PATIENT DEMOGRAPHICS

Patient Information

Patient Name: _____ Date of Birth: _____

Street Address: _____ SSN# _____

City: _____ State: _____ Zip: _____

Telephone # _____ Additional Telephone # _____

Gender: M or F (Please Circle) Marital Status: Single Married Divorced Widowed (Please Circle)

Employer Name: _____ Telephone # _____

Family Physician: _____ Referring Physician: _____

Primary Insurance Information

Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Member ID # _____ Group # _____

Named of Insured: _____ Insured Date of Birth: _____

Secondary Insurance Information

Company: _____ Telephone: _____

Address: _____ City, State, Zip: _____

Member ID # _____ Group # _____

Named of Insured: _____ Insured Date of Birth: _____

Relationship of patient to insured: _____

Emergency Notification

Contact Name: _____

Telephone # _____ Relationship: _____

Release of Authorization/Assignment of Benefits

I authorize the release of any medical information necessary to process my insurance claims(s). I authorize and request payment of medical bills directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_____ _____

Signed (Patient or Representative) (Date)

UGH Pain & Spine
5445 La Branch St.
Houston TX 77044

Assignment of Benefits for UGH Pain and Spine

Assignment of Benefits:

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to UGH Pain & Spine. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan, to issue payment check(s) directly to Alliance Surgery Center for ALL medical services I receive. I also authorize UGH Pain & Spine to appeal claims on my behalf in order to be paid for services that I receive.

Financial Responsibility:

___ I understand that UGH Pain and Spine will file ALL medical services to my insurance carrier(s) on my behalf with the insurance information that I provide them. I attest that the insurance information that I provide is correct and accurate. If for whatever reason, my insurance is not correct, I will provide the correct insurance information to UGH Pain and Spine in order for them to be reimbursed for services in which I receive. In the event that my insurance coverage was not in effect at the time of service, my insurance company does not cover the services or that I have not met my deductible/co-ins, I understand that I will be responsible to pay for the medical services that I receive from UGH Pain & Spine.

___ I understand that if I do not have insurance and I am a self-pay patient, I will be billed by UGH Pain & Spine and I will pay for the medical services that I receive.

___ I understand in the event that UGH Pain & Spine has to resort to collection efforts by turning my account to a Collection Agency or by engaging in the services of an attorney, I will be responsible to pay for all collection fees as well as my balance.

Authorization to Release Information:

I hereby authorize UGH Pain & Spine to: (1) release any information necessary to insurance carriers regarding medical services that I receive; (2) process insurance claims generated in the course of treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. A photocopy of this assignment is to be considered as valid as the original.

___ I give my permission for UGH Pain & Spine and its representatives to communicate with me via email and/or electronic media.

Patient/Responsible Party Signature	Date
Witness	Date

UGH Pain & Spine
5445 La Branch St.
Houston TX 77044

Informed Consent & Pain Management Agreement

AS REQUIRED BY THE TEXAS MEDICAL BOARD (REFERENCED: TEXAS ADMINISTRATIVE CODE, TITLE 22, PART 9, CHAPTER 170) Developed by the Texas pain Society, August 2007 (www.texaspain.org)

NAME OF PATIENT: _____ DATE: _____

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used, so that you may make the informed decision whether or not to take the drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

CONSENT TO TREATMENT AND / OR DRUG THERAPY: I voluntarily request my physician at UGH Pain & Spine, L.L.C., and such associates, technical assistants, nurses and other health care providers as he may deem necessary or advisable, to treat my condition which has been explained to me as chronic pain. I hereby authorize and give my voluntary consent to administer or prescribe the prescription(s) for dangerous and/or scheduled drugs (medications) as an element in the treatment of my chronic pain.

It has been explained to me that these medications(s) include opioid / narcotic drug(s), which can be harmful if taken without medical supervision. I further understand that these medication (s) may lead to physical dependence an/or addition and may, like other drugs used in the practice of medicine, produce adverse side effects or results. The alternative methods of treatment, the possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medications(s).

I HAVE BEEN INFORMED AND understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. Presence of unauthorized substances may result in my discharge.

For female patients only: To the best of my knowledge, I am NOT pregnant. Patients Initials: _____

If I am not pregnant, I will use appropriate contraception during my course of treatment. I promise and it is MY responsibility to inform my physician and/or his/her appropriately authorized assistant(s) immediately if I become pregnant.

If I am pregnant or am uncertain, I WELL NOTIFY MY PHYSICIAN IMMEDIATELY. Besides the possible risks involved with the long-term use of medication(s) i.e. opioids / narcotic(s), I further understand that information on the effects of medication(s) on pregnant women and their unborn children is at present inadequate to guarantee that I and/or my unborn children may not experience significant or serious side effect(s).

All of the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies on the long-term use of many medication(s) to assure complete safety.

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ACKNOWLEDGEMENT OF PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient or Personal Representative Signature

Date

Patient Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

UGH Pain & Spine (ENTITY) PRIVACY NOTICE

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

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or further physical or mental health or condition.

I. Uses and Disclosures of Protected Health Information

The ENTITY may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless the ENTITY has obtained your authorization or the use of disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **Treatment:** We will use and disclose your potted health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fill a prescription or to a laboratory to order a blood test We may also disclose protected health information to physicians who maybe treating you or consulting with the ENTITY with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

B. **Payment:** Your protected health information will be used, as needed, to obtain payment for the services that we provide, this may include certain communications to your health insurance company to get approval for the procedure that we have scheduled. For example, we may need to disclose information to your health insurance company to get prior approval for the surgery. We may also disclose protected health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan. In order to get payment for the services we provide to you, we may also need to disclose your protected health information to your health insurance company to demonstrate the medical necessity of the services or, as required by your insurance company, for utilization review. We may also disclose patient information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia care providers for payment of their services.

C. **Operations:** We may use or disclose your protected health information, as necessary, for our own health care operations to facilitate the function of all or a portion of the ENTITY and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities; employee review activities, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensing or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities. In certain situations, we may also disclose patient information to another provider or health plan for their health care operations.

D. **Other Uses and Disclosures:** As part of treatment, payment and health care operations, we may also disclose your protected health information for the following purposes:

1. To remind you of your surgery date.
2. We may, from time to time, contact you to provide information about treatment alternatives or other health-related benefits and services that we provide and that may be of interest to you.

II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. When Legally Required or Permitted: We will disclose your protected health information when we are required or permitted to do so by any federal, state, or local law. One situation in which we may disclose your protected health information is in the instance of a breach involving your protected health information, to notify you, law enforcement and regulatory authorities, as necessary, of the situation, and others as appropriate to resolve the situation.

B. When There Are Risks to Public Health: We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track PDA regulated products, enable product recalls, repairs or replacements to the PDA and to conduct post marketing surveillance.
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. To Report Suspected Abuse, Neglect or Domestic Violence: We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

D. To Conduct Health Oversight Activities: We may disclose your protected health information to a health oversight agency for activities including audits, civil, administrative, or criminal investigations, proceedings, or actions, inspections, licensure or disciplinary actions, or other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

E. In Connection with Judicial and Administrative Proceedings: We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we may disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. For Law Enforcement Purposes: We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physician injuries.
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the ENTITY has a suspicion that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. To Coroners, Funeral Directors, and for Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Once you have been dead for 50 years [or such other period as specified by law), we may use and disclose your health information without regard to the restrictions set forth in this notice. Protected health information may be used and disclosed for cadaveric organ eye or tissue donation purposes.

H. For Research Purposes: We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information. Under certain circumstances, your information may also be disclosed without your authorization to researchers preparing to conduct a research project or for research on decedents or to researchers pursuant to a written data user agreement.

I. In the Event of a Serious Threat to Health or Safety: We may, consistent with applicable law and ethical standards of conduct,use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

J. For Specified Government Functions: In certain circumstances, federal regulations authorize the ENTITY to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical stability determinations, correctional institutions, and law enforcement custodial situations.

K. For Worker's Compensation: The ENTITY may release your health information to comply with worker's compensation laws or similar programs.

L. Business Associates: We may contract with one or more business associates through the course of our operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We require that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

III. Use and Disclosures Permitted without Authorization but with Opportunity to Object

We may disclose your protected health information to your family member, or a close personal friend, if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures, or we can infer from the circumstances that you do not object, or we determine in the exercise of our professional judgement, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information as described.

IV. Uses and Disclosures which you Authorize:

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization, in writing, at any time except to the extent that we have taken action in reliance upon the authorization. Examples of disclosures that require your authorization are:

A. Marketing: Except as otherwise permitted by law, we will not use or disclose your health information for marketing

purposes without your written authorization. However, in order to better serve you, we may communicate with you about refill reminders and alternative products. Should you inquire about a particular product-specific good or service, we may also provide you with information materials. We may also, at times, send you informational materials about a particular product or service that may be helpful for your treatment.

B. No Sale of Your Health Information: We will not sell your health information to a third party without your prior written authorization.

V. Your Rights

You have the following rights regarding your health information:

A. The right to inspect and copy your protected health information: You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your surgeon and the ENTITY use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for the use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgement, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced within the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is listed on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. Please contact our Privacy Officer if you have questions about access to your medical record.

B. The right to request a restriction on uses and disclosures of your protected health information: You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If you request that the ENTITY not disclose your protected health information to your health plan for the purposes of payment or healthcare operations (hut not treatment), and if you are paying for your treatment out-of-pocket in full, then the ENTITY must honor your requested restriction. Otherwise, the ENTITY is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the ENTITY does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. The right to request to receive confidential communications from us by alternative means or at an alternative location: You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specifications of an alternative address or other method of contact We will not require you to provide an explanation for your request. Requests must be made in writing to our Privacy Officer.

D. The right to request amendments to your protected health information: You may request an amendment of protected

health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Request for amendment must be in writing and must be directed to our Privacy Officer. In this written request, you must also provide a reason to support the requested amendment.

E. The right to receive an accounting: You have the right to request an accounting of certain disclosures of your protected health information made by the ENTITY. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for an ENTITY directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. After January 1, 2014 (or a later date as permitted by HIPAA), the list of disclosures will include disclosures made for treatment, payment or health care operations using our electronic health record (if we have one for you). We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. The right to obtain a paper copy of this notice: Upon, request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice or have agreed to accept this notice electronically.

VI. Our Duties

The ENTITY is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all future protected health information that we maintain. If the ENTITY changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact at your next visit. In the event there has been a breach of your secured protected health information, we will notify you.

VII. Complaints

You have the right to express complaints to the ENTITY and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the ENTITY by contacting the ENTITY'S Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be related against in any way for filing a complaint.

VIII. Contact Person

The ENTITY'S contact person for all issues regarding patient privacy and your rights under the federal privacy Standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by the ENTITY you may submit a complaint to our Privacy Officer by sending it to:

Privacy Officer
UGH Pain & Spine
5445 La Branch
Houston, TX 77004

The Privacy Officer can be contacted by telephone at 713-528-6800.

UGH Pain & Spine PATIENT RIGHTS AND RESPONSIBILITIES

The staff of this health care facility recognizes you have rights while a patient receiving medical care. In return, there are responsibilities for certain behavior on your part as the patient. This statement of rights and responsibilities is posted in our facility in at least one location that is used by all patients.

Your rights and responsibilities include:

A patient, patient representative or surrogate has the right to:

- Receive information about rights, patient conduct and responsibilities in a language and manner the patient, patient representative or surrogate can understand.
- Be treated with respect, consideration and dignity.
- Be provided appropriate personal privacy.
- Have disclosures and records treated confidentially and be given the opportunity to approve or refuse record release except when release is required by law.
- Be given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons,
- Receive care in a safe setting.
- Be free from all forms of abuse, neglect or harassment
- Exercise his or her rights without being subject to discrimination or reprisal with impatient access to medical treatment or accommodations, regardless of race, national origin, religion, physical disability, or source of payment.
- Voice complaints and grievances, without reprisal.
- Be provided, to the degree known, complete information concerning diagnosis, evaluation, treatment and know who is providing services and who is responsible for the care. When the patient's medical condition makes it inadvisable or impossible, the information is provided to a person designated by the patient or to a legally authorized person.
- Exercise of rights and respect for property and persons, including the right to:
    - Voice grievances regarding treatment or care that is (or fails to be) furnished.
    - Be fully informed about a treatment or procedure and the expected outcome before it is performed.
    - Have a person appointed under State law to .act on the patient's behalf if the patient is adjudged incompetent under applicable State health and safety laws by a court of proper jurisdiction. If a State court has not adjudged a patient incompetent, any legal representative designated by the patent in accordance with State law may exercise the patient's rights to the extent allowed by State law.
- Refuse treatment to extent permitted by law and be informed of medical consequences of this action. - Know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in such experimental research.
- Have the right to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- A prompt and reasonable response to questions and requests.
- Know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care and know, upon request and prior to treatment, whether the facility accepts the Medicare assignment rate.
- Receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- Formulate advance directives and to appoint a surrogate to make health care decisions on his/her behalf to the extent permitted by law and provide a copy to the facility for placement in his/her medical record.
- Know the facility policy on advance directives.

- Be informed of the names of physicians who have ownership in the facility.
- Have properly credentialed and qualified healthcare professionals providing patient care.

A patient, patient representative or surrogate is responsible for

- Providing a responsible adult to transport him/her home form the facility and remain with him/her for 24 hours, unless specifically exempted from this responsibility by his/her provider.

- Providing to the best of his or her knowledge, accurate and complete information about his/her health, present complaints, past illnesses, hospitalizations, any medications, including over-the-counter products and dietary supplements, any allergies or sensitivities, and other matters relating to his/her health.

- Accept personal financial responsibility for any charges not covered by his/her insurance.

- Following the treatment plan recommended by his/her health care provider.

- Be respectful of all health providers and staff, as well as, other patients.

- Providing a copy of information that you desire us to know about a durable power of attorney, health care surrogate, or other advance directive.

- His/her actions if he/she refuses treatment or does not follow the health care provider's instructions.

- Reporting unexpected changes in his/her condition to the health care provider.

- Reporting to his/her health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.

- Keeping appointments.

COMPLAINTS:

Please contact us if you have a question or concern about your rights or responsibilities. You can ask any of our staff to help you contact the Compliance Officer at the facility. Or, you can call 713-528-6800.

We want to provide you with excellent service, including answering your questions and responding to your concerns. You may also choose to contact the licensing agency of the state:

Health Facility Compliance Group (MC
1979) Texas Department of State Health
Services P.O. Box 149347

If you are covered by Medicare, you may choose to contact the Medicare Ombudsman at 1-800-MEDICARE (1-800-633-4227) or online at http://www.medicare.gov/claims-and-appeals/index.html. The role of the Medicare Beneficiary Ombudsman is to ensure that Medicare beneficiaries receive the information and help you need to understand your Medicare options and to apply your Medicare rights and protections.

RIDE HOME INFORMATION

Patients Name:

_____

Contact Name:

_____

Contact Number:

_____

Relationship:

_____

Location (circle): Lobby Call for Pickup

Are you using Medical Transport? (Circle)

Yes No

*** If yes please notify pre-op nurse ***

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