

**PATIENT REGISTRATION**

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

**PLEASE PRESS FIRMLY**

Patient's Name \_\_\_\_\_  
First M.I. Last  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_  
 Date of Illness/Injury \_\_\_\_\_ Name of referring doctor \_\_\_\_\_ Not Applicable   
 Employer \_\_\_\_\_ Work Phone Number (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Nearest relative not living with you \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

**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 \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_ Group # \_\_\_\_\_ I.D. # \_\_\_\_\_  
 Subscriber is:  Self  Spouse  Parent  Other Subscriber's Name \_\_\_\_\_  
 Social Security Number of Subscriber (if other than self) \_\_\_\_\_ Birthdate of Subscriber \_\_\_\_\_  
 Do you have secondary insurance?  Yes  No Carrier Name \_\_\_\_\_ I.D. # \_\_\_\_\_

**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 on your policy.*

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

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

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

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

Attorney's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**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 and 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 \_\_\_\_\_

- 6355 Walker Lane Ste 507 • Alexandria, VA 22310 • (703) 738-4332
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**HEALTH QUESTIONNAIRE**

**PERSONAL DATA:**

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Who is your regular/family doctor or Primary Care Physician? \_\_\_\_\_

**CHIEF COMPLAINT:**

What is the reason for your visit? \_\_\_\_\_

**HISTORY OF PRESENT PROBLEM:**

When did this problem start? \_\_\_\_\_  Work Injury  Auto Accident  Other \_\_\_\_\_

Have you ever had these symptoms or similar symptoms in the past?  Yes  No If yes, when? \_\_\_\_\_

Previous medical care for this condition:

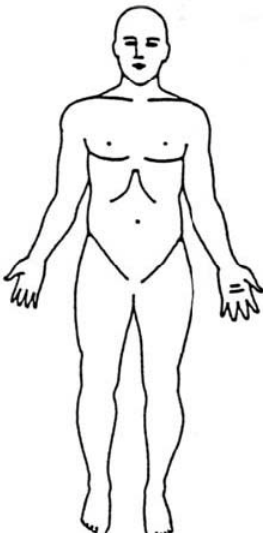
Doctor seen:	Tests done:	Results:	Date treatment given:	Helpful? Y/N:
1) _____	_____	_____	_____	_____
2) _____	_____	_____	_____	_____
3) _____	_____	_____	_____	_____

Since the onset of the problem, has it improved?  Yes  No How much: \_\_\_\_\_%

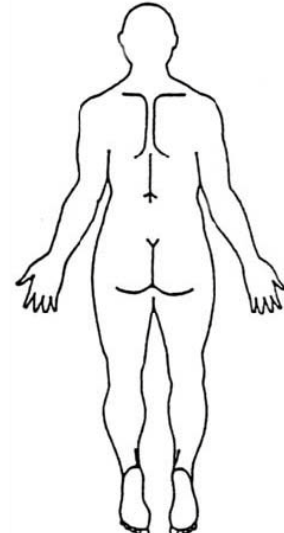
Indicate work status:  Regular duty  Light duty  Off from work because of this problem. Dates off work: \_\_\_\_\_

Please use the diagram below to indicate the area of the most significant pain.  
 Use XXX for location, ::: for areas of numbness and/or tingling.  
 Use → to show if the pain travels from one area to another.

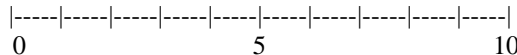
RIGHT LEFT



LEFT RIGHT



Please indicate your current level of pain:  
 (0 = No Pain and 10 = Unbearable Pain)



PLEASE COMPLETE  
 REVERSE SIDE AS WELL



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Is your pain:     constant     intermittent     sharp     dull     stabbing     burning     other \_\_\_\_\_

Do you experience:     numbness     burning     cramping     tingling     other \_\_\_\_\_

How long can you sit? \_\_\_\_\_  no limit    How long can you stand? \_\_\_\_\_  no limit    How long can you walk? \_\_\_\_\_  no limit

What activities or motions increase your symptoms? \_\_\_\_\_

What activities or motions decrease your symptoms? \_\_\_\_\_

Medications currently taking, including over-the-counter medications: \_\_\_\_\_

ALLERGIES? (include allergies to Medications or Seafood) \_\_\_\_\_

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

- headaches     stroke     TMJ     thyroid disease     cancer     lung disease/asthma     blood clots
- high blood pressure     peripheral vascular disease     heart disease     heart attack     coronary artery disease
- diabetes     gastrointestinal disease     ulcers     kidney disease     hepatitis     fracture     joint replacement
- arthritis     neurologic disorders     pinched nerves     seizures     psychiatric treatments     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:**

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

History of:  tobacco use     alcohol use    Do you have problems with drug or alcohol use or dependency?  Yes     No

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

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

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

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

\_\_\_\_\_  
Date



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Welcome and thank you for selecting *Capitol Spine and Pain Centers*®.

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*®

### 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 you call our *pharmacy refill line* 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.

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Signature of Patient or Responsible Party

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Date



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## 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



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## 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. Virginia law authorizes that if such an incident occurs, we may test your blood for HIV. The same law requires that you be informed of this.

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

## **NOTICE OF PRIVACY PRACTICES**

Effective 12/1/06

**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 (HIPPA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend 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. This information includes demographics (age, address, e-mail address) and relates to your past, present, or future physical or mental health or condition and related health care services. We are required by law to (1) make sure that your protected health information is kept private; (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; (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. You may also obtain a Notice of Privacy Practices by calling our Privacy Officer and requesting a copy be mailed to you, or 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 health information to you 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 (DHHS) for investigations or determinations of our compliance with laws on the protection of your health information.

#### **Treatment**

We will 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 (for example, 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.

#### **Payment**

Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that may be required before your insurance carrier, for example, approves or pays 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. For example, obtaining approval for a hospital stay might require that your relevant protected health information be disclosed to obtain approval for the hospital admission.

#### **Health Care Operations**

We may use or disclose, as needed, your protected health information to support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, investigations oversight or staff performance reviews, performing auditing functions, resolving internal grievances, licensing, communications about a product or service, conducting or arranging for other health care related activities and other uses specifically authorized by law. For example, we may call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third-party "business associates": who perform various activities (for example, billing, transcription services) for us. The business associates will also be required to protect your health information.

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. For example, your name and address may be used to send you a newsletter about us and the services we offer. We may also send you information about practices or services that we believe might benefit you.

### **Required by Law**

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

### **Public Health**

We may disclose your protected health information to a public health authority that is permitted by law to collect or receive the information. 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; (4) Report reactions to medications or problems with products; (5) notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (6) notify the government authority if we believe a patient has been the victim of abuse, neglect or domestic abuse.

### **Communicable Diseases**

We may disclose your protected health information, if authorized by law, to a person who might have been exposed to a communicable disease or might otherwise be at risk of contracting or spreading the disease or condition.

### **Health Oversight**

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

### **Food and Drug Administration**

We may disclose your protected health information to a person or company required by the Food and Drug Administration to (1) report adverse events, product defects, or problems and biologic product deviations; (2) track products; (3) enable product recalls; (4) make repairs or replacement; and (5) conduct post-marketing surveillance as required.

### **Legal Proceedings**

We may disclose protected health information during any judicial or administrative proceeding, in response to a court order or administrative tribunal (if such a disclosure is expressly authorized), 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

### **Criminal Activity**

Under applicable Federal and State laws, we may disclose your protected health information if we believe that its use or disclosure is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

## **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 de termination by the Department of Veteran Affairs (V A) of eligibility for benefits; or (3 ) to a foreign military authority of 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 and our treatment facility created or received your protected health information while providing care to you. This disclosure would be necessary (1) for the institution to provide you with health care; (2) for your health and safety or the health and safety of others; or (3) for the safety and security of the correctional facility.

## **Prescription Monitoring in the State of VA**

We may use a prescription monitoring program instituted by the Drug Enforcement Agency and State of Virginia to review history of medication prescription data/information obtained from a statewide prescription database.

## **Parental Access**

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.

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

For any other activity or purpose not listed herein or as otherwise permitted by law, we must obtain your written permission (authorization) prior to using or sharing you 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.

## **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 related 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 and coordinate uses and disclosures to family or other individuals involved in your health care.

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

You may exercise the following rights by submitting a written request or electronic message to our Privacy Officer. Depending on your request, you may also have rights under the Privacy Act of 1974. The Privacy Officer can guide you in pursuing these options. Please be aware the Privacy Office might deny your request; however, you may seek a review of denial.

### **Right to Inspect and Copy**

You may inspect and obtain a copy of your protected health information that is contained in a "designated records 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.

This right does not include inspection and copying of the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. 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.

## **Right to Request Restrictions**

You may ask us not to use or disclose any part of your protected health information for treatment, payment or health care options. Your request must be made in writing to our Privacy Office where you wish the restriction instituted. Restrictions are not transferable to our other facilities, if any, unless requested by you to be throughout all of our facilities. 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.

## **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 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 are not required to agree to the amendment.

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

You may obtain a paper copy of this notice from us or view it electronically on our web site, if any, listed in the Contact Information of the Notice.

## **PRIVACY LAWS**

This Notice of Privacy Practices is provided to you as a requirement of HIPPA. There are several other privacy laws that also apply including the Freedom of Information Act, The Privacy Act, and the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act. These laws have not been superseded and have been taken into consideration on developing our policies and this notice of how we will use and disclose your protected health information.

## **COMPLAINTS**

If you believe these privacy rights have been violated, you may file a written complaint without Privacy Office or the Department of Health and Human Services. No retaliation will occur against you for filing a complaint.

## **CONTACT INFORMATION**

You may contact our Privacy Officer for further information about the complaint process, or for further explanation of this document. Our Privacy Officer may be contacted at:

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

**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*