SPINE & PAIN INSTITUTE
OF ORANGE COUNTY

113 Waterworks Way Suite 240, Irvine, CA 92618
Phone: 949-340-9622
Fax: 949-528-3969
E-Mail: info@spioc.com

Assignment of Benefits to:

Spine & Pain Institute of Orange County
113 Waterworks Way, Suite 240
Irvine, California 92618
Phone: 949-340-9622 Fax: 949-528-3969

Patient Name: _____

Insurance Policy #:_____

Insured Name: _____Insured Date of Birth_____

Your relationship to the Insured: ❑ Parent ❑ Spouse ❑ Other: _____

Claim #_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Spine and Pain Institute of Orange County
113 Waterworks Way, Suite 240
Irvine, California 92618
Phone: 949-340-9622 - Fax: 949-528-3969

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Spine and Pain Institute of Orange County to deposit checks made in my name.
- ☐ I authorize Spine and Pain Institute of Orange County to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____
Signature of Policyholder Witness

_____
Signature of Claimant, if other than Policyholder

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Patient Information

Patient Last Name:_____ First Name:_____ MI:_____ Birthdate:_____ Age:_____ SS#: _____

Street:_____ City:_____ St:_____ Zip:_____

Hm Phone:_____ Cell Ph:_____ Sex:_____ Marital Status:_____ Driver Lic:_____

Employer:_____ Occupation:_____ Work Ph:_____ Ext._____

Email:_____ Alt Phone:_____ Spouse:_____

Race:_____ Ethnicity:_____ Language:_____

Responsible Party

Patient's Relationship to Insured:_____ SS# of Insured:_____ Hm Ph:_____

Insured's Last Name:_____ First Name:_____ MI:_____ Title:_____ Birthdate:_____

Insured's Street:_____ City:_____ St:_____ Zip:_____ Cell Ph:_____

Insured's Employer Name_____ Employer's Ph:_____

Employer's Address_____ State_____ Zip Code_____

Emergency Contact

Name: _____ Relationship:_____ Hm Phone:_____ Cell Ph:_____

Address: _____ City:_____ State:_____ Zip:_____ Wk Ph:_____

Primary Insurance

Insurance Carrier:_____ Eligible From:_____ ID#:_____ Group#:_____

Secondary Insurance

Insurance Carrier:_____ Eligible From:_____ ID#:_____ Group#:_____

Secondary Insured

Patient's Relationship:_____ Insured's Last Name:_____ First Name:_____ MI:_____

Supplemental Insurance

Insurance Carrier:_____ Eligible From:_____ ID#:_____ Group#:_____

Patient's Additional Information

Primary Care Doctor: _____City:_____

Referring Doctor: _____City: _____

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HIPAA NOTICE OF PRIVACY PRACTICES

HEALTH INFORMATION THAT WE MAINTAIN ABOUT YOU:

We maintain records of:

- Your name and (if different) the name and relationship of the person receiving treatment.
- Your address
- Your telephone number
- Your (or the patient's, if different) condition
- The date the doctor diagnosed the condition
- Clinical findings related to the condition such as results of blood tests, procedures, examinations, and diagnostic modalities.
- Your insurance and other coverage information such as billing records.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

You have the right to:

- request restrictions on certain uses and disclosures (we are not required to agree to the restriction)
- **receive communications of protected health information by alternative means or at alternative locations such as home telephone numbers, cell phones, etc. We may leave messages at any or all telephone numbers listed by patient on the patient information form. We may contact any person left as an emergency contact listed on patient information form. We may contact the patient's spouse relaying any message regarding care, appointment or any necessary information deemed necessary for the patient's treatment or care.**
- inspect, copy and amend your protected health information held at Premier Pain Consultants.
- receive an accounting of certain disclosures (of your protected health information)
- receive a paper copy of this notice even if you have received it electronically.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION:

We only use or disclose your health information as state and federal laws require or permit. In some cases, the law requires that you authorize the disclosure. In other cases, the law allows us to disclose your health information without your authorization.

Use and Disclosure Not Requiring Your Authorization:

Treatment: We may use your health information for our treatment activities, such as disclosing it to other healthcare providers as helpful to treat you.
Payment: We may use and disclose your health information for our payment and collection activities, such as sending claims to insurance companies for the payment of metabolic treatment products.
Healthcare Operations: We may use and disclose your health information to manage our program operations, such as reviewing the quality of services you receive.
Business Associates: We may disclose your health information to organizations that help us with our work, such as the billing service we use to process claims to your health insurance company. We have a written agreement that requires these organizations to use your health information for only the reasons necessary to do the work, and protect it from other uses or disclosures, just like we do.

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To Contact You: We may use the information in your health records to contact you if we have information about treatment or other health-related benefits and services that may be of interest to you.

Other Permitted Uses and Disclosures:

HIPAA specifically permits us to use or disclose your health information for other purposes without your consent or authorization. In our experience such disclosures are rare, and the limited information we maintain is generally not applicable. However, when authorized by law, and to the extent we may have the information, HIPAA permits us to disclose it to:

• comply with the requirements of federal, state, or local laws, court orders or other lawful process and for administrative or court proceedings
• report a public health authority for the purpose of preventing or controlling disease, injury, or disability
• report to the FDA for the quality, safety or effectiveness of FDA-regulated products or activities
• notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
• report abuse, neglect or domestic violence to a government authority
• provide necessary information to a health oversight agency for activities such as audits, investigations, inspections, licensure of the healthcare system, government benefit programs and regulated entities
• a law enforcement official for specified law enforcement purposes
• coroners or medical examiners for identification or determining cause of death
• funeral directors to carry out their duties with respect to the descendent
• organ procurement organizations for facilitating donation and transplantation
• researchers conducting studies approved by an Institutional Review Board
• prevent or lessen a serious and imminent threat to the health of safety of a person or the public
• authorized federal officials for specialized government functions such as military and veterans activities; national security and intelligence activities; protective services for the president; medical suitability determinations; correctional institutions; government entities providing public benefits and
• comply with workers' compensation laws

Uses and Disclosures with Your Authorization:

Other uses and disclosures or your personal information require your written authorization. You may revoke your authorization at any time by doing so in writing.
By signing this form I acknowledge that I have read and understood the contract agreement and will follow these instructions during my treatment. I have also received a copy of this agreement for my files.

Patient Name (printed):_____

Patient Signature:_____

Date:_____

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Patient Number:«PNumber»

Patient Partnership Plan

Dear Patient,

Welcome to our practice. We intend to provide you with the care and service that you expect and deserve. As a specialty practice, we work closely with your primary care doctor/family doctor to help you achieve your ***best possible health.*** Reaching this goal requires a "partnership" between you and your doctors. As our "partner in health," we ask you to help us in the following ways:

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serious health condition. I will make every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor if I Decide *Not* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she feels is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that *not* following my treatment plan can have serious negative effects on my health. I will let my doctor know whenever I decide *not* to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or refuse treatment.

Schedule Visits with My Primary Care Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my specialist doctor work closely with my primary care doctor. My specialist doctor does not treat conditions outside his/her area of expertise. I will need to follow up with my primary care doctor for non-specialty care. My primary care doctor will explain to me which regular health screenings are appropriate for my age, gender, and person and family history. I understand I will need to complete these recommended health screenings (mammogram, immunizations, pap smears, etc). **These health screenings are test that can help detect life-threatening diseases and conditions.** If I visit my primary care doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite you, at any time, to ask questions, report symptoms, or discuss any concerns you may have. If you need more information about your health or condition, please ask.

_____	_____	_____
Patient Name	**Date**	**Physician Signature**