



# PATIENT REGISTRATION

Account #: \_\_\_\_\_  
 Home Phone #: (\_\_\_\_) \_\_\_\_\_  
 Cell Phone #: (\_\_\_\_) \_\_\_\_\_  
 Email Address\*: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_ Date of Illness/Injury: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 SS #: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Preferred Language: \_\_\_\_\_ Race: \_\_\_\_\_  
 Name of referring doctor: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  Not applicable  
 Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Nearest relative not living with you: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

**HEALTH INSURANCE COVERAGE** - *To be completed by all patients. (In the case of workers' compensation, this information will only be used if your compensation is denied).*

Health Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Phone #: (\_\_\_\_) \_\_\_\_\_ Group #: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Subscribe is:  Self  Spouse  Parent  Other Subscriber's Name: \_\_\_\_\_  
 Social Security # of Subscriber (if other than self): \_\_\_\_\_ DOB of Subscriber: \_\_\_\_\_  
 Do you have secondary insurance?  Yes  No Carrier Name: \_\_\_\_\_ ID #: \_\_\_\_\_

**LIABILITY** - *Please complete this section if your illness/injury is the result of an accident (auto or otherwise – but NOT work related). Please provide us with the med-pay/PIP benefits of your policy.*

Insurance Company Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Claims Adjuster: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
 Location of Accident (State): \_\_\_\_\_

**WORKERS COMPENSATION** – *Please complete this section if your illness/injury is work related.*

Insurance Company Name: \_\_\_\_\_ Date of Accident: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Claims Adjuster: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Rehab Nurse (if applicable): \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
 Employer at the time of the accident: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
 When was the First Report of Accident filed? \_\_\_\_\_

**ATTORNEY** – *Please complete if an attorney is representing you regarding this particular illness/injury.*

Attorney Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**PATIENT AUTHORIZATION AND ASSIGNMENT**

I, \_\_\_\_\_, hereby authorize Physical Medicine Associates, Ltd., doing business as Capitol Spine & Pain Centers (hereby referred to as CSPC), to apply for benefits on my behalf for services rendered. I request that payment be made directly to CSPC. I certify that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to my insurance companies. I permit a copy of this authorization an assignment to be used in place of original. This will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I agree to assume responsibility for all charges incurred should collection of this balance become necessary including court costs and attorney's fees. I understand that CSPC may refer me to a facility in which it has a financial interest. I am not obligated to use that facility and may make my appointment at another one of my choice.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**NEW PATIENT QUESTIONNAIRE**

*\*\*Office use only*

Provider \_\_\_\_\_ Appt time \_\_\_\_\_  
 \_\_\_\_\_ entered \_\_\_\_\_ vitals

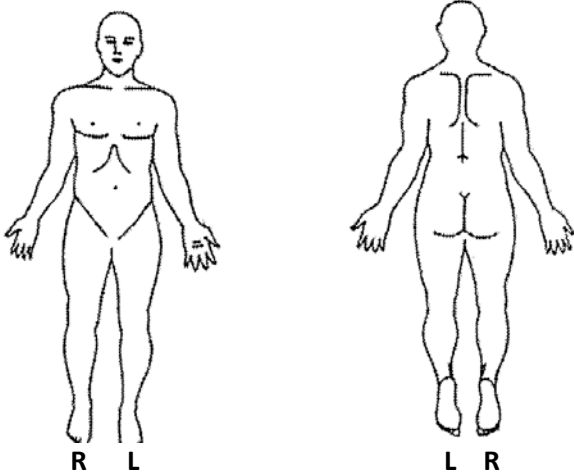
Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

This visit is related to a:  Workers' Compensation injury  Motor Vehicle Accident

Chief Complaint (reason for visit) \_\_\_\_\_ Side  right  left

On the diagram, shade in the areas where you feel pain?



**Current Pharmacy**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_

Your pain occurs:  intermittent  continuous  occasional  rare

Describe your pain:  throbbing  dull  aching  shooting  stabbing  burning

Is your pain:  mild  moderate  severe  unbearable

The onset of your pain was:  suddenly following an injury  suddenly without an injury  gradually following an injury  
 gradually without an injury  after a work related injury  after a motor vehicle accident

Your pain has been occurring for: \_\_\_\_\_  days  weeks  months  years

Pain level today |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----| (0 = no pain 10 = unbearable pain)  
 0 1 2 3 4 5 6 7 8 9 10

Do you experience:  numbness  weakness  bowel incontinence  bladder incontinence

What activities increase your symptoms:  sitting  standing  walking  lifting  lying flat

What activities decrease your symptoms:  nothing  sitting  standing  walking  rest

Medications tried  Ibuprofen/Motrin  Tylenol  Hydrocodone  Vicodin  Percocet  Dilaudid  
 Neurontin  Lyrica  Oral steroids  prescription NSAIDS  Lidoderm patch  over the counter patches

Please indicate any of the following treatment/activity that you have undergone and if they provided no relief, some relief or good relief of your symptoms.

Treatment	No Relief	Some Relief	Good Relief
<input type="checkbox"/> physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> chiropractic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> cortisone injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> surgical intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**NEW PATIENT QUESTIONNAIRE**

**ALL CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER** (please list): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES** (include allergies/side effects to medications or seafood): \_\_\_\_\_  
 \_\_\_\_\_

**PAST MEDICAL HISTORY:** Please check any of the following conditions you have or have had:

- |                                                   |                                                      |                                               |                                                  |                                      |                                              |                                      |
|---------------------------------------------------|------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|--------------------------------------|----------------------------------------------|--------------------------------------|
| <input type="checkbox"/> headaches                | <input type="checkbox"/> stroke                      | <input type="checkbox"/> TMJ                  | <input type="checkbox"/> thyroid disease         | <input type="checkbox"/> cancer      | <input type="checkbox"/> lung disease/asthma | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> high blood pressure      | <input type="checkbox"/> peripheral vascular disease | <input type="checkbox"/> heart attack         | <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> diabetes    |                                              |                                      |
| <input type="checkbox"/> gastrointestinal disease | <input type="checkbox"/> stomach ulcers              | <input type="checkbox"/> kidney disease       | <input type="checkbox"/> hepatitis A             | <input type="checkbox"/> hepatitis B | <input type="checkbox"/> hepatitis C         |                                      |
| <input type="checkbox"/> fracture                 | <input type="checkbox"/> arthritis                   | <input type="checkbox"/> neurologic disorders | <input type="checkbox"/> pinched nerves          | <input type="checkbox"/> seizures    | <input type="checkbox"/> HIV/AIDS            |                                      |

Please list any other past or present medical conditions you have: \_\_\_\_\_

Please indicate any prior accidents or work injuries: \_\_\_\_\_

**PAST SURGICAL HISTORY:** \_\_\_\_\_

**FAMILY HISTORY:**  None  Unknown

Please list all medical conditions that are common in your family: \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_  Full-time  Part-time  Retired  Not Working

Marital Status:  S  M  W  D  P Tobacco use:  Yes  No Former smoker:  Yes  No

Alcohol use:  Yes  No Do you have problems with drug or alcohol use or dependency?  Yes  No

**REVIEW OF SYSTEMS - PROBLEMS EXPERIENCING AT THE PRESENT TIME:**

- |                     |                                                |                                               |                                            |                                           |                                                                     |
|---------------------|------------------------------------------------|-----------------------------------------------|--------------------------------------------|-------------------------------------------|---------------------------------------------------------------------|
| General:            | <input type="checkbox"/> weight changes        | <input type="checkbox"/> appetite changes     | <input type="checkbox"/> fever             | <input type="checkbox"/> fatigue          | <input type="checkbox"/> sleep disturbance                          |
| Eyes:               | <input type="checkbox"/> vision loss           | <input type="checkbox"/> discharge            | <input type="checkbox"/> pain              | <input type="checkbox"/> glaucoma         |                                                                     |
| Ears, Nose, Throat: | <input type="checkbox"/> hearing loss          | <input type="checkbox"/> sore throat          | <input type="checkbox"/> nasal congestion  | <input type="checkbox"/> hoarseness       |                                                                     |
| Cardiovascular:     | <input type="checkbox"/> chest pain            | <input type="checkbox"/> fainting             | <input type="checkbox"/> leg swelling      | <input type="checkbox"/> racing heart     | <input type="checkbox"/> cramping                                   |
| Respiratory:        | <input type="checkbox"/> shortness of breath   | <input type="checkbox"/> cough                | <input type="checkbox"/> wheezing          |                                           |                                                                     |
| Gastrointestinal:   | <input type="checkbox"/> ulcers                | <input type="checkbox"/> diarrhea             | <input type="checkbox"/> constipation      | <input type="checkbox"/> heartburn        | <input type="checkbox"/> reflux                                     |
| Urination:          | <input type="checkbox"/> frequency             | <input type="checkbox"/> urgency              | <input type="checkbox"/> painful urination | <input type="checkbox"/> decreased stream |                                                                     |
| Musculoskeletal:    | <input type="checkbox"/> joint pain            | <input type="checkbox"/> spasm                | <input type="checkbox"/> cramps            | <input type="checkbox"/> joint swelling   | <input type="checkbox"/> redness <input type="checkbox"/> stiffness |
| Derm/Skin:          | <input type="checkbox"/> plaques               | <input type="checkbox"/> color change         | <input type="checkbox"/> lesions           | <input type="checkbox"/> rashes           | <input type="checkbox"/> dryness                                    |
| Neurologic:         | <input type="checkbox"/> seizures              | <input type="checkbox"/> difficulty w/balance | <input type="checkbox"/> headache          | <input type="checkbox"/> weakness         |                                                                     |
| Psychiatric:        | <input type="checkbox"/> depression            | <input type="checkbox"/> mania                | <input type="checkbox"/> anxiety           |                                           |                                                                     |
| Endocrine:          | <input type="checkbox"/> heat/cold intolerance |                                               | <input type="checkbox"/> nervousness       | <input type="checkbox"/> lethargy         |                                                                     |
| Hematological:      | <input type="checkbox"/> bruising              | <input type="checkbox"/> anemia               | <input type="checkbox"/> bleeding          |                                           |                                                                     |

*The above information is accurate to the best of my knowledge:*

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_



- |                                                |                                              |                                    |                                          |
|------------------------------------------------|----------------------------------------------|------------------------------------|------------------------------------------|
| <input type="checkbox"/> Alexandria/Franconia  | <input type="checkbox"/> Fairfax             | <input type="checkbox"/> Herndon   | <input type="checkbox"/> National Harbor |
| <input type="checkbox"/> Arlington/Shirlington | <input type="checkbox"/> Fredericksburg      | <input type="checkbox"/> Lansdowne | <input type="checkbox"/> Washington DC   |
| <input type="checkbox"/> Centreville           | <input type="checkbox"/> Glen Allen/Richmond | <input type="checkbox"/> McLean    | <input type="checkbox"/> Woodbridge      |

Welcome and thank you for selecting *Capitol Spine and Pain Centers*<sup>®</sup>.

Our mission is to offer you the highest quality care in a comfortable, efficient and safe manner. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel welcome to contact any member of our team with questions or need for any information.

Wishing you good health,

*The Physicians & Staff at Capitol Spine and Pain Centers*<sup>®</sup>

**Guidelines**

- **Primary Care Referrals:** Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.
- **Co-Payments:** Co-payments and deductibles must be paid upon the patient’s arrival. We accept checks, debit cards, Visa, and MasterCard.
- **Non-covered services** (prolotherapy, acupuncture, supplies and equipment) must be paid for at the time of service.
- **Tardiness:** Please call if you are running late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time - if we are running late, the session will be completed in its entirety.
- **Cancellations:** We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other patients that could benefit from this treatment slot. Patients that do not contact the office within the 24 hour period to cancel their appointment will be charged a \$75 fee for the missed appointment.
- **Repeated Missed Appointments:** We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our intervention/treatment plan.
- **Medication Refills:** To ensure that your medication needs are met in a timely manner, we request that you notify us at least three (3) days prior to the date your medication is scheduled to run out. There will be a \$15.00 fee assessed when a prescription is obtained prior to a scheduled appointment.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date



- Alexandria/Franconia
- Arlington/Shirlington
- Centreville
- Fairfax
- Fredericksburg
- Glen Allen/Richmond
- Herndon
- Lansdowne
- McLean
- National Harbor
- Washington DC
- Woodbridge

## AUTHORIZATION FOR CLAIMS, PAYMENT AND REVIEWS

Thank you for selecting Capitol Spine & Pain Centers® as your health care provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our claims, payment and review policies which we require you to read and sign prior to any treatment.

**Full payment for professional services is due at the time of service. We accept checks, Visa, or MasterCard.**

Our practice participates with most insurance carriers. As a courtesy, we will contact your carrier to confirm coverage and estimate their payment for services rendered.

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to Capitol Spine & Pain Centers® for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay larger co-pay, co-insurance or other charges. In the event that the insurance does not reimburse these services provided, I acknowledge that I will be responsible for any balance that it declines to pay for such services \_\_\_\_\_ (initials).

We require you to make your payment at time of service. Prompt payment allows us to control costs which ultimately keep our fees to a minimum. Patients with a standard co-payment (i.e. \$10.00, \$12.00 or \$15.00 per visit) are required to pay this at the time of service. Patients whose co-insurance is based upon a percentage of the charge are required to pay an estimated percentage of their bill at the time of service. This payment will be applied toward your ultimate responsibility. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible. We require you to pay your deductible at the time of service.

### NOTICE TO TRICARE BENEFICIARIES

If you are a TRICARE beneficiary, the prior two paragraphs do not apply to you. When you visit one of our physicians or physician's assistants, please identify yourself as a TRICARE beneficiary. If the services to be rendered to you are excluded from your TRICARE benefits, your payment options for these excluded services will be discussed with you at the time of your visit. If the services to be rendered to you are covered as TRICARE benefits, your only charge will be the applicable deductible, copayment and/or cost-sharing amount.

If you have insurance coverage, we are glad to help you receive maximum allowable benefits and will file your claim(s) for you. If your insurance carrier fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you are asked to assist us in contacting your insurance carrier.

Please be aware that few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the costs. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

**As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates you are also responsible to obtain the appropriate authorizations for medical treatment.**

In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

I authorize release of information, including financial information and confidential health information and medical records for services rendered regarding my injury or any other services, which may include records related to treatment for substance abuse, to my insurance carrier(s), managed care plan or other pay or, including past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law.

There is a \$15 charge for prescription refills prior to a scheduled appointment and a \$75 charge for No Show or Call to Cancel appointments with less than a 24 business hour notice.

Returned checks will be processed with a service charge of \$35. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

Our staff is available to answer questions relating to how your claim was filed or any additional information the carrier may need to process your claim. However, coverage issues are best addressed by your employer or group plan administrator. Your insurance policy is a contract between you and your insurance carrier. Capitol Spine & Pain Centers<sup>®</sup> is not a party to that contract and cannot act as a mediator with the carrier or your employer.

In my capacity as patient, legal representative or representative payee for the patient, I agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs.

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to 703-914-8000.

**By signing below I certify that I have read and understand the Authorization for Claims, Payment, and Reviews, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnessed by CSPC Representative

\_\_\_\_\_  
Date



- Alexandria/Franconia
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- Woodbridge

## YOU AND THE HIV VIRUS

We are all concerned with minimizing the risks of exposure to the HIV virus,

We are very conscientious about this at Capitol Spine & Pain Centers. We have very careful protocols that comply with government regulations for safety (monitored by the Occupational Health and Safety Administration). We would like you to know that we use disposable needles, and you are at no time exposed to blood or bodily fluids of any other patient.

We are obligated to provide a safe workplace. This ensures a safe treatment environment for you. There may be an occasion when we are accidentally in contact with your blood or other bodily fluids. If such an incident occurs at one of our Virginia or DC offices, we may test your blood for HIV and may release the results of the test to the employee who may have been exposed. If such an incident occurs at our Maryland office, we may obtain your informed consent to test your blood for HIV.

Again, these precautions are taken in the interest of safety for you and our staff members.

Please sign below that you understand this information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## **HIPAA NOTICE OF PRIVACY PRACTICES**

**Effective: July 17, 2011**

**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 of Privacy Practices is provided to you as a requirement of the Health Information Portability and Accountability Act (HIPAA). It describes how Capitol Spine & Pain Centers may use or disclose your protected health information, and with whom that information may be shared. This notice also describes your rights regarding your protected health information.

### **ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE**

Please sign the Acknowledgement of Receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement.

### **OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION**

"Protected health information" is individually identifiable health information that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or the payment of such health care. It includes certain demographic information, such as your age, address, and e-mail address, which we maintain about you.

We are required by law to (1) maintain the privacy of your protected health information; (2) give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information; (3) follow the terms of the notice currently in effect; and (4) communicate any changes in the notice to you. We reserve the right to change this notice. Its effective date is at the top of the first page and at the bottom of the last page. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. If we change this notice, we will make a current copy of the notice available at our office and website [www.treatingpain.com](http://www.treatingpain.com). You may also obtain a copy of this notice by contacting our Privacy Officer to requesting that a copy be mailed to you, or by asking for a copy at your next appointment.

### **HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

#### Required Uses and Disclosures

By law, we must disclose your protected health information to you or someone who has the legal right to act on your behalf unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services (HHS) for investigations or determinations of our compliance with laws to protect the privacy of your protected health information.

#### Treatment, Payment and Health Care Operations

##### *Treatment*

We may use and disclose your protected 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 example, we may disclose your protected health information, as necessary from time-to-time to another physician or health care provider (e.g. a specialist, pharmacist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment. We may also use your protected health information to process on-line prescription refill requests.

##### *Payment*

We may use your protected health information, as needed, to obtain payment for your health care services. This may require us to disclose your protected health information to your insurance carrier in order for the carrier to approve or pay for the health care services recommended for you such as determining eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. This may also include disclosing your relevant protected health information in order to obtain approval for a hospital stay.

##### *Health Care Operations*

We may use or disclose, as needed, your protected health information to support our daily business activities related to your health care. These activities include, but are not limited to, quality assessment activities, review of our services or staff performance reviews, performing auditing functions, resolving internal grievances, licensing, conducting or arranging for other health care related activities and uses specifically authorized by law.

### *Appointment Reminders*

We may use or disclose your protected health information, as necessary, to contact you or to remind you of your appointment.

### *Treatment Alternatives and Health-Related Benefits and Services*

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that might interest you subject to limits imposed by law. For example, your name, address and email may be used us to send you a newsletter about the services we offer. We may also send you information about practices or ancillary services that we believe might benefit you.

### Other Permitted and Required Uses and Disclosures

We may also use or disclose your protected health information for the following purposes in certain circumstances:

#### *Required by Law*

We may use or disclose your protected health information if law or regulation requires the use or disclosure.

#### *Business Associates*

We may share your protected health information with third-party "business associates" who perform various activities (for example, billing, transcription services) for us if the information is necessary for such functions or services. The business associates will also be required to protect your protected health information.

#### *Individuals Involved in Your Health Care*

Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. Additionally, we may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity in disaster relief efforts for the purpose of coordinating with such organizations to locate a family member or other individuals involved in your health care.

#### *Public Health Risks*

We may disclose your protected health information for public health activities as permitted by law. The disclosure may be necessary to (1) prevent or control disease, injury or disability; (2) report births and deaths; (3) report child abuse or neglect; or (4) notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. In addition, we may disclose your protected health information to a person or company required by the Food and Drug Administration to (1) report adverse events, such as reactions to medications or product defects; (2) track products; (3) enable product recalls; (4) make repairs or replacement; and (5) conduct post-marketing surveillance as required.

#### *Abuse, Neglect or Domestic Violence*

We may disclose protected health information to notify an authorized government authority if we believe a patient has been the victim of abuse, neglect or domestic abuse.

#### *Health Oversight Agencies*

We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, licensure, and inspections. These health oversight agencies might include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs.

#### *Legal Proceedings*

We may disclose protected health information for a judicial or administrative proceeding, in response to an order by a court or administrative tribunal, and in certain conditions in response to a subpoena, discovery request, or other lawful process.

#### *Law Enforcement*

We may disclose protected health information for law enforcement purposes, including (1) responses to legal proceedings; (2) information requests for identification and locations; (3) circumstances pertaining to victims of a crime; (4) deaths suspected from criminal conduct; (5) crimes occurring at our site; and (6) medical emergencies (not on our premises) believed to result from criminal conduct.

#### *Coroners, Funeral Directors and Organ Donations*

We may disclose protected health information to coroners or medical examiners for identification to determine the cause of death or for the performance of other duties authorized by law. We may also disclose protected health information to funeral directors as authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donations.

#### *Research*

We may disclose your protected health information to researchers when authorized by law, for example, if their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

#### *Military Activity and National Security*

When the appropriate conditions apply, we may use or disclose protected health information on individuals who are Armed Forces personnel (1) for activities believed necessary by appropriate military command authorities to ensure the proper execution of the military mission including determination of fitness for duty (2) for determination by the Department of Veteran Affairs (VA) of eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized Federal officials for conducting national security and intelligence activities including protective services to the President or others.

#### *Workers' Compensation*

We may disclose your protected health information to comply with workers' compensation laws and other similar legally established programs.

#### *Inmates*

We may use or disclose your protected health information if you are an inmate of a correctional facility if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional facility.

#### *Data Breaches*

We may use your contact information to provide you with notice of an unauthorized access, use, disclosure, or acquisition of your health information.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION**

For any other activity or purpose not listed in this Notice of Privacy Practices, we must obtain your written permission (authorization) prior to using or sharing your protected health information. If you provide a written authorization and you change your mind, you may revoke your authorization in writing at any time. Once an authorization has been revoked, we will no longer use or share the protected health information as outlined in the authorization form; however, you should be aware that we may not be able to retract a use or disclosure that was previously made on a valid authorization.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You may exercise the following rights by submitting a written request or electronic message to our Privacy Officer at the address provided in the "Contact Information" section of this notice. Please be aware that in certain circumstances, when permitted by law, we may deny your request; however, you may be able in certain instances to seek a review of any such denial.

#### *Right to Inspect and Copy*

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 we use for making decisions about you.

If you request a copy of your designated record set, a fee for the costs of the copying, mailing or other associated supplies may be charged. Under certain circumstances, we may deny your request to inspect or obtain a copy of your protected health information. If we deny your request, we will notify you in writing and may provide you the option to have the denial reviewed.

If we maintain an electronic health record containing your protected health information and we are required to comply with the new federal privacy requirements related to electronic access, you will have the right to request that we send a copy of your protected health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your protected health information.

#### *Right to Request Restrictions*

You may ask us to restrict our uses or disclosures of your protected health information for treatment, payment or health care options. You also have the right to ask to restrict disclosures to family members or others who are involved in your health care or payment for your health care. Your request must be made in writing to our Privacy Officer. In your request, you must tell us (1) what information you want restricted; (2) whether you want to restrict our use, disclosure or both; (3) to whom you want the restriction to apply, for example, disclosures to your spouse; and (4) an expiration date. **We are not required to agree to any requested restriction.**

#### *Right to Request Confidential Communications*

You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

#### *Right to Restrict Certain Disclosures to Health Plans*

You may request that in certain circumstances we not send protected health information to health plans if the protected health information concerns a health care item or service you have paid for out-of-pocket.

#### *Right to Request Amendment*

If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we may deny the amendment request in certain circumstances.

#### *Right to Request an Accounting of Disclosures*

You have a right to an accounting of certain disclosures of your health information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or your personal representative; (iii) pursuant to your authorization; (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.

#### *Right to Obtain a Copy of this Notice*

You may obtain a paper copy of this notice from us upon request at any time, even if you have agreed to receive this Notice electronically. You may also view this notice electronically on our web site, listed in the "Contact Information" section of this Notice.

### **OTHER APPLICABLE LAWS**

This Notice of Privacy Practices is provided to you as a requirement of HIPAA. There are other federal and state privacy laws that may apply and limit our ability to use and disclose your protected health information beyond what we are allowed to do under HIPAA. Below is a list of the categories of protected health information that are subject to these more restrictive laws and a summary of those laws. These laws have been taken into consideration in developing our policies of how we will use and disclose your protected health information.

#### ➤ **Alcohol and Drug Abuse**

We are allowed to use and disclose alcohol and drug abuse information without your permission under certain limited circumstances, and/or disclose only to specific recipients.

#### ➤ **HIV/AIDS**

Restrictions apply to the use and/or retention of HIV/AIDS information

#### ➤ **Mental Health**

We are allowed to use and disclose mental health information without your permission under certain limited circumstances, and/or disclose only to specific recipients

#### ➤ **Minors**

Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such state laws.

### **COMPLAINTS**

If you believe these privacy rights have been violated, you may file a written complaint with our Privacy Officer at the address provided in the "Contact Information" section of this notice or HHS. No retaliation will occur against you for filing a complaint.

### **CONTACT INFORMATION**

For further information about the complaint process, or for further explanation of this document, contact:

Privacy Officer/Administrator  
Capitol Spine & Pain Centers  
3031 Javier Road, Suite 210, Fairfax VA 22031  
Phone: 703-914-8000  
Email: adm@treatingpain.com  
Web: www.treatingpain.com

Policy Effective Date: July 17, 2011

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

*Please print your name here*

*Signature*

*Date*

**FOR OFFICE USE ONLY**

We have made every possible effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

*Employee Signature*

*Date*