A division of Arizona Spine and Pain Specialists, LLC

Patients' Rights and Responsibilities

At Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC our goal is to provide excellent health care to every patient. Our patients have the following rights and responsibilities regardless of race, color, culture, language, ethnicity, religion, sex, sexual orientation, gender identity or expression, socioeconomic status, age, national origin, physical or mental disability, and / or veteran status:

It is your responsibility to:

- Give correct and complete information about your health status and health history.
- Ask questions if you do not understand information or instructions.
- Inform your caregivers if you do not intend to or cannot follow the treatment plan.
- Accept health consequences that may occur if you decide to refuse treatment or instructions.
- Cooperate with your caregivers.
- Respect the rights and property of other patients.
- Tell your caregivers of any medications you take at home.
- Report any changes in your health status to your caregivers.

You have the right to:

- Respect and Privacy
  - Respect in a caring and safe environment
  - Personal privacy and confidentiality of your information
- Quality Care
  - Proper evaluation and treatment
  - Proper pain assessment and pain management
  - Be free from abuse.
  - Have access to protective services.
  - Have your concerns heard and resolved when possible
- Information & Communication
  - Know the names and roles of those caring for you.
  - Communicate with your caregivers in a language or method you can understand.
  - Be informed about your health status, recommended treatments, options, risks and benefits.
  - Information about the costs of your care and payment methods.
  - Review and receive a copy of your medical record, subject to state law and hospital policy.
- Make Decisions
  - Be involved with your care through discussions with your caregivers.
  - Be informed of benefits and risks of your treatment options and agree to or refuse a course of action.
  - Designate a support person (or persons) of your choosing to be involved in your care when appropriate.
  - Direct your care through an Advance Directive. Advance Directives are legal forms which state your choices about the care you want to receive in serious health situations. Advance Directives are also used to name someone to make decisions for you if you cannot speak for yourself. At your request, we will help you create an Advance Directive.
  - Seek an alternate doctor or ask for a second opinion.

BARBEE™
PRIMARY CARE

A division of Arizona Spine and Pain Specialists, LLC

PATIENT INFORMATION

Date ____/____/______

First Name__________________ Middle Initial__________ Last Name __________________

Date of Birth____ /___ /_____ Social Security Number ____ /___ /_____ Gender □ Male □ Female

Marital Status□ Married □ Single □ Divorced □ Separated □ Widowed

Email address:____

Address____ Apartment/Suite__________________

City______________________ State_____________ Zip Code______________

Home Phone____________________ Cell Phone____________________ Work Phone____________________

Race:____________________ Ethnicity:____________________ Primary Language:______________

Employment Status □ Employed □ Self Employed □ Unemployed □ Disabled □ Retired □ Student

Occupation____________________________ Employer____________________________________

Emergency Contact____________________________ Relation______________ Phone______________

Previous Primary Care Doctor Phone____________________

Spouse/Partner/Parent/Guardian Phone____________________

Who may we thank for referring you?____

Primary Insurance Information

Name of Insurance Company______________________________ Phone____________________

ID/Subscriber Number ______________________________ Group or Plan#____________________

Subscriber Name ______________________________ Relationship to Patient____________________

Subscriber SSN ____/___/_____ Subscriber Date of Birth ____/___/____ Subscriber Gender □ Male □ Female

Additional Insurance Information (if applicable)

Name of Insurance Company______________________________ Phone____________________

ID/Subscriber Number______________________________ Group or Plan#____________________

Subscriber Name______________________________ Relationship to Patient____________________

Subscriber SSN____/___/_____ Subscriber Date of Birth____/___/_____ Subscriber Gender □ Male □ Female

We are required to gather Pharmacy information in order to use electronic prescriptions and exchange information with your Pharmacy. By providing us with the crossroads to your Pharmacy, we will be able to send and receive refill authorizations in a more HIPPA compliant and timely manner. We will also be able to receive current medication information directly from your Pharmacy, which will eliminate your need to bring us lists or try to remember what medication and dosages you are currently taking.

Please look up on your smart phone while waiting.

Pharmacy name, address with zip code and x-streets:____

Consent to allow electronic exchange between your pharmacy and Barbee Primary Care a division of Arizona Spine and Pain Specialists, LLC:

Signature:____

Name:____ Date:_____________________________________

BARBEE™ PRIMARY + CARE
A division of Arizona Spine and Pain Specialists, LLC

Name: ____
Preferred Name:____________________Date:_____________
Birthday: __________________________Age:______________
Gender:__________Sexual Orientation __ __ __ __ __ __ __ __
Marital status:_______________________________________
Occupation:____

PRIOR SURGERIES/HOSPITALIZATIONS

____
____
____
____
____
____

MEDICAL HISTORY

____
____
____
____
____
____

CURRENT MEDICATIONS (include Non-prescription medications)

Name	Dose	Times / Day

ALLERGIES	REACTION

FAMILY HISTORY

	Age (if living)	Age (at death)	Heart Disease	Stroke	Hypertension	High Cholesterol	Diabetes	Cancer (type)	Thyroid Problem	Osteoporosis
Mother										
Father										
Maternal GM										
Maternal GF										
Paternal GM										
Paternal GF										
Brothers										
Sisters										
Children										

Name:______________________________________ Date:_____________________________________

HABITS/SOCIAL

Exercise (amount)?___________________________
Alcohol (amount)?___________________________
Tobacco?_________________________________
Packs per day?_____________________________
Number of years?___________________________
Year quit?________________________________

GYNECOLOGICAL

Method of birth control_____________________
First day of last period_____________________
# of pregnancies___________________________
# of miscarriages__________________________
# of abortions_____________________________
# of childbirths____________________________

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Diabetes	Anemia	Stroke
Hypertension	Heart Attack	Cancer (type)_____________
Pneumonia	High Cholesterol	Valley Fever
Tuberculosis	Asthma	HIV/AIDS
Hepatitis	Depression/Anxiety	Kidney Stones
Thyroid problem	Abnormal Pap ________	Other: ____________________

PLEASE CHECK IF YOU HAD ANY OF THE FOLLOWING IN THE **PAST 30 DAYS**:

Head/Eyes/Ears/Nose/Throat

____Headache
____Visual Changes
____Glasses/Contacts
____Hearing loss
____Dizziness
____Sinus/allergy problems
____Bleeding gums
____Sore throat

Respiratory

____Shortness of breath
____Cough
____Coughing up blood
____Wheezing
____Abnormal chest x-ray
Explain:________________
____

Vascular

____Varicose veins
____Deep vein thrombosis
____Pulmonary embolus

Skin

____Itching
____Rash

Gastointestinal

____Nausea/Vomiting
____Loss of appetite
____Rectal bleeding
____Difficulty swallowing
____Indigestion
____Constipation
____Diarrhea
____Abdominal pain

Genitourinary

____Frequent urination
____Blood in urine
____Decreased urination
____Frequent infection
____Incontinence
____Irregular periods
____Pelvic pain

Cardiac

____Heart murmur
____Palpitations
____Chest pain
____Feet/ankle swelling
____Abnormal EKG
Explain:________________
____

Neurological/Psychiatric

____Seizures
____Tremors
____Fainting/Dizziness
____Migraine
____Numbness
____Depression
____Anxiety
____Insomnia

Hematological

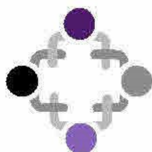
____Bleeding tendencies
____Anemia
____Previous transfusion
Explain:________________
____

Musculoskeletal

____Back pain
____Neck pain
____Muscle pain
____Joint pain/stiffness
____Tendonitis

General

____Weight loss/gain
____Fatigue
____Fevers/night sweats



COMPLETED BY:_____________________ RELATIONSHIP TO PATIENT__________________

A division of Arizona Spine and Pain Specialists, LLC

Preventive Health Questionnaire

Patient Name:____**Date:**____________

Date of Birth:________________________

1. Date of last Flu vaccination: (**6 months** & **Older)** ____________

2. Over the last 2 weeks: **(12 & Older)**

	None	**Few Days**	**>1/2 Days**	**Every Day**
I have had little interest or pleasure in doing things	______	______	______	______
I am feeling down, depressed or hopeless.	______	______	______	______

3. Do you use any form of tobacco? **(18 & Older) YES**_________ **NO** ________

4. Date and results of last Mammogram. ____________

5. Have you have had a colorectal cancer screening? (ages **50-75)** YES____ NO___

   *If yes, date of last screening: Colonoscopy: ______________ Sigmoidoscopy:_________

   Results: __________________Repeat Due: 3 yrs 5 yrs 10 yrs

6. Have you been to the Emergency Room or hospitalized for any reason within the last 30 days?

   (65 & Older) YES _______ NO______

   *If yes, list any changes to your Medications:

____

____

7. Date and type of Pneumococcal vaccination: **(65 & Older)** ____________

8. Date of Tetanus vaccination: ____________

9. Date of Shingles vaccination: **(50 & Older)** ____________

10. Date of last PAP **(Women Only):** ____________

11. Date of last Bone Density: ____________

<u>Please look up on your smart phone while waiting.</u>

Pharmacy name, address with zip code and x-streets:____

A division of Arizona Spine and Pain Specialists, LLC

Medical History and Consent for Treatment

I certify that the above information is accurate, complete, and true.

I authorize Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC will not release my Protected Health Information to any other party (including family) without my completing a written “Patient Authorization for Use and Disclosure of Protected Health Information” form, available at its facility and on its website.

I understand that data collected during assessment or treatment may be utilized for research and teaching purposes and all identifying demographic PHI will remain confidential.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested.** I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed:_________________________________Date: ____

A division of Arizona Spine and Pain Specialists, LLC

Patient Authorization for Use and Disclosure of Protected Health Information

Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC will not disclose your medical records (protected health information) to any party without your signed consent, except as stipulated in our Notice of Privacy Practices. This form authorizes Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC to release your medical records to parties indicated.

Barbee Primary Care takes your privacy seriously!

Your Name:____Date of Birth: ________________________________

Authorized Parties

By signing below, I authorize Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC, its agents and employees ("Provider"), to use and / or disclose any and all of my protected health information of any kind and description to the following party or parties ("Recipients"):

Party Relationship

____

____

____

Authorization to Disclose Protected Health Information Including HIV & AIDS Related Information

I understand that neither Provider nor Recipient may condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. In addition, I understand that Recipient may re-disclose the Records and that the Records may no longer be protected by the Federal privacy regulations.

I acknowledge and agree that the protected health information authorized to be disclosed under this Authorization may include records for drug or alcohol abuse or psychiatric illness, and records of testing, diagnosis or treatment for HIV, HIV-related diseases and communicable disease-related information.

With respect to any communicable disease-related information protected by State confidentiality rules and disclosed under this Authorization, Recipient is prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by applicable law.

Further, with respect to any drug and alcohol abuse treatment information disclosed under this Authorization, this information has been disclosed from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit the recipient of this information from making any further disclosure of this information unless further disclosure is expressly permitted by me pursuant to a separate written authorization or is otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

A division of Arizona Spine and Pain Specialists, LLC

Authorized Parties

I acknowledge that I have had the opportunity to review Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I understand I have the right to refuse to sign this authorization and that I do not have to sign this authorization to receive treatment at Barbee Primary Care, A division of Arizona Spine and Pain Specialists, LLC. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Health Insurance Portability and Accountability Act (HIPAA). I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer whose address is listed below:

Privacy Officer

Barbee Primary Care, A division of Arizona Spin and Pain Specialists, LLC

20280 N 59th AVE #115 – 617 Glendale, AZ 85308

Expiration

This Authorization will remain effective until the expiration date specified below or, if no date is set forth below, for one-year following the date of this signing, at which time this Authorization will expire. A photocopy of this Authorization will be considered effective and valid as the original.

Date authorization expires (if any): ______________________________

Signature

Signature of Patient or Legal Guardian______________________________Today's Date ____________________

Relationship to Patient ______________________________

"A division of Arizona Spine and Pain Specialists, LLC"

Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC, believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT -** is expected at the time of your visit. (This includes Copayments, Deductibles, Coinsurance, Missed Appointments, Procedure Prepayment; unpaid balance after insurance has paid their portion, Past Due, etc.). If you are unable to make a full payment Barbee Primary Care a division of Arizona Spine and Pain Specialists, LLC reserves the right to reschedule your appointment for a later time when you are able to make your full payment, (any payment due or owed at time of service). If a prepayment is made for any services and a refund is due after insurance processes, any outstanding balance on your account will be deducted before issuing your refund. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit. We do ask for a copy of an ID card or license and insurance cards.
2. **INSURANCE -** We are participating providers with several insurance plans. We will file all of these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral, prior authorization if required by your insurer and responsible for payment if your claim rejects for the lack of one.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy.

Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC only has a specific amount of time to submit a claim to your insurance carrier. If your coverage/ insurance company changes and we bill your old carrier we may miss the time limit to process the claim. In this case the claim becomes your responsibility for payment, so please notify us immediately if your coverage changes so that we can accurately submit the claims.

3. **TOXICOLOGY LAB -** In the event that I am asked to provide a urine and/or blood sample, I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested. I have the right to refuse specific tests but understand this may impact treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected within 30 days of being notified of any balance due.
4. **COLLECTION -** If you have an outstanding balance over 120 days old and have failed to make payment arrangements (or become delinquent on an existing payment plan), we may turn your balance over to a collection agency and/or an attorney, which may result in reporting to credit bureaus and/or legal action. Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC reserves the right to refuse treatment to patients with outstanding balances over 120 days old. You agree to pay Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC for any expenses we incur to collect on your account,

including attorney fees, collection fees, and contingent fees to collection agencies that can be more than 35% of the delinquent balance. Contingency fees will be added and assigned to the collection agency immediately upon our referral of your account to the collection agency of our choice. You agree that in order for us to service your account or to collect any amounts you may owe, we may contact you by phone at

any number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded voice messages and/or use of an automatic dialing device.

5. **RETURNED CHECKS -** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments or overturned chargebacks on your credit card constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Maricopa County.

6. **ACCOUNTING PRINCIPALS -** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

7. **FORMS AND CONSULTS FEES -** Completing insurance forms, copying medical records, etc... requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. On occasion, our staff may be asked to provide a deposition and/or other testimony or actions concerning your care. There is a separate fee schedule for such activity. The fees for such activity are to be paid by the patient regardless of the party requesting the activity.

8. **CANCELLATIONS OR MISSED APPOINTMENTS -** If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $25 missed appointment fee. If you do not cancel your procedure with at least 24 hours' notice, you will be assessed a $150.00 missed procedure fee. Any missed visits may result in discharge from the practice.

9. **RESPONSIBILITY FOR PAYMENT -** I understand that I, personally, am financially responsible to Barbee Primary Care, a division of Arizona Spine and Pain Specialists LLC care for charges not covered by the assignment of insurance benefits.

10. **ASSIGNMENT OF INSURANCE BENEFITS -** I hereby assign, transfer, and set over directly to Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC. I authorize Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

11. **RELEASE OF INFORMATION -** I hereby authorize and direct Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

I have read and understand the practice's financial policy of Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC and I agree to be bound by its terms. I understand that I am financially responsible for ALL services I receive from Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC. I hereby assign all medical and surgical benefits and authorize my insurance carrier (s) to issue payment directly to Barbee Primary Care, a division of Arizona Spine and Pain Specialists, LLC. This financial policy is binding upon you, your estate, executors and/or administrators, if applicable.

I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient (or Guarantor, if applicable)__________________________________**Date:**______________

Please print the name of the patient ____