NY Spine Care Interventional Pain Management

영문으로 기재해주십시오

Patient Information (환자정보)	
이름	
생년 월일	
성별	[ ] 남자 [ ] 여자
결혼 여부 :	[ ] 유 [ ] 무 [ ] 그외:
소셜 시큐리티 #	
집주소	
시 / 주 / 우편 번호	
집 전화번호	
직장 번호	
휴대폰 번호	
사용하는 언어	
이메일	

보증인/주보험자 정보	
주 보험자 이름	
생년 월일	
관계	[ ] 본인 [ ] 배우자
	[ ] 그외 :
소셜 시큐리티 #	
집주소	
시 / 주 / 우편 번호	
집 전화번호	
직장 번호	
휴대폰 번호	
사용하는 언어	

1차 건강 보험 (보험카드를 제출해주십시오)	
보험회사	
보험카드 번호	
그룹 번호	
생년 월일	

2차 건강보험 (보험카드를 제출해주십시오)	
보험회사	
보험카드 번호	
그룹 번호	
생년 월일	

비상 연락처			
이름		관계	
집 전화번호		휴대폰/직장 번호	

추천 의사	
전화 번호 / 주소	

주치의	
전화 번호 / 주소	

신경과	
전화 번호 / 주소	

물리치료사	
전화 번호 / 주소	

카이로프렉터	
전화 번호 / 주소	

그외 병원 정보	
전화 번호 / 주소	

NY SPINE CARE
INTERVENTIONAL PAIN MANAGEMENT
188-16 NORTHERN BLVD
FLUSHING, NY 11358
TEL : 718-762-7000
FAX : 718-762-7002

- WELCOME -

Welcome to our practice.

We are here to help you. Our practice firmly believes that a physician-patient relationship is based upon mutual understanding and good communications.

Included in this packet are several forms. Please read and initial each page, then sign the acknowledgement form on the last page.

Thank you for choosing NY Spine Care.

- Facility Disclosure –

NY Spine Care Interventional Pain Management is owned and operated by Ji Han M.D.

- PRIVACY NOTICE -
- CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION -

I understand that as part of my healthcare, NY Spine Care Interventional Pain Management (NY Spine Care) originates and maintains health records. This information serves as:

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

I hereby authorize NY Spine Care to use and disclose protected health information about me to carry out treatment, payment, and health care operations. The Notice of Privacy Practices (NOTICE) provided by NY Spine Care describes such uses and disclosures more completely and is continually posted on the wall in the waiting room.

I understand I have the right to review the NOTICE prior to signing this consent. NY Spine Care reserves the right to revise the NOTICE at any time. A revised NOTICE may be obtained by forwarding a written request to the Privacy Officer, at the address listed below.

 I have read this page and understand its contents : Initial here _____

With this consent, NY Spine Care may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, NY Spine Care may send mail or e-mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment, and health care operations, such as appointment reminder cards and patient statements.

With this consent, NY Spine Care may access my medical records at any other healthcare facility, institution or clinic while I am a patient of NY Spine Care. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.

I understand I do not have to sign this authorization in order to receive treatment from the NY Spine Care. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I understand I have the right to revoke this authorization in writing except to the extent that the NY Spine Care has acted in reliance upon this authorization. The written revocation must be submitted to the privacy officer at :

NY Spine Care Interventional Pain Management
ATTN : Privacy Officer
188-16 Northern Blvd
Flushing, NY 11358

A photocopy of this authorization shall be considered as effective and valid as the original.

- NY Spine Care Financial Policy –

We are committed to providing you with quality and affordable health care. Because you may have questions regarding patient and insurance responsibility for services rendered, we have developed this Financial Policy. Please read it and ask us any questions. A copy will be provided to you upon request.

1. Insurance. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please note that Anesthesia may be billed as Out Of Network claim and therefore may have a higher deductable and co-payment.

2. Referrals. If your insurance carrier requires you to have a referral from your primary physician to see a specialist, it is your responsibility to provide the referral information to NY Spine Care the day of your visit. This includes follow-up visits. Please be advised that if a referral is not provided, you will be responsible for full payment.

3. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

 I have read this page and understand its contents : Initial here _____

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may ask you to supply certain information directly, such as accident details, co-ordination of benefits, or student status, etc. It is your responsibility to comply with their request in a timely manner. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 30 days, the balance will automatically be billed to you.

7. Usual and Customary. Insurance companies sometimes use the phrase "usual and customary" when discussing physicians fees. Please note that the insurance companies set their own "usual and customary" rates based on a wide geographical area and the actual fees we charge may differ. We do not write off balances based on this language.

9. Workers Comp / Auto Insurance. Workers compensation laws require the employee to report injuries to their employer. If your care involves a work related injury, we must know the date of onset, location and nature of the accident, and the telephone number of the adjuster for your case. If this information is not provided, you are responsible for payment of the entire balance due base on our normal fee schedule. We cannot bill your regular health insurance for work related injuries. If you were involved in an automobile accident, we need a copy of your insurance policy and case number.

10. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise previously arranged. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this were to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

11. Insurance Checks. If your insurance mistakenly sends you our payment, please forward us the check immediately. Failure to do so may result in your account being turned over to a collection agency. We will also notify the IRS as this is required by law.

12. Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours on business days. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

13. Schedule of Miscellaneous Fees.

- Returned Check Fee	$30.00
- Missed Appointment Fees	
Office visit	$50.00
Procedure appointments	$100.00
- Medical Records	$0.75 per page.
- A Collection Charge:	For accounts that are unpaid after 60 days, a fee of 1.5% per month shall apply.

I have read this page and understand its contents : Initial here _____

- BILL OF RIGHTS –

You have certain rights.

1. You have the right to be treated with respect, consideration and dignity.
2. You have the right to high-quality medical care delivered in a safe, timely, efficient and cost-effective manner and the right to be assured that the expected results can be reasonably anticipated.
3. You have the right to privacy to the extent possible.
4. You have the right to have your disclosures and records treated confidentially and, except when required by law, those disclosures and records will not be released without your approval.
5. You have the right to be provided, to the degree known, complete information concerning your diagnosis, evaluation, treatment and prognosis.
6. You have the right to copies of your medical records at a nominal cost and, if you request it, those records will be transferred to another practitioner in a timely manner.
7. You have the right to be informed of all reasonable options or alternatives for care and/or treatment and of the potential advantages and disadvantages of each including the advantages or disadvantages and the alternatives to having the procedure performed in an office or other out-patient facility.
8. You have the right to participate in decisions regarding all aspects of care.
9. No procedure or treatment will be undertaken without your informed consent after the alternatives mentioned in #7, above have been discussed with you.
10. You have the right to refuse any diagnostic procedure or treatment and to be advised of the likely medical consequences of such refusal.
11. You have the right to know all of your rights as outlined above.
12. You have the right to know the conduct expected of you in the facility and the consequences of failure to comply with these expectations.
13. You have the right to know the services available at the facility
14. You have the right to know the provisions for after-hours and emergency care.
15. You have the right to know if any of the planned procedures or treatments is part of a research study and the right to refuse to participate in that study.
16. You have the right to know whether or not your providers are insured.
17. You have the right to know how to go about expressing suggestions to the facility and the policies regarding grievance procedures and external appeals in the event that you are dissatisfied with your treatment.
18. You have the right to know the name of your provider.
19. You have the right to know what fees are expected and what the payment policies are.
20. You have the right to know what your provider's credentials are.
21. You have the right to change providers.

- CONTROLLED MEDICATIONS AGREEMENT –

Your condition may warrant treatment with controlled pain medication(s). Your physician will explain the risks, benefits, and alternatives of such treatment. If you agree to be treated with such medications, you must agree to abide by the terms of this Controlled Medication Agreement (Agreement).

You understand that this Agreement is essential to the trust necessary in the physician/patient relationship and that my physician undertakes to treat you based on this Agreement.

If you break any terms of this Agreement, your physician will stop prescribing those medications and has the right to discharge you from his practice. If this were to occur, you will be notified by regular and certified mail that you

 I have read this page and understand its contents : Initial here _____

have 30 days to find alternative medical care. During that 30 day period, your physician shall provide you with a 30 day prescription of medications (provided medication was not already obtained from another provider(s) and he will only be able to treat you on an emergency basis.

Your physician will discuss the appropriate realistic goals, side effects, development of tolerance, dependence, and withdrawal problems due to these medications, and you will have a chance to ask questions regarding the these issues.

Some of the possible complications that may occur are:

- chemical and/or physical dependence and addiction
- severe constipation which may require medical treatment
- difficulty with urination
- drowsiness
- nausea
- itching
- slowed breathing
- reduced or absent sexual desire and/or function

If you take more medication that your physician has prescribed, serious and life-threatening complications may occur, such as:

- coma
- organ damage or failure
- death

If you suddenly stop taking my medication(s), you could have withdrawal symptoms that can be very painful and life-threatening.

If you need to alter the dose or frequency of medication(s), particularly to take more than what have been prescribed, you agree to immediately contact NY Spine Care to discuss the situation with your doctor. You agree that you will not increase any dose of medication until you have received clear permission from my NY Spine Care physicians.

You will communicate fully with your physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medications are helping to relieve the pain.

You understand and agree that:

- **You must maintain regularly scheduled appointments.**
- **It is your responsibility to schedule these appointments in advance.**
- **It is your responsibility to assure that you have enough medication to last through the weekend, holiday, and/or after hours.**
- **On-call physicians will NOT refill your medications as they do not have charts available for review.**
- **NY Spine Care will not accept telephone requests for controlled medication prescriptions and that you must be seen at your regularly scheduled appointment to receive a prescription.**

You agree to bring all unused prescriptions at any time when requested by your physician. You will comply with all requests for laboratory testing including random urine monitoring as ordered by my physicians.

 I have read this page and understand its contents : Initial here _____

You certify that you are not pregnant and will notify the physician immediately if you do become pregnant.

You understand that driving under the influence of any medication that act on the brain could impair your motor skills, reaction times, and judgment.

If there is any question of impairment of your ability to safely perform any activity, you agree to NOT attempt to do so until your ability has been evaluated or you have not used medication(s) for one week.

You agree to safeguard your medications from loss or theft. Lost or stolen medication will not be replaced and that a police report must be filed for the theft and copy provided to NY Spine Care.

You authorize NY Spine Care and your pharmacy to cooperate fully with any city, state, or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion of my pain medication. You authorize NY Spine Care to provide a copy of this agreement to my pharmacy or any other healthcare providers from whom I seek care.

If you demonstrate unacceptable behavior patterns, NY Spine Care may discontinue prescribing the medications and discharge you from the practice.

I attest to the following (Initial below) :

_____ **I am not undergoing treatment for substance (drugs or alcohol) dependence or abuse.**

_____ **I will not sell or trade my medications with anyone.**

_____ **I will not use drugs prescribed for someone other than myself.**

_____ **I will not attempt to obtain pain medications, controlled stimulants, or anti anxiety medications from any other physician unless discussed with Dr. Han of NY Spine Care.**

_____ **If for any reason I am unable to fill my prescription at this designated pharmacy, I agree to notify NY Spine Care.**

Pharmacy Name: _____
Address: _____
_____
Phone Number: (_____) _____ - _____

Please note, that for patients who are undergoing procedures, our policy is to **suspend** the DNR order while the procedure is being performed. If you have any questions, please ask our physician.

 I have read this page and understand its contents : Initial here _____

- PATIENT ACKNOWLEDGEMENT & CONSENT –

Circle One

Y **N** **- Treatment Authorization**
I hereby authorize Dr. Han of NY Spine Care Interventional Pain Management (NY Spine Care) and its staff to provide health care, including any examinations, diagnostic tests, diagnostic and/or therapeutic procedures.

Y **N** **- Privacy Notice**
- Consent for Use and Disclosure of Protected Health Information
I have received a Notice of Privacy Practices that explains how my personal health information will be used. I hereby authorize NY Spine Care to use and disclose protected health information about me to carry out treatment, payment, and health care operations.

Y **N** **- Controlled Substance Agreement**
I have read the controlled substance agreement or had it read to me. I agree to adhere to the agreement/contract.

Y **N** **- Assignment of Benefits & Financial Policy**
I hereby assign to NY Spine Care all payment for medical services rendered to myself or my dependents. I acknowledge that I have read the Financial Policy and I understand that I am responsible for any amount not covered by insurance.

Y **N** **- Pregnancy Notice – (Females only)**
I understand that pregnancy is not advisable during course of any treatment at NY Spine Care.

I attest that I am not pregnant and will inform NY Spine Care if I intend to become pregnant or if I become pregnant.

Y **N** **- Attestation**
I hereby certify that I have completed and answered all information requested to the best of my knowledge.

_____ _____ / _____ / _____
Signature of Patient or Legal Guardian Date

_____ _____
Name of Patient or Legal Guardian, if applicable. Relationship to Patient

_____
Witness

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:
NY Spine Care Interventional Pain Management - Dr. Ji Han P: (718) 762-7000 F: (718) 762-7002

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____
Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information: ❑ At request of individual ❑ Other:	11. Date or event on which this authorization will expire:
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**