BRIER CREEK INTEGRATED PAIN & SPINE, PLLC

PATIENT INFORMATION FORM

Page 1

Last Name _____First Name_____ Middle_____

Date of Birth_____ Maiden Name/Alias_____

Mailing Address_____

CITY STATE ZIP

Street Address_____

CITY STATE ZIP

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Sex: M or F SS#_____

Employed ☐ FT ☐ PT ☐ Not employed

Employer_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Primary Care Physician_____ Phone _____

If you were referred by a physician or other professional, please list his or her name, so we may thank them:
_____

If not referred, how did you hear about us? ☐Yellow Pages ☐ Newspaper ☐Internet ☐ Family/Friend ☐ Ins.Company ☐Other _____

Is there another person other than you who is legally responsible for payment? ☐Yes ☐No If yes, name & relationship of person: _____

1.Name of Primary Insurance:_____
Subscriber's Name:_____
Subscriber date of birth: _____
Subscriber's SS#: _____
Subscriber's relationship to patient_____: Policy #:_____ Group #_____
2.Name of Secondary Insurance:_____
Subscriber's Name:_____
Subscriber date of birth: _____
Subscriber's SS#: _____
Subscriber's relationship to patient_____: Policy #:_____ Group #_____

Do you currently reside in a Skilled Nursing Facility or Rehab? Yes or No

If YES please provide Facility Name _____
Facility Phone # _____

Patient Information Page 2

Last Name _____First Name_____ Middle_____

Date of Birth_____

Is This Due To an Auto Accident? Yes or No If Yes, Which State _____ Date of Injury_____
Insurance Company responsible for claim _____
Adjuster Name_____Claim#_____Phone_____

Are you now, or have you ever been on disability ☐Yes ☐No If yes, date disability began:_____

Emergency Contact: Name_____Relationship _____

Phone#_____

ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF HOSPITALIZATION IS NECESSARY, THE PATIENT IS RESPONSIBLE FOR FURNISHING ALL INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE AS APPLICABLE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICESWHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEENMADE IN ADVANCE.
INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized insurance company benefits be made on my behalf to Brier Creek Integrated Pain& Spine for any services furnished to me by that party who accepts assignment. I authorize any holder of medical or other information about me to release to the Centers for Medicaid/Medicare Services (CMS) and its intermediaries, SSA, DHHS, or commercial insurance companies any information needed to process my insurance claim for benefits. I understand that my signature requests payment be made, and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS- 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In contracted insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the insurance company as the full charge, and the patient is responsible only for any deductible, copay, coinsurance and non-covered services as applicable. Coinsurance and the deductible are based upon the charge determination of the insurance company or payer involved.

Patient/Guardian Signature_____ Date:_____

Please read and complete Attachment 1 of the Patient Information Sheet. Thank you.

Patient Name _____ DOB _____

Attachment 1: Patient Information Form

Why do we ask about race and ethnic groups?

We ask for this information to be sure all patients get the best care, regardless of race or ethnic background. Additionally, as part of the Health Insurance Reform Act, questions such as these will be required and also utilized to assist physicians and hospitals in providing the best care possible. For information on how this information will play a major role in the overall goal of Patient Centered Care, please refer to

http://www.ahrq.gov/research/iomracereport/reldata1.htm

LANGUAGE(s) SPOKEN: _____

Which of the following race categories best identifies you? Choose one or more.

- ☐White
- ☐Black or African American
- ☐American Indian, Aluet or Alaskan Native
- ☐Hawaiian or Pacific Islander
- ☐Asian: Please select one or more as best describes you.

☐Chinese ☐Japanese ☐Filipino ☐Korean ☐Vietnamese ☐Laotian ☐Hmong ☐ Kampuchean/Cambodian ☐Thai ☐Asian Indian

☐Other please specify:_____

Are you Hispanic/Latino? Please select one or more. ☐Non-Spanish

- ☐Mexican
- ☐Puerto Rican
- ☐Cuban
- ☐South or Central American (except Brazil)
- ☐Other Specified Spanish/Hispanic origin _____
- ☐Spanish NOS, Hispanic NOS, Latinos, NOS
- ☐Spanish surname only
- ☐Dominican Republic
- ☐Unknown whether Spanish or not

(Assurance of confidentiality) All personal information will be kept confidential. If general information as race and ethnicity is released, it will not include your name, address, or other information that could identify you. This information is voluntary.

Thank you.

*******ADVANCE CARE PLAN DIRECTIVE: ***Please Circle Which Best Applies*******

1. No, I DO NOT Have an Advance Care Directive in place

2. Yes, I DO have an Advance Care Directive (a.k.a. Living Will)

If you have answered YES please supply our office with a copy of your directive so we may adhere to your instructions. Please note, any changes made to your Advance Directive must be updted with your healthcare provider during your active care with BCIPS.

X _____ SIGN HERE

BRIER CREEK INTEGRATED PAIN & SPINE
Patient Consent for Use and Disclosure of Protected Health Information

I understand that Brier Creek Integrated Pain & Spine ("BCIPS") may use and disclose my protected health information ("PHI") to carry out treatment, payment and health care operations ("TPO"), and further use and disclose my PHI in a manner consistent with the Notice of Privacy Practices provided to me by BCIPS.

With this consent indicated below, BCIPS may call my home/cell or other alternative location and leave a message on voice mail in reference to any items that may assist BCIPS in carrying out TPO, such as appointment reminders and insurance or payment inquiries.

YES ___ NO___ Alternative Phone Number _____

With this consent indicated below, I authorize BCIPS to discuss my PHI with the following relatives or friends:

YES ___ NO___

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I understand that BCIPS cannot require me to sign this consent form in order to receive treatment.

I understand that I have the right to revoke this consent at any time by sending a written request to BCIPS. My decision to revoke this consent does not apply to any information disclosed in reliance upon my prior consent.

Signature of Patient:	
Printed Name:	Date:

When someone other than patient signs, the following must be completed:

Signature of Representative: _____ Date Signed: _____

Relationship to Patient: □ Parent □ Guardian □ Executor of estate □ Power of Attorney
□ Other (Specify): _____

Reason patient unable to sign: _____

BRIER CREEK INTEGRATED PAIN & SPINE, PLLC
FINANCIAL POLICY

Patient's Name: _____ Date of Birth: _____

As a courtesy to our patients, we will file insurance claim forms to your carrier on your behalf. However, your active participation in the insurance claims process may be required. We recommend you confirm your insurance will cover services provided by our practice before your appointment.

All co-pays, deductibles, or co-insurance amounts are due at the time the service is rendered. Please bring your insurance cards and any referral forms with you each time you visit. BCIP&S accepts cash, Visa, MasterCard, American Express, and Discover. We do not accept checks.

Fees for procedures do not include follow-up visits, and will be charged separately.

After payment is received from the insurance carrier, any patient responsibility amounts that remain will be transferred to a patient balance. A statement will be sent to the patient. The balance due amount showing on the statement should be paid in full when the first statement is received.

We are contracted, "participating providers", with most insurance companies. The insurance company reimbursements are based on a negotiated, discounted fee schedule. You are responsible for your co-payment and deductible according to your plan. In most cases, we are obligated to accept these fees as payment in full. However, your insurance company may determine that your service was not a covered benefit or "medically necessary". You may be responsible for payment for these services as appropriate.

Should you have a change in coverage or personal status, we request you contact our Business Office as soon as possible so that we may update this information and avoid payment delays.

If you have any questions regarding our financial policies or your account, call 919-596-3400. Our business office is open Monday through Friday from 8:00 a.m. until 5:00 p.m.

_____ _____

Patient or Legally Authorized Signature Date

_____

Relationship to patient if signed by anyone other than the patient (Parent, Legal Guardian, etc)

Secure Patient Internet Portal

Dear Valued Patient,

We are honored that you have chosen us as your healthcare provider.

As we continue in our efforts to provide our patients with the highest quality of care, we are constantly looking for methods of working together with you to ensure that you are not only aware of, but also involved in the management and improvement of your health.

We are proud to inform you that our practice now offers the opportunity to use the power of the web to track the most important aspects of your healthcare through our office.

Our Secure Patient Portal enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet.

By simply providing BCIPS with your email address we can send you a link to safely and confidentially set up your account.

Participating patients are given secure User IDs and passwords

Through the Patient Portal, you are able to:

- **Ask questions of doctors, nurses, and staff members and receive a prompt reply**
- Update your personal demographic info…i.e. address, phones, contacts, and pharmacy name.
- Request and confirm appointments
- Review your personal health record
- Examine your current and past statements
- Request referrals

… all from the comfort of your home, whenever it is convenient for you!

Please provide your email address on the following page and you can begin to take an active role in managing your healthcare!

Yours truly,

Brier Creek Integrated Pain & Spine Providers, Management, and Staff

Brier Creek Integrated Pain & Spine

7780 Brier Creek Parkway, Suite 200
Raleigh, NC 27617
Telephone: (919) 596-3400; Fax: (919) 596-3499
www.painandspine.org

E-MAIL CONSENT FORM

I,_____, DOB_____hereby consent to providing Brier Creek Integrated Pain & Spine ("BCIPS") my e-mail address to allow for activation of the "BCIPS" **SECURE PATIENT INTERNET PORTAL**.

BCIPS **may** communicate with me via my direct email for urgent matters, otherwise all patient communication will be provided directly from the **BCIPS secure patient portal**.

Acknowledgments: I acknowledge and agree to the following:

- E-mail is not a secure or confidential form of communication. E-mail messages are sent over the Internet where they could be intercepted and read. For this reason, BCIPS cannot guarantee the security of e-mail messages that are sent to and by me.
- E-mail should be used only for non-sensitive and non-urgent issues.
- A printout of any e-mail communication related to treatment or care will be stored in my medical record, and therefore, would be accessible to others in accordance with HIPAA and other applicable law.
- If I believe that I need a response within 48 hours, I will not use e-mail but will call BCIPS. If I do not receive an answer to an e-mail message within three (3) working days, I understand that I should call BCIPS.
- I should only e-mail BCIPS from the e-mail address that I have listed below, since BCIPS cannot confirm my identity through another person's e-mail address. I understand that it is my responsibility to notify BCIPS, in writing, of any change of the e-mail address listed below.

Creating a Message: On the "Subject" line, include the general topic of the message (such as Appointment or Advice). In the body of the message, include your name and your medical record number or your date of birth.

Ending E-mails: Either you or BCIPS may request to discontinue using e-mail as a means of communication, either by indicating so in an e-mail or by letter.

I have read and understand the information above, and had any questions answered to my satisfaction. I agree to these guidelines for e-mail communications and fully understand the risks of using e-mail.

_____	_____	_____
Date	Signature of Patient or Personal Representative	Print Name and Relationship (if other than Patient)

Patient E-mail address (please print):_____

BCIPS Internal Use Only
Date Received:_____/_____/_____; Initials of who received form:_____

BRIER CREEK INTEGRATED PAIN & SPINE

ATTENTION: FOR MEDICAID PATIENTS ONLY

Brier Creek Integrated Pain and Spine, PLLC has identified that North Carolina's Adult Medicaid/Medicaid Carolina Access program offers coverage for 22 medically necessary visits per year. BCIPS verified these benefits per NC Medicaid's online website: http://www.ncdhhs.gov/dma/provider/AnnualVisitLimit.htm.

See Below:

"Mandatory Services

ANNUAL VISIT LIMITS

Adults may have up to 22 medically necessary visits per year (July 1 to June 30) with any MD, NP, PA, Nurse Midwife, Health Dept, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC)."

Be Aware:

Office visit services, rendered at BCIPS office locations ***after*** NC Medicaid's 22 office visit limit has been exceeded, ***will be*** patient responsibility. Office visit services will be adjusted to BCIPS's self pay rate of $120.00. Payment will be expected in full at the time services are rendered. BCIPS's self pay rate will remain in effect until NC Medicaid's fiscal year resets July 1st.

Additionally, BCIPS does not fall within the scope of family Planning Services Only or Pregnancy Related Services. If you are covered under these programs your visits at BCIPS will not be paid by NC Medicaid. You will be subject to BCIPS's self pay fees for all services at BCIPS offices.

Lastly, BCIPS does not retroactively courtesy file NC Medicaid claims after recipient coverage has been activated.

Please sign below acknowledging receipt of this information as well as understanding of your responsibility:

_____

Patient Name

_____ _____

Patient Signature Date

Robert Wadley, M.D. ◊ Seung Kim, M.D.
7780 Brier Creek Parkway, Suite 200, Raleigh, NC 27617
Telephone 919-596-3400 ◊ Fax 919-596-3499

BRIER CREEK INTEGRATED PAIN & SPINE, LLC

WORKERS COMPENSATION/TRAFFIC ACCIDENT INFORMATION

Patient's Name:_____Date of birth: _____

Is this a work related injury? ( ) No

( ) Yes (Please fill out the following information)

Was this accident reported to supervisor and/or employer? ( ) No ( ) Yes

Has Workers Compensation Claim been filed? ( ) No ( ) Yes

Date of accident _____

Employer_____

Business _____

Describe the accident _____

_____

_____

Is this a traffic accident injury? ( ) No

( ) Yes (Please fill out the following information)

Were you a: ( ) Driver ( ) Passenger ( ) Pedestrian Date of Accident _____

If a passenger, where were you sitting? ( ) Right-Front ( ) Right- Rear ( ) Left-Rear

What type was your vehicle? ( ) Car ( ) Truck ( ) Motorcycle ( ) Other _____

What type was the other vehicle? ( ) Car ( ) Truck ( ) Motorcycle ( ) Other _____

Did your vehicle hit the other vehicle? ( ) No ( ) Yes Where? _____

Did the other vehicle(s) hit your vehicle? ( ) No ( ) Yes Where? _____

Were you wearing a seat belt at the time of the accident? ( ) No ( ) Yes

Were traffic citations issued? ( ) No ( ) Yes To Whom? _____

Describe the accident including the cause(s) and surrounding circumstance: _____

_____

_____

Do you have an attorney? ( ) No ( ) Yes Name: _____

Robert Wadley, M.D. ◊ Seung Kim, M.D.
7780 Brier Creek Parkway, Suite 200, Raleigh, NC 27617
Telephone 919-596-3400 ◊ Fax 919-596-3499

BRIER CREEK INTEGRATED PAIN & SPINE

ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices tells you how we can use and disclose your health information. It also describes certain rights you have about your health information kept by us.

The undersigned acknowledges receipt of Notice of Privacy Practices for Brier Creek Integrated Pain & Spine ("BCIPS") and each of its locations.

_____	_____
Patient's Printed Name	Signature of Patient or Patient's Representative
_____	_____
Printed Name of Patient's Representative (if signed by anyone other than Patient)	Relationship to Patient (if signed by anyone other than Patient)

BCIPS Internal Use Only

If the patient or patient's representative did not sign an acknowledgement of receipt of BCIPS' Notice of Privacy Practices, please complete the following.

Attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ Communication barriers prohibited obtaining the acknowledgment
□ Emergency situation prevented us from obtaining acknowledgement
□ Other (Please specify) _

Staff Member Initials _; Date / _/ _

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO BRIER CREEK INTEGRATED PAIN & SPINE

I, or my authorized personal representative, authorize the use, release or disclosure of my health information to the Brier Creek Integrated Pain & Spine location set forth below.

1. Patient whose information is being disclosed:

   Patient Name: _____ Date of Birth: ____/____/_____
   Patient Address: _____ City: _____ State:_____ Zip Code: _____
   Patient Telephone Number: _____

2. I authorize the following facility/person/organization to disclose my patient information:

Facility Name: _____
Address: _____
Phone: _____ Fax: _____

3. I authorize the above-named facility/person/organization to disclose my information to:

Name of Person or Facility: **Brier Creek Integrated Pain & Spine**			
Location/Address:	City:	State:	Zip Code:
Phone (including area code):	Fax (including area code):		

4. Purpose of the disclosure (please check (√) appropriate box):

□ Continuity of Care □ Insurance □ Attorney/Legal □ Personal use □ Other (Specify):_____

5. Dates of Service Requested: From: ____/____/____ To: ____/____/____

6. Information to be disclosed (please check (√) appropriate box):

□ Entire Medical Record □ X-ray reports □ Provider orders
□ History and Physical □ Laboratory results □ Consultation reports
□ Clinic notes □ Film / CD (Imaging support) □ Procedure and Operative notes
□ Pathology reports □ Radiology reports
□ Behavioral Health/Substance Abuse *(Please Initial Here)* _____

7. Format of information to be released and how to disclose information (please check (√) appropriate box):

□ CD via Regular US Mail (if available)
□ PDF Format via Encrypted Email (if available) (Email address: _____)
□ Fax (if available) (Fax number, including area code: _____)
□ Paper Copy via Regular US Mail

8. Patient Rights and Signature:

   a. I hereby authorize the disclosure of my individually identifiable health information as described above.
   b. I understand that this authorization is voluntary and my treatment is not conditioned on signing.
   c. Unless revoked, I understand that this authorization will expire 90 days from the date signed unless a date is otherwise stated: _____.

d. I understand that I have the right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
e. I understand that if I request my health information to be faxed that this is not a secure method and my health information could be viewed by someone not authorized to view it.
f. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information disclosed may no longer be protected under the law.
g. I understand that there may be a fee charged for the release of my health information.

I have read and understand the information in this Authorization form.

Signature of Patient:	
Printed Name:	Date:

When someone other than patient signs, the following must be completed:

I, _____ (print your name) hereby certify and attest that I am the duly authorized personal representative of the above patient, and that I have the lawful authority to enter into this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization, and agree that the above-named facility/person/organization may disclose the information of such individual for the purposes set forth.

Signature of Representative: _____ Date Signed: _____

Relationship to Patient: □ Parent □ Guardian □ Executor of estate □ Power of Attorney
□ Other (Specify): _____

Reason patient unable to sign: _____

Internal Use Only

Date Authorization Received: ___/___/___ Date Information Released: ___/___/___
Sent: Mail Encrypted Email Fax (Circle One)
Individual who Released Information: _____