# FINANCIAL POLICY

**Professional fees**: Our fees for medical services are comparable to other similarly trained Physicians in the community and reflect the complexity of your specific needs. The Physician's time is dedicated to your care, the specialized nature of the Doctor's training, education and supplies determines the cost associated with providing and coordinating your care. Patient understands that it is his/her obligation to know his/her Payer's requirements and ensure that they have been fulfilled, including having a valid authorization for service in place prior to his/her Medical Health Services. Comprehensive Pain Specialists will check for prior authorization as a courtesy, but this is not a guarantee of payment by the insurance company. Insurances that fail to pay for claims filed will lead to the Patient and/or Guarantor being responsible for payment of the remaining uncovered charges. Insurance companies will often deny claims when the insurance is not presented at the time of service. Most insurance companies have requirements for authorization prior to or within 24 hours of service. If insurance information is presented after treatment, we will file a claim to your insurance company on your behalf. However, you will be held liable for the charges if the insurance denies the claim as untimely because of late presentation of coverage or for lack of timely authorization due to late presentation of coverage.

**Insurance Payments:** We participate with most of the insurance plans in the area. Some services may not be covered by your insurance policy. Your insurance coverage is a contract between you and your insurance plan. Co-payment, deductibles, co-insurances and services not covered by your insurance plan and/or outstanding balances are all patient's responsibility to pay in full. Co-payments are due at time of service. **Patient specifically agrees to pay for any services which are determined not to be covered by any health benefit plan or insurance company.**

**Missed Appointments:** We will charge a fee of **$100.00** for any office appointment missed or cancelled under 48 hours' notice and a fee of **$500.00** for any procedure/injection appointment missed or cancelled under 48 hours' notice. Your account will be charged if **NOT** cancelled 48 hours in advance. These fees are patient responsibility and will not be submitted through insurance or liens.

**Medical Records:** We offer patients free electronic records through our patient portal. We will **fax** all records for free to any Physician's Office or Other Medical Facility as courtesy to our patients. You will be subjected to a fee for any printed records. A signed HIPAA authorization may be required to send your medical records.

**Collection Agencies**: A late fee may be charged to you at the rate of 3% of your total balance if there are no payments within 90 days and/or if no formal payment arrangement has been made. After 90 days your account will be considered past due and can be turned over to a third-party collection agency. If it becomes necessary to turn your account over to a third-party collection agency due to your non-payment you will be dismissed from our practice.

**Self-Pay:** Patients who are not billing a third party or health insurance must pay in full at the time of service.

**By signing this I acknowledge that I have been notified and have read and understand the Financial Policy. I agree to the above policy and authorize payment directly to Comprehensive Pain Specialists.**

| | |
|---|---|
| _____ | _____ |
| **Signature of Patient or Personal Representative** | **Relationship to Patient** |
| _____ | _____ |
| **Printed Name of Patient or Personal Representative** | **Date** |

# HIPAA AUTHORIZATION

**Disclaimer:** This document is provided solely for reference purposes. Covered Entities under HIPAA are advised to refer to their Institution's Privacy Policy for Specific requirements for the HIPAA Authorization.

**I, (Legal Name)_____DOB:_____Phone:_____**

**Give Permission to COMPREHENSIVE PAIN SPECIALISTS to:**

- Receive and release medical information/records from other entities as listed in section A - C
- Disclose the following protected health information as listed in section D
- Use the following protected health information

**Section A: Name of whom Comprehensive Pain Specialists (CPS) can release your medical information to:**

Family/Friend:_____Relationship:_____Phone:_____
PCP/Specialist:_____Phone:_____

Attorney/Law Firm **(required if you have a Lien or an open Litigation Case):**

Name:_____Phone:_____
Address:_____

**Section B: Pharmacy Information:_____**

**Section C: Laboratory** (designated by Comprehensive Pain Specialists)

**Section D: Information to be disclosed (Please check all that apply):**

□ Medical Records □ Treatment Records □ Diagnostic/Imaging Reports □ Other: _____

**Can confidential messages be left on your phone answering machine, voicemail and/or email?** □ Yes □ No

**This authorization expires 12 months from the date signed.**

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment.

You may inspect or receive a copy of the Protected Health information to be used or disclosed under this authorization. For Protected Health Information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

_____ _____
**Signature of Patient or Personal Representative** **Relationship to Patient**

_____ _____
**Printed Name of Patient or Personal Representative** **Date**

COMPREHENSIVE
PAIN SPECIALISTS

# URINALYSIS POLICY

As part of your healthcare plan we require that you provide random urine samples prior to your visit. This is a DEA regulation and at Comprehensive Pain Specialists we abide by their standards.

The Laboratory (Lab) choice is unfortunately not up to the patient's discretion and/or insurance. The Lab is picked by our Physicians because they need specific results from the Laboratory, and these are government required tests.

As a company of Practitioners, our role in the proper prescribing, administering and dispensing of controlled substances is critical to patients' health and to safeguard society against the diversion of controlled substances. The American Society of Interventional Pain Physicians adopted guidelines based off the U.S. Department of Justice Drug Enforcement Administration (DEA) requiring its 4,000 members to implement urine tests to determine if patients are already misusing drugs or are likely to do so. In addition, three other Pain Physician Groups—including the American Pain Society—have endorsed drug testing for high-risk patients, while at least 10 states, including Kentucky, Washington, and Colorado have recommended some level of testing. The Federal controlled substance laws are designed to work in tandem with State-controlled substance laws and the guidelines of the DEA. Law Enforcement Officials ensure that pharmaceutical controlled substances are prescribed, administered and dispensed for legitimate medical purposes in accordance with Federal and State Laws.

Please note the Laboratory will bill you separately. You are responsible for payment of any bill that you receive directly from the Lab. We encourage all patients to contact the Lab if you have any questions related to a bill or statement from the Lab or your Insurance Company. Often the Lab will work with our patients to determine final payment.

□ **I do NOT wish to receive any opioid medication at this time, but I acknowledge, understand and will adhere to the required testing as described in the Opioid Contract if it at any time I choose to receive any opioid medication during my treatment at Comprehensive Pain Specialists.**

**By signing this I acknowledge that I have been notified and have read and understand the policy surrounding medication compliance.**

_____ _____

**Signature of Patient or Personal Representative** **Relationship to Patient**

_____ _____

**Printed Name of Patient or Personal Representative** **Date**

# PHYSICIAN-PATIENT CONTRACT FOR OPIOID MEDICATIONS

***The following contract must be read and signed by the patient before any narcotic prescriptions will be written for the patient.***

- I understand Comprehensive Pain Specialists may check my prescription history before medication will be prescribed by this Practice.
- I will obtain prescriptions for opioids and other controlled medications **only** from my Provider at Comprehensive Pain Specialists.
- I will have my prescriptions filled at only **one Pharmacy and** will notify Comprehensive Pain Specialists if this Pharmacy changes.

  Pharmacy Name: _____ Pharmacy Phone: _____
  Pharmacy Address:_____

- I will take the medications only as prescribed and will promptly notify the Medical Staff/Physician if I do not.
- I agree to random Urine Drug Screens to assess my medication compliance. If I refuse to provide an adequate sample, I understand this can result in the Provider no longer prescribing opioid medications and can result in discharge from the Practice.
- I understand at any time, for any reason, I may be asked to bring in my pain medications for a pill count. If I am requesting a new prescription, I will discontinue the previous medication per the Providers request.
- I understand it is my responsibility to keep medications away from children, animals, and other persons.
- To justify the use of opiates, I will report improved pain control, increased functional level, no serious side effects, and no episodes of running out of medications early, and lost or stolen medications.
- I understand all medications have side effects, some of them serious, I understand almost all medications can be fatal if used inappropriately.
- I understand Alcohol is not considered safe in conjunction with the medications typically prescribed by this Practice.

***Lost, Misplaced, or Stolen Medications will NOT be replaced for any reason. It is always your responsibility to keep your medications locked and secure. ***Refills will Not be given early for any reason. ***The eventual goal of treatment is the tapering of the opioid medication. I will meet regularly with the Physician to assess my progress.**

**□ I do NOT wish to receive any opioid medication at this time, but I acknowledge, understand and will adhere to the Opioid Contract as stated above if it at any time I choose to receive any opioid medication during my treatment at Comprehensive Pain Specialists.**

**By signing this contract, I am acknowledging that I been notified and have read, understand and agree to the terms and conditions of the Opioid Medication contract**. ***If this contract is violated in any way, it can be terms for immediate discharge from the Practice.***

_____ _____

**Signature of Patient or Personal Representative** **Relationship to Patient**

_____ _____

**Printed Name of Patient or Personal Representative** **Date**

# TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable Healthcare Providers to deliver health care services to patients when located at different sites.

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    - If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my Healthcare Provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    - I may revoke my right at any time by contacting Comprehensive Pain Specialists at 303-469-3182.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
- I understand that my insurance carrier will have access to my medical records for quality review/audit.
- I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
- I understand that this document will become a part of my medical record.

**This authorization expires 12 months from the date signed.**

**By signing this I acknowledge that I have been notified and have read and understand telemedicine services and I give my consent to telemedicine appointments.**

_____ _____

**Signature of Patient or Personal Representative** **Relationship to Patient**

_____ _____

**Printed Name of Patient or Personal Representative** **Date**