GENERAL CONSENT FOR MEDICAL TREATMENT

[Patient/Patient's guardian or legal representative] agree to permit the doctors, other authorized health care providers and staff of the clinic or ambulatory surgery facility affiliated with Lenchig Spine and Pain Institute (and identified above) to perform tests and other services they deem necessary for my care. I understand that I have the right to make informed decisions about my health care treatment, and that I have the right to refuse any procedure or treatment. These may include, but are not limited to, vital signs, lab tests, drawing blood for lab tests, x-rays and other imaging services. I understand that, except in an emergency, any further treatment or procedures will be performed only after I have been informed of the benefits, material risks and possible complications associated with such treatment or procedures and after I have given my consent.

Patient's Printed Name: _____

_____ Date: _____
Patient's Signature

_____ Date: _____
Parent or Guardian (if applicable): Signature

_____
Parent or Guardian: Printed Name

_____ Date: _____
Patient's Legal Representative (if applicable): Signature

_____
Parent's Legal Representative: Printed Name

FINANCIAL POLICY

This Financial Policy is provided to you by **Lenchig Spine and Pain Institute** on behalf of its affiliated health care professionals and ambulatory surgery facilities. As used in this form, "You" and "you" means the patient whose name is printed below. "We", "we", and "our" means the clinic and staff who provide your medical treatment and care, and if applicable, the ambulatory surgery center and staff where procedures and other services are provided to you.

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following financial policy and sign. If you have any questions or concerns, please ask our staff.

INSURANCE

As the responsible party, you are responsible for providing us with up-to-date insurance information. We will keep a copy of your insurance card(s) on file. Kindly report any changes in your insurance coverage immediately by telephone or upon your arrival at your appointment. You may be responsible for the full amount if your insurance changes and you do not notify our office.

REFERRALS

If your insurance plan requires referrals from your PCP to our office, YOU are responsible for obtaining the referral. If you do not obtain a required referral from your PCP, you may be responsible for the full amount for services rendered. Please check with your health plan or insurance company if you are not sure if a referral is required for you to be seen in our office.

Patient Responsibilities

Copays must be paid at the time of service. Please come prepared to pay the specialist copay at each visit, or we may require you to reschedule.

ASSIGNMENT OF BENEFITS AND PAYMENT RESPONSIBILITY

As a courtesy, we will submit your bills to your insurance carrier(s) for processing. By signing below, you give Lenchig Spine and Pain Institute the right to release your medical records and information to your available insurance providers or other third-party payers to receive payment for services rendered Lenchig Spine and Pain Institute. You assign payment otherwise payable to you from Medicare, Medicaid, insurance carriers, employee's health benefit plans and other third-party payers to Lenchig Spine and Pain Institute and its affiliated health care facilities, practices and professionals

who provide services, care, or treatment to you. Any balances due after insurance processing will be your responsibility and will be due upon receipt. **If you fail to pay any balance within 60 days, you may not be seen in the office until said balance is settled. Failure to pay will result in the ability to schedule future appointments.**

MEDICARE

Medicare patients are responsible for their annual deductible, coinsurance, and any non-covered services for which you agree to pay (Advanced Beneficiary Notice). We will bill your secondary insurance as appropriate to be processed in accordance with your plan. Any balances due after insurance processing will be your responsibility and will be due upon receipt.

MOTOR VEHICLE ACCIDENT

If your charges are related to a motor vehicle accident, and you have Med Pay or Personal injury protection (PIP) coverage, we will bill your auto insurance carrier. Any balances not covered by your carrier are your responsibility.

WORKERS COMPENSATION

We will submit all claims to your worker's compensation carrier **only if you let our office know** that you have a work-related injury or illness and that you have made or intend to make a claim for workers compensation insurance coverage. You agree that you may be financially responsible for treatment and services rendered if you fail to inform our office that your visit relates to a work-related injury or illness and that you have made a claim or will make a claim for workers compensation insurance coverage.

PATIENTS WITHOUT INSURANCE

Patients are charged a fee for service rate. Payments are due at the time of service.

LATE CANCELLATION/NO-SHOW FEES

We require 24 hours' notice for canceling an appointment. If you do not give adequate notice or fail to show up for your appointment, we reserve the right to charge a $75.00 fee for a missed appointment and $200.00 for a missed procedure. The fee must be paid prior to rescheduling the missed appointment.

RETURNED CHECKS

Each returned check is subject to a $25.00 service fee.

I have read, understand and agree to the above Financial Policy.

Patient's Printed Name: _____

_____ Date: _____
Patient's Signature

_____ Date: _____
Parent or Guardian (if applicable): Signature

_____
Parent or Guardian: Printed Name

_____ Date: _____
Patient's Legal Representative (if applicable): Signature

_____
Parent's Legal Representative: Printed Name

CONSENT TO RECEIVE CERTAIN METHODS OF COMMUNICATION

By signing below, or otherwise providing my phone number to Lenchig Spine and Pain Institute, [**Patient/ Patient's guardian or legal representative**] authorize and expressly consent to receive SMS/text messages and phone calls from or on behalf of Lenchig Spine and Pain Institute, its affiliated facilities, practices and professionals, and their partners and affiliates, at any telephone number I provide at this time or later. This includes text messages and calls placed using automated dialing technology and pre-recorded messages and includes (without limitation) calls and texts that contain advertising or relate to debt collection and those relating to medical care. I understand that my consent is not a condition of purchasing or receiving any service and that I may revoke my consent at any time. I understand that if I do not wish to receive calls or SMS/texts or later wish to withdraw my consent, it is my responsibility to send **an email to Team@TreatingPain.com, call (855)-836-7246, or respond "STOP" to a text message**. For each phone number provided below, I represent that I am authorized to give this consent with respect to that phone number and to do so on behalf of all users of the phone number. I further agree to notify Lenchig Spine and Pain Institute immediately in the event that any of the phone number(s) shown below is changed or is no longer registered to me. I hereby acknowledge that I have read and agree to all of the terms of this consent.

I consent to receive phone calls, voicemails and text messages at the following phone number(s):**[DO NOT PROVIDE ANY PHONE NUMBER IF YOU DO NOT WISH TO RECEIVE ANY RECORDED OR TEXT MESSAGES AT THAT PHONE NUMBER]**

□ Home Phone #_____

□ Cell Phone #_____

□ Work Phone #_____

If there are any changes to this information, you understand that you must notify us of the change in writing.

ACCESS TO MY INFORMATION

Please list the names below of anyone who may need to speak to us regarding your health information.

LSPI may release my health information to the following people:

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

If there are any changes to this information, you understand that you must notify us of the change in writing.

AUDIO/VIDEO ACKNOWLEDGEMENT

Please be advised that in order to enable us better to assure compliance with HIPAA privacy and security laws and regulations and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited.

We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Patient's Printed Name: _____

_____ Date: _____
Patient's Signature

_____ Date: _____
Parent or Guardian (if applicable): Signature

_____
Parent or Guardian: Printed Name

_____ Date: _____
Patient's Legal Representative (if applicable): Signature

_____
Parent's Legal Representative: Printed Name

Authorization for Access to Medication History

Lenchig Spine & Pain Institute uses secure technology to connect to your medication history data stored in community pharmacies and pharmacy benefit managers' databases. This allows our healthcare providers to make informed decisions about your care.

By signing below, you grant permission for our providers to electronically access your medication history. You understand that this information will be used solely for your treatment and care.

Please note that you have the right to revoke this authorization at any time. However, refusing or revoking authorization may limit our ability to provide comprehensive care.

_____

Print Name of Patient

_____

Signature of Patient or Patient's Legal Representative

_____

Date

Lenchig SPINE & PAIN INSTITUTE

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth Lenchig Spine and Pain Institute's privacy practices and my rights regarding privacy of my protected health information.

PATIENT SIGNATURE (or Representative) **DATE**

FOR OFFICE USE ONLY

We have made every possible effort to obtain written acknowledgement of receipt of our notice of privacy practices from this patient but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement
- ☐ We were unable to communicate with the patient
- ☐ Other (please provide specific details)

_____
_____
_____
_____

_____ _____

Employee Signature Date

NATIONAL® Spine & Pain CENTERS

A Patient's Rights

Your Rights and Responsibilities as Our Patient

Quality Treatment You Can Expect

PATIENT RIGHTS

The patient has the right to:

- Be informed of his/her rights in advance of, receiving care. The patient may appoint a representative to receive this information.
- Exercise these rights without regard to race, color, national origin, age, disability, sex, sexual orientation, religious background, physical handicap, or the source of payment for care.
- Be provided with a qualified interpreter free of charge if you have limited English proficiency. The patient has the right to decline language assistance services.
- Receive considerate, respectful and dignified care, provided in a safe environment, with the protection of privacy, free from all forms of abuse, neglect, harassment and/or exploitation.
- Receive appropriate assessment and management of pain.
- Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see them. The patient has a right to request a change in providers if other qualified providers are available.
- Receive complete information from his/her physician about his/her illness, course of treatment, alternative treatments, outcomes of care (including unanticipated outcomes), and prospects for recovery in terms that he/she can understand.
- Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
- Participate in the development and implementation of his/her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
- Refuse medication and treatment to the extent permitted by law and to be informed of the medical consequences of refusal.
- Receive a copy of a clear and understandable itemized bill and receive an explanation of his/her bill regardless of the source of payment.
- Receive upon request, full information and necessary counseling on the availability of the known financial resources for his /her care, including information regarding facilities discounts and charity policies.
- Know which facility rules and policies apply to his/her conduct while a patient.
- Have all patient rights apply to the person who may have a legal responsibility to make decisions regarding medical care on behalf of the patient.
- Receive treatment for any emergency medical condition that could deteriorate from failure to provide treatment.
- Full consideration of privacy concerning his/her medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his/her health care.

NATIONAL® Spine & Pain CENTERS

A Patient's Rights

- Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her permission will be obtained before medical records can be made available to anyone not directly concerned with their care.
- Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language-impaired patient will be appropriate to the impairment.
- Access information contained in his/her medical record per federal guidelines.
- Receive a prompt and reasonable response to questions and requests.
- Be advised of the facility's grievance process, should he/she wish to communicate a concern regarding the quality of the care they received. Notification of the grievance process includes: whom to contact to file a grievance and that he/she will be provided with written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his/her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
- Be advised of contact information for the state agency to which complaints can be reported, as well as contact information for the Office of the Medicare Beneficiary Ombudsman.
- Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting their care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
- Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
- Be informed by his/her physician or a delegate thereof of the continuing healthcare requirement following their discharge from the facility.
- Be informed if Medicare is eligible, upon request and in advance of treatment, whether the health care provider or healthcare facility accepts the Medicare assignment rate.
- Receive upon request, prior to treatment, a reasonable estimate of charges for medical care.

PATIENT RESPONSIBILITIES

- The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past illnesses, hospitalizations, medications (including over-the-counter products and dietary supplements, prescriptions), allergies and sensitivities and other matters relating to his/her health.
- The patient is responsible for keeping appointments and for notifying the facility or physician when he/she is unable to do so.
- The patient is responsible for asking questions when he/she does not understand what they have been told about the patient's care or what they are expected to do.
- The patient is responsible for following the treatment plan established by his/her physician, including the instructions of nurses and other health professionals as they carry out the physician's orders.
- The patient is responsible for reporting to the health care provider any unexpected changes in his/her condition.
- The patient is responsible for providing a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if applicable.

A Patient's Rights

- In the case of pediatric patients, a parent or guardian is to remain in the facility for the duration of the patient's stay in the facility.
- The patient is responsible for his/her actions should you refuse treatment or not follow your physician's orders.
- The patient is responsible for assuring that the financial obligations of his/her care are fulfilled prior to surgery or other services.
- The patient is responsible for following facility policies and procedures.
- The patient is responsible for being considerate of the rights of other patients and facility personnel.
- The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.

Patient Complaint or Grievance:

If you have a problem or complaint, please speak to the receptionist or your caregiver. We will address your concern(s) promptly. If necessary, your problem or complaint will be advanced to the Administrator for resolution. You will receive a letter or phone call to inform you of the actions taken to address your complaint.

Please Address Questions or Concerns to:
Compliance/Privacy Officer
National Spine & Pain Centers
5280 Corporate Drive
Suite C-250
Frederick, MD 21703
Phone: 561-279-3613
Web: www.treatingpain.com
Compliance@treatingpain.com

We recognize that you have a choice for healthcare services, and we are grateful that you have chosen us as your provider.

For more information or to report a problem or if you have questions or would like additional information, please contact the Privacy Officer at compliance@treatingpain.com. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

It is important for you to know what you can expect from our relationship.

We want you to be satisfied with the treatment you receive. Please notify your physician or another member of our staff if there is any way we can serve you better.

Visit our website: www.treatingpain.com

By signing this document, I acknowledge that I have received a copy, read, and understand all of its contents:

By: _____Date: _____
(Patient /Patient Representative Signature)