Spine Care Delaware
4102 Ogletown-Stanton Road
Newark, Delaware 19713

PATIENT INFORMATION

Date:_____

Name_____ Date of Birth_____ Age_____

_____Single _____Married _____Male _____Female SS#_____

Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Daytime Phone ( )_____ Cell Phone ( )_____

Employed By _____ Business Phone _____ Family Doctor _____

INSURANCE INFORMATION

Health Insurance (Only here)
Primary
Subscriber's Name_____ I.D.#_____

Insurance Company_____ Relationship to Patient_____

Secondary
Subscriber's Name_____ I.D.#_____

Insurance Company_____ Relationship to Patient_____

AUTO ACCIDENT INFORMATION Date of Accident_____

Your Insurance Company_____

Address_____ City_____ State_____ Zip_____

Claim Number_____ Where Accident Happened_____

State you have coverage: Delaware New Jersey Pennsylvania Other_____

Attorney_____ Attorney Phone_____

WORKMAN'S COMPENSATION INFORMATION Date of Accident_____

Insurance Company_____

Address_____ City_____ State_____ Zip_____

Claim Number_____ State Accident Happened_____

State you work in: Delaware New Jersey Pennsylvania Other_____

Attorney_____ Attorney Phone_____

What company were you employed by at the time of accident_____

Spine Care Delaware, 4102 Ogletown-Stanton Road, Newark, Delaware 19713

Patient Name:_____ Acct#:_____

WHO MAY WE TALK TO ABOUT YOUR CARE?

Name_____ Relationship_____ Phone # ( )_____

Name_____ Relationship_____ Phone # ( )_____

Phone #'s we can leave a message on for pre and post call:

1) Phone # ( )_____ 2) Phone # ( )_____

SPINE CARE FEES

Spine Care Delaware, LLC is an Ambulatory Surgery Center where diagnostic and pain management procedures are performed. You will receive a separate billing from Spine Care Delaware for a facility fee and an equipment fee for fluoroscopic imaging. You will also receive a separate bill for anesthesia services.

ACKNOWLEDGEMENT OF PHYSICIAN'S FINANCIAL INTEREST

I acknowledge that I have been advised by my physician that he/she has a financial interest or ownership in the facility or entity to which he/she has referred me, and that he/she has advised me that I am free to choose another facility or entity to provide services.

_____ _____

Signature of Patient Date

MEDICARE SIGNATURE ON FILE

"I request that payment of authorized Medicare benefits be made on my behalf to Spine Care Delaware, LLC, for any services furnished me by that facility. I authorize any holder of medical information about me to release to the United State Department of the Health Care Financing Administration, which oversees the Medicare program, and its agents any information needed to determine these benefits or the benefits payable for related services."

_____ _____

Signature of Patient Date

FINANCIAL RESPONSIBILITY STATEMENT/INSURANCE ASSIGNMENT

I accept responsibility to insure that payment is made for all services rendered on my behalf. I understand that my insurance policy is a contract between me and my insurance company and that I am responsible to Spine Care Delaware, LLC, for all fee balances determined to be patient responsibility.

I hereby authorize and direct payment to Spine Care Delaware, LLC, for surgical and/or medical benefits, if any, otherwise payable to me under the terms of any applicable insurance. I authorize the release of any medical information necessary to process claims. I hereby authorize photocopies of this form to be as valid as the original.

Spine Care Delaware, LLC, is hereby authorized to take any legal action which may be necessary either in law or in equity in my name against any insurance company for any and all fees balances, and I covenant and agree to cooperate fully with Spine Care Delaware, LLC in the presentation of such claims and to furnish all papers and documents necessary in such proceedings and to attend court and testify if Spine Care Delaware, LLC, deems such to be necessary.

In the event of default on any payment die to Spine Care Delaware, LLC, which are my responsibility, I agree to pay all cost of collection including attorney fees. Balances not paid within 90 days are subject to collection procedures and a collection fee.

_____ _____

Signature of Patient Date

Spine Care Delaware, 4102 Ogletown-Stanton Road, Newark, Delaware 19713

PATIENT MEDICATION LIST

Date:_____

Name_____ Date of Birth_____

Please complete and bring in with you on the day of your procedure.

Please list all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers, and homeopathic remedies, and their dosages.

MEDICATION NAME	DOSE (mg/units, drops)	WHEN TAKEN (daily, bedtime, etc.)	REASON (blood pressure, diabetes, etc.)

ALLERGIES

LATEX ALLERGY circle one: YES OR NO _____ No Known Drug Allergies

Please check all in which you have an allergy and list the reaction (hives, nausea, anaphylaxis, etc.)

ALLERGY	REACTION	ALLERGY	REACTION
_____ Aspirin	_____	_____ Narcotics	_____
_____ Codeine	_____	_____ Penicillin	_____
_____ IV Dye	_____	_____ Sulfa	_____
_____ NSAIDS	_____	_____ Other:	_____
_____ Other:	_____	_____ Other:	_____

Medication Reconciliation:

Processed by: _____ Date:_____ Processed by: _____ Date:_____

Spine Care Delaware, 4102 Ogletown-Stanton Road, Newark, Delaware 19713

Consent and Acknowledgement of Receipt of Notice of Privacy Practices for

Purposes of Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Spine Care Delaware for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations at Spine Care Delaware.

I have the right to revoke this consent, in writing, at any time, except to the extent that Spine Care Delaware has taken action in reliance on this consent.

My "protected health information" (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Spine Care Delaware Notice of Privacy Practices (NPP) prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations at Spine Care Delaware. The Notice of Privacy Practices for Spine Care Delaware is also provided **in the lobby** and on the group website at www.spinecaredelware.com. This Notice of Privacy Practices also describes my rights and Spine Care Delaware duties with respect to my protected health information.

Spine Care Delaware reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the group's website, calling the office and requesting a revised copy be sent in the mail, or asking for one at the time of my next appointment. I acknowledge I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Rep's Authority

Parent or Personal Representative

refused to sign acknowledgement

_____ Staff Initials

_____ Date

Spine Care Delaware, 4102 Ogletown-Stanton Road, Newark, Delaware 19713

September 10, 2013

NOTICE OF PRIVACY

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 describes the practice at our Spine Care Delaware office, as well as the practices of the medical staff who provide services at Spine Care Delaware. If you have any questions about this notice, please contact the Spine Care Delaware Privacy Officer.

SPINECARE DELAWARE LEGAL RESPONSIBILITIES

We are required by applicable federal and state law to maintain the privacy of your health information, including demographic information that may identify you that relates to your past, present or future physical health and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. This notice takes effect April 14, 2003, and will remain in effect until any changes are made. We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. The new notice will be effective for all Protected Health Information (PHI), we maintain at that time. Upon request, we will provide you with any revised Notice of Privacy. This can be obtained through verbal request or at the time of your appointment.

I. USES AND DISCLOSURES OF YOUR PHI

FOR TREATMENT: We may use and disclose your health information to provide medical treatment or services. We may use or disclose your health information to a physician or other healthcare providers providing you treatment. We may disclose your medical information to providers (e.g. physicians, nurses, pharmacist's, physical therapist's and other health care facilities involved in your treatment).

FOR PAYMENT: Your PHI will be used, as needed, to obtain payment for treatment and services you receive at Spine Care Delaware. Spine Care Delaware may bill and receive payment from you, an insurance company or a third party. For example, we may need to give your health plan information regarding your treatment in order for your plan to reimburse you or us for services rendered, to obtain prior approval for services or determination of covered benefits. In order to manage your care and treatment, we will also disclose your PHI to worker's compensation and auto carriers, adjusters, nurse case managers, employers, disability carriers, attorneys and your various insurance companies.

FOR HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, employee review activities, training of medical students, conducting training programs, accreditation, certification and licensing or credentialing activities. For example, we may disclose your PHI to medical school students at our office. In addition, we may have you sign in at the registration desk indicating your physician. We may also call you by name from the waiting room when the physician is available. We may use or disclose your PHI necessary to contact you to remind you of your appointment. We will share your PHI with third party "business associates" that provide activities, such as billing and transcription services for the practice. Whenever an arrangement between the office and a business associate involves the use of disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your protected information.

APPOINTMENT REMINDERS: We may use and disclose medical information to contact you as a reminder of an appointment for treatment or medical care. Unless you object, we may leave a message on an answering machine in order to contact you or provide you with appointment reminders. No details regarding your diagnosis or treatment will be left on an answering machine.

YOUR AUTHORIZATION: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke this, in writing, at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

II. OTHER USES AND DISCLOSURES OF YOUR PHI FOR WHICH AUTHORIZATION IS NOT REQUIRED

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: We may disclose your PHI to a family member, other relative, friend or any other person involved in your medical care if we: (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure, and you do not object; or (3) we reasonably assume that you do not object. If we provide information to any individual(s) listed above, we will release only information that we believe is directly relevant to that person's involvement with your health care or payment related to your health care. We may also disclose your PHI in the event of an emergency or to notify (or assist in notifying) such persons of your location, general condition or death. We may release information to persons named in any durable health care power of attorney or similar document provided to us.

LAW ENFORCEMENT, LAWSUITS & DISPUTES: We may release medical information if asked to do so by law enforcement officials in response to a valid court order, subpoena, discovery request, warrant, summons or similar process. We will disclose medical information about you when required to do so by federal, state or local law. If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a valid court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

VICTIMS OF ABUSE, NEGLECT OR DOMESTIC VIOLENCE: If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect or domestic violence.

MILITARY, VETERANS, NATIONAL SECURITY: If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counter intelligence and other national security activities.

PUBLIC HEALTH ACTIVITES: We may disclose medical information about you for public health activities. These activities generally include the prevention of controlled diseases, injury or disability; to report a death; to report reactions to medications or problems with products; or to notify people of recalls of products they may be using. We may also notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence or the possible victim of other crimes. We will only make this disclosure if you agree or when required or authorized by law. We may disclose your health information to the extent necessary to avert a serious threat to your health or the health or safety of others.

CORONERS, MEDICAL EXAMINERS & FUNERAL DIRECTORS: We may release medical information to a coroner, medical examiner or funeral director. This may be necessary to identify a deceased person or determine cause of death.

RESEARCH PURPOSES: We may use or disclose your PHI 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 address the privacy of your PHI.

WORKER'S COMPENSATION: We may disclose your PHI as authorized by state law relating to worker's compensation or other similar programs.

INMATES: If you are or become an inmate of a correctional institution or you are in the custody of a law enforcement official, we may release your PHI to the institution or official if required to provide you with healthcare or to protect the health and safety of others; or to obtain payment for services provided to you.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system and government programs.

III. USES AND DISCLOSURE REQUIRING YOUR SPECIFIC WRITTEN AUTHORIZATION

For any purpose other than the ones described above, we may use or disclose your PHI only when you give Spine Care Delaware your specific written authorization. For instance, you will need to sign an authorization form before we send your PHI to a Life Insurance Company. The following are examples of other uses or disclosures for which your specific written authorization is required:

HIGH CONFIDENTIALITY INFORMATION: Federal and state law require special privacy protections for certain highly confidential information about you. This includes PHI: (1) maintained in psychotherapy notes; (2) documenting mental health and development disabilities services; (3) about drug and alcohol abuse, prevention, treatment and referral; (4) relating to HIV/AIDS testing, diagnosis or treatment and other sexually transmitted diseases; and (5) genetic testing.

MARKETING: We must also obtain your written permission (authorization) prior to using your PHI to send you any marketing materials. However, we may communicate with you about products or services related to your treatment, case management, care coordination, alternative treatments, therapies, health care providers, or care settings without your permission. For example, we may not sell your PHI without your written authorization.

Generally, we must obtain your written authorization to release this type of information. However, there are limited circumstances under the law when this information may be releases without your consent. For example, certain sexually transmitted diseases must be reported to the Department of Health.

IV. PATIENT RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding medical information we maintain about you.

RIGHT TO INSPECT AND COPY: You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing or complete one of our release forms. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, cahrt retrieval or other supplies we use to fulfill your request.

We ordinarily will respond to your request within 30 working days if the information is located in our facility. If your information is in our off site storage facility, we may require an extension with respect to the time limits for providing access. If we need additional time to respond, we will notify you in writing within the time frame above to explain the reason for the delay. The right to inspect your medical information will be carried out in a private room with a privacy officer or an appointed Spine Care Delaware representative.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we deny part or your entire request, we will provide a written denial that explains our reasons for doing so, and a description of your rights to have that decision reviewed and how you can exercise those rights. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect of copy.

RIGHT TO AMEND: You have the right to request that we amend your PHI maintained in your medical or billing records. You have the right to request an amendment for as long as the information is kept. Your request to amend must be made in writing and you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask to amend information that was not created by us, if it is not part of the medical information kept by Spine Care Delaware, if it is not part of the information which you would be permitted to inspect for copy or is accurate and complete.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to requests a “accounting of disclosures”. This is a list of the disclosures we made of medical information about you. The list does not include uses and disclosures that have been made for treatment, payment, or health care operations, or disclosures that were made to you or with your authorization or consent. You must submit your request in writing. Your request must state a time period no longer than six years and may not include dates before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Spine Care Delaware Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

RIGHT TO CONFIDENTIAL COMMUNICATIONS: You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. You must make your request in writing. You are not required to provide us with an explanation; however, your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

RIGHT TO REVOKE YOUR AUTHORIZATION: You may revoke your authorization, except to the extent that we have already used or disclosed your PHI. The revocation must be in writing and is not effective until it is returned to the Privacy Officer at Spine Care Delaware. In addition, a written revocation is not effective with respect to actions Spine Care Delaware took in reliance on a valid authorization, or where the authorization was obtained as a condition of obtaining insurance coverage and other law provides the insurer with the right to contest a claim under the policy or the policy itself.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have the right to a paper copy of the Notice. To obtain another copy of this Notice, request a copy from the Spine Care Delaware Privacy Officer in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medial information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice in our waiting rooms. This Notice will contain on the first page, in the top right-hand corner, the effective date.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided.

QUESTIONS AND COMPLAINTS

If you desire further information about your privacy rights, are concerned that your privacy rights were violated, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer, Administrator and/or Medical Director at:

Privacy Officer
Spine Care Delaware
Harmony Plaza
4102 Ogletown-Stanton Rd., Suite B
Newark, DE 19713
Phone number: 302-565-6203

Administrator / Medical Director
Spine Care Delaware
Harmony Plaza
4102 Ogletown-Stanton Rd., Suite B
Newark, DE 19713
Phone number: 302-894-1900

If you have a complaint and want to notify our accrediting organization, you can contact: the Centers for Medicare & Medicaid, 7500 Security Boulevard, Baltimore, MD 21244-1850, www.cms.hhs.gov/center/ombudsman.asp.
(800) MEDICARE, or TTY/TDD (877) 486-2048.

You may also contact Delaware Health and Social Services at 2055 Limestone Rd. Wilmington, DE 19808 (302) 995-8521

We support your right to the privacy of your health information. We will not penalize you in any way if you choose to file a complaint with us or the Secretary of the Department of Health and Human Services.