# Welcome to Prairie Spine & Pain Institute

Dear Sir or Madam,

Welcome to Prairie Spine & Pain Institute. Our practice specializes in the operative and non-operative treatment of spinal disorders. Our experienced staff includes medical assistants, radiology technologists, surgery schedulers and receptionists. Please read the following information, as it will assist you with your first visit to our office.

The office has an operator to assist our staff with phone calls that are received each day. Our staff tries to answer all calls immediately and returns calls normally within 24 hours. If your problem is an emergency, call 911 or go to the nearest Emergency Room. If you require a medication refill, those are handled between 8am and 5pm Monday through Friday only. Although usually done promptly, please allow up to 2 business days for medication refills. Medications WILL NOT be refilled after hours or over the weekend, or on holidays.

To help make your time at our office more efficient, please complete all of the enclosed forms and bring them with you at the time of your appointment. If you have had any imaging studies (XRay, CAT scan, MRI, etc.), please **bring the actual films with you to your appointment**. **This is your responsibility**. Dr. Kube will need to review the actual images to make an accurate diagnosis and begin treatment. If you do not bring the films, your appointment may have to be rescheduled. Please also bring a list of your current medications (this includes ALL dietary supplements and vitamins) and allergies.

Please read the attached information regarding our financial policy. Please call (309) 691-7774 if you have any questions regarding insurance or payments. We will need a copy of your insurance card and driver's license. We also need to be aware of any present or planned litigation and the name of your attorney.

Please notify the office as soon as possible if you need to cancel or reschedule your appointment. Excessive cancellations or failure to show for an appointment may lead to discharge from our practice. Please call (309) 691-7774 if you have any questions regarding your appointment.

We look forward to our opportunity to assist you through the healing process. We firmly believe in our mission, "EXPERT SPINE CARE, ONE PATIENT AT A TIME." Because each patient is unique, we will customize your treatment to suit your needs. We will use our experience and expertise to provide you with state of the art spinal care.

Sincerely,

Richard A. Kube II, MD, FACSS, FAAOS, CIME
Founder, CEO Prairie Spine & Pain Institute
Founder, CEO Prairie SurgiCare
Treasurer, American Board of Spine Surgery



Prairie
SPINE & PAIN INSTITUTE

# New Patient: Stem Cell Form

FOR OFFICE USE

☐ Return ☐ Pre-op ☐ 6-week ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ More than 24 Months

*To be filled out by Physician/Staff*

1. Ht ..... Wt ..... BMI .....
2. General ROM .....

PATIENT NAME:

DOB: AGE: DATE:

## A. GENERAL INFORMATION

1. **Referring Doctor name and full address:**
   .....
   .....
   .....
   .....
   .....

2. **Have you ever been injured before:**
   ☐ Yes ☐ No
   If so, date of injury:
   .....
   .....
   .....

3. **Chief complaint:**
   .....
   .....
   .....

4. **Your Age:** ..... Years ..... Months

5. **Your Gender:** ☐ Male ☐ Female

6. **How long has your problem been present?**
   .....
   .....
   .....

7. **What started the problem?**
   .....
   .....
   .....

8. **Note your pain by marking a line through the line below. (Average over the last week)**

   No pain — Worst pain possible

## B. ALL PATIENTS PLEASE ANSWER THE FOLLOWING:

1. **Previous doctors you have seen about this problem:** ☐ None
   .....
   .....
   .....

2. **Tests done to evaluate your problems with dates and locations:** ☐ None

| | Date | Location |
|---|---|---|
| Plain x-rays | | |
| Myelogram | | |
| CT Scan | | |
| MRI | | |
| EMGs | | |
| Bone Scan | | |
| FCE | | |
| Vascular Studies | | |
| Dexa Scan | | |

## C. MEDICAL HISTORY

☐ None Apply

- ☐ Heart Attack
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Serious Injuries
- ☐ Stomach Ulcer
- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Mental Illness
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Osteoporosis
- ☐ Lung Disease
- ☐ Liver Trouble
- ☐ Thyroid trouble
- ☐ Tuberculosis
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Bleeding Disorders
- ☐ Hepatitis
- ☐ HIV
- ☐ AIDS
- ☐ Anemia
- ☐ Cancer
- ☐ Gout
- ☐ Asthma

Other: .....
.....
.....



Prairie SPINE & PAIN INSTITUTE

# New Patient: Stem Cell Form CONTINUED

## D. SURGICAL HISTORY

List procedures, surgeon and date.

| Procedure | Surgeon | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## E. LIST OF MEDICATIONS

List medications and dose taken

☐ No medication

| Medication/Dosage | Medication/Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## F. ALLERGIES

☐ No known drug allergies

Latex Allergy? ☐ Yes ☐ No

Food Allergies? .....

.....

.....

| Medication | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

## G. SOCIAL HISTORY

**1. Work Status**

☐ Homemaker ☐ Retired ☐ Disabled
☐ On Leave ☐ Unemployed
☐ Working Full-Time ☐ Working Part-Time

Occupation: .....

Employer: .....

**Social History, continued**

**2. Marital Status**

☐ Married ☐ Single ☐ Cohabitating
☐ Widowed ☐ Divorced

**3. Number of Living Children** .....

**4. I live** ☐ Alone ☐ With .....

**5. Tobacco Use** ☐ Never (Skip to next question)
☐ Cigar ☐ Chew ☐ Pipe ☐ Cigarettes
..... packs per day for ..... years.

**6. Alcohol** ☐ Never or Rare
☐ Social ☐ Frequently Drunk (more than 2x a week)
☐ Alcoholic ☐ Recovering Alcoholic

**7. Drug Overuse/Abuse**

☐ Never ☐ Currently ☐ In the past

## H. FAMILY HISTORY

Check all that apply ☐ None Apply

☐ Stroke
☐ Heart Trouble
☐ Seizures
☐ Spine problems
☐ Arthritis
☐ Gout
☐ Cancer
☐ Bleeding disorders
☐ Mental illness
☐ Diabetes
☐ Kidney trouble or stones
☐ High blood pressure
☐ Scoliosis
☐ Alcoholism

## I. REVIEW OF SYMPTOMS

Check all that apply ☐ None apply

☐ Reading Glasses
☐ Change of vision
☐ Loss of hearing
☐ Ear pain
☐ Hoarseness
☐ Nosebleeds
☐ Difficulty swallowing
☐ Morning cough
☐ Shortness of breath
☐ Fever or chills
☐ Heart or chest pain
☐ Abnormal heartbeat
☐ Swollen ankles
☐ Calf cramps with walking
☐ Poor appetite
☐ Toothache
☐ Gum trouble
☐ Nausea or vomiting
☐ Stomach pain
☐ Ulcers
☐ Frequent belching
☐ Frequent diarrhea
☐ Frequent constipation
☐ Hemorrhoids
☐ Frequent urination
☐ Burning on urination
☐ Difficulty starting urination
☐ Get up more than once a night to urinate
☐ Frequent headaches
☐ Blackouts
☐ Seizures
☐ Frequent rash
☐ Hot or cold spells
☐ Recent wt. change
☐ Nervous exhaustion
☐ Depression
☐ Anxiety

**WOMEN ONLY**

☐ Irregular periods
☐ Vaginal discharge
☐ Frequent spotting

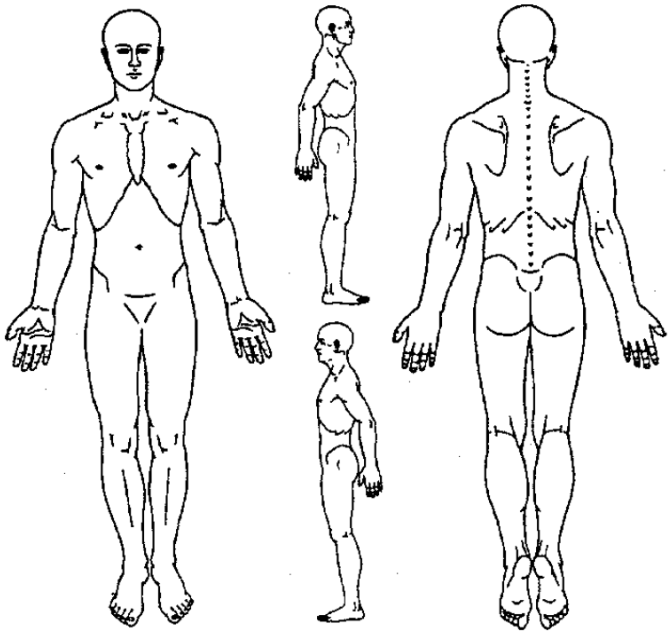


Prairie SPINE & PAIN INSTITUTE

# New Patient: Stem Cell Form CONTINUED

## J. PAIN DIAGRAM

On the diagram below, indicate where you are experiencing pain.



.....
PATIENT SIGNATURE

.....
DATE

.....
PROVIDER SIGNATURE

.....
DATE



Prairie SPINE & PAIN INSTITUTE

# New Patient Information Form

PowerCORE for Life

***Please complete all appropriate information fields***

**PATIENT NAME:**

**Responsible Party Name** *(if different from patient)*:

Patient Home Address:

Patient Home City: State: Zip:

Patient D.O.B.: Patient Gender: ☐ F ☐ M Patient Social Security #:

Preferred Language: ☐ English ☐ Spanish ☐ Other _____ **Race:**_____ **Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Injury Type: ☐ Auto ☐ Personal ☐ Sports ☐ **Work**

Patient Age: **Marital Status:** ☐ Single ☐ Married ☐ Divorced

Patient Home Phone: Patient Mobile Phone:

Patient E-Mail Address:

Employer:

Employer Address:

Employer Phone: Employer Contact *(if work related)*:

Emergency Contact Name:

Emergency Contact Phone Number:

Reason for Visit:

What is your main complaint: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ SI ☐ Other _____

Preferred Pharmacy Name:

Preferred Pharmacy Address:

## PATIENT PRIMARY INSURANCE INFORMATION:

**Insurance Provider:** **Insurance Group/Policy #:**

Policy Holder's Name:

Policy Holder's D.O.B.: / /

Insurance Authorization Phone #: Insurance Contact:

## PATIENT SECONDARY INSURANCE INFORMATION:

**Insurance Provider:** **Insurance Group/Policy #:**

Policy Holder's Name:

Policy Holder's D.O.B.: / /

Insurance Authorization Phone #: Insurance Contact:

## PRIMARY CARE PHYSICIAN:

**Primary Care Physician Name:**

Address:

City: State: Zip:

Phone: Fax:



Prairie SPINE & PAIN INSTITUTE

# New Patient Information Form CONTINUED

PowerCORE for Life

## REFERRING PROVIDER:

**Referring Provider:**

Address:

City: State: Zip:

Phone: Fax:

## WORK COMP INFORMATION: *(if applicable)*

**W/C Insurance Carrier:**

Phone: Fax:

Address:

City: State: Zip:

Phone: Fax:

Contact Name:

Date of Injury: / / CLAIM NUMBER:

Do you have an Attorney?: ☐ Yes ☐ No Attorney's Name:

Body Part Injured: Did you go to an ER or Prompt Care?: ☐ Yes ☐ No

If yes, Name, Address & Phone of Facility & Physician:

Does your Employer have a Preferred Provider Network?: ☐ Yes ☐ No

Did you see the physician in the Company Network?: ☐ Yes ☐ No

If you did not choose to see the physician in the Company Network, did you give your employer a written statement: ☐ Yes ☐ No

## PERSONAL INJURY & AUTO ACCIDENT INFORMATION: *(if applicable)*

**Your Auto Insurance Company:**

Phone: Fax:

Address:

City: State: Zip:

Adjuster Name:

Were you the: ☐ Driver ☐ Passenger

Date of Personal Injury or Auto Accident: / / CLAIM NUMBER:

**Other Driver's Auto Insurance Provider:**

Phone: Fax:

Address:

City: State: Zip:

Adjuster Name:

Contact Name:

Date of Personal Injury or Auto Accident: / / CLAIM NUMBER:



Prairie SPINE & PAIN INSTITUTE

# Provider Notice of Privacy Practices

PowerCORE for Life

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice of Privacy has been created by the Provider to inform you of how we may use your protected health information for treatment, payment and health care operations purposes and as otherwise permitted by law. Protected health information is information about you which can be used to identify you and which relates to your physical or mental condition, our provision of health care services to you, or the payment for health care services we provide to you. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with regard to accessing, amending, and controlling the use of your protected health information.

We will abide by the terms of the Notice of Privacy Practices currently in effect. However, we reserve the right to change the terms of this Notice of Privacy Practices at any time as it applies to all protected health information in our custody without providing any notice of such change. Upon the occurrence of any revision of the terms of the Notice of Privacy Practices currently in effect, you may obtain a revised copy of this Notice of Privacy Practices from our registration personnel at our office located at 7620 North University Street # 104 Peoria, IL 61614 at your request.

The Privacy Contact for the Provider is Scott R. Anderson. Please direct all questions and requests to the Privacy Contact in writing at the Peoria, IL address listed in the preceding paragraph.

### I. Treatment, Payment, and Health Care Operations

Your protected health information may be **used and disclosed by us and other health care providers outside of our office that are involved in your care and treatment** for the purpose of providing health care services to you. We may use and disclose your protected health information in order for us to obtain payment for the health care services and goods which we provide to you. We may also use and disclose your protected health information in order to conduct the business of the Provider.

Following are examples of the types and uses and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures we may make.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination of management of your health care with another health care provider. For example, we could disclose **your protected health information**, as necessary, **to a hospital that provides care to you**. We will also disclose protected health information to **other physicians who may be treating you**. For example, your protected health information may be provided to a physician to whom you have been referred so that the physician has the necessary information to diagnose you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. We will disclose to your health insurance company information about the goods and services rendered to you in order to obtain payment from your insurance company.

We may also disclose your protected health information to another entity so that it may seek payment.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support our business activities. These activities include, but are not limited to, quality assessment activities, employment review activities, face-to-face marketing activities, and conducting or arranging for other business activities.

For example, **we may share your protected health information with other physicians in the practice** for quality assurance or peer review purposes. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to **remind you of your appointment**. We may use or disclose your protected health information, as necessary, to contact you to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We will share your protected health information with third party business associates that perform various activities (e.g. **billing, transcription services**) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may disclose your protected health information to another entity for: **health care fraud and abuse** detection or compliance, conducting **quality assessment** and improvement activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and **care coordination**, contracting of health care providers and patients with information about treatment alternatives, and related functions that do not include treatment, **reviewing the competence of health care professionals**, conducting training programs, accreditation, certification, licensing, credentialing or other similar activities. Disclosures described in the preceding sentence will only be made if the other entity has or had a relationship with you.

We may disclose your protected health information to an organized health care arrangement in which we participate for any health care operation activities of said organized health care arrangement. An example of an organized health care arrangement is a hospital and its medical staff.

### II. Uses and Disclosures of Protected Health Information Based upon our Written Authorization

Other uses and disclosures of your protected health information for purposes other than treatment, payment and health care operations will be made only with your written authorization, unless otherwise permitted or required by law as described below. For example, if you wish to have a life insurance company have access to your protected health information which is in our files, you will need to sign a written authorization permitting us to disclose such information. You may revoke an authorization at any time in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.



Prairie SPINE & PAIN INSTITUTE

### III. Uses and Disclosures for Which You Have the Opportunity to Agree or Object

We may use or disclose your protected health information in the circumstances described in this Section III, without seeking an authorization, provided we first give you an opportunity to object to such use or disclosure. If you are present, we may either obtain your agreement to use or disclose your protected health information as described below, or we may provide you with an opportunity to object and accept your failure to object as your agreement, or we may reasonably infer from the circumstances that you do not object. If you are not present or are unable to agree or object to such use or disclosure of your protected health information, we may use our professional judgment to determine whether the use or disclosure of your protected health information is in your best interest. All communications described in this Section III may be done orally.

**Individuals Involved in your Care.** Unless you object, we may disclose your protected health information to your family member, other relative or close personal friend or any other individual identified by you as being a person who is directly involved with your care or payment relating to your care or treatment.

**Disaster Relief.** Unless you object, we may use or disclose your protected health information to a public or private entity authorized to assist in disaster relief efforts for the purpose of coordinating with such entities the notification of your family or other persons involved in your care.

**Notification of Family or Friends.** Unless you object, we may use or disclose protected health information to notify or assist in the notification of a family member, a personal representative, or other person responsible for your care of your location and general condition.

### IV. Uses and Disclosures of Protected Health Information Which Do Not Require Your Authorization or Opportunity to Object

We are permitted to make the following uses and disclosures of your protected health information without having to obtain your authorization, or give you an opportunity to object:

**Uses and Disclosures Required by Law.** We may use or disclose your protected health information when the use or disclosure is required by law, as long as the use or disclosure meets all applicable requirement by of such law.

**Uses and Disclosures for Public Health Activities.**

**Governmental Activities.** We may disclose your protected health information to a public health authority, including but not limited to: the reporting of **disease**, injury, vital events such as **birth or death**, and the conduct of public health surveillance, public health investigations, and public health interventions; or at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; the reporting of **child abuse or neglect**; reporting to the Food and Drug Administration adverse events, product defects or problems, any biological deviations, to track products, to enable **product recalls**, repairs or replacements, or to conduct post marketing surveillance, reporting a person who may have been exposed to a **communicable disease** or otherwise be at risk for contracting or spreading a disease or condition as authorized by law.

**Employers.** We may disclose your protected health information to an employer if you are a member of the employer's workforce and we have been requested by the employer to conduct **an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury**. This only applies if the employer needs such findings to comply with the requirements of federal or state law regarding recording of illness or injury or to carry out responsibilities for workplace medical surveillance. In such an instance, **we will provide you with written notice at the time we provide you health care that your protected health information** relating to medical surveillance or the workplace and work-related injuries will be disclosed to the employer.

**Uses and Disclosures about Victims of Abuse, Neglect, or Domestic Violence.** We may disclose your protected health information, to a government authority if we reasonably believe that you are a **victim of abuse, neglect or domestic violence**. Such disclosure is only allowed if it is required by law or if it is expressly authorized by law and certain other requirements are met.

**Uses and Disclosures for Oversight Activities**. We may disclose your protected health information to health oversight agencies (e.g., the U.S. Department of Health and Human Services) for oversight activities authorized by law, including the following: audits, **civil**, **administrative, or criminal investigations; inspections**, licensure or disciplinary actions; audits, civil, administrative, or criminal proceedings or actions; or other appropriate oversight activities.

**Disclosures for Judicial Proceedings.** We may disclosure your protected health information in a judicial or administrative proceeding if the request for such protected health information is made through or pursuant to: (A) an order from a court or administrative tribunal or (B) in response to a subpoena or discovery request from a party to the proceeding if certain assurances have been provided to us.

**Disclosures for Law Enforcement Purposes.** Under certain circumstances, we may disclose your protected heath information to law enforcement officials.

**Uses and Disclosures Concerning Decedents.** We may disclose protected health information to coroners and medical examiners for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may also disclose protected health information to funeral directors to carry out their duties in accordance with applicable laws.

**Uses and Disclosures for Cadaveric Organ, Eye or Tissue Donation Purposes.** We may disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye, or tissue donation or transplantation.

**Uses and Disclosures for Research Purposes.** We may use or disclose your protected health information for research purposes, provided, the research has been approved by appropriate oversight entities and sufficient privacy protections have been implemented.

**Uses and Disclosures to Avert a Serious Threat to Health or Safety.** We may disclose your protected health information if we believe the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is made to a person(s) able to prevent or lessen the threat including the target of the threat; or the disclosure is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activities.** If you are a member of the Armed Forces we may use and disclose your protected health information for activities deemed necessary by appropriate military command authorities.

**National Security and Intelligence Activities.** We may disclose your protected health information to authorized federal officials for the conduct of lawful intelligence, counterintelligence and other national security activities authorized by the National Security Act or for the provision of protective services to the President.

# Provider Notice of Privacy Practices CONTINUED

PowerCORE for Life

**Correctional Activities.** We may disclose protected health information of persons in custody of correctional authorities under certain circumstances if requested those authorities.

**Workers' Compensation.** We may disclose your protected health information as authorized to comply with workers compensation laws.

**V. Emergencies.**

We may use or disclose your protected health information without your authorization or acknowledgement of receipt of this notice in order to treat you or assist with coordinating your treatment in an emergency situation. As soon as reasonably practicable after treatment has been provided to you, we will seek your acknowledgement of receipt of this notice of privacy practices.

**VI. Your Rights.**

With regard to your protected health information, you have the following rights:

**The Right to Request Restriction of Uses and Disclosures.** You have the right to request that we restrict the uses or disclosures of your protected health information to carry out treatment, payment or health care operations to family members, other relatives or persons directly involved in your care or payment. We are not required to agree to any such restrictions, but if we do, we must comply with such restrictions, other than in an emergency or certain other circumstances permitted or required by law.

**The Right to Confidential Communications.** You have the right to request that we provide you with an alternative means of communication in the event you tell us that our customary methods of communication may not preserve the confidentiality of your information. You may request that we send such communications to you to alternative locations.

This request must be made by you, in writing, to our Privacy Contact. The request must specify how or where you wish to be contacted. We will attempt to accommodate all reasonable requests.

**The Right to Access Protected Health Information. You have a right to access to inspect and copy your protected health information.** Under certain circumstances, we may deny your request for access to inspect and copy your protected health information. Depending on the circumstances, our denial of your request for access may be reviewed by a licensed health care professional who was not involved in the original decision to deny your request to review your information.

To request access to your protected health information in our custody, you must submit your request in writing to our Privacy Contact. If you request a copy of your information, we may charge a fee for the cost of copying, postage or other items or services involved with your request. You may not remove our records from the premises.

**The Right to Amend Protected Health Information. You have the right to request that we amend your protected health information** in our custody. We may deny your request to amend your protected health information if a) we did not create the information unless the individual or the entity that created the information is no longer available to make the request amendment, b) the information is not maintained by or in our custody, c) you do not have the right to access such information, or d) we have determined that such information is accurate and complete.

You must submit your request for an amendment to your protected health information in writing to our Privacy Contact and explain the basis for your request.

**The Right to an Accounting of Disclosures of Protected Health Information. You have the right to an accounting of how we have disclosed your protected health information** we have made in the six-year period prior to the date of your request for accounting.

We are not required to account for uses and disclosures of your protected health information by us:

1. To carry out treatment, payment or health care operations performed by us or our business associates;
2. To other healthcare providers to provide treatment to you;
3. To other covered entities or health care providers for payment activities of said persons;
4. To other covered entities which have had a treatment relationship with you for certain health care operation purposes of said entities;
5. To you pursuant to your rights to access your protected health information;
6. Made pursuant to an authorization signed by you;
7. To friends and family involved in your care and treatment or payment for your care and treatment, or for certain notification purposes;
8. For national security or intelligence purposes;
9. To correctional authorities with respect to persons in custody;
10. That occurred prior to April 13, 2003;
11. For facility directory purposes, if applicable; or
12. Incident to use or disclose or otherwise permitted or required by law.

Your request for an accounting must be made in writing to our Privacy Contact at the 7620 North University Street # 104 Peoria, IL 61614 address. Your first request in any twelve (12) month period will be provided to you at no charge, however, additional requests will be charged to you based on our cost of conducting the accounting. We will inform you of the fee for the additional accountings prior to our conducting the accounting so that you may consider whether to modify or withdraw your request before you incur any fees.

**Right to Receive Paper Notice.** If you have agreed to receive this notice electronically, you have the right to receive a paper copy of this notice at our Peoria, IL Office or Marion, IL office address.

**VII. Complaints.**

If you believe that your privacy rights have been violated or that we have not complied with this Notice for Privacy Practices, you may file a written complaint to our Privacy Contact at the 7620 North University Street # 104 Peoria, IL 61614 Address or with the Secretary of the U.S. Department of Health and Human Services. Our Privacy Contact can also be reached by calling (309) 691-7774. We will not penalize or charge you for filing a complaint with our Privacy Contact.

**VIII. Additional Rights; Effective Date.**

This notice of Privacy Practices has been prepared to reflect your rights under the Health Insurance Portability and Accountability Act. If state law provides you with greater access to information, or provides greater protection to that information, than as described in this policy, then Provider shall follow the provisions of state law. Examples of such state laws are the Mental Health and Developmental Disabilities Confidentiality Act, and the AIDS Confidentiality Act and the Genetic Information Privacy Act. In addition, if a Federal law creates a greater protection for the information described in this Policy, the Provider shall follow the provisions of such federal law. An example of such a Federal Law is the Federal Drug Abuse, Prevention, Treatment and Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970.



Prairie SPINE & PAIN INSTITUTE

# HIPAA
# Receipt of Notice of Privacy Practices

PowerCORE for Life

I, ..... (Patient name printed) acknowledge that I have received a Notice of Privacy Practices from Prairie Spine & Pain Institute, S.C.

I understand that I have rights under the Health Insurance Portability and Accountability Act (HIPAA) as to the ways my protected health information (PHI) may be disclosed.

I understand that if I have any questions or concerns about my PHI that I can contact PSPI and speak with the privacy officer who will provide additional information and address any concerns I may have.

---

**PATIENT SIGNATURE:** **DATE: / /**

**Patient Representative:**

**Relation to Patient:**



Prairie SPINE & PAIN INSTITUTE

# Financial Policy

PowerCORE for Life

**It is our hope that you will understand that the financial and billing policies at Prairie Spine & Pain Institute, S.C. (PSPI) are necessary to maintain the health of our organization so that we may provide you with the highest quality and best possible healthcare. Please be advised that our financial policies may be changed at any time without notice. In the event of a modification in our policies, we will provide you with an updated policy for review and approval.**

## YOUR HEALTHCARE PLAN BENEFITS AND COVERAGE

PSPI agrees to bill all insurance healthcare plans on your behalf, as well as any secondary insurance plans on your behalf. It is your obligation to provide us with complete and accurate insurance plan coverage information, as well as any changes of your address, telephone number or employer. In the event you do not inform us of any change in the status of your plan, you will be responsible for all charges incurred for healthcare services delivered by PSPI.

We will accept assignment for all healthcare plans that we are in network with. For out-of-network plans we generally accept "matching" benefits coverage, subject to meeting your obligations for annual deductible and out-of-pocket patient obligations as stated in your healthcare member handbook.

## PPO/HMO

PSPI strives to be members of as many healthcare payer networks as possible. Prior to your initial visit we will provide you with a detailed review of your current plan coverage benefits and obligations, including:

- Your current remaining obligation for your annual deductible allowance, as of the date of our review
- Your current remaining obligation for any out-of-pocket expenses remaining in your healthcare plan
- Any co-pay requirements as stated by your healthcare plan for services delivered by us
- Any non-covered healthcare services that we may provide as stated in your healthcare plan benefits
- Any required referrals for healthcare services to be provided by us, as required in your healthcare member plan benefits or handbook

## MEDICARE

Prairie Spine & Pain Institute accepts Medicare assignment. If your Medicare insurance plan is an HMO you may be required to obtain a referral/authorization from your primary care physician prior to an office visit at PSPI. Patients wanting to see one of our providers without a HMO referral will be required to sign a waiver assuming responsibility for payment.

## CO-PAYMENTS – COMMERCIAL INSURANCE

Co-payments will be collected on the day of your appointment. All healthcare insurance plans require that the physician collect all required co-pays from the patient. It is the patient's responsibility to be fully informed as it relates to your insurance benefits and obligations. PSPI is not responsible for any disputes between you and your healthcare plan.

## WORKMAN'S COMP AND YOUR LIABILITY

All workers' compensation cases regarding work related injuries must have a valid filed work injury claim number prior to being seen as a patient at PSPI. Illinois law states that you are responsible for supplying all healthcare providers you see in regards to your work injury with any and all workers compensation case information. Patients are also responsible for keeping PSPI informed of all disputes and legal issues as it relates to your work injury case.

## REFUND

Patient refunds are issued monthly in the event of an overpayment by your insurance plan. Refunds will not be issued until all outstanding charges or pending claims have been settled with your insurance plan.

## PRIVATE SUPPLEMENT POLICY

Service fees will be charged to the patient for information requested for insurance policies for which the patient is solely reimbursed, for example FMLA, SSDI, WC Status, Disability Policies, etc.

## STATEMENTS

Itemized services statements are issued monthly for accounts with patient due balances. Messages on the statements will indicate the status of your account. Payment is due immediately for all patient balances after insurance payer allowances have been posted to your account.



Prairie SPINE & PAIN INSTITUTE

Financial Policy CONTINUED

PowerCORE for Life

## ANCILLARY SERVICES

Technical or facility fees for clinical services provided by hospitals, surgery centers or diagnostic service providers will not be billed by PSPI. It is your obligation to determine the fees and obligations for these services as PSPI shall not be responsible for the charges for services provided by them. PSPI is not obligated to determine on your behalf the in-plan or network status of these healthcare services providers.

## CANCELLATION & NO SHOW POLICY

Please contact our office 24 hours in advance if you need to cancel or reschedule your appointment. Failure to do so will result in a $40 administrative fee. If you do not call to cancel your appointment, you will be considered a No Show and subject to a $40 administrative fee. This policy applies to appointments for Prairie SurgiCare as well and are subject to a $150 administrative fee. Any administrative fees are the responsibility of the patient and must be paid in full before your next appointment.

## SELF PAY

All cash patients and patients that present without valid insurance coverage information are considered "self-pay patients". All self-pay patients are required to make payment in full at the time of service. All self-pay patients requiring surgery are required to pay the entire cost of the procedure before the date of service. At this time, PSPI does not honor hospital charity.

## AUTHORIZATION TO RELEASE INFORMATION AND FINANCIAL OBLIGATION

**Permission is hereby granted to PSPI to release any and all medical information requested by my insurance company or by another doctor for healthcare services provided to me by PSPI subject to full compliance with all HIPAA guidelines, included in this is insurance companies and their authorizing third party administrators for all self funded plans. I request that payment of all insurance benefits be made directly to PSPI for the healthcare services received by me at PSPI. Any insurance or litigation settlement payments received by me or my agents from any insurance company for any and all healthcare services provided at PSPI shall be immediately forwarded to PSPI, regardless of my financial status. By executing this I agree to provide PSPI with a full and complete assignment of all proceeds received by me for services rendered by PSPI.**

**I understand that my insurance coverage is a contract between me and my insurance company. I agree to accept full financial responsibility for payment of charges incurred for the healthcare services I receive at PSPI.**

**I also understand that I am responsible for any costs of collection (if necessary) including any collection fees, attorney fees and court costs for the healthcare services provided for my care at PSPI.**

**I have received, reviewed and understand this financial policy. Further, I agree to comply with all of the provisions in this financial policy.**

**PATIENT NAME:** **D.O.B.: / /**

(please print)

**PATIENT SIGNATURE:** **DATE: / /**

(Parent or guardian if patient is a minor)



Prairie SPINE & PAIN INSTITUTE

# Medication Management Agreement

PowerCORE for Life

**Controlled substances have the potential to be addictive and must be taken exactly as prescribed. I understand that if I am prescribed a controlled substance I must adhere to the following restrictions.** ***Failure to conform to any of the below listed restrictions may resume in being dismissed as a patient of Prairie Spine & Pain Institute, S.C.***

Prairie Spine & Pain Institute, S.C. (PSPI) may prescribe controlled substances for my chronic pain condition, sometimes called narcotic analgesics, to me for a diagnosis of:

**Diagnosis #1:** .....

.....

.....

**Diagnosis #2:** .....

.....

.....

**Diagnosis #3:** .....

.....

.....

*All patients should initial (agreeing to) each item in the following list, in the event you require medications as a component of your care plan at PSPI.*

_____ I will not use any alcohol or illegal drugs.

_____ I authorize PSPI to communicate with my primary care physician.

_____ I understand that it is illegal to share this medication.

_____ I understand that drinking alcohol with this medication may be fatal.

_____ I understand that this medication may cause drowsiness and slower reflexes, interfering with the ability to drive and operate heavy machinery, and short-term memory impairment.

_____ I also understand that part of my treatment may involve reduction and discontinuation of any addictive medications.

_____ I will submit to random urine and/or serum drug screens as ordered.

_____ I will purchase all of my medication at one pharmacy and authorize PSPI to communicate with my pharmacist.

_____ I authorize PSPI to communicate with my primary care physician.

_____ I agree to keep my medication locked in order to prevent loss or theft.

_____ I understand that I will be taken off this medication if there is evidence of addiction and or abuse.

_____ I agree to keep all scheduled appointments with my physician/therapist. My medication may be weaned and discontinued if I fail to attend my scheduled appointments.

_____ I authorize this office to release a copy (or original) of this controlled substance contract to the Peoria Police Department if I violate any of the listed terms or at their request.

_____ (Y or N) Have you received any prescription medications from ***any*** other physician in the past thirty days? If yes, please list physician and medication on back. No refills will be authorized on weekends, Holidays, after office hours or by producing a police report. Lost/stolen medications will not be replaced.

_____ I will notify PSPI immediately of any other physician(s) currently prescribing me a controlled substance(s) or that have been prescribed to me in the past thirty days (including: Dentists, Emergency Rooms & Immediate Care Centers). **Failure to do so is a Felony Crime and may be reported to the Police Department.**

This decision was made because my condition is serious or other treatments have not helped my pain.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, dizziness, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, physical dependence, tolerance to analgesia, addiction and possibility that the medicine will not provide complete pain relief.



Prairie SPINE & PAIN INSTITUTE

## Medication Management Agreement CONTINUED

PowerCORE for Life

I am aware about the possible risks and benefits of other types of treatments that do not involve the use of controlled substances. The other treatments discussed included:

**Treatment #1:**

**Treatment #2:**

**Treatment #3:**

I will tell my doctor about all other medicines and treatments that I am receiving. I will not be involved in any activity that may be dangerous to me or someone else if I feel drowsy or I am not thinking clearly. I am aware that even if I do not notice it, my reflexes and reaction time might still be slowed. Such activities include, but are not limited to:

- Using heavy equipment or a motor vehicle
- Working in unprotected heights
- Being responsible for another individual who is unable to care for himself or herself.

I understand that physical dependence is a normal, expected result of using these medicines for a long time. I understand that physical dependence is not the same as addiction. I am aware physical dependence means that if my pain medicine use is markedly decreased, stopped or reversed by some of the agents mentioned above, I will experience a withdrawal syndrome. This means I may have any or all of the following: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, irritability, aches throughout my body and a flu-like feeling. I am aware that opioid withdrawal is uncomfortable but not life threatening.

I am aware that tolerance to analgesia means that I may require more medicine to get the same amount of pain relief. I am aware that tolerance to analgesia does not seem to be a big problem for most patients with chronic pain, however, it has been seen and may occur to me. If it occurs, increasing doses may not always help and may cause unacceptable side effects. Tolerance or failure to respond well to controlled substances may cause my doctor to choose another form of treatment.

(Males only) I am aware that long term use of controlled substances has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

(Females Only) If I plan to become pregnant or believe that I have become pregnant while taking this pain medicine, I will immediately call my obstetric doctor and this office to inform them. I am aware that, should I carry a baby to delivery while taking these medicines, the baby will be physically dependent upon controlled substances. I am aware that the use of controlled substances is not generally associated with a risk of birth defects. However, birth defects can occur whether or not the mother is on medicines and there is always the possibility that my child will have a birth defect while I am taking a controlled substance.

I have read this form or have it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. By signing this form voluntarily, I give my consent for the treatment of my pain with controlled substance medicines.

**PATIENT SIGNATURE:** **DATE OF BIRTH: / /**

**DATE: / /**

**WITNESS TO ABOVE:**



Prairie SPINE & PAIN INSTITUTE

# Medical Record Release and Communication Authorization

**LAST NAME:** **FIRST NAME:**

**Date of Birth:** **Social Security:**

**Address:** **Apt#:**

**City:** **State:** **Zip:**

Our policy at Prairie Spine & Pain Institute, S.C. is to strictly protect your privacy while following the legal rules regarding confidentiality. Therefore, in order to discuss medical billing and/or treatment with anyone besides yourself (either in the office or by telephone), we need your written consent.

*Please initial next to each of your selections, complete the corresponding information, sign and date below.*

☐ **Only discuss with me.**

**ATTORNEY:**

☐ Do Not Share ☐ May Discuss Billing
☐ May Discuss Medical ☐ May Discuss Both

**WORK COMP:**

**CASE MANAGER:**

☐ Do Not Share ☐ May Discuss Billing
☐ May Discuss Medical ☐ May Discuss Both

**OTHER:**

**EMPLOYER:**

☐ Do Not Share ☐ May Discuss Billing
☐ May Discuss Medical ☐ May Discuss Both

**PHYSICIAN:**

☐ Do Not Share ☐ May Discuss Billing
☐ May Discuss Medical ☐ May Discuss Both

**INSURANCE/ADJUSTER/3RD PARTY ADMIN FOR SELF FUNDED PLANS:**

☐ Do Not Share ☐ May Discuss Billing
☐ May Discuss Medical ☐ May Discuss Both

**OTHER:**

**RELATIONSHIP:**

☐ Do Not Share ☐ May Discuss Billing
☐ May Discuss Medical ☐ May Discuss Both

An automated voice call or text message will be sent to your phone 24 hours prior to remind you of your appointment. Please provide a number at which you feel has adequate privacy to receive such a message ( _____ ) _____ - _____ ☐ Voice ☐ Text

Our office periodically sends emails with updates and educational informaton. Please provide a current and secure email address where we may send these communications. _____ ☐ I wish to opt out.

I acknowledge that Prairie Spine & Pain Institute, S.C., in accordance with their Notice of Privacy Practices (NOPP) and Omnibus HIPAA Law will release my specified medical and/or billing records to the parties listed above. I have reviewed the NOPP of Prairie Spine & Pain Institute, S.C. and have been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Prairie Spine & Pain Institute, S.C.. its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Prairie Spine & Pain Institute S.C. to use and disclose verbally, by fax, encrypted or unencrypted email, the following types of super-confidential information as stated in the NOPP.

**PATIENT SIGNATURE:** **DATE:** / /



Prairie SPINE & PAIN INSTITUTE