURGICAL HISTORY

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Have you ever had or been diagnosed with any of the following? Please check all that apply:

NEUROLOGICAL (BRAIN & SPINE)

- ☐ Stroke (CVA)
- ☐ Mini-Stroke (TIA)
- ☐ Headaches / Migraines
- ☐ Seizures
- ☐ Fainting
- ☐ Parkinson's Disease
- ☐ Tumor
- ☐ Paralysis
- ☐ Restless Leg Syndrome (RLS)
- ☐ Family history of neurological disease

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure (CHF)
- ☐ Heart Murmur
- ☐ High Cholesterol (Hyperlipidemia)
- ☐ Atrial Fibrillation
- ☐ Heart Attack / Myocardial Infarction
- ☐ Mitral Valve Prolapse
- ☐ DVT - Blood clot in leg
- ☐ Varicose Veins
- ☐ Pacemaker / Defibrillator
- ☐ EKG - Date: _____
- ☐ Cardiac Stents - Date: _____
- ☐ Open Heart Surgery - Date: _____
- ☐ Peripheral Vascular Disease/Poor circulation

RESPIRATORY (LUNGS)

- ☐ Asthma
- ☐ Bronchitis
- ☐ Pulmonary Embolism (PE)
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Pneumonia
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Chronic Cough
- ☐ Use Oxygen
- ☐ Use a CPAP

ENDOCRINE

- ☐ Thyroid
- ☐ Diabetes

GASTROINTESTINAL

- ☐ Acid Reflux (GERD)
- ☐ Peptic (Stomach) Ulcers
- ☐ Diverticulosis
- ☐ Hemorrhoids
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome

GENITOURINARY

- ☐ Bladder Infections
- ☐ Enlarged Prostate (BPH)
- ☐ Kidney Stones
- ☐ Kidney Infections
- ☐ Kidney Dysfunction / Insufficiency
- ☐ Kidney Failure / Dialysis

DERMATOLOGY

- ☐ Fungal Infections
- ☐ Psoriasis
- ☐ Skin Cancer
- ☐ Delayed healing of wounds

OPHTHALMOLOGY (EYES)

- ☐ Wear Glasses or Contacts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataract: RIGHT LEFT
- ☐ Blindness: RIGHT LEFT

Patient Name: _____ Date of Birth: _____ Date: _____

OTOLARYNGOLOGY (EAR/NOSE/THROAT)

☐ Ear infections ☐ Sinus Problems ☐ Vertigo ☐ Hearing Loss

MUSCULOSKELETAL

☐ Arthritis (Osteoarthritis) ☐ Rheumatoid Arthritis ☐ Fibromyalgia

☐ Gout ☐ Connective Tissue Disease ☐ Lupus

☐ Knee Replacement - RIGHT Date: _____ LEFT Date: _____

☐ Hip Replacement - RIGHT Date: _____ LEFT Date: _____

HEMATOLOGIC/IMMUNE SYSTEM

☐ Anemia ☐ Low Platelet Count ☐ Bleeding Disorder

☐ Bleed or Bruise Easily ☐ Leukemia ☐ Lymphoma

☐ Hepatitis B ☐ Hepatitis ☐ HIV/AIDS

PSYCHIATRIC

☐ Bipolar ☐ Schizophrenia ☐ Anxiety

☐ Depression ☐ Suicidal Thoughts

GYNECOLOGICAL

☐ Pregnant ☐ Previous Pregnancies: _____ ☐ Previous Deliveries: _____

☐ Menopause ☐ Hysterectomy

CANCER

Type: _____ Chemotherapy Radiation

Other Treatment:

Please list any prior surgeries, implants, or hospitalizations not indicated above (include dates):

SC PAIN & SPINE SPECIALISTS LLC

UNIVERSAL MEDICATION FORM

Patient Name / DOB: _____

Today's Date: _____

PHARMACY NAME	PHONE NUMBER	LOCATION
ALLERGIES / Describe Reaction:		

I grant permission for SC Pain & Spine Specialists, LLC to review my pharmacy record online:* **YES / NO _____(initial)

Please list all current medications: Include **prescription** and over-the-counter medications such as **aspirin,** anti-inflammatories or antacids, as well as herbal supplements and vitamins, ginseng, garlic, fish oil, etc.
Also include medications taken **as needed** like nitroglycerin.

PATIENT TO COMPLETE			STAFF to complete at each Date of Service													
Current Medications	**Dose**	**How often do you take the medication?**														

Please list the provider that prescribes any anticoagulant, antiplatelet, or "blood thinner" medication(s) for this patient:

_____

Staff Initials	Staff Signature	Staff Initials	Staff Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used or disclosed. It also explains how you may get access to this information. Please review this notice carefully. The privacy of your health information is very important to us.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another physician or healthcare provider that may be treating you, or to any family member or friend that you may have designated.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of your PHI (Personal Health Information), or to request alternative means of communication to ensure privacy, such as only using home phone number or not contacting you at work.

Marketing Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages or letters).

PATIENT RIGHTS

Access: You have the right to obtain copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information as well as postage if you want the copies mailed to you. We will provide the information within 30-days of your written request.

Amendment: You have the right to request, in writing, that we amend your health information if you believe it is incorrect.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made

about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at an

alternative location, you may submit a written complaint to us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Practice Administrator who serves as the Privacy Office.

Please read and acknowledge below with your signature:

I acknowledge that I have received an electronic copy of the NOTICE OF PRIVACY PRACTICES from SC Pain & Spine Specialists, LLC and I consent to the uses described within it.

_____ _____

Signature of Patient or Legal Guardian Date

PATIENT RIGHTS & RESPONSIBILITIES

PURPOSE: To establish a list of patient rights and responsibilities.

The patient has the **right** to:

1. Become informed of his/her rights as a patient in advance of, or when discontinuing, the provision of care. Patient may use appointed representative.
2. Exercise these rights without regard to race, sex, cultural, educational, or religious background, and regardless of the source of payment for care.
3. To have considerate and respectful care, provided in a safe environment.
4. Remain free from seclusion or restraints of any form.
5. Coordinate his/her care with physicians and healthcare providers they will see.
6. Receive information from the physician about diagnosis, course of treatment, and the prospects for recovery in terms that he/she can understand.
7. Receive sufficient information about any proposed treatment or procedure in order to give informed consent or to refuse treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, the alternate course of treatment of non-treatment and the risks involved.
8. Have a family member or representative of his/her choice be involved in his/her care.
9. Full consideration of patient privacy concerning consultation, examination, treatment, and surgery.
10. Confidential treatment of all communications and records pertaining to patient care. Written permission will be obtained before medical records can be released to anyone not directly concerned with patient care.
11. Access information to his/her medical record.
12. Leave the facility, even against medical advice.
13. Have access to a facility grievance process.
14. Be informed by the physician or designee of the continuing healthcare requirements after discharge.
15. Examine and receive an explanation of the bill, regardless of the source of payment. Be able to know the fee for services that are to be provided prior to procedure.
16. Have all patient's rights apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient.
17. Have the right to refuse to participate in medical research.
18. Have the right to request if their physician is credentialed.
19. Have the right to know who has current ownership of SC Pain & Spine Specialists, LLC.
20. Advanced directives are honored prior to the onset of anesthesia. However, once anesthesia is administered, the patient will be fully resuscitated, unless prior arrangements have been made with the healthcare provider. The patient's advanced directives are reinstated after the patient is discharged from this facility.
21. All facility personnel performing patient care activities shall observe the above-listed patient rights.

PATIENT RIGHTS & RESPONSIBILITIES

The patient has the **responsibility** to:

1. Provide accurate and complete information concerning present complaints, past illnesses, hospitalizations, or any other health-related issues.
2. Follow the treatment plan established by the physician, including instructions by other providers or clinical staff of the Practice.
3. Express whether the risks, benefits, and/or alternative treatments related to the planned surgical procedure/treatment have been explained and understood.
4. Keep appointments or notify the facility/physician in advance if unable to do so.
5. Accept full responsibility for refusal of treatment and/or not following instructions.
6. Ensure that the financial obligations of his/her care are fulfilled as promptly as possible. The patient is responsible for all deductible and co-pay charges upon arrival at the facility.
7. Be respectful of the rights of others in the facility.
8. Always follow facility policies and procedures.
9. Obtain a ride to and from the facility when sedation is involved. There must be a responsible person to assume responsibility for the patient upon discharge.

Thank you for choosing SC Pain & Spine Specialists, LLC for your healthcare needs. This physician practice is owned and operated by Jason C. Rosenberg, MD.

Please read and acknowledge below with your signature:

I acknowledge that I have received an electronic copy of the Patient Bill of Rights from SC Pain & Spine Specialists, LLC and I consent to the uses described within it.

_____ _____

Signature of Patient or Legal Guardian Date

FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance about our office policies and what to expect at your visit allows for a good flow of communication and enables us to achieve this goal. Please read this carefully and do not hesitate to contact a member of our staff with any questions.

1. On arrival, please sign in at the front desk and present your current identification and insurance card(s) at every visit. We will check these against our current records for accuracy and update as needed to ensure that all claims are filed on your behalf with the most current information you have provided us. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL RECEIVE AN INVOICE AND WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED. YOU WILL HAVE 30 DAYS FROM THE DATE OF SERVICE TO SUBMIT CORRECT INSURANCE INFORMATION FOR US TO REBILL ON YOUR BEHALF.

2. According to your insurance plan, you are responsible for any and all deductibles, copays, and coinsurance. SC Pain & Spine Specialists will initiate prior authorizations for all procedures ordered.

   I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR THE COST OF THE PROCEDURE IF THE PROCEDURE IS CONSIDERED EXPERIMENTAL OR INVESTIGATIONAL BY MY INSURANCE CARRIER, AND/OR IS NOT COVERED UNDER MY MEDICAL POLICY FOR ANY OTHER REASON.

   Initial: _____

3. It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure, and what services are covered.

4. If our Providers do not participate in your insurance plan, payment in full will be required when service is rendered. Prior balances must be paid before your visit or procedure or we reserve the right to reschedule you until such time you can pay the balance due.

5. If you have no insurance, we require full payment in advance of our New Patient fee, and fees for all subsequent visits will be required to be paid upon check-in. If you are unable to pay in full at the time of your visit, we reserve the right to reschedule you until such time as you can pay the balance due.

6. All copayments are due at time of service. No exceptions will be considered as this is a Provider contractual obligation with insurance company, and we are bound to insurance contractual obligations.

7. Patient balances are billed immediately on receipt of your insurance plan's Explanation of Benefits (EOB) and are due within 10 days of receipt of your bill.

8. If previous arrangements have not been made with our office, any account balance outstanding for greater than 30 days will be considered past due and will be subject to collection activity. Any outstanding balance that is greater than 90 days will be forwarded to collection agency for further collection activity. **IF YOUR ACCOUNT IS SENT TO THE COLLECTION AGENCY, YOU**

WILL BE RESPONSIBLE FOR THE BALANCE FOR SERVICES RENDERED AND THE COLLECTION AGENCY FEES.

9. **CANCELLATION POLICY:** We require a 24-hour notice to cancel appointments. A fee will be imposed if you do not notify the Practice twenty-four hours prior to your appointment and/or if we receive no notice to cancel or reschedule your appointment. Our fees are as follows:

Established Patient No-Show Fee	$50.00
New Patient No-Show Fee	$100.00
Procedure No-Show Fee	$250.00

10. A $30.00 fee will be charged for any checks returned for insufficient funds. A credit card or cash will be required for any and all future payments. Checks will no longer be accepted under any circumstance.

11. There will be a minimum $25.00 administrative fee for any Medical Record or Patient Form requests. Pre-payment is required before any forms will be completed. Completed forms and records requests will be available for pickup within 7 to 10 days of fee paid.

12. Not all services provided by our office are covered by every plan. **Any service determined to not be covered by your plan will be your responsibility.**

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

_____	_____	_____
Signature of Patient or Responsible Party	**Relationship**	**Date**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____to release the following information from the health records of:

Patient Name: _____**Date of Birth:**_____

Covering the period of treatment from _____ to _____

Information to be Released:

☐ History & Physical ☐ Discharge Summary ☐ Emergency Room ☐ Progress Notes

☐ Consultation Reports ☐ Cardiac Studies ☐ Imaging Reports ☐ Laboratory Reports

☐ Other (please specify): _____

_____ I understand that this information may include references to treatments of drug or alcohol abuse, psychological illness, or test results for HIV/AIDS.
Please Initial

Purpose of Disclosure:

☐ Continued Health Care ☐ Insurance ☐ Legal

☐ Other (please specify): _____

This authorization shall remain in effect until such time as it is ***revoked in writing*** by the patient. A photocopy of this authorization is to be considered as valid as the original.

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that redisclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Fees will comply with all laws and regulations applicable to release of medical information.

_____ _____
Patient Signature **Date Signed**

_____
Relationship to Patient

Please release information to:

SC Pain & Spine Specialists, LLC | Phone: 843.839.7246 | Fax: 843.839.7323 | www.scpainandspine.com

GENERAL INSURANCE INFORMATION

Each insurance carrier has their own rules, policies, and procedures in order to allow payment for services. Below please find some of the most commonly used terms and definitions you should be aware of prior to receiving healthcare services from a Provider. It is your responsibility to know the terms of your plan prior to your visit in order to be prepared to meet the necessary requirements.

If your plan has a **deductible**, you must meet the deductible amount by paying the Provider *before* the insurance company will begin paying for any services you receive. If your deductible has been met, the carrier will then pay a percentage of the allowed service amount and an additional percentage may be due from the patient to the Provider (this is called **coinsurance**). The patient is also responsible to pay any **copay** required by their plan at every visit (this is separate from deductible and coinsurance amounts). Not every plan has all of these requirements which is why it is important to know about your individual plan.

Benefit Plan
A certificate of coverage, summary plan description, or other document or agreement which specifies the healthcare services to be provided or reimbursed for the benefit of a Participant (patient).

Deductible
A payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant to the Provider under a Benefit Plan prior to qualifying for reimbursement for subsequent healthcare costs under the Terms of a Benefit Plan.

Coinsurance
A payment that is the financial responsibility of the Participant to the Provider under a benefit plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than fee-for-service amount, as a percentage of a plan-determined fee schedule or as a plan-determined percentage of actual charges.

Copayment
A payment that is the financial responsibility of the Participant to the Provider under a benefit plan for covered services - a fixed dollar amount.

Medically Necessary / Medical Necessity
Services and supplies that satisfy the Medical Necessity/Medical Policy requirements under the applicable Benefit Plan. No service is a Covered Service unless it is deemed medically necessary. You will be informed if a service is not covered and will be asked to sign an Informed Financial Consent Form stating that non-covered services are the responsibility of the patient and must be paid in advance of services rendered.