CAROLINA PAIN PHYSICIANS
2811 Tricom Street North Charleston, SC 29406
Office: (843) 737-0437 Fax: (843) 789-3053

Financial and Office Policies

Thank you for choosing Carolina Pain Physicians for your medical needs. The following financial and office policies have been established to assist us providing the highest quality medical care.

Fill out the following information:

Last Name: _____ First Name: _____ MI: ____ Preferred Name: _____

Sex: ☐ Male ☐ Female DOB: _____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Consent to text? ☐ Yes ☐ No

Patient Email: _____ Would you like portal access via email? ☐ Yes ☐ No

Contact preference: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐ Portal Language: ☐ English ☐ Other: _____

Race/Ethnicity: ☐ Caucasian ☐ African-American ☐ Latino ☐ Other: _____

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

Pharmacy name and phone: _____

Referring provider: _____ Primary Care Provider: _____

Primary Insurance Company: _____ ID #: _____
Are you the primary insurer? ☐ Yes ☐ No If not list name and DOB: _____

Secondary Insurance Company: _____ ID#: _____
Are you the primary insurer? ☐ Yes ☐ No If not list name and DOB: _____

Please initial each line after reading the paragraph to acknowledge your understanding of the policy.

_____ **Insurance:** It is your responsibility to know and understand your coverage and benefits. As a courtesy, we will file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number and relationship to the patient to file all claims. Patients are responsible for all fees at the time of service including co-payments, coinsurance, deductibles and non-covered services. At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly. **Our office does NOT backdate any insurance claims including Medicaid. We will file active insurances provided to our office at the time of service only.** If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. We do offer self-pay rates at a reduced price. We do NOT accept checks.

_____ **Past Due Balances:** Accounts that are not paid within sixty (60) days from the date of service may be sent to a collections agency. A collection fee will be added to the balance. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

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Financial and Office Policies continued

_____ **No Show/Late Cancelation Policy:** No shows and late cancellations cause our office financial hardship and reduce our ability to provide patient care to those that need it. Our office requires at least 24-hour notice if you cannot make your scheduled appointment. We provide patients with one courtesy missed appointment. After your courtesy is used a no show fee of $25.00 will be charged to your account for each occurrence and must be paid before any future appointments can be scheduled. This fee is not billable to your insurance company and is the sole responsibility of the patient.

_____ **Ancillary Fees:** Fees that will be charged include the following:

- $25.00 no show/late cancellation fee
- $10.00 per page paperwork fee
- $30.00 insufficient funds fee
- $15.00 medical record request clerical fee plus $0.65 per page 1-30 and $0.50 per page 31 on.
- $5.00 per month payment processing fee for accounts not paid in full

_____ **Refunds:** If you have a credit on your account, we will gladly refund the amount within sixty (60) days of your request.

_____ **Dismissal Process:** There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally or physically abusive to staff
- Failure to pay financial obligations
- Repeated cancellations/rescheduling within 24 hours

We will notify you in the event that you are being dismissed from our practice. If you have an emergency within thirty (30) days of your dismissal, one of our providers will be available for advice. After the thirty (30) days, you will no longer be seen at our practice by any provider. Being dismissed does NOT in any way release you from your financial responsibility.

_____ **Prescription Consent:** Our office uses multiple sources to collect prescription information including surescripts, your other providers, your insurance company, DHEC, and electronic sources. It is vital that we are 100% correct on your current medications so that we avoid any medication interactions that could occur. It is ultimately the patient responsibility to keep us updated as all the sources may not be completely accurate. Please notify us of any medication changes as soon as possible.

Patient Acknowledgement:

I, _____, have read, understand, and agree to the Financial and Office Policies. I consent to treatment by the providers at Carolina Pain Physicians. I authorize Carolina Pain Physicians to furnish my information to my insurance carriers for claim payment. I agree to pay at the time of service. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I authorize Carolina Pain Physicians to communicate with my pharmacy, insurance companies, and my other providers regarding my healthcare in order to provide me with the best possible medical care. By signing this form, I am agreeing that the personal information at the top of this page is correct and up-to-date. I understand that Carolina Pain Physicians will only file the current active insurances listed at the top of this page. Any insurance changes are my responsibility to inform the office of at the time of service. Any incomplete or inaccurate information is my responsibility for which I will be held financially liable. Carolina Pain Physicians is not responsible for refiling any claims due to patient error. By signing below, I am agreeing to the terms of the Carolina Pain Physicians policies. I acknowledge this form was signed electronically and may not exactly match my written signature. I understand that putting my mark or signature below makes this a binding legal agreement.

Signature: _____ Date: _____

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HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already taken action in reliance thereon.

I authorize the practice to disclose or provide protected health information about me to the individual(s) listed below (list each family member, friend, or other individual to receive PHI):

Name: _____ Phone: _____

Relationship: _____ ☐ All information ☐ Appointment ☐ Financial ☐ Health

Name: _____ Phone: _____

Relationship: _____ ☐ All information ☐ Appointment ☐ Financial ☐ Health

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

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PAIN MANAGEMENT AGREEMENT

The purpose of this agreement is to prevent misunderstandings about certain medicines you will be taking for pain management. This is to help you and your doctor to comply with the law regarding controlled pharmaceuticals.

1. I understand this agreement is essential to the trust and confidence necessary in a doctor/patient relationship. The physicians plan for treatment relies on my compliance with this agreement.

2. I understand that there are possible adverse effects of opioid medications that can be potentially dangerous. These risks include, but are not limited to, addiction, physical dependence, psychological dependence, increased risk of fall and impaired judgment. Patients should not drive, operate heavy machinery or engage in other activities that would place themselves or others in danger for several days after changing a medication dose or initiating a new medication. These activities should not be resumed until any impairing side effects have resolved.

3. I understand that breaking this agreement is grounds for dismissal from the practice and discontinuation of all opioid medications. A drug dependence treatment program may be recommended.

4. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve pain.

5. I will not use any illegal controlled substances, including marijuana, cocaine, etc.

6. I will not share, sell or trade my medication with anyone.

7. I will not attempt to obtain any controlled medicines from any other provider. If I am prescribed controlled medications by another provider for a new condition (after surgery, in the emergency room, etc.), I will call to notify this office as soon as possible. I will also ensure that the other provider is aware of the medicines prescribed to me from this office.

8. I will safeguard my pain medicine from loss or theft. Lost or stolen medicines will not be replaced.

9. I agree that refills of my prescriptions for pain medicine will be made only at the time of an office visit or during regular office hours. No refills or medication changes will be available by phone or on evenings and weekends.

10. I agree to use only one Pharmacy for filling prescriptions for all of my pain medicine. My pharmacy of choice is

_____

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

12. I agree that I will submit to a blood or urine test at any time, if requested by my doctor, to determine my compliance with my program of pain control medicine. In addition, I may be required to present to the office with all medications (pill bottles) for a pill count and urine drug screening within 24 hours shall the office require any reports that I may not be taking my medication as prescribed. Failure to report within 24 hours may result in the loss of controlled medications being prescribed to control my pain.

13. I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine at a greater rate will result in my being without medication for a period of time.

14. I will utilize the after-hours emergency line for post-procedure complications ONLY. I understand that attempting to use this line for medication refills or for any reason other than post-procedure complications may result in dismissal from the practice.

15. I understand that non-emergent medical and prescription concerns will NOT be addressed via phone. Designated same-day appointments are available for patients. I understand that these are work-in appointments and that I may have an extended wait time.

16. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document is available to me as requested.

Signature: _____ Date: _____