NEW PATIENT PAIN EVALUATION FORM

Patient Name: _____ DOB: _____ Age: _____

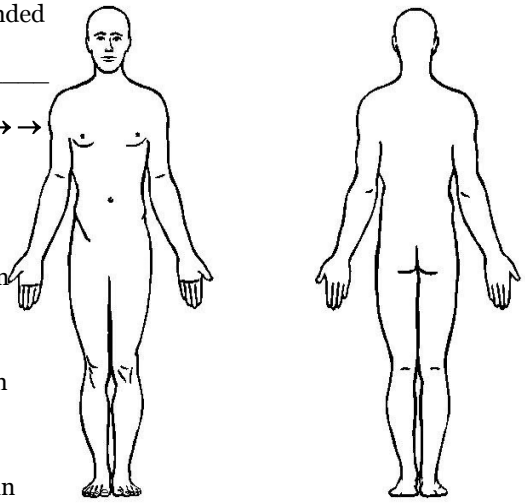
Place of Birth: City _____ State____ Country _____ Who referred you to our office? _____

Who is your primary care doctor? Name: _____ Practice Name: _____

Height: _____ Weight: _____ Please circle: Male Female R-Handed L-Handed

Where is your pain? _____

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



Please rate the intensity of your pain below:

What is the pain at its **WORST**?

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

What is the pain at its **BEST**?

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

What is your **CURRENT** *pain level?*

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

When did your pain start? _____

Was there an injury or precipitating event? Yes / No If yes, please indicate date of injury and describe what happened: _____

_____

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

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

Have you had back surgery? Y / N Type/Date/Facility: _____

Please indicate which of the following therapies you have tried FOR THIS PROBLEM and whether they have helped.

NSAIDs	Did it help? Yes / No / Not Tried	Brace/Collar	Did it help? Yes / No / Not Tried
Physical Therapy	Did it help? Yes / No / Not Tried	Epidural steroid injections	Did it help? Yes / No / Not Tried
Oral steroids	Did it help? Yes / No / Not Tried	Chiropractic therapy/OMT	Did it help? Yes / No / Not Tried
Pain medication	Did it help? Yes / No / Not Tried	Tens Unit	Did it help? Yes / No / Not Tried
Muscle relaxants	Did it help? Yes / No / Not Tried	Other:_____	Did it help? Yes / No / Not Tried

FOR CLINICAL STAFF ONLY: BP _____ P _____ R _____ O2 Sat. _____

CLINICAL SUMMARY:

Intake Clinician Signature: _____

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

Have you seen other doctors for this problem? Yes / No Name(s): _____

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? _____

Describe the **TYPE** of pain you are having (circle all that apply):

aching burning shooting sharp stabbing dull cramping throbbing gnawing

sickening fearful punishing cruel tearing tender other: _____

Where is the pain most present? _____

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

What makes your pain worse? _____

What makes your pain better? _____

What daily activities are currently affected by your pain/discomfort (e.g., washing dishes, getting the mail, cooking)? _____

_____

What is the **ONE** most important activity you wish you could do today, but can't do because of your pain? _____

_____

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

Prescribing Physician: _____ Phone No. _____

Did you complete a Universal Medication Form? Yes / No **ALLERGIC TO IODINE OR SHELLFISH?** Yes / No

OTHER ALLERGIES? Please indicate type: _____

Do you currently take **ASPIRIN**? Yes / No Other **BLOOD THINNERS**? Yes / No If yes, please list: _____

_____

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 How many? _____

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

Do you ***currently*** **smoke**? Yes / No How much per day? _____ For how many years? _____

Did you ***previously*** **smoke**? Yes / No How much and for how many years? _____ Quit date: _____

Do you **drink alcohol**? Yes / No How much? _____ How often? _____

Do you **use illicit drugs**? Yes / No Current or Prior? _____ Name of Drug(s): _____

Did you serve in the **Military**? Yes / No Current or Prior? _____ Branch: _____

Highest Level of **Education** (please circle): Grammar School / High School / College Degree: _____

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 **TODAY**:

CONSTITUTIONAL
- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Weakness
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Difficulty Sleeping
- ☐ Decline in Health

OPHTHALMOLOGY (EYES)
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Eye Pain
- ☐ Vision Loss
- ☐ Sensitivity to Light
- ☐ Dry Eyes

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Short of Breath on Exertion
- ☐ Swelling of Legs
- ☐ Varicose Veins
- ☐ Leg Pain with Walking
- ☐ Fainting
- ☐ Recent EKG

MUSCULOSKELETAL
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Muscle Stiffness
- ☐ Muscle Cramps
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Instability/Falls

GASTROINTESTINAL
- ☐ Indigestion
- ☐ Heartburn
- ☐ Dry Mouth
- ☐ Nausea
- ☐ Vomiting
- ☐ Regurgitation
- ☐ Abdominal Pain
- ☐ Loss of Appetite
- ☐ Bloody Stools
- ☐ Diarrhea
- ☐ Constipation
- ☐ Jaundice
- ☐ Rectal Bleeding

OTOLARYNGOLOGY (EAR/NOSE/THROAT)
- ☐ Trouble Hearing
- ☐ Ringing in the Ears
- ☐ Vertigo (Spinning)
- ☐ Ear Pain
- ☐ Ear Discharge
- ☐ Hoarse Voice
- ☐ Trouble Swallowing

ENDOCRINE
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Excessive Appetite
- ☐ Increased Thirst
- ☐ Excessive Urination
- ☐ Change in Sweating

SKIN/INTEGUMENTARY
- ☐ Hair Loss
- ☐ Nail Changes
- ☐ Dryness
- ☐ Itching
- ☐ Suspicious Moles
- ☐ Skin Rash

NEUROLOGICAL
- ☐ Headaches
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Fainting
- ☐ Clumsiness
- ☐ Blackouts
- ☐ Tremors
- ☐ Seizures
- ☐ Paralysis
- ☐ Memory Loss
- ☐ Slurred Speech
- ☐ Dizziness

RESPIRATORY
- ☐ Chronic Cough
- ☐ Coughing Blood
- ☐ Short of Breath
- ☐ Wheezing
- ☐ Recent Chest X-Ray

HEME/LYMPHATIC
- ☐ Abnormal Bleeding
- ☐ Abnormal Bruising
- ☐ Nose Bleeds
- ☐ Swollen Glands

GENITOURINARY
- ☐ Incontinence - Bowel
- ☐ Incontinence – Bladder
- ☐ Frequency/Urgency
- ☐ Painful Urination
- ☐ Blood in Urine

PSYCHIATRIC
- ☐ Feeling Depressed
- ☐ Memory Loss
- ☐ Disorientation
- ☐ Hallucinations
- ☐ Suicidal Thoughts

Revised 03/16/2022

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)
- ☐ Seizures
- ☐ Fainting
- ☐ Tumor
- ☐ Paralysis
- ☐ Headaches
- ☐ Parkinson's Disease
- ☐ Migraines
- ☐ Restless Leg Syndrome (RLS)
- ☐ Family History of Neurological Disease

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

GASTROINTESTINAL
- ☐ Acid Reflux (GERD)
- ☐ Peptic Ulcers (Stomach)
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Diverticulosis
- ☐ Hemorrhoids
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Vomiting
- ☐ Loss Of Appetite
- ☐ Rectal Bleeding

DERMATOLOGY
- ☐ Rashes
- ☐ Psoriasis
- ☐ Fungal Infections
- ☐ Delayed Healing of Wounds
- ☐ Skin Cancer

MUSCULOSKELETAL
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Connective Tissue Disease
- ☐ Knee Replacement - Please Circle: Right Left
  Date: _____
- ☐ Hip Replacement - Please Circle: Right Left
  Date: _____

PSYCHIATRIC
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Anxiety
- ☐ Depression
- ☐ Suicidal Thoughts

CANCER:
Type: _____ ☐ Chemotherapy ☐ Radiation
Other Treatment: _____

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ High Cholesterol
- ☐ Heart Murmur
- ☐ Atrial Fibrillation
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Varicose Veins
- ☐ Mitral Valve Prolapse
- ☐ DVT - Blood Clot
- ☐ Pacemaker/Defibrillator
- ☐ Peripheral Vascular Disease/Poor Circulation
- ☐ Open Heart Surgery - Date: _____
- ☐ Cardiac Stents - Date: _____
- ☐ EKG - Date: _____

ENDOCRINE
- ☐ Thyroid
- ☐ Diabetes

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

OPHTHALMOLOGY (EYES)
- ☐ Wear Glasses/Contacts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataract: Please Circle: Right Left
- ☐ Blindness: Please Circle: Right Left

OTOLARYNGOLOGY (EAR/NOSE/THROAT)
- ☐ Ear Infections
- ☐ Sinus Problems
- ☐ Vertigo (Spinning)
- ☐ Hearing Loss

HEMATOLOGIC/IMMUNE SYSTEM
- ☐ Low Platelet Count
- ☐ Anemia
- ☐ Bleed/Bruise Easily
- ☐ Bleeding Disorder
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Hepititis B
- ☐ Hepatitis C
- ☐ HIV/AIDS

GYNECOLOGICAL
- ☐ Currently Pregnant
- ☐ Menopause
- ☐ Hysterectomy
- ☐ Previous Pregnancies: # _____
- ☐ Previous Deliveries: #_____

PRIOR SURGERIES, **IMPLANTS** or **HOSPITALIZATIONS** not indicated above (include dates): _____

_____

_____

UNIVERSAL MEDICATION FORM

Patient Name / DOB: _____

Today's Date: _____

PHARMACY NAME	PHONE NUMBER	LOCATION	
COVID VACCINES	**VACCINES: Date of Last Dose**	**HEIGHT**	**WEIGHT**
1st Dose:	Flu:		
2nd Dose:	Pneumonia:		
Booster:	Shingles:		
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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SC PAIN & SPINE SPECIALISTS LLC

UNIVERSAL MEDICATION FORM

Patient Name / DOB: _____

Today's Date: _____

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 the anticoagulant, antiplatelet, or "blood thinner" medication(s) for this patient:

_____

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

PATIENT REGISTRATION FORM

Patient First Name:_____ Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Social Security No.: _____ Date of Birth: _____ Sex: Male / Female

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

Employer/School: _____ Phone: _____

Emergency Contact/Release Medical Information: _____

Relationship: _____ Phone: _____

Referring Physician: _____ 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

_____ _____

SCP&SS Representative Date

Updated 11/11/21

SC PAIN & SPINE SPECIALISTS LLC

FINANCIAL POLICY

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

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.

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

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. Our office offers a one-time installment plan for the New Patient fee and/or procedure fees in excess of $200.00. You must sign an Installment Agreement authorizing us to use a debit or credit card to process your balance in three monthly installments not to exceed 60 days from original appointment/date of service. No more than one Installment Agreement will be authorized to be in effect per patient. If an authorized draft is declined for any reason, the patient is considered to be in breach of the Installment Agreement, and the balance will be due immediately from patient. No further appointments will be honored until past due balances are paid in full.

10. **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	$25.00
New Patient No-Show Fee	$50.00
Procedure No-Show Fee	$100.00

11. 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.

12. 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.

13. 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**

SC PAIN & SPINE SPECIALISTS LLC

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 ☐ Personal Reasons ☐ 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

SC PAIN & SPINE SPECIALISTS LLC

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 Officer.

SC PAIN & SPINE SPECIALISTS LLC

PATIENT ACKNOWLEDGEMENT

Patient Name (please print): _____ Today's Date: _____

Please read and acknowledge below with your signature:

I acknowledge that I have received a copy of the NOTICE OF PRIVACY PRACTICES from SC Pain & Spine Specialists, LLC (or that it was made available to me but I did not wish to receive it) and I consent to the uses described within it.

_____
Signature of Patient, Parent or Legal Guardian

SC PAIN & SPINE SPECIALISTS LLC

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.