For Staff Use
Reviewed: Y / N
Date: _______________
Initialed: ____________

New Patient Information Packet

Patient Demographics

First Name: ______________________ Middle: ______________ Last: ________________

Patient's Address:____

City: ________________ St: ___________ Zip:_________ Email: ____

Home Phone: ____________________________ Work Phone: ______________________ Cell: _________________

SSN: _____--_____--______ Gender: M F Date of Birth: ______/______/_______

Marital Status: Single Married Divorced Widowed Legal Separated

Employment Status: Employed Self-Employed Unemployed Disabled Retired

Part-time Student Full-time Student

If employed, where?____

Insurance Information

Insurance Carrier: ______________________________

Group #: _________________ Start Date: _________________ Member ID: _______________________________

Is the patient the subscriber/policy holder: Y / N

If no, patient's relationship to subscriber: Child Wife Husband Parent Special Dependent

Grandparent Aunt Uncle Grandchild Niece Other

If no, subscriber's name: ____ SSN: _____--_____--______

Gender: M F Date of Birth: ______/______/_______

Marital Status: Single Married Divorced Widowed Legal Separated

Employment Status: Employed Self-Employed Unemployed Disabled Retired

Part-time Student Full-time Student

If employed, where?____

Subscriber's Address (if different from patient): ____

City: ________________ St: ___________ Zip:_________ Email: ____

Home Phone: ____________________________ Work Phone: ______________________ Cell: _________________

For Staff Use
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Initialaled: ____________

Emergency Contact

Emergency Contact Name: ____ Gender: ___ M / ___ F

Home Phone: ____________________________ Work Phone: _____________________ Cell: _________________

Relationship to patient: ____

Parent/Guardian (If patient is minor, please complete)

Parent/Guardian same as Emergency Contact: _____Y / _____ N

Parent/Guardian Name: ____

Relationship to patient: ____

SSN: _______________________________________ Gender: ______ M / ______ F

Home Phone: ____________________________ Work Phone: _____________________ Cell: _________________

Pharmacy

Preferred Pharmacy: ___________________________________ City: ________________ Phone: ______________

I understand that I am requesting to receive care from Novus Spine & Pain Center. I also authorize the clinic to contact my emergency contact in case of emergency. Also, by leaving my contact numbers I am consenting to leaving messages regarding my care and appointments. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

____

Patient Printed Name

____ ___________________________

Patient's Signature Date

Novus Spine & Pain Center
The First Step To A Pain Free Life

HIPAA Acknowledgement Form

This notice describes how our practice may use/or disclose your protected health information (PHI). PHI is the individual identifiable health information including actual medical information, your name, address, phone number, identification number, insurance information, or other identifiers. Please review this notice carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates that patients be provided with advance written notice of the practice's policies regarding the use and/or disclosure of protected health information. The notice takes effect April 14, 2003.

A patient's information may be used and/or disclosed for the following reasons:

Treatment- we may use PHI to provide you with medical treatment or services. This includes communications between other health care professionals, other healthcare facilities, and other providers for administering treatment.

Payment - we may use and/or disclose your PHI so the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third-party. This includes typical payment activities such as verification of coverage, pre-certification, referrals, and claims processing.

Administrative or Healthcare Operations Activities - we may use and or disclose medical information about you for certain administrative, healthcare and management activities, such as compliance monitoring, quality improvement, and business planning. These uses and or disclosures are necessary to run the practice and to ensure that our patients receive quality care and services.

For Communicable Diseases/Public Health Safety - we may disclose your PHI if Authorized by law, if the public may have been exposed to a communicable disease.

For Legal Proceedings - we may disclose PHI in response to a court order.

The patient reserves the right to request restrictions on the policies listed in this notice, and receive a copy of all information used and or disclosed. Request for patients own PHI will be provided only with a photo proof of identification from the patient. You have the right to designate a personal representative to authorize the disclosure of protected health information.

We reserve the right to contact patients regarding appointments. Also, please be advised we have open adjusting areas. If you wish any discussion to be confidential please request a private room. If you believe your privacy rights have been violated with respect to our protection of your PHI please contact us in writing.

I hereby verify that I have read and understand this notice of privacy practices.

Patient/Representative Signature__________________________________Date_____________

NOVUS SPINE
& PAIN CENTER
The First Step To A Pain Free Life

Financial Policy

Patient Name: ____ **Acct #:** __________________ **Date:**__________

Thank you for choosing Novus Spine & Center. We strive to offer the best healthcare services to our patients. Part of that service is providing transparency regarding any financial responsibilities. If at any time during your visit you have questions or concerns regarding your potential costs of services, please alert one of our team members.

Please review the following.

1. Novus Spine & Pain Center verifies your benefits with your insurance company prior to each visit. Verification of your benefits with your insurance company is not a guarantee of benefits or payment. You are responsible for paying any out-of-pocket expenses as part of your benefit coverage. Be advised having more than one insurance policy is not a guarantee that all of your out-of-pocket expenses will be covered.
2. As a courtesy, Novus Spine & PainCenter provides 2 options for you to pay your out-of-pocket expenses for services provided.

   Estimate of Cost

   Pay today an ***estimate*** of fees owed for your visit. A team member will review your estimated out-of-pocket expenses at the end of your visit today. After your insurance company processes your claim you may have additional out-of-pocket expenses for which you will be billed or you may be due a refund.

   Authorized Payment Option

   Pay your ***exact*** out-of-pocket expenses after your insurance company processes your claim. This process requires us to secure your credit card information. After your insurance company has processed your claim your credit card will be charged the determined amount for any balance owed. You will be notified of the exact amount before your credit card is charged.
3. Assignment of Benefits: In consideration of the treatment being rendered, you hereby irrevocably assign any and all insurance benefits you have to Novus Spine & Pain Center for services provided to you. You understand you remain personally financially responsible for any services not covered by your insurance benefits or plan.
4. For Self-Pay patients with no active insurance coverage, Novus Spine & Pain Center offers a flat rate of $250.00 for the initial office visit and $125.00 for each follow-up office visit. Please note separate fees apply for Urine Drug Screens. Additional charges apply for services not included in the office visit (examples include DME, MRI, EMG, therapy, surgery). Payment is required prior to services being rendered.
5. If your balance is not paid or a payment arrangement has not been made after two (2) attempts to collect, a **$25 service charge** may be assessed as a late fee on your account. Any unpaid balance may be turned over to an outside collection agency.
6. There will be a $35 fee assessed for insufficient funds when paying by check.
7. **A No Show fee of $50 may be charged for patients who do not cancel or reschedule their Office visit appointments prior to 24 hours before their scheduled appointment. ANo Show fee of $300 may be charged for patients who do not cancel or reschedule their Office Procedure appointments prior to 48 hours before their scheduled appointment.**
8. There is a charge for completing individual medical forms, disability, work restriction, employer forms, school forms, etc. Please allow five (5) business days to process all form requests.
9. There is a cost for other service(s) such as copying x-ray images and medical records.

By signing below I understand and accept the financial policy Novus Spine & Center.

______________________________ ______________________________

Patient or Patient's Representative or Responsible Party Date

____

Print Name (and relationship to patient)

NOVUS SPINE
& PAIN CENTER
The First Step To A Pain Free Life

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to medical examination and treatment for myself or for the patient for whom I am the parent or legally authorized representative. (If a patient is a minor, the parent having legal custody, a legal guardian, or a person authorized by them in writing must sign. If a patient is incompetent, a legal guardian or conservator must sign.)

I consent to the use or disclosure of my protected health information by Novus Spine & Pain Center (NSPC) for the purpose of diagnosing and/or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations for NSPC. I understand that diagnosis and/or treatment of me by NSPC may be conditional upon my consent, as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, and my employer or a health care clearinghouse. This protected health information relates to my past, present, and/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 the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. NSPC is not required to agree to the restrictions that I may request; however, if NSPC agrees to a restriction that I request then the restriction is binding.

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

I understand I have the right to review NSPC's Notice of Privacy Practices, which has been made available to me, prior to signing this document. 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, and in the performance of health care operations of the NSPC. The Notice of Privacy Practices for NSPC is also posted at each office location and on the NSPC website at www.novusspinecenter.com. This Notice of Privacy Practices also describes my rights and NSPC's duties with respect to my protected health information.

NSPC 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 NSPC 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.

____
Signature of Patient or Personal Representative

____
Name of Patient or Personal Representative

____
Date

____
Description of Personal Representative's Authority

I hereby authorize the release of my Protected Health Information to the following individuals (Please Print):

____

____

____